AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
BOARD MEETING THAT WILL BE HELD ON:
SEPTEMBER 23, 2017, 9:00 AM
AT:
SANFORD BEMIDJI MEDICAL CENTER
1300 ANNE STREET NW
EDUCATION ROOM A&B
BEMIDJI, MN  56601

PUBLIC SESSION

President: Gerald T. Kaplan, M.A., L.P.

1. Call to Order and Roll Call

2. Minutes of the July 8, 2017, Board Meeting

3. Presentation by Lisa Johnson, BSN, RN: First Steps to Healthy Babies

4. Presentation by Gregory Roberts, MD: Compliance with Pain Management

5. Report of New Credentials, July 1, 2017 to August 31, 2017

6. August 1 and 10, 2017, Licensure Committee Reports
   a) Minutes
      ➢ August 1, 2017, Minutes
      ➢ August 10, 2017, Minutes
   b) Registered Naturopathic Doctor Advisory Council Appointment

7. August 9, 2017, Policy & Planning Committee Report
   a) Minutes
   b) Policy & Planning Committee Agenda

8. Health Professionals Services Program (HPSP) Program Committee Report

9. Federation of State Medical Boards
   a) 2018 Annual Meeting (see attached)
   b) Call for Nominations (see attached)
   c) Call for Amendment of Bylaws (see attached)

10. Executive Director’s Report

11. Executive Director’s Performance Evaluation

12. Appointment of a Nominating Committee

13. Proposed 2018 Meeting Dates

14. New Business

15. Corrective or Other Actions
# MINNESOTA BOARD OF MEDICAL PRACTICE

## ROLL CALL

**SEPTEMBER 23, 2017**

**BOARD MEETING**

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONGRESSIONAL DISTRICT</th>
<th>APPOINTMENT FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>KAPLAN, Gerald T., M.A., L.P. (President)</td>
<td>3</td>
<td>3/29/11</td>
<td>1/19</td>
</tr>
<tr>
<td>LINDHOLM, Patricia J., M.D., FAAFP (Vice President)</td>
<td>7</td>
<td>10/30/13</td>
<td>1/20</td>
</tr>
<tr>
<td>JOHNSON, Kelli, Ph.D. (Secretary)</td>
<td>4</td>
<td>3/09/10</td>
<td>1/18</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>EGGEN, Mark A., M.D.</td>
<td>4</td>
<td>4/27/09</td>
<td>1/17</td>
</tr>
<tr>
<td>ELLA, V. John, J.D.</td>
<td>5</td>
<td>3/09/10</td>
<td>1/18</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>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>RASMUSSEN, Allen G., M.A.</td>
<td>8</td>
<td>9/29/14</td>
<td>1/18</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>
</tr>
<tr>
<td>THOMAS, Jon V., M.D., M.B.A.</td>
<td>At large</td>
<td>3/09/10</td>
<td>1/18</td>
</tr>
<tr>
<td>TOWNLEY, Patrick R., M.D., J.D.</td>
<td>5</td>
<td>6/06/16</td>
<td>1/20</td>
</tr>
<tr>
<td>WILLETT, Joseph R., D.O., FACOI</td>
<td>7</td>
<td>3/29/11</td>
<td>1/19</td>
</tr>
</tbody>
</table>
DATE: September 23, 2017
SUBJECT: Approve the Minutes of the July 8, 2017, Board Meeting

SUBMITTED BY: Kelli Johnson, Ph.D., Secretary

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the minutes of the July 8, 2017, 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 July 8, 2017, at its offices in Minneapolis, Minnesota.

The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Gerald T. Kaplan, M.A., L.P., President; Patricia J. Lindholm, M.D., FAAFP; Vice President; Kelli Johnson, Ph.D., Secretary; Christopher Burkle, M.D., J.D., FCLM; Mark A. Eggen, M.D.; Irshad H. Jafri, M.B., B.S., FACP; Kathryn D. Lombardo, M.D.; William Parham, III, M.D., FACP, FCCP, Allen G. Rasmussen, M.A.; Kimberly W. Spaulding, M.D., M.P.H.; Maria K. Statton, M.D., Ph.D.; and Joseph R. Willett, D.O., FACOI.

PUBLIC SESSION

Agenda Item 1: Call to Order and Roll Call
The meeting was called to order by Board President Gerald T. Kaplan, M.A., L.P. Roll call was taken by Board staff.

Agenda Item 2: Minutes of the May 13, 2017, Board Meeting
The minutes of the May 13, 2017, Board meeting were received and approved as circulated.

Agenda Item 3: Assistant Attorney General Hans Anderson’s Presentation on Attorney General Lori Swanson’s Opioid Prevention Initiative
Assistant Attorney General Hans Anderson provided a presentation on Attorney General Lori Swanson’s Opioid Prevention Initiative Public Awareness Campaign to raise awareness about the proper use, disposal and storage of opioids.

Mr. Anderson extended an invitation from Attorney General Lori Swanson to the Board of Medical Practice to become a supporting agency for the Dose of Reality Public Awareness Campaign (https://doseofreality.mn.gov/). The website and the campaign itself were modeled after an initiative launched a couple of years ago by Wisconsin’s Attorney General Josh Shapiro. If the Board becomes a supporting agency, the Board’s logo will be added to the supporters’ page on the Dose of Reality’s website. The content of the Dose of Reality’s website is not expected to undergo significant changes. The website has been vetted by the Minnesota Attorney General’s office and the Anoka County Attorney’s office.

After Board discussion, a motion was made and passed unanimously to become a supporting agency of the Dose of Reality Public Awareness Campaign.

Executive Director Ruth Martinez, MA, presented Board members with a viable option for unused medication disposal, a biodegradable Deterra Drug deactivation bag. Medications are placed in the bag, water is added, the medications are deactivated and the bag is disposed of in the trash. The bags will be distributed at the Board’s exhibit table at the 2017 Minnesota Medical Association’s (MMA) Annual Meeting. Ms. Martinez suggested that prescribing practitioners could distribute the bags to patients when they are prescribed an opioid. Additional information will be distributed to Board members.

Agenda Item 4: June 29, 2017, Policy & Planning Committee Report
Policy & Planning Committee Chair Allen G. Rasmussen, M.A., provided an overview of the June 29, 2017, Policy & Planning Committee meeting.
1. Implementation of Mandatory Prescription Monitoring Program Registration:
   - Users noted a lack of clarity in the statutory language as to where the licensee must hold a DEA registration. Questions have been raised about whether a Minnesota Licensee with DEA registration in another state must register an account. As the statutory language is broad, licensees have been advised to register in such circumstances.
   - Maintaining a user account is necessary for the account to remain active. The user must enter the account at least once every six months to change the password and keep the account active.

2. Issues Related to the Opioid Crisis:
   - Legislative bills that were introduced in the 2017 legislative session which could be introduced in the 2018 session.
   - Attorney General’s Initiatives:
     - November 2016 report and recommendations of Attorney General Lori Swanson.
     - Proposed legislation related to the report recommendations.
     - February 2017 *Dose of Reality* campaign and website.

3. Planning for the 2018 Legislative Session:
   - Administrative Law Judge’s report as the final decision after a contested case.
   - Opioid related bills.

4. Expo 2023 – “Healthy People, Healthy Planet”
   The United States/Minnesota, was selected as a finalist following a June 2017 presentation to the General Assembly of the Bureau International des Expositions (BIE) in Paris, France. Also being considered as potential sites are Argentina/Buenos Aires and Poland/Lodz. The BIE will select the site in November 2017.

Additional Agenda Item: Request for Input Regarding the Federation of State Medical Boards’ (FSMB) Taskforce on Mandatory Use of Prescription Drug Monitoring Programs (PDMPs)

Board member Joseph R. Willett, D.O., FACOI, will attend a meeting of the FSMB’s Taskforce to Study the Impact of Mandatory PDMPs, in Washington, DC, in September 2017. The taskforce was formed in response to the Minnesota Board’s resolution submitted for consideration at the 2017 FSMB Annual Meeting. Dr. Willett solicited input from the Board to bring to the Taskforce meeting. Feedback included:

- Ease of use of the PMP is critical so it will not be burdensome for users.
- Integration of the PMP into the electronic health record would be tremendously helpful.

A representative of the MMA was not present at the Board meeting, however, Ms. Martinez is confident that they do not support mandatory PMP use.

After discussion, the Board decided to invite Minnesota’s PMP Program Director Barbara Carter to attend the August 9, 2017, Policy & Planning Committee meeting to respond to Board members’ questions and comments regarding the PMP. Ms. Carter will also be invited to a future Board meeting for a presentation to the full Board. Feedback from the Policy & Planning Committee discussion will be provided to Dr. Willett. Dr. Willett will try to attend the August Policy & Planning Committee meeting.

Agenda Item 5: Health Professionals Services Program (HPSP) Program Committee Report

HPSP Program Committee Chair and member of the HPSP Governance Work Group Allen Rasmussen provided a summary of the May 9, 2017, HPSP Program Committee Report.

The HPSP Program Committee invited members to suggest meaningful topics for discussion, such as the effects of medical cannabis on HPSP monitoring. Mr. Rasmussen and Ms. Martinez will present on Health Care Worker Burnout at the August 8, 2017, HPSP Program Committee meeting. If Board members have any suggestions for relevant and meaningful topics, please contact Mr. Rasmussen.

The HPSP Program Committee asked for a regular report on the activities of the Executive Directors (ED) Forum. Jennifer Mohlenhoff, ED Forum Chair and Executive Director of the Board of Marriage and Family Therapy, will provide regular updates to the HPSP Program Committee on behalf of the ED Forum.
Agenda Item 6: Report of New Credentials, May 2 to June 29, 2017
An informational report was provided of licenses issued on a weekly basis by Board staff between May 2 and June 29, 2017.

Agenda Item 7: Motion to Approve Physician License
The Licensure Committee made a motion to approve the physician license of applicant #1 of Board agenda item #7, contingent on receipt of all required documents and pending approval of a proposed Stipulation and Order that will be presented during Executive Session. Motion passed unanimously.

Agenda Item 8: June 8, 2017, Licensure Committee Report
Licensure Committee Chair Patricia J. Lindholm, M.D., FAAFP, summarized the Licensure Committee’s June 8, 2017, teleconference meeting.

8a: Minutes of the June 8, 2017, Licensure Committee Meeting
Dr. Lindholm presented the minutes of the June 8, 2017, Licensure Committee meeting.

Agenda Item 8b: Respiratory Therapy Advisory Council Appointment
The Licensure Committee’s motion to appoint John Boatright, Ph.D., RRT, to the Respiratory Therapy Advisory Council passed unanimously.

Agenda Item 9: September 23, 2017, Out-state Board Meeting
The Board was advised that the September 23, 2017, outstate Board meeting in Bemidji conflicts with the 2017 MMA Annual Meeting scheduled in Rochester, Minnesota on the same date. Ms. Martinez noted that the Board is exhibiting at the MMA Annual Meeting and Board staff will be present to distribute materials at the exhibit table.

The Board discussed whether it should consider an alternate Board meeting date.

After discussion and a polling of members regarding proposed alternate dates, the Board passed a motion was to keep the September 23, 2017, Board meeting date in Bemidji.

Agenda Item 10: Update on the 2018 Federation of State Medical Boards’ (FSMB) Annual Meeting
The 2018 FSMB Annual meeting will be held in North Carolina on April 26 – 29, 2018. Governor Dayton has imposed a travel restriction for all state employees or appointees to North Carolina because of North Carolina’s bathroom law, even though they have made changes to the law. Board members may be asked to attest to their interest in attending the FSMB Annual Meeting in support of a formal request for permission from Governor Dayton for Board members and staff to travel to North Carolina. Board President Kaplan and Ms. Martinez will prepare and submit a request to the Governor’s Office on behalf of the Board.

Ms. Martinez informed the Board that North Carolina is interested in hosting a reception equivalent to the Minnesota Welcome Reception. It is unclear if North Carolina is aware of Governor Dayton’s travel restriction. The FSMB asked if the Board would relinquish its slot for the Minnesota Welcome Reception at the 2017 FSMB Annual Meeting to the host state of North Carolina.

After discussion, the Board decided that, if the Board is unable to obtain permission to attend the FSMB Annual Meeting in North Carolina, the Board would allow North Carolina to use its slot to host a reception. The Board would like to continue to host a reception at future meetings and will revisit this topic at a later time.

Agenda Item 11: Executive Director’s Report
- End of Legislative Session
  On May 22, 2017, the 2017 the regular session of the Minnesota Legislature adjourned without passing state budget bills. A multi-day special session began immediately, after which budget appropriation bills were finalized, including the Health and Human Services budget bill that
includes the Health Licensing Boards (HLBs) budget appropriations. The Board received its proposed budget appropriation and an additional unsolicited appropriation, which may be recalled in the upcoming session. The Board’s budget appropriation includes increases for implementing new license types, technology costs and staff salaries. Details of other relevant bills will be discussed during the legislative report.

- Update of the Boards Automated License Information Management System (ALIMS)
  Ms. Martinez noted that the Board was authorized to move some of its budget surplus to an Odyssey fund which allows funds to carry over to the next biennium for specific IT projects. The Board has moved approximately $300,000.00 into an Odyssey fund to support an update of the Board’s ALIMS database, which is approximately 11 years old. The Board’s database has been replicated in a new updated form and is being implemented across most of the health licensing boards. The project is a multi-year project to begin in this fiscal year and continue for approximately three years. IT staff assisted the Board in approximating project costs. There are no plans to increase licensing fees to cover the ALIMS project.

- Interstate Medical Licensure Compact (IMLC) Update
  On May 22, 2017, Minnesota hosted the in-person meeting of the Interstate Medical Licensure Compact Commission (IMLCC) in St. Paul, which was well attended. The IMLCC reviewed the expedited licensing process that launched in April 2017.

  Ms. Martinez noted that Maine recently joined the IMLC as a member state. There are now 22 states in the IMLC.

A bill passed during the 2017 legislative session that modified the Medical Practice Act relating to the IMLC. The language responds to concerns raised by the FBI about how criminal background check data will be used or shared in the IMLC process. Specifically, the language assures that criminal background check data will not be shared with the IMLC Commission (IMLCC) or member states and will only be used by the Minnesota Board of Medical Practice to determine the eligibility of a licensee to participate in the IMLC. Minnesota has not yet obtained FBI approval to allow the Board to receive criminal background check data as a state of principal license. Minnesota is, however, participating as a member state in the IMLC to issue expedited licenses. Further legislation may be necessary before the Board is allowed to act as a state of principal license.

Seven of 22 member states are currently fully participating as states of principal license and member states. The Board is reviewing the statutory language in those states. The FBI has suggested that Minnesota add “expedited license” as a license type in chapter 214, which authorizes the Minnesota HLBs to require criminal background checks for new licensure applicants. The Board does not, however, require a criminal background check for an expedited license, rather, the criminal background check is required to authorize current licensees to participate in the IMLC process. It has been difficult to challenge the FBI’s conclusions. Mr. Kaplan stated that the FBI’s determination is unfortunate because the purpose of Minnesota joining the IMLC was to allow Minnesota licensees to be licensed in other jurisdictions quickly.

The IMLCC has passed an emergency rule that limits use of criminal background check data by member states and the IMLCC Executive Committee recently wrote to the FBI on behalf of all IMLC member states affirming states’ collective responsiveness to concerns raised about use of FBI criminal background check data in the IMLC process. To date, the IMLCC Executive Committee has not received a reply from the FBI. In Minnesota, the FBI communicates through the Bureau of Criminal Apprehension (BCA) and the BCA forwards the response to the Board.

The Board has issued approximately 20 expedited licenses through the IMLC as a member state. The shortest processing time of an expedited license was 35 minutes and the longest was two days. Ms. Martinez thanked Licensure Specialist Elizabeth Larson and Licensure Unit Supervisor Molly Schwanz for the terrific job they are doing in managing the IMLC applications.
Meetings & Outreach
The Board was invited to present at the 2017 Health Law Institute on June 15, 2017. Ms. Martinez and co-presenter David Aafedt facilitated a discussion on the history and trends related to opioid prescribing during their breakout session entitled, *As the Pendulum Swings, Collaborating to Curb Opioid Prescribing*. The presentation prescribing practices and the regulatory response over the past three decades. It also reviewed the practicing community’s role in establishing practice standards. It was a well-attended session and attendees, primarily attorneys representing large entities, hospitals and insurers, were very engaged in the discussion.

The Health Licensing Boards’ Executive Directors are collaborating on:
- Upcoming legislative initiatives.
- Policy issues.
- Technology Projects.
- Health Professional Services Program (HPSP) Participation Agreement/forms and renewal questions related to illness on Board renewal application forms.

HPSP’s Participation Agreement has recently been revised to be more user friendly and more legally sound in terms of what information can be shared between HPSP and the Boards. Ms. Martinez thanked the Attorney General’s Office (AGO), particularly Greg Schaefer, who worked closely with HPSP on the new Participation Agreement.

The HPSP Participation Agreement and release forms have not been updated for several years. Board members will receive copies of the HPSP Participation Agreement as soon as it is available.

Licensing Processes:
- Genetic Counselor
  On July 3, genetic counselor application materials were posted on the Board’s website. Ms. Martinez thanked Ms. Schwanz for preparing the applications forms and instructions, and Mark Chu for his assistance in posting the forms on the website.
  The Board anticipates it will process more than 100 genetic counselor applications between July 1, 2017 and January 1, 2018.
- Prescription Monitoring Program (PMP) Mandatory Registration
  PMP mandatory registration went into effect July 1, 2017. The Board has received many calls with questions similar to those discussed by the Board.
  The executive directors of the Health Licensing Boards (HLB) that have mandatory registrants are working together and with the Attorney General’s office to develop consistent procedures for enforcement of compliance.

Staff Performance Evaluations
All performance evaluations for staff have been completed.

New Staff Members
Ms. Martinez welcomed Kathryn Van Etta-Olson, J.D., and Laurie Hanrahan to the Board. Kate joined the staff on May 31, 2017, as the new Legal Analyst and Laurie joined the staff on June 2 as the new Office Manager. Both bring great experience to their positions. Ms. Van Etta-Olson was in attendance at the Board meeting and was introduced to the Board. Ms. Hanrahan was unable to attend.

Legislative Report
SF 482/HF 632
A bill for an act relating to health licensing; clarifying title protection and grounds for disciplinary action; making technical changes; amending Minnesota Statutes 2016, sections 147.081; 147.091, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 147.
This is the Board’s housekeeping bill.

The bill passed and was signed by Governor Dayton on May 17, 2017. Effective August 1, 2017.

SF 300/HF 474
Medical Practice Board criminal background checks authorized and physicians exempted from criminal background checks under the Interstate Medical Licensure Compact.

This is a bill with technical amendments to the Medical Practice Act to address concerns raised by the FBI regarding the use of criminal background check data for the purpose of licensure through the Interstate Medical Licensure Compact.

The bill passed and was signed by Governor Dayton on May 12, 2017. Effective the day following enactment.

The FBI has not yet granted approval.

SF 815/HF 959
A bill for an act relating to health licensing; making the medical faculty license permanent; repealing Minnesota Statutes 2016, section 147.0375, subdivision 7.

This bill removed the sunset date from the Medical Faculty License section of the Medical Practice Act.

The bill passed and was signed by Governor Dayton on May 23, 2017. Effective the day following enactment.

There have been four medical faculty licenses processed to date and they are all from Mayo. Although, the Medical Faculty License is for any teaching hospital in Minnesota.

SF 1353/HF 1314
A bill for an act relating to health occupations; establishing requirements for the practice of telemedicine; proposing coding for new law in Minnesota Statutes, Chapter 147.

At the March 11, 2017 Board meeting, the Board discussed its concern that placement of a comma allows for an interpretation that “interactive audio only constitutes telemedicine – as opposed to “interactive audio and visual communication” in combination. The Board opposes placement of the comma and objects to an interpretation that audio-only communication is considered telemedicine. The Board believes that removal of the comma creates a less ambiguous description of acceptable telemedicine communication.

The Board’s concerns were communicated to the legislature, but the comma was not removed and the bill passed. Ms. Martinez will monitor this statute to see if it creates any problems.

S.F. No. 1844/ HF 2177
A bill for an act relating to health and human services; adding advanced practice registered nurses and physician assistants to certain statutes; amending Minnesota Statutes 2016 sections 62Q.56, subdivision 1a; 144.213, subdivision 1; 144.441, subdivision 3; 145.867, subdivision 2; 252A.21, subdivision 2; 256.9365, subdivision 2; 256B.056, subdivision 2; 256B.057, subdivision 9; 256B.0653, subdivision 4; 256B.15, subdivision 1a; 256D.44, subdivisions 4, 5; 514.981, subdivision 2; 626.556, subdivision 11d.

This bill gives advanced practice registered nurses and physician assistants the authority to sign certain documents and forms that must currently be signed by a physician. The Board did not oppose this bill.

The bill passed and went into effect on May 17, 2017.
SF 527/HF 733
A bill for an act relating to health occupations; modifying the nurse practices act; clarifying licensure requirements for advanced practice registered nurses; amending Minnesota Statutes 2016, section 148.171, subdivision 76, by adding a subdivision; 148.211, subdivisions 1a, 1c, repealing Minnesota Statutes 2016, sections 148.211, subdivision 1b; 148.243m subdivision 15.

This bill allows advanced practice nurses coming into Minnesota from other states to have their collaborative relationship with a non-Minnesota physician.

The bill passed. The Board supported the bill. Ms. Martinez thanked the Board on behalf of the Board of Nursing.

Additional Agenda Item: Dr. Day Comments to the Board
Dr. Day was allowed to address the Board.

Dr. Day addressed the Board about his Stipulation and Order and his interactions with the Board and the Attorney General’s office representing the Board.

Agenda Item 12: New Business
- Diagnostic Error Community Dialogue
  Ms. Martinez stated that the Board has been a participant in the Diagnostic Error Community Dialogue group for quite some time. The group has recently sent a notice, which was forwarded to Board members prior to the Board meeting, asking if the Board wants to opt out or stay in as a noted participant of the group. Ms. Martinez believes that it a worthwhile group, the work they do is important, and the projects are appropriate and reasonable. Ms. Martinez feels comfortable with the Board being identified as a participant in the group. The Board agreed.

- Federation Duty to Report
  Also distributed to Board members prior to the Board meeting was the Federation Duty to Report which is for Board member information.

Agenda Item 13: Corrective or Other Actions
The corrective and other actions were presented for Board information only.

Mr. Kaplan adjourned the public session of the Board.
The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Gerald T. Kaplan, M.A., L.P., President; Patricia J. Lindholm, M.D., FAAFP; Vice President; Kelli Johnson, Ph.D., Secretary; Christopher Burkle, M.D., J.D., FCLM; Mark A. Eggen, M.D.; Irshad H. Jafri, M.B., B.S., FACP; Kathryn D. Lombardo, M.D.; William Parham, Ill, M.D., FACP, FCCP, Allen G. Rasmussen, M.A.; Kimberly W. Spaulding, M.D., M.P.H.; Maria K. Statton, M.D., Ph.D.; and Joseph R. Willett, D.O., FACOI.

MATTHEW P. BOENTE, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for indefinite suspension signed by Dr. Boente. Dr. Parham recused.

TIMOTHY L. BURKE, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license.

NATHANIA K. HAMMEL, D.O.
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for indefinite suspension signed by Dr. Hammel.

KARLA R. JUVONEN, P.A.
On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license.

KEVIN A. KIMM, D.O.
On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license.

GAYLE C. LEEN, P.A.
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for stayed suspension, reprimand and conditioned and restricted license signed by Ms. Leen.

BLAIR A. NELSON, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for stayed suspension, conditioned and restricted license signed by Dr. Nelson.

DEBORAH M. NOWAK, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for stayed suspension, conditioned and restricted license signed by Dr. Nowak.

ROXANEE E. PIERRE, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for reprimand and conditioned license signed by Dr. Pierre.

MEGHABHUTI ROTH, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license.

DR. ANCA I. ZAMFiRESCU
On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for reprimand and conditioned license signed by Dr. Zamfirescu.

There being no further business, the meeting was adjourned.

Kelli Johnson, Ph.D.
Secretary
MN Board of Medical Practice

September 12, 2017
Date
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:
For information only

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

BACKGROUND:

Lisa Johnson, BSN, RN, Director of Women’s and Children’s Services at the Sanford Bemidji Medical Center will provide a presentation on *First Steps to Healthy Babies*. Ms. Johnson will provide an overview of Neonatal Abstinence Syndrome and treatment of opioid addiction in pregnancy.
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:
For information only

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

BACKGROUND:

Gregory Roberts, M.D. is a family practice physician at the Sanford Bemidji Medical Center. Dr. Roberts will provide a presentation on *Pain Management Compliance*.
DATE: September 23, 2017

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 July 1, 2017 to August 31, 2017.
## Minnesota Board of Medical Practice
### New Credential Summary in July and August 2017

**License Type:** IMLC Physician & Surgeon

<table>
<thead>
<tr>
<th>Name</th>
<th>License #</th>
<th>Date</th>
<th>Grant Date</th>
<th>Expire Date</th>
<th>SPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siddiqi, Nauman Ahmed M.B., B.S.</td>
<td>62661</td>
<td>7/10/2017</td>
<td>7/11/2017</td>
<td>1/31/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Makkuni, Premraj M.B.</td>
<td>62660</td>
<td>7/1/2017</td>
<td>7/13/2017</td>
<td>3/31/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Fedge, Alan Kenneth M.D.</td>
<td>62698</td>
<td>7/17/2017</td>
<td>7/17/2017</td>
<td>3/31/2018</td>
<td>IA</td>
</tr>
<tr>
<td>Moore, Kevin Leon M.D.</td>
<td>62697</td>
<td>7/14/2017</td>
<td>7/17/2017</td>
<td>9/30/2018</td>
<td>IA</td>
</tr>
<tr>
<td>Eimermann, Heidi Marie M.D.</td>
<td>62699</td>
<td>7/18/2017</td>
<td>7/18/2017</td>
<td>8/31/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Vaisman, Uri M.D.</td>
<td>62700</td>
<td>7/18/2017</td>
<td>7/18/2017</td>
<td>3/31/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Omari, Bashar A M.B., B.S.</td>
<td>62701</td>
<td>7/19/2017</td>
<td>7/19/2017</td>
<td>7/31/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Simonenko, Iouri Ivanovich</td>
<td>62738</td>
<td>7/24/2017</td>
<td>7/26/2017</td>
<td>11/30/2018</td>
<td>KS</td>
</tr>
<tr>
<td>McRae, Gina Alexandra M.D.</td>
<td>62774</td>
<td>7/26/2017</td>
<td>7/27/2017</td>
<td>1/31/2018</td>
<td>AL</td>
</tr>
<tr>
<td>Villareal, Alexander Marcario</td>
<td>62775</td>
<td>7/28/2017</td>
<td>7/31/2017</td>
<td>6/30/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Kewalramani, Ashok Chetan D.O.</td>
<td>62802</td>
<td>8/2/2017</td>
<td>8/4/2017</td>
<td>7/31/2018</td>
<td>IA</td>
</tr>
<tr>
<td>Clarke, Gregory Dresel M.D.</td>
<td>62804</td>
<td>8/9/2017</td>
<td>8/10/2017</td>
<td>9/30/2018</td>
<td>WV</td>
</tr>
<tr>
<td>Ahmed, Atif Umair M.D.</td>
<td>62842</td>
<td>8/1/2017</td>
<td>8/10/2017</td>
<td>11/30/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Munnerlyn, Kenneth Arcedrick M.D.</td>
<td>62803</td>
<td>7/31/2017</td>
<td>8/10/2017</td>
<td>2/28/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Grassi, Michael George</td>
<td>62868</td>
<td>8/22/2017</td>
<td>8/24/2017</td>
<td>6/30/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Stone, James Robert</td>
<td>62887</td>
<td>8/25/2017</td>
<td>8/25/2017</td>
<td>1/31/2018</td>
<td>IA</td>
</tr>
</tbody>
</table>
# Minnesota Board of Medical Practice
## New Credential Summary for 07/06/2017

**License Type:** Physician and Surgeon

<table>
<thead>
<tr>
<th>Name</th>
<th>License #</th>
<th>Expire Date</th>
<th>Seq #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al Badri, Osamah Taher Abdulhameed M.B., Ch.B.</td>
<td>62463</td>
<td>02/28/2018</td>
<td>1</td>
</tr>
<tr>
<td>Andrews, Jack Rogers M.D.</td>
<td>62464</td>
<td>11/30/2018</td>
<td>2</td>
</tr>
<tr>
<td>Aung, Khin Nyein Chan M.B., B.S.</td>
<td>62465</td>
<td>06/30/2018</td>
<td>3</td>
</tr>
<tr>
<td>Ballard, Thomas William M.D.</td>
<td>62466</td>
<td>11/30/2018</td>
<td>4</td>
</tr>
<tr>
<td>Barclay, Eta Queen M.D.</td>
<td>62467</td>
<td>10/31/2018</td>
<td>5</td>
</tr>
<tr>
<td>Barras, Laurel Ann M.D.</td>
<td>62468</td>
<td>09/30/2018</td>
<td>6</td>
</tr>
<tr>
<td>Barreto Siqueira Parrilha Terra, Simone</td>
<td>62469</td>
<td>10/31/2018</td>
<td>7</td>
</tr>
<tr>
<td>Bartels, Douglas William M.D.</td>
<td>62470</td>
<td>05/31/2018</td>
<td>8</td>
</tr>
<tr>
<td>Bartlett, David Joseph M.D.</td>
<td>62471</td>
<td>11/30/2018</td>
<td>9</td>
</tr>
<tr>
<td>Bastyr, Emily R D.O.</td>
<td>62472</td>
<td>05/31/2018</td>
<td>10</td>
</tr>
<tr>
<td>Beckman, Olivia Hwa M.D.</td>
<td>40634</td>
<td>02/28/2018</td>
<td>11</td>
</tr>
<tr>
<td>Bennett, Elizabeth Emily M.D.</td>
<td>62473</td>
<td>01/31/2018</td>
<td>12</td>
</tr>
<tr>
<td>Bettini, Layne Mauro M.D.</td>
<td>62474</td>
<td>05/31/2018</td>
<td>13</td>
</tr>
<tr>
<td>Bhatia, Subir M.D.</td>
<td>62475</td>
<td>04/30/2018</td>
<td>14</td>
</tr>
<tr>
<td>Bole, Raevti M.D.</td>
<td>62476</td>
<td>03/31/2018</td>
<td>15</td>
</tr>
<tr>
<td>Bonura, Erica Danielle M.D.</td>
<td>62477</td>
<td>11/30/2018</td>
<td>16</td>
</tr>
<tr>
<td>Boswell, Timothy Charles M.D.</td>
<td>62478</td>
<td>05/31/2018</td>
<td>17</td>
</tr>
<tr>
<td>Braga Neto, Manuel Bonfim M.D.</td>
<td>62479</td>
<td>08/31/2018</td>
<td>18</td>
</tr>
<tr>
<td>Brinkman, Beth Diane M.D.</td>
<td>62480</td>
<td>02/28/2018</td>
<td>19</td>
</tr>
<tr>
<td>Brower, Ryan Floyd M.D.</td>
<td>62481</td>
<td>10/31/2018</td>
<td>20</td>
</tr>
<tr>
<td>Byrne, David Michael</td>
<td>62482</td>
<td>10/31/2018</td>
<td>21</td>
</tr>
<tr>
<td>Carlstrom, Lucas Paul M.D.</td>
<td>62483</td>
<td>01/31/2018</td>
<td>22</td>
</tr>
<tr>
<td>Chamberland, Cree Dorann M.D.</td>
<td>62484</td>
<td>10/31/2018</td>
<td>23</td>
</tr>
<tr>
<td>Chao, Stephen Alwi M.D.</td>
<td>62485</td>
<td>04/30/2018</td>
<td>24</td>
</tr>
<tr>
<td>Chen, Alicia M.D.</td>
<td>62486</td>
<td>09/30/2018</td>
<td>25</td>
</tr>
<tr>
<td>Chen, Chieh-Yu M.D.</td>
<td>62487</td>
<td>08/31/2018</td>
<td>26</td>
</tr>
<tr>
<td>Childs, Christopher Stephen M.D.</td>
<td>62488</td>
<td>10/31/2018</td>
<td>27</td>
</tr>
<tr>
<td>Cho, Janice Me-Hyun M.D.</td>
<td>62489</td>
<td>10/31/2018</td>
<td>28</td>
</tr>
<tr>
<td>Chodnicki, Kevin Daniel M.D.</td>
<td>62490</td>
<td>09/30/2018</td>
<td>29</td>
</tr>
<tr>
<td>Christoffel, Kelsey Elizabeth M.D.</td>
<td>62491</td>
<td>12/31/2017</td>
<td>30</td>
</tr>
<tr>
<td>Clark, Jennifer Elizabeth M.D.</td>
<td>62492</td>
<td>11/30/2018</td>
<td>31</td>
</tr>
<tr>
<td>Clark, Leah Margaret M.D.</td>
<td>62493</td>
<td>04/30/2018</td>
<td>32</td>
</tr>
<tr>
<td>Clarke, Nathan Hughes M.D.</td>
<td>62494</td>
<td>05/31/2018</td>
<td>33</td>
</tr>
<tr>
<td>Coffey, Caitrin Margaret M.D.</td>
<td>62495</td>
<td>10/31/2018</td>
<td>34</td>
</tr>
<tr>
<td>Cohen, Devon Ashley M.D.</td>
<td>62496</td>
<td>02/28/2018</td>
<td>35</td>
</tr>
<tr>
<td>Colbenson, Cheryl Myra Lynn D.O.</td>
<td>62497</td>
<td>10/31/2018</td>
<td>36</td>
</tr>
<tr>
<td>Contreras, Nicolas M.D.</td>
<td>62498</td>
<td>02/28/2018</td>
<td>37</td>
</tr>
<tr>
<td>Cordes, Mitchel Fredrick M.D.</td>
<td>62499</td>
<td>11/30/2018</td>
<td>38</td>
</tr>
<tr>
<td>Cox, Benjamin Caleb M.D.</td>
<td>62500</td>
<td>11/30/2018</td>
<td>39</td>
</tr>
<tr>
<td>Crenshaw, Yvonka Deleice M.D.</td>
<td>62501</td>
<td>04/30/2018</td>
<td>40</td>
</tr>
<tr>
<td>D'souza, Ryan Steven M.D.</td>
<td>62502</td>
<td>12/31/2017</td>
<td>41</td>
</tr>
<tr>
<td>Davies, Becky Sue M.D.</td>
<td>62503</td>
<td>04/30/2018</td>
<td>42</td>
</tr>
<tr>
<td>Davis, Paul Richard M.D.</td>
<td>62504</td>
<td>07/31/2018</td>
<td>43</td>
</tr>
<tr>
<td>De La Fuente, Jaime M.D.</td>
<td>62505</td>
<td>09/30/2018</td>
<td>44</td>
</tr>
<tr>
<td>Denbo, Jason William M.D.</td>
<td>62506</td>
<td>04/30/2018</td>
<td>45</td>
</tr>
<tr>
<td>DeVries, Anthony Hans M.D.</td>
<td>62507</td>
<td>11/30/2018</td>
<td>46</td>
</tr>
<tr>
<td>Dey, Jacob Klein M.D.</td>
<td>62508</td>
<td>03/31/2018</td>
<td>47</td>
</tr>
<tr>
<td>Dilger, Benjamin Thomas M.D.</td>
<td>62509</td>
<td>09/30/2018</td>
<td>48</td>
</tr>
<tr>
<td>Ducharme-Smith, Allison Lynn M.D.</td>
<td>62510</td>
<td>05/31/2018</td>
<td>49</td>
</tr>
<tr>
<td>Duethman, Nicholas Clayton M.D.</td>
<td>62511</td>
<td>09/30/2018</td>
<td>50</td>
</tr>
</tbody>
</table>
Minnesota Board of Medical Practice
New Credential Summary for 07/06/2017

<table>
<thead>
<tr>
<th>Name</th>
<th>License Type: Physician and Surgeon</th>
<th>License #</th>
<th>Expire Date</th>
<th>Seq #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elliott, Abigail Krin M.D.</td>
<td>62512</td>
<td>07/31/2018</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Erickson, Stephanie Lynn M.D.</td>
<td>62513</td>
<td>10/31/2018</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Fang, Hong M.B.</td>
<td>62514</td>
<td>04/30/2018</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Farrell, Michael Shane D.O.</td>
<td>62515</td>
<td>05/31/2018</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Feist, Elizabeth Anne M.D.</td>
<td>62516</td>
<td>05/31/2018</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Feng, Steven Li-Yang M.D.</td>
<td>62517</td>
<td>10/31/2018</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Finch, Alexander Stuart M.D.</td>
<td>62518</td>
<td>03/31/2018</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Fondell, Nathaniel Anderson M.D.</td>
<td>62519</td>
<td>05/31/2018</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Franssen Canovas, Bernardo M.D.</td>
<td>62520</td>
<td>11/30/2018</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Gaertner, Michele Marie M.D.</td>
<td>62521</td>
<td>05/31/2018</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Garda, Allison Elizabeth M.D.</td>
<td>62522</td>
<td>05/31/2018</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Gast, Kelly Catherine M.D.</td>
<td>62523</td>
<td>11/30/2018</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Gerke, Benjamin Taylor M.D.</td>
<td>62524</td>
<td>02/28/2018</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Gits, Alexandra Ann M.D.</td>
<td>62525</td>
<td>04/30/2018</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Goldman, Joseph Douglas D.O.</td>
<td>62526</td>
<td>10/31/2018</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Gonzalez Juarrero, Alexandra Beatriz M.D.</td>
<td>62527</td>
<td>01/31/2018</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Gunn, Jordan Matthew M.D.</td>
<td>62528</td>
<td>06/30/2018</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Haggerty, Brielle Joy M.D.</td>
<td>62529</td>
<td>05/31/2018</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Hanhan, Eric Tolga M.D.</td>
<td>62530</td>
<td>07/31/2018</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Harper, Laura Kelly M.D.</td>
<td>62531</td>
<td>03/31/2018</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Harper, Lauren Shiaoiling Pan M.D.</td>
<td>62532</td>
<td>04/30/2018</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Hebert, Brielle Madeline M.D.</td>
<td>62533</td>
<td>07/31/2018</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Hebert, Kevin Joseph M.D.</td>
<td>62534</td>
<td>04/30/2018</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Hegland, Robyn Ivy M.D.</td>
<td>62535</td>
<td>02/28/2018</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Heitmiller, Dwayne R. M.D.</td>
<td>62536</td>
<td>12/31/2017</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Herberts, Michelle Beth M.D.</td>
<td>62537</td>
<td>01/31/2018</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Hevesi, Mario M.D.</td>
<td>62538</td>
<td>07/31/2018</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Hicks, Stephen Bradley M.D.</td>
<td>62539</td>
<td>05/31/2018</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Hill, James Cordell M.D.</td>
<td>62540</td>
<td>03/31/2018</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Hill, Larisa Jean Nordstrom M.D.</td>
<td>62541</td>
<td>08/31/2018</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Hilliebrand, Elizabeth Marie M.D.</td>
<td>62542</td>
<td>05/31/2018</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>Ho, Ivana M.D.</td>
<td>62543</td>
<td>03/31/2018</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Hoversten, Katherine Patricia M.D.</td>
<td>62544</td>
<td>04/30/2018</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Hsu, Adam Jeremy M.D.</td>
<td>62545</td>
<td>02/28/2018</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>Huang, Jeffrey M.D.</td>
<td>62546</td>
<td>03/31/2018</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Idossa, Dame Wedajo M.D.</td>
<td>62547</td>
<td>09/30/2018</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>Jackson, Lauren Marie Jones M.D.</td>
<td>62548</td>
<td>06/30/2018</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Jacobi, Jaclyn Elyse M.D.</td>
<td>62549</td>
<td>04/30/2018</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Johnson, Katie Lynn M.D.</td>
<td>62550</td>
<td>03/31/2018</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Johnson, Kimberly Rene M.D.</td>
<td>62551</td>
<td>07/31/2018</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Johnson, Stephen Abraham M.D.</td>
<td>62552</td>
<td>01/31/2018</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Kamboj, Amrit Kamal M.D.</td>
<td>62553</td>
<td>07/31/2018</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Kappes, Amy Lynn D.O.</td>
<td>62554</td>
<td>01/31/2018</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>Kapurch, Caitlin Joanna M.D.</td>
<td>62555</td>
<td>07/31/2018</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Kaszuba, Megan Christine M.D.</td>
<td>62556</td>
<td>03/31/2018</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Keleshian, Vasken Leon M.D.</td>
<td>62557</td>
<td>01/31/2018</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Kellund, Anna Elizabeth M.D.</td>
<td>62558</td>
<td>05/31/2018</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Khan, Zaki Hussain MB, BS</td>
<td>62559</td>
<td>03/31/2018</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>Kilgore, Khin Pyae E M.D.</td>
<td>62560</td>
<td>03/31/2018</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Kim, Sharon Jee Yong M.D.</td>
<td>62561</td>
<td>11/30/2018</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Physician and Surgeon</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>King, Amanda Nicole M.D.</td>
<td></td>
<td>62562</td>
<td>11/30/2018</td>
<td>101</td>
</tr>
<tr>
<td>Klassen, Aaron Bradley M.D.</td>
<td></td>
<td>62563</td>
<td>03/31/2018</td>
<td>102</td>
</tr>
<tr>
<td>Klemmetsen, Shiela Marie M.D.</td>
<td></td>
<td>62564</td>
<td>05/31/2018</td>
<td>103</td>
</tr>
<tr>
<td>Kropko, Joshua Samuel D.O.</td>
<td></td>
<td>62565</td>
<td>10/31/2018</td>
<td>104</td>
</tr>
<tr>
<td>Lane, Kathleen Pladson M.D.</td>
<td></td>
<td>62566</td>
<td>05/31/2018</td>
<td>105</td>
</tr>
<tr>
<td>Larson, Daniel Philip M.D.</td>
<td></td>
<td>62567</td>
<td>09/30/2018</td>
<td>106</td>
</tr>
<tr>
<td>Larson, David Paul M.D.</td>
<td></td>
<td>62568</td>
<td>02/28/2018</td>
<td>107</td>
</tr>
<tr>
<td>Larson, David Paul M.D.</td>
<td></td>
<td>62568</td>
<td>02/28/2018</td>
<td>107</td>
</tr>
<tr>
<td>Larson, Kathryn Farni M.D.</td>
<td></td>
<td>62569</td>
<td>02/28/2018</td>
<td>108</td>
</tr>
<tr>
<td>Leafblad, Nels Daniel M.D.</td>
<td></td>
<td>62570</td>
<td>10/31/2018</td>
<td>109</td>
</tr>
<tr>
<td>Leoz Callizo, Guillermo</td>
<td></td>
<td>62571</td>
<td>06/30/2018</td>
<td>110</td>
</tr>
<tr>
<td>Lewis, Lorelii Odland M.D.</td>
<td></td>
<td>62572</td>
<td>11/30/2018</td>
<td>111</td>
</tr>
<tr>
<td>Liao, Dan</td>
<td></td>
<td>62573</td>
<td>11/30/2018</td>
<td>112</td>
</tr>
<tr>
<td>Lloyd, James Wesley M.D.</td>
<td></td>
<td>62574</td>
<td>06/30/2018</td>
<td>113</td>
</tr>
<tr>
<td>Lovik, Kimberly Kay M.D.</td>
<td></td>
<td>62575</td>
<td>09/30/2018</td>
<td>114</td>
</tr>
<tr>
<td>Low, Christopher Matthew M.D.</td>
<td></td>
<td>62576</td>
<td>11/30/2018</td>
<td>115</td>
</tr>
<tr>
<td>Luettmer, Marianne Teresa M.D.</td>
<td></td>
<td>62577</td>
<td>12/31/2017</td>
<td>116</td>
</tr>
<tr>
<td>Maass, Zachary James D.O.</td>
<td></td>
<td>62578</td>
<td>10/31/2018</td>
<td>117</td>
</tr>
<tr>
<td>Makhlouf, Ahmed T.M.B., B.Ch.</td>
<td></td>
<td>62579</td>
<td>03/31/2018</td>
<td>118</td>
</tr>
<tr>
<td>Markota, Matej M.D.</td>
<td></td>
<td>62580</td>
<td>03/31/2018</td>
<td>119</td>
</tr>
<tr>
<td>Martinson, Carin Marie M.D.</td>
<td></td>
<td>62581</td>
<td>04/30/2018</td>
<td>120</td>
</tr>
<tr>
<td>May, Matthew Monte M.D.</td>
<td></td>
<td>62582</td>
<td>09/30/2018</td>
<td>121</td>
</tr>
<tr>
<td>McThenia, Sheila Stafford M.D.</td>
<td></td>
<td>62583</td>
<td>10/31/2018</td>
<td>122</td>
</tr>
<tr>
<td>Mehta, Kabir M.B., B.S.</td>
<td></td>
<td>62584</td>
<td>08/31/2018</td>
<td>123</td>
</tr>
<tr>
<td>Miller, Keith Andrew M.D.</td>
<td></td>
<td>62585</td>
<td>08/31/2018</td>
<td>124</td>
</tr>
<tr>
<td>Mitchell, Scott Archer M.D.</td>
<td></td>
<td>62586</td>
<td>02/28/2018</td>
<td>125</td>
</tr>
<tr>
<td>Moore, Kyle Von D.O.</td>
<td></td>
<td>62587</td>
<td>01/31/2018</td>
<td>126</td>
</tr>
<tr>
<td>Moors, Courtney Elizabeth M.D.</td>
<td></td>
<td>62588</td>
<td>05/31/2018</td>
<td>127</td>
</tr>
<tr>
<td>Mugu, Vamshi Krishna M.D.</td>
<td></td>
<td>62589</td>
<td>02/28/2018</td>
<td>128</td>
</tr>
<tr>
<td>Murphy, Shane Peter</td>
<td></td>
<td>62590</td>
<td>02/28/2018</td>
<td>129</td>
</tr>
<tr>
<td>Muthuvel, Gajanthan M.D.</td>
<td></td>
<td>62591</td>
<td>08/31/2018</td>
<td>130</td>
</tr>
<tr>
<td>Nagarajan, Priya Veda D.O.</td>
<td></td>
<td>62592</td>
<td>05/31/2018</td>
<td>131</td>
</tr>
<tr>
<td>Neil, Randy Keith M.D.</td>
<td></td>
<td>62593</td>
<td>04/30/2018</td>
<td>132</td>
</tr>
<tr>
<td>Nelson, Mark L M.D.</td>
<td></td>
<td>62594</td>
<td>04/30/2018</td>
<td>133</td>
</tr>
<tr>
<td>Nelson, Sean Everett M.D.</td>
<td></td>
<td>62595</td>
<td>01/31/2018</td>
<td>134</td>
</tr>
<tr>
<td>Nesvick, Cody Lee M.D.</td>
<td></td>
<td>62596</td>
<td>08/31/2018</td>
<td>135</td>
</tr>
<tr>
<td>Ngaw, Samantha Min Min M.D.</td>
<td></td>
<td>62597</td>
<td>01/31/2018</td>
<td>136</td>
</tr>
<tr>
<td>Niaz, Talha M.B., B.S.</td>
<td></td>
<td>62598</td>
<td>06/30/2018</td>
<td>137</td>
</tr>
<tr>
<td>Nichol, Heidi Renae M.D.</td>
<td></td>
<td>62599</td>
<td>03/31/2018</td>
<td>138</td>
</tr>
<tr>
<td>Oblizajek, Nicholas Richard M.D.</td>
<td></td>
<td>62600</td>
<td>04/30/2018</td>
<td>139</td>
</tr>
<tr>
<td>Olen, Jessica May M.D.</td>
<td></td>
<td>62601</td>
<td>01/31/2018</td>
<td>140</td>
</tr>
<tr>
<td>Orme, Jacob Jennings M.D.</td>
<td></td>
<td>62602</td>
<td>11/30/2018</td>
<td>141</td>
</tr>
<tr>
<td>Ortiz, Liza Milagros M.D.</td>
<td></td>
<td>62603</td>
<td>10/31/2018</td>
<td>142</td>
</tr>
<tr>
<td>Pajot, Gregory Joseph M.D.</td>
<td></td>
<td>62604</td>
<td>07/31/2018</td>
<td>143</td>
</tr>
<tr>
<td>Peterson, Lynne Schmid M.D.</td>
<td></td>
<td>34504</td>
<td>11/30/2018</td>
<td>144</td>
</tr>
<tr>
<td>Pitcher, Grayson Sigurd M.D.</td>
<td></td>
<td>62605</td>
<td>05/31/2018</td>
<td>145</td>
</tr>
<tr>
<td>Pope, Matthew Charles M.D.</td>
<td></td>
<td>62606</td>
<td>03/31/2018</td>
<td>146</td>
</tr>
<tr>
<td>Powers, John Michael M.D.</td>
<td></td>
<td>62607</td>
<td>01/31/2018</td>
<td>147</td>
</tr>
<tr>
<td>Rainer, William Gerald III D.O.</td>
<td></td>
<td>62608</td>
<td>04/30/2018</td>
<td>148</td>
</tr>
<tr>
<td>Ramsey, Lonzale Jr. M.D.</td>
<td></td>
<td>62609</td>
<td>07/31/2018</td>
<td>149</td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Ravi , Praful Kumar</td>
<td>MB BChir</td>
<td>62610</td>
<td>10/31/2018</td>
<td>150</td>
</tr>
<tr>
<td>Reiland , Matthew David</td>
<td>M.D.</td>
<td>62611</td>
<td>05/31/2018</td>
<td>151</td>
</tr>
<tr>
<td>Reynolds , Grace</td>
<td>M.D.</td>
<td>62612</td>
<td>07/31/2018</td>
<td>152</td>
</tr>
<tr>
<td>Reynolds , Jacob Daniel</td>
<td>M.D.</td>
<td>62613</td>
<td>09/30/2018</td>
<td>153</td>
</tr>
<tr>
<td>Sangtani , Ajleeta</td>
<td>M.D.</td>
<td>62614</td>
<td>04/30/2018</td>
<td>154</td>
</tr>
<tr>
<td>Schmugge , Michelle Rose</td>
<td>M.D.</td>
<td>62615</td>
<td>11/30/2018</td>
<td>155</td>
</tr>
<tr>
<td>Schuh , Allison Ruth</td>
<td>M.D.</td>
<td>62616</td>
<td>01/31/2018</td>
<td>156</td>
</tr>
<tr>
<td>Schumacher , Steven Michael</td>
<td>M.D.</td>
<td>62617</td>
<td>01/31/2018</td>
<td>157</td>
</tr>
<tr>
<td>Shafi , Reem Mohamed Abdel</td>
<td>M.B., M.S.</td>
<td>62618</td>
<td>07/31/2018</td>
<td>158</td>
</tr>
<tr>
<td>Shen , Stephanie</td>
<td>M.D.</td>
<td>62619</td>
<td>01/31/2018</td>
<td>159</td>
</tr>
<tr>
<td>Shoib , Irsa</td>
<td>M.D.</td>
<td>62620</td>
<td>09/30/2018</td>
<td>160</td>
</tr>
<tr>
<td>Slostad , Brody Dean</td>
<td>M.D.</td>
<td>62621</td>
<td>09/30/2018</td>
<td>161</td>
</tr>
<tr>
<td>Slostad , Jessica Anne</td>
<td>M.D.</td>
<td>62622</td>
<td>07/31/2018</td>
<td>162</td>
</tr>
<tr>
<td>Smith , Kelsey Marie</td>
<td>M.D.</td>
<td>62623</td>
<td>10/31/2018</td>
<td>163</td>
</tr>
<tr>
<td>Sorenson , Carl Robert</td>
<td>M.D.</td>
<td>62624</td>
<td>09/30/2018</td>
<td>164</td>
</tr>
<tr>
<td>Stageberg , Elaine Laco</td>
<td>M.D.</td>
<td>62625</td>
<td>04/30/2018</td>
<td>165</td>
</tr>
<tr>
<td>Suarez Pardo , Laura</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summerfield , Daniel Darrell</td>
<td>M.D.</td>
<td>62627</td>
<td>12/31/2017</td>
<td>167</td>
</tr>
<tr>
<td>Szuber , Natasha Christina</td>
<td>M.D.</td>
<td>62628</td>
<td>10/31/2018</td>
<td>168</td>
</tr>
<tr>
<td>Talaat , Sherine</td>
<td>M.D.</td>
<td>62629</td>
<td>01/31/2018</td>
<td>169</td>
</tr>
<tr>
<td>Talley , Heather Nicole</td>
<td>M.D.</td>
<td>62630</td>
<td>08/31/2018</td>
<td>170</td>
</tr>
<tr>
<td>Taylor , Sabrina</td>
<td>M.D.</td>
<td>62631</td>
<td>12/31/2017</td>
<td>171</td>
</tr>
<tr>
<td>Thalji , Nassir Maath Ahmad</td>
<td>MB BChir</td>
<td>62632</td>
<td>03/31/2018</td>
<td>172</td>
</tr>
<tr>
<td>Tibbo , Meagan Elizabeth</td>
<td>M.D.</td>
<td>62633</td>
<td>12/31/2017</td>
<td>173</td>
</tr>
<tr>
<td>Tomov , Marko Nikolov</td>
<td>M.D.</td>
<td>62634</td>
<td>07/31/2018</td>
<td>174</td>
</tr>
<tr>
<td>Traylor , Michael Donovan Jr.</td>
<td>M.D.</td>
<td>62635</td>
<td>07/31/2018</td>
<td>175</td>
</tr>
<tr>
<td>Tschauhtscher , Craig Franz</td>
<td>M.D.</td>
<td>62636</td>
<td>03/31/2018</td>
<td>176</td>
</tr>
<tr>
<td>Tschauhtscher , Marcella Ali</td>
<td>M.D.</td>
<td>62637</td>
<td>12/31/2017</td>
<td>177</td>
</tr>
<tr>
<td>Vahidi , Shifteh</td>
<td>M.D.</td>
<td>62638</td>
<td>10/31/2018</td>
<td>178</td>
</tr>
<tr>
<td>Verma , Kundan Raj</td>
<td>M.D.</td>
<td>62639</td>
<td>04/30/2018</td>
<td>179</td>
</tr>
<tr>
<td>Voelkel , Jacob Eugene</td>
<td>M.D.</td>
<td>62640</td>
<td>06/30/2018</td>
<td>180</td>
</tr>
<tr>
<td>Vohs , Jacob Edward</td>
<td>D.O.</td>
<td>62641</td>
<td>04/30/2018</td>
<td>181</td>
</tr>
<tr>
<td>Von Drehle , Casey Telder</td>
<td>D.O.</td>
<td>62642</td>
<td>06/30/2018</td>
<td>182</td>
</tr>
<tr>
<td>Vu , Trang Ngoc Diem</td>
<td>M.D.</td>
<td>62643</td>
<td>08/31/2018</td>
<td>183</td>
</tr>
<tr>
<td>Wahlquist , Trevor Charles</td>
<td>M.D.</td>
<td>62644</td>
<td>08/31/2018</td>
<td>184</td>
</tr>
<tr>
<td>Weber , Jaimi Lynn</td>
<td>D.O.</td>
<td>62645</td>
<td>04/30/2018</td>
<td>185</td>
</tr>
<tr>
<td>Weil , Erika Layne</td>
<td>M.D.</td>
<td>62646</td>
<td>11/30/2018</td>
<td>186</td>
</tr>
<tr>
<td>Wilson , Jessica Ann</td>
<td>M.D.</td>
<td>62647</td>
<td>03/31/2018</td>
<td>187</td>
</tr>
<tr>
<td>Woge , Matthew James</td>
<td>M.D.</td>
<td>62648</td>
<td>01/31/2018</td>
<td>188</td>
</tr>
<tr>
<td>Wong , Hailin Tan</td>
<td>M.D.</td>
<td>62649</td>
<td>08/31/2018</td>
<td>189</td>
</tr>
<tr>
<td>Woods , Charonn Donte'</td>
<td>M.D.</td>
<td>62650</td>
<td>02/28/2018</td>
<td>190</td>
</tr>
<tr>
<td>Woolley , Joseph Coburn</td>
<td>D.O.</td>
<td>62651</td>
<td>08/31/2018</td>
<td>191</td>
</tr>
<tr>
<td>Wyles , Cody Clayton</td>
<td>M.D.</td>
<td>62652</td>
<td>07/31/2018</td>
<td>192</td>
</tr>
<tr>
<td>Wymer , Kevin Michael</td>
<td>M.D.</td>
<td>62653</td>
<td>10/31/2018</td>
<td>193</td>
</tr>
<tr>
<td>Xu , Chao Ying</td>
<td>M.D.</td>
<td>62654</td>
<td>11/30/2018</td>
<td>194</td>
</tr>
<tr>
<td>Zandvakili , Inuk</td>
<td>M.D.</td>
<td>62655</td>
<td>11/30/2018</td>
<td>195</td>
</tr>
<tr>
<td>Zhang , Catherine Dani</td>
<td>M.D.</td>
<td>62656</td>
<td>04/30/2018</td>
<td>196</td>
</tr>
<tr>
<td>Zhang , Xiaotun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zhao , Fang</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zietlow , John Michael</td>
<td>M.D.</td>
<td>62659</td>
<td>05/31/2018</td>
<td>199</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------</td>
<td>----------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Horn, Allen Leo M.D. (Emeritus)</td>
<td>20473</td>
<td>05/31/2017</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Johnson, Daniel Anton M.D. (Emeritus)</td>
<td>16957</td>
<td>06/30/2017</td>
<td>201</td>
<td></td>
</tr>
</tbody>
</table>
## Minnesota Board of Medical Practice
New Credential Summary for 07/06/2017

<table>
<thead>
<tr>
<th>Name</th>
<th>License Type</th>
<th>License #</th>
<th>Expire Date</th>
<th>Seq #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haptonstahl, Heidi Jo M.OM</td>
<td>Acupuncturist</td>
<td>1855</td>
<td>06/30/2018</td>
<td>202</td>
</tr>
<tr>
<td>Petersen, Rebecca Marie M.AC</td>
<td></td>
<td>1856</td>
<td>06/30/2018</td>
<td>203</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Benjamin, Tucker J</td>
<td>2968</td>
<td>06/30/2018</td>
<td>204</td>
<td></td>
</tr>
<tr>
<td>DeKanick, Amanda Marie</td>
<td>2969</td>
<td>06/30/2018</td>
<td>205</td>
<td></td>
</tr>
<tr>
<td>Heyward, Makaylah Deanna</td>
<td>2970</td>
<td>06/30/2018</td>
<td>206</td>
<td></td>
</tr>
<tr>
<td>Mallinger, Matthew Lee</td>
<td>2971</td>
<td>06/30/2018</td>
<td>207</td>
<td></td>
</tr>
<tr>
<td>Nemes, Candice Mae</td>
<td>2972</td>
<td>06/30/2018</td>
<td>208</td>
<td></td>
</tr>
<tr>
<td>Olson, Alexandra JoAnne</td>
<td>2973</td>
<td>06/30/2018</td>
<td>209</td>
<td></td>
</tr>
<tr>
<td>Olson, Julia Elinor</td>
<td>2974</td>
<td>06/30/2018</td>
<td>210</td>
<td></td>
</tr>
<tr>
<td>Welch, Sara Rose</td>
<td>2975</td>
<td>06/30/2018</td>
<td>211</td>
<td></td>
</tr>
</tbody>
</table>
**Name** | **License Type:** Physician Assistant | **License #** | **Expire Date** | **Seq #**
---|---|---|---|---
Beuchler, Benjamin  | MSPA | 12443 | 06/30/2018 | 212
Burgstahler, Laura Lee  | MSPA | 12444 | 06/30/2018 | 213
Butler, Michael Steven  | MSPA | 12445 | 06/30/2018 | 214
Cropp, Mariah Rae  | MSPA | 12446 | 06/30/2018 | 215
Grindal, Erik Haakon  | MSPA | 12447 | 06/30/2018 | 216
Hodny, Jennifer Lea  | MSPA | 12448 | 06/30/2018 | 217
Jacobson, Marcus Philip  | MSPA | 12449 | 06/30/2018 | 218
Lewis, Reginald Demond  | MSPA | 12450 | 06/30/2018 | 219
Luell, Amy Jolene  | MSPA | 12451 | 06/30/2018 | 220
Michalski, Amanda Marilyn  | MSPA | 12452 | 06/30/2018 | 221
Misstishin, Lee Ann  | MSPA | 12453 | 06/30/2018 | 222
Ramler, Jenna Laurel  | MSPA | 12454 | 06/30/2018 | 223
Sadowy, Alison Marie  | MSPA | 12455 | 06/30/2018 | 224
Sroda, Ciarra Marie  | MSPA | 12456 | 06/30/2018 | 225
Minnesota Board of Medical Practice
New Credential Summary for 07/06/2017

<table>
<thead>
<tr>
<th>Name</th>
<th>License Type: Respiratory Therapist</th>
<th>License #</th>
<th>Expire Date</th>
<th>Seq #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giddens , Daniel Benjamin</td>
<td>BS</td>
<td>4475</td>
<td>06/30/2018</td>
<td>226</td>
</tr>
<tr>
<td>Gruen , Samantha Rae</td>
<td>AAS</td>
<td>4476</td>
<td>06/30/2018</td>
<td>227</td>
</tr>
<tr>
<td>Johnson , Donald Robert</td>
<td>AAS</td>
<td>4477</td>
<td>06/30/2018</td>
<td>228</td>
</tr>
<tr>
<td>Johnson , Kate Lynn</td>
<td>AAS</td>
<td>4478</td>
<td>06/30/2018</td>
<td>229</td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Nelson, Blair Allen M.D.</td>
<td>Physician and Surgeon</td>
<td>43550</td>
<td>06/30/2018</td>
<td>1</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Physician and Surgeon</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Bonetti, Renee Wittendorfer M.D.</td>
<td></td>
<td>62662</td>
<td>05/31/2018</td>
<td>1</td>
</tr>
<tr>
<td>Caplan, Murray Frederick M.D.</td>
<td></td>
<td>62663</td>
<td>04/30/2018</td>
<td>2</td>
</tr>
<tr>
<td>Cassano, Charvi Ashok M.D.</td>
<td></td>
<td>62664</td>
<td>04/30/2018</td>
<td>3</td>
</tr>
<tr>
<td>Christopoulos, Georgios</td>
<td></td>
<td>62665</td>
<td>05/31/2018</td>
<td>4</td>
</tr>
<tr>
<td>Davis, Drew Bennett M.D.</td>
<td></td>
<td>62666</td>
<td>07/31/2018</td>
<td>5</td>
</tr>
<tr>
<td>Donovan, Sheila Kathleen M.D.</td>
<td></td>
<td>62667</td>
<td>09/30/2018</td>
<td>6</td>
</tr>
<tr>
<td>Dornfeld, Bradleigh Jill</td>
<td></td>
<td>62668</td>
<td>07/31/2018</td>
<td>7</td>
</tr>
<tr>
<td>Dudo, James Edward</td>
<td></td>
<td>62669</td>
<td>12/31/2017</td>
<td>8</td>
</tr>
<tr>
<td>Ebner, Derek Wayne M.D.</td>
<td></td>
<td>62670</td>
<td>02/28/2018</td>
<td>9</td>
</tr>
<tr>
<td>Eckmann, Jason David M.D.</td>
<td></td>
<td>62671</td>
<td>03/31/2018</td>
<td>10</td>
</tr>
<tr>
<td>Elleby, Eric Christian M.D.</td>
<td></td>
<td>62672</td>
<td>05/31/2018</td>
<td>11</td>
</tr>
<tr>
<td>Emmel, John Paul M.D.</td>
<td></td>
<td>62673</td>
<td>11/30/2018</td>
<td>12</td>
</tr>
<tr>
<td>Goenka, Naila M.B., B.S.</td>
<td></td>
<td>62674</td>
<td>10/31/2018</td>
<td>13</td>
</tr>
<tr>
<td>Hassan, Mohamed Basil M.D.</td>
<td></td>
<td>62675</td>
<td>04/30/2018</td>
<td>14</td>
</tr>
<tr>
<td>Hu, Marie M.D.</td>
<td></td>
<td>62676</td>
<td>03/31/2018</td>
<td>15</td>
</tr>
<tr>
<td>Inda, Jacob James M.D.</td>
<td></td>
<td>62677</td>
<td>07/31/2018</td>
<td>16</td>
</tr>
<tr>
<td>Johnson, Charles Edward M.D.</td>
<td></td>
<td>62678</td>
<td>12/31/2017</td>
<td>17</td>
</tr>
<tr>
<td>Karth, Peter Alan M.D.</td>
<td></td>
<td>62679</td>
<td>05/31/2018</td>
<td>18</td>
</tr>
<tr>
<td>Knutson, Andrew Paul M.D.</td>
<td></td>
<td>62680</td>
<td>02/28/2018</td>
<td>19</td>
</tr>
<tr>
<td>Lee, Kyoung Ho</td>
<td></td>
<td>62681</td>
<td>12/31/2017</td>
<td>20</td>
</tr>
<tr>
<td>Linatoc, Julie Ann Tan M.D.</td>
<td></td>
<td>62682</td>
<td>07/31/2018</td>
<td>21</td>
</tr>
<tr>
<td>McNiven, Elizabeth Marie Sproat M.D.</td>
<td></td>
<td>62683</td>
<td>03/31/2018</td>
<td>22</td>
</tr>
<tr>
<td>Melugin, Heath Philip M.D.</td>
<td></td>
<td>62684</td>
<td>01/31/2018</td>
<td>23</td>
</tr>
<tr>
<td>Miller, Heather Lauren M.D.</td>
<td></td>
<td>62685</td>
<td>03/31/2018</td>
<td>24</td>
</tr>
<tr>
<td>Mohamed, Ahmed Abdullahi M.D.</td>
<td></td>
<td>62686</td>
<td>04/30/2018</td>
<td>25</td>
</tr>
<tr>
<td>Murray, Ann Margaret M.D.</td>
<td></td>
<td>62687</td>
<td>11/30/2018</td>
<td>26</td>
</tr>
<tr>
<td>Nash, Richard Gene M.D.</td>
<td></td>
<td>23608</td>
<td>12/31/2017</td>
<td>27</td>
</tr>
<tr>
<td>Riemer, Christie Anna M.D.</td>
<td></td>
<td>62688</td>
<td>08/31/2018</td>
<td>28</td>
</tr>
<tr>
<td>Rogers, Julie Marie Glasscock M.D.</td>
<td></td>
<td>62689</td>
<td>06/30/2018</td>
<td>29</td>
</tr>
<tr>
<td>Ryan, Samantha Morley M.D.</td>
<td></td>
<td>62690</td>
<td>07/31/2018</td>
<td>30</td>
</tr>
<tr>
<td>Salim, Fardows Omar M.D.</td>
<td></td>
<td>62691</td>
<td>05/31/2018</td>
<td>31</td>
</tr>
<tr>
<td>Shoo, Brenda Aika M.D.</td>
<td></td>
<td>62692</td>
<td>10/31/2018</td>
<td>32</td>
</tr>
<tr>
<td>Susa, Jesse John M.D.</td>
<td></td>
<td>62693</td>
<td>02/28/2018</td>
<td>33</td>
</tr>
<tr>
<td>Sutton, Elizabeth M.D.</td>
<td></td>
<td>62694</td>
<td>03/31/2018</td>
<td>34</td>
</tr>
<tr>
<td>Usmani, Nadeem M.B., B.S.</td>
<td></td>
<td>62695</td>
<td>05/31/2018</td>
<td>35</td>
</tr>
<tr>
<td>Zheng, Danielle M.D.</td>
<td></td>
<td>62696</td>
<td>01/31/2018</td>
<td>36</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Respiratory Therapist</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Acker, Christopher Thomas</td>
<td>BS</td>
<td>4479</td>
<td>06/30/2018</td>
<td>46</td>
</tr>
<tr>
<td>Amsden, Taylor Lee</td>
<td>AAS</td>
<td>4480</td>
<td>06/30/2018</td>
<td>47</td>
</tr>
<tr>
<td>Dabadji, Jonathan Anael</td>
<td>BS</td>
<td>4481</td>
<td>06/30/2018</td>
<td>48</td>
</tr>
<tr>
<td>Jensen, Lori J</td>
<td>AAS</td>
<td>4482</td>
<td>06/30/2018</td>
<td>49</td>
</tr>
<tr>
<td>Kaithoff, Karl Anna</td>
<td>BS</td>
<td>4483</td>
<td>06/30/2018</td>
<td>50</td>
</tr>
<tr>
<td>Rose, Stacey Roxanne</td>
<td>AAS</td>
<td>4484</td>
<td>06/30/2018</td>
<td>51</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Kirchmeier, Morgan Marie</td>
<td>2976</td>
<td>06/30/2018</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Miles, Mekenna Marie</td>
<td>2977</td>
<td>06/30/2018</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Mulder, Evan Richard</td>
<td>2978</td>
<td>06/30/2018</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Olson, Andrew Jacob</td>
<td>2979</td>
<td>06/30/2018</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Sattler, Aaron John</td>
<td>2980</td>
<td>06/30/2018</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Schelling, Kassidy Connie</td>
<td>2981</td>
<td>06/30/2018</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Smith, Mikala Ruth</td>
<td>2982</td>
<td>06/30/2018</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Alcaraz, Cristina M.D.</td>
<td>62702</td>
<td>09/30/2018</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bodnia, Elizabeth Ann D.O.</td>
<td>62703</td>
<td>12/31/2017</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Bohn, Oksana Alexandra Goldman M.D.</td>
<td>62704</td>
<td>01/31/2018</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Burns, Samuel Tucker M.D.</td>
<td>62705</td>
<td>02/28/2018</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Ceremuga, George Allen M.D.</td>
<td>62706</td>
<td>09/30/2018</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Conboy, Caitlin Borelli-Martin M.D.</td>
<td>62707</td>
<td>07/31/2018</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Dombovy-Johnson, Marissa Lynne M.D.</td>
<td>62708</td>
<td>06/30/2018</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Dowling, Eric Michael M.D.</td>
<td>62709</td>
<td>11/30/2018</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Ellis, Joshua Charles M.D.</td>
<td>62710</td>
<td>03/31/2018</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Fader, Ryan Robert M.D.</td>
<td>62711</td>
<td>09/30/2018</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Ho, Aaron K M.D.</td>
<td>62712</td>
<td>02/28/2018</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Hoover, Ruth Durand M.D.</td>
<td>62713</td>
<td>05/31/2018</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Hoversten, Patrick Scott M.D.</td>
<td>62714</td>
<td>08/31/2018</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Jarnot, Nathan Anton M.D.</td>
<td>62715</td>
<td>01/31/2018</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Kruse, Katherine Elizabeth M.D.</td>
<td>62716</td>
<td>01/31/2018</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Lai, Kenneth Ethan M.D.</td>
<td>62717</td>
<td>12/31/2017</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>McMurray, Nathan Stewart M.D.</td>
<td>62718</td>
<td>03/31/2018</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Nilan, Laura Michelle D.O.</td>
<td>62719</td>
<td>01/31/2018</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Obi, Chike Uchenna Anthony M.D.</td>
<td>62720</td>
<td>12/31/2017</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Odeke, Sylvester M.B., B.Ch.</td>
<td>62721</td>
<td>12/31/2017</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Paris, Patti Anne M.D.</td>
<td>62722</td>
<td>09/30/2018</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Quale, MacKenzie Glee Kalis M.D.</td>
<td>62723</td>
<td>04/30/2018</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Richter, Michael David M.D.</td>
<td>62724</td>
<td>12/31/2017</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Roberts, Traci Arnette M.D.</td>
<td>62725</td>
<td>06/30/2018</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Robin, Ryan Michael M.D.</td>
<td>62726</td>
<td>08/31/2018</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Sayeed, Yusef M.D.</td>
<td>62727</td>
<td>08/31/2018</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Stay, Jessica Lynn M.D.</td>
<td>62728</td>
<td>03/31/2018</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Stewart, Cory Michael M.D.</td>
<td>62729</td>
<td>08/31/2018</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Tayal, Amit M.B., B.S.</td>
<td>62730</td>
<td>10/31/2018</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Titone, Alexandra D.O.</td>
<td>62731</td>
<td>01/31/2018</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Viscuse, Paul Vincent M.D.</td>
<td>62732</td>
<td>09/30/2018</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Vogels, Ellen Delores D.O.</td>
<td>62733</td>
<td>04/30/2018</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Willette, Jennifer Ann Lueth M.D.</td>
<td>62734</td>
<td>10/31/2018</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Williams, Lindsay Nicole M.D.</td>
<td>62735</td>
<td>04/30/2018</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Williams, Sandra Faye M.D.</td>
<td>62736</td>
<td>01/31/2018</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Wood, Robert Miguel M.D.</td>
<td>62737</td>
<td>08/31/2018</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Physician Assistant</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Backer, Elliot Daniel MSPA</td>
<td>12466</td>
<td>06/30/2018</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Berry, Kevin Alan MSPA</td>
<td>12467</td>
<td>06/30/2018</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Bjelland, Kathryn Nicole MSPA</td>
<td>12468</td>
<td>06/30/2018</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Johnson, Lauren Ann MSPA</td>
<td>12469</td>
<td>06/30/2018</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Pippi, Eric Joseph MSPA</td>
<td>12470</td>
<td>06/30/2018</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Suarez, Sarah Catheran MSPA</td>
<td>12471</td>
<td>06/30/2018</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Respiratory Therapist</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Forster, MiKaela Carol BS</td>
<td></td>
<td>4485</td>
<td>06/30/2018</td>
<td>43</td>
</tr>
<tr>
<td>Guptill, Josie Kay BS</td>
<td></td>
<td>4486</td>
<td>06/30/2018</td>
<td>44</td>
</tr>
<tr>
<td>Hoots, Jason Gussa BS</td>
<td></td>
<td>4487</td>
<td>06/30/2018</td>
<td>45</td>
</tr>
<tr>
<td>Kautzman, Brian James BS</td>
<td></td>
<td>4488</td>
<td>06/30/2018</td>
<td>46</td>
</tr>
<tr>
<td>Schouweiler, Andreah Lynn BS</td>
<td></td>
<td>4489</td>
<td>06/30/2018</td>
<td>47</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Athletic Trainer</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Bachofen , Sara Beth</td>
<td>NATA Intern</td>
<td>2983</td>
<td>06/30/2018</td>
<td>48</td>
</tr>
<tr>
<td>Breyer , Hayley Catherine</td>
<td>NATA Approved</td>
<td>2984</td>
<td>06/30/2018</td>
<td>49</td>
</tr>
<tr>
<td>Dewald , Evan Michael</td>
<td>NATA Approved</td>
<td>2985</td>
<td>06/30/2018</td>
<td>50</td>
</tr>
<tr>
<td>Hansen , Megan Elizabeth</td>
<td>NATA Approved</td>
<td>2986</td>
<td>06/30/2018</td>
<td>51</td>
</tr>
<tr>
<td>Heacox , Hannah Grace</td>
<td>NATA Approved</td>
<td>2987</td>
<td>06/30/2018</td>
<td>52</td>
</tr>
<tr>
<td>Higgins , Anna Rosina</td>
<td>NATA Approved</td>
<td>2988</td>
<td>06/30/2018</td>
<td>53</td>
</tr>
<tr>
<td>Jacob , Emily Jean</td>
<td>NATA Approved</td>
<td>2989</td>
<td>06/30/2018</td>
<td>54</td>
</tr>
<tr>
<td>Mazzola , Rachel Ann</td>
<td>NATA Approved</td>
<td>2990</td>
<td>06/30/2018</td>
<td>55</td>
</tr>
<tr>
<td>Olsen , Morgan Laux</td>
<td>NATA Approved</td>
<td>2991</td>
<td>06/30/2018</td>
<td>56</td>
</tr>
<tr>
<td>Poling , Connor Mark</td>
<td>NATA Approved</td>
<td>2992</td>
<td>06/30/2018</td>
<td>57</td>
</tr>
<tr>
<td>Schouten , Matthew Lesley</td>
<td>NATA Approved</td>
<td>2993</td>
<td>06/30/2018</td>
<td>58</td>
</tr>
<tr>
<td>Schulz , Gabriel Nathan</td>
<td>NATA Approved</td>
<td>2994</td>
<td>06/30/2018</td>
<td>59</td>
</tr>
<tr>
<td>Spooner , Bridget Mary</td>
<td>NATA Approved</td>
<td>2995</td>
<td>06/30/2018</td>
<td>60</td>
</tr>
<tr>
<td>Name</td>
<td>License Type:</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Calva, Jason Joseph</td>
<td>Acupuncturist</td>
<td>1857</td>
<td>06/30/2018</td>
<td>61</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seg #</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Betts, Tavniah Leigh</td>
<td>1064</td>
<td>06/30/2018</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Physician and Surgeon</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Bagameri, Gabor</td>
<td></td>
<td>62739</td>
<td>07/31/2018</td>
<td>1</td>
</tr>
<tr>
<td>Chadha, Ryan Mukes M.D.</td>
<td></td>
<td>62740</td>
<td>06/30/2018</td>
<td>2</td>
</tr>
<tr>
<td>Corman, Adam Ransford M.D.</td>
<td></td>
<td>62741</td>
<td>09/30/2018</td>
<td>3</td>
</tr>
<tr>
<td>Cunningham, Grace M.D.</td>
<td></td>
<td>62742</td>
<td>04/30/2018</td>
<td>4</td>
</tr>
<tr>
<td>Dinani, Aliraza M.D.</td>
<td></td>
<td>62743</td>
<td>08/31/2018</td>
<td>5</td>
</tr>
<tr>
<td>Dugani, Chandrasagar M.D.</td>
<td></td>
<td>62744</td>
<td>06/30/2018</td>
<td>6</td>
</tr>
<tr>
<td>Dyer, Spencer C. M.D.</td>
<td></td>
<td>62745</td>
<td>12/31/2017</td>
<td>7</td>
</tr>
<tr>
<td>Erickson, Gregory Arthur M.D.</td>
<td></td>
<td>62746</td>
<td>01/31/2018</td>
<td>8</td>
</tr>
<tr>
<td>Ganick, Samantha Jaimee M.D.</td>
<td></td>
<td>62747</td>
<td>03/31/2018</td>
<td>9</td>
</tr>
<tr>
<td>Gaster, Emily Elizabeth M.D.</td>
<td></td>
<td>62748</td>
<td>07/31/2018</td>
<td>10</td>
</tr>
<tr>
<td>Higgins, Alexandra Shea M.D.</td>
<td></td>
<td>62749</td>
<td>12/31/2017</td>
<td>11</td>
</tr>
<tr>
<td>Holaday, Kristopher Wayne M.D.</td>
<td></td>
<td>62750</td>
<td>11/30/2018</td>
<td>12</td>
</tr>
<tr>
<td>Johnson, Daniel Steven D.O.</td>
<td></td>
<td>62751</td>
<td>01/31/2018</td>
<td>13</td>
</tr>
<tr>
<td>Johnson, Shelby Elizabeth M.D.</td>
<td></td>
<td>62752</td>
<td>03/31/2018</td>
<td>14</td>
</tr>
<tr>
<td>Jurgens, Andrea Michelle M.D.</td>
<td></td>
<td>62753</td>
<td>12/31/2017</td>
<td>15</td>
</tr>
<tr>
<td>Milshteyn, Michael M.D.</td>
<td></td>
<td>62754</td>
<td>12/31/2017</td>
<td>16</td>
</tr>
<tr>
<td>Ng, Brandon Clifford M.D.</td>
<td></td>
<td>62755</td>
<td>05/31/2018</td>
<td>17</td>
</tr>
<tr>
<td>Nookala, Anupama Upadhyaya M.D.</td>
<td></td>
<td>62756</td>
<td>02/28/2018</td>
<td>18</td>
</tr>
<tr>
<td>Ojukwu, Frederick Obiora M.D.</td>
<td></td>
<td>62757</td>
<td>06/30/2018</td>
<td>19</td>
</tr>
<tr>
<td>Piovezani Ramos, Guilherme</td>
<td></td>
<td>62758</td>
<td>03/31/2018</td>
<td>20</td>
</tr>
<tr>
<td>Prisco, Sasha Zheng M.D.</td>
<td></td>
<td>62759</td>
<td>04/30/2018</td>
<td>21</td>
</tr>
<tr>
<td>Roberts, Erin Elizabeth M.D.</td>
<td></td>
<td>62760</td>
<td>09/30/2018</td>
<td>22</td>
</tr>
<tr>
<td>Sahni, Deshdeepak M.D.</td>
<td></td>
<td>62761</td>
<td>06/30/2018</td>
<td>23</td>
</tr>
<tr>
<td>Shittu, Shefiu Olanrewaju M.B., B.S.</td>
<td></td>
<td>62762</td>
<td>09/30/2018</td>
<td>24</td>
</tr>
<tr>
<td>Stoltz, Steven Michael M.D.</td>
<td></td>
<td>62763</td>
<td>09/30/2018</td>
<td>25</td>
</tr>
<tr>
<td>Stutz, Amber Marie M.D.</td>
<td></td>
<td>62764</td>
<td>02/28/2018</td>
<td>26</td>
</tr>
<tr>
<td>Subat, Yosuf Waid M.D.</td>
<td></td>
<td>62765</td>
<td>02/28/2018</td>
<td>27</td>
</tr>
<tr>
<td>Sully, Keziah Antoinett M.D.</td>
<td></td>
<td>62766</td>
<td>10/31/2018</td>
<td>28</td>
</tr>
<tr>
<td>Swenson, Casey Tad M.D.</td>
<td></td>
<td>46875</td>
<td>05/31/2018</td>
<td>29</td>
</tr>
<tr>
<td>Syed, Junaid Ali M.B., B.S.</td>
<td></td>
<td>62767</td>
<td>10/31/2018</td>
<td>30</td>
</tr>
<tr>
<td>Tetyuk, Natalia</td>
<td></td>
<td>62768</td>
<td>10/31/2018</td>
<td>31</td>
</tr>
<tr>
<td>Tsogmo, Calvin</td>
<td></td>
<td>62769</td>
<td>09/30/2018</td>
<td>32</td>
</tr>
<tr>
<td>Vela Aquino, Marcelo Fernando</td>
<td></td>
<td>62770</td>
<td>05/31/2018</td>
<td>33</td>
</tr>
<tr>
<td>Waite, Bruce Kevin D.O.</td>
<td></td>
<td>62771</td>
<td>09/30/2018</td>
<td>34</td>
</tr>
<tr>
<td>Wilson, Joy Denise M.D.</td>
<td></td>
<td>62772</td>
<td>02/28/2018</td>
<td>35</td>
</tr>
<tr>
<td>Zoller, Isaac David M.D.</td>
<td></td>
<td>62773</td>
<td>03/31/2018</td>
<td>36</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Physician Assistant</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Bedard, Marie Jean</td>
<td>MSPA</td>
<td>12472</td>
<td>06/30/2018</td>
<td>37</td>
</tr>
<tr>
<td>Jenson, Michael John</td>
<td>MSPA</td>
<td>12473</td>
<td>06/30/2018</td>
<td>38</td>
</tr>
<tr>
<td>Jones, Ronald Eugene</td>
<td>MSPA</td>
<td>12474</td>
<td>06/30/2018</td>
<td>39</td>
</tr>
<tr>
<td>Larson, Alissa Lan</td>
<td>MSPA</td>
<td>12475</td>
<td>06/30/2018</td>
<td>40</td>
</tr>
<tr>
<td>Rezac, Julie Anne</td>
<td>MSPA</td>
<td>12476</td>
<td>06/30/2018</td>
<td>41</td>
</tr>
<tr>
<td>Sivanich, Ashley Lauren</td>
<td>MSPA</td>
<td>12477</td>
<td>06/30/2018</td>
<td>42</td>
</tr>
<tr>
<td>Vang, Soua</td>
<td>MSPA</td>
<td>12478</td>
<td>06/30/2018</td>
<td>43</td>
</tr>
<tr>
<td>Ward, Caitlin Bennett</td>
<td>MSPA</td>
<td>12479</td>
<td>06/30/2018</td>
<td>44</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seg #</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Kunsal, Tenzin Cert Res Care</td>
<td>4490</td>
<td>06/30/2018</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Neal, Mathew Dwane AS</td>
<td>4491</td>
<td>06/30/2018</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Sadiq, Ahmednoor Haji AAS</td>
<td>4492</td>
<td>06/30/2018</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Thienes, Raven Lee AAS</td>
<td>4493</td>
<td>06/30/2018</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Wermske, Megan JoLynn AAS</td>
<td>4494</td>
<td>06/30/2018</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Busanich, Brian Martin</td>
<td>NATA Approved</td>
<td>2996</td>
<td>06/30/2018</td>
<td>50</td>
</tr>
<tr>
<td>Gomer, Brock James</td>
<td>NATA Approved</td>
<td>2997</td>
<td>06/30/2018</td>
<td>51</td>
</tr>
<tr>
<td>Lechner, Kelsey Marie</td>
<td>NATA Approved</td>
<td>2998</td>
<td>06/30/2018</td>
<td>52</td>
</tr>
<tr>
<td>Timgren, Joseph Daniel</td>
<td>NATA Approved</td>
<td>2999</td>
<td>06/30/2018</td>
<td>53</td>
</tr>
<tr>
<td>Walters, Bethany Anne</td>
<td>NATA Approved</td>
<td>3000</td>
<td>06/30/2018</td>
<td>54</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Physician and Surgeon</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Alkuwaiti, Mohammed Hamad M.D.</td>
<td></td>
<td>62776</td>
<td>07/31/2018</td>
<td>1</td>
</tr>
<tr>
<td>Buckarma, Eeeln M.D.</td>
<td></td>
<td>62777</td>
<td>05/31/2018</td>
<td>2</td>
</tr>
<tr>
<td>Campbell, Maura Lynne M.D.</td>
<td></td>
<td>62778</td>
<td>11/30/2018</td>
<td>3</td>
</tr>
<tr>
<td>Dumitrascu, Catalina Ioana M.D.</td>
<td></td>
<td>62779</td>
<td>04/30/2018</td>
<td>4</td>
</tr>
<tr>
<td>Espinosa, Amy Jeanne D.O.</td>
<td></td>
<td>62780</td>
<td>01/31/2018</td>
<td>5</td>
</tr>
<tr>
<td>Hammond, Tara Broyard M.D.</td>
<td></td>
<td>62781</td>
<td>03/31/2018</td>
<td>6</td>
</tr>
<tr>
<td>Inklab, Mahakit M.D.</td>
<td></td>
<td>62782</td>
<td>05/31/2018</td>
<td>7</td>
</tr>
<tr>
<td>Karalus, Sarah Marie D.O.</td>
<td></td>
<td>62783</td>
<td>07/31/2018</td>
<td>8</td>
</tr>
<tr>
<td>Kilby, Nicole Marie D.O.</td>
<td></td>
<td>62784</td>
<td>05/31/2018</td>
<td>9</td>
</tr>
<tr>
<td>Kolmodin, Joel David M.D.</td>
<td></td>
<td>62785</td>
<td>01/31/2018</td>
<td>10</td>
</tr>
<tr>
<td>Kubbara, Aahd M.B., B.S.</td>
<td></td>
<td>62786</td>
<td>12/31/2018</td>
<td>11</td>
</tr>
<tr>
<td>LaFrance, Marie E M.D.</td>
<td></td>
<td>30953</td>
<td>02/28/2018</td>
<td>12</td>
</tr>
<tr>
<td>Lynch, Mary Elizabeth M.D.</td>
<td></td>
<td>62787</td>
<td>03/31/2018</td>
<td>13</td>
</tr>
<tr>
<td>Moen, Kathryn Marie M.D.</td>
<td></td>
<td>62788</td>
<td>11/30/2018</td>
<td>14</td>
</tr>
<tr>
<td>Myers Wolfson, Barret Joella M.D.</td>
<td></td>
<td>62789</td>
<td>01/31/2018</td>
<td>15</td>
</tr>
<tr>
<td>Okonkwo, Nzube Chibuzor M.D.</td>
<td></td>
<td>62790</td>
<td>12/31/2018</td>
<td>16</td>
</tr>
<tr>
<td>Patel, Viral Rajanikant M.B., B.S.</td>
<td></td>
<td>62791</td>
<td>07/31/2018</td>
<td>17</td>
</tr>
<tr>
<td>Petrun, Branden Michael M.D.</td>
<td></td>
<td>62792</td>
<td>10/31/2018</td>
<td>18</td>
</tr>
<tr>
<td>Robien, Mark Andrew M.D.</td>
<td></td>
<td>48314</td>
<td>12/31/2018</td>
<td>19</td>
</tr>
<tr>
<td>Sachak, Sakina M.D.</td>
<td></td>
<td>62793</td>
<td>12/31/2018</td>
<td>20</td>
</tr>
<tr>
<td>Sinha, Raina M.D.</td>
<td></td>
<td>62794</td>
<td>12/31/2018</td>
<td>21</td>
</tr>
<tr>
<td>Soule, Matthew Richard M.D.</td>
<td></td>
<td>62795</td>
<td>07/31/2018</td>
<td>22</td>
</tr>
<tr>
<td>Taylor, Connie Natalie M.D.</td>
<td></td>
<td>62796</td>
<td>02/28/2018</td>
<td>23</td>
</tr>
<tr>
<td>Tsvilina, Alexandra</td>
<td></td>
<td>62797</td>
<td>06/30/2018</td>
<td>24</td>
</tr>
<tr>
<td>Waris, Samir M.D.</td>
<td></td>
<td>62798</td>
<td>03/31/2018</td>
<td>25</td>
</tr>
<tr>
<td>Windsor, John Herbert D.O.</td>
<td></td>
<td>62799</td>
<td>09/30/2018</td>
<td>26</td>
</tr>
<tr>
<td>Witkowski, Julie Ellen M.D.</td>
<td></td>
<td>62800</td>
<td>05/31/2018</td>
<td>27</td>
</tr>
<tr>
<td>Zakaib, John Salem M.D.</td>
<td></td>
<td>62801</td>
<td>11/30/2018</td>
<td>28</td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Boyd, Katharine Elizabeth</td>
<td>MSPA</td>
<td>12480</td>
<td>06/30/2018</td>
<td>29</td>
</tr>
<tr>
<td>Carmona, Vanessa Elizabeth</td>
<td>MSPA</td>
<td>12481</td>
<td>06/30/2018</td>
<td>30</td>
</tr>
<tr>
<td>Larson, Annette Marie</td>
<td>MSPA</td>
<td>12482</td>
<td>06/30/2018</td>
<td>31</td>
</tr>
<tr>
<td>Pollock, Catherine Marie</td>
<td>MSPA</td>
<td>12483</td>
<td>06/30/2018</td>
<td>32</td>
</tr>
<tr>
<td>Pollock, Catherine Marie</td>
<td>MSPA</td>
<td>12484</td>
<td>06/30/2018</td>
<td>33</td>
</tr>
<tr>
<td>Pollock, Catherine Marie</td>
<td>MSPA</td>
<td>12485</td>
<td>06/30/2018</td>
<td>34</td>
</tr>
<tr>
<td>Pollock, Catherine Marie</td>
<td>MSPA</td>
<td>12486</td>
<td>06/30/2018</td>
<td>35</td>
</tr>
<tr>
<td>Pollock, Catherine Marie</td>
<td>MSPA</td>
<td>12487</td>
<td>06/30/2018</td>
<td>36</td>
</tr>
<tr>
<td>Pollock, Catherine Marie</td>
<td>MSPA</td>
<td>12488</td>
<td>06/30/2018</td>
<td>37</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Abdullahi, Salahudin Hassan</td>
<td>4495</td>
<td>06/30/2018</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Aboubaker, Hannan Yassin</td>
<td>4496</td>
<td>06/30/2018</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Clark, Charla Marie</td>
<td>4497</td>
<td>06/30/2018</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Darling, Benjamin Andrew</td>
<td>4498</td>
<td>06/30/2018</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Dockendorf, Kyndra Clair</td>
<td>4499</td>
<td>06/30/2018</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Dunstan, Linnea Jane</td>
<td>4500</td>
<td>06/30/2018</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Holtz, Kristin Marie</td>
<td>4501</td>
<td>06/30/2018</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Isaq, Fatuma Abdinur</td>
<td>4502</td>
<td>06/30/2018</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Larson, David Wesley</td>
<td>4503</td>
<td>06/30/2018</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Lo, Jonathan Chau</td>
<td>4504</td>
<td>06/30/2018</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Mohamed, Omar Abdinur</td>
<td>4505</td>
<td>06/30/2018</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Noyes, Jennifer A</td>
<td>4506</td>
<td>06/30/2018</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Rump, Olivia Ann</td>
<td>4507</td>
<td>06/30/2018</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Sheikh, Sakaria Abukar</td>
<td>4508</td>
<td>06/30/2018</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Siriouthay, Anna</td>
<td>4509</td>
<td>06/30/2018</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Tahja, Shelly Ann</td>
<td>4510</td>
<td>06/30/2018</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Yang, Julie Maydawb</td>
<td>4511</td>
<td>06/30/2018</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Zech, Jennifer Louise</td>
<td>4512</td>
<td>06/30/2018</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>
**Name** | **License Type:** Athletic Trainer | **License #** | **Expire Date** | **Seq #**
---|---|---|---|---
Bosn, Timothy Daniel | NATA Approved | 3001 | 06/30/2018 | 56 |
Brodersen, Joshua Michael | NATA Approved | 3002 | 06/30/2018 | 57 |
Hoffer, Joseph Timothy | NATA Intern | 3003 | 06/30/2018 | 58 |
Krause-Roberts, Shawn Marie | NATA Intern | 3004 | 06/30/2018 | 59 |
Lay, Hannah Maria | NATA Approved | 3005 | 06/30/2018 | 60 |
Lindstrom, Anders Christian | NATA Approved | 3006 | 06/30/2018 | 61 |
Meyer, Alex Daniel | NATA Approved | 3007 | 06/30/2018 | 62 |
Morem, Janelle Suzanne | NATA Approved | 3008 | 06/30/2018 | 63 |
Petersen, Melissa Lee | NATA Approved | 3009 | 06/30/2018 | 64 |
Sandell, Joshua James | NATA Intern | 3010 | 06/30/2018 | 65 |
Schmit, Kallie Marie | NATA Approved | 3011 | 06/30/2018 | 66 |
Walsh, Michael James | NATA Approved | 3012 | 06/30/2018 | 67 |
<table>
<thead>
<tr>
<th>Name</th>
<th>License Type</th>
<th>License #</th>
<th>Expire Date</th>
<th>Seq #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghani, Carla Marie M.AC</td>
<td>Acupuncturist</td>
<td>1858</td>
<td>06/30/2018</td>
<td>68</td>
</tr>
<tr>
<td>Kleeberger, Anne May M.OM</td>
<td>Acupuncturist</td>
<td>1859</td>
<td>06/30/2018</td>
<td>69</td>
</tr>
<tr>
<td>Nelson, Sarah Elise Lee M.OM</td>
<td>Acupuncturist</td>
<td>1860</td>
<td>06/30/2018</td>
<td>70</td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Agboola, Opeyemi Olaide M.B., B.S.</td>
<td>Physician and Surgeon</td>
<td>62805</td>
<td>08/31/2018</td>
<td>1</td>
</tr>
<tr>
<td>Anderson, Leanne Joan D.O.</td>
<td>Physician and Surgeon</td>
<td>62806</td>
<td>01/31/2018</td>
<td>2</td>
</tr>
<tr>
<td>Aniskevich, Stephen M.D.</td>
<td>Physician and Surgeon</td>
<td>62807</td>
<td>12/31/2018</td>
<td>3</td>
</tr>
<tr>
<td>Balts, Joshua William M.D.</td>
<td>Physician and Surgeon</td>
<td>62808</td>
<td>08/31/2018</td>
<td>4</td>
</tr>
<tr>
<td>Barrett, Mary Therese M.D.</td>
<td>Physician and Surgeon</td>
<td>31245</td>
<td>03/31/2018</td>
<td>5</td>
</tr>
<tr>
<td>Beeler, Jonathon Craig M.D.</td>
<td>Physician and Surgeon</td>
<td>62809</td>
<td>08/31/2018</td>
<td>6</td>
</tr>
<tr>
<td>Bell, William Robert MB, BCh, BAO</td>
<td>Physician and Surgeon</td>
<td>62810</td>
<td>11/30/2018</td>
<td>7</td>
</tr>
<tr>
<td>Burkett, Brian Joseph M.D.</td>
<td>Physician and Surgeon</td>
<td>62811</td>
<td>09/30/2018</td>
<td>8</td>
</tr>
<tr>
<td>Carroll, Patrick Francis M.D.</td>
<td>Physician and Surgeon</td>
<td>62812</td>
<td>01/31/2018</td>
<td>9</td>
</tr>
<tr>
<td>Ching, William M.D.</td>
<td>Physician and Surgeon</td>
<td>62813</td>
<td>12/31/2018</td>
<td>10</td>
</tr>
<tr>
<td>Duvoir, Leah Rachelle D.O.</td>
<td>Physician and Surgeon</td>
<td>62814</td>
<td>04/30/2018</td>
<td>11</td>
</tr>
<tr>
<td>Eberle, Bryan Anthony M.D.</td>
<td>Physician and Surgeon</td>
<td>62815</td>
<td>09/30/2018</td>
<td>12</td>
</tr>
<tr>
<td>Ezeonu, Chidinma C M.D.</td>
<td>Physician and Surgeon</td>
<td>62816</td>
<td>06/30/2018</td>
<td>13</td>
</tr>
<tr>
<td>Fahey-Ahrndt, Donald Joe M.D.</td>
<td>Physician and Surgeon</td>
<td>62817</td>
<td>08/31/2018</td>
<td>14</td>
</tr>
<tr>
<td>Giubellino, Alessio</td>
<td>Physician and Surgeon</td>
<td>62818</td>
<td>05/31/2018</td>
<td>15</td>
</tr>
<tr>
<td>Gladso, Julie Akiko M.D.</td>
<td>Physician and Surgeon</td>
<td>62819</td>
<td>11/30/2018</td>
<td>16</td>
</tr>
<tr>
<td>Heuring, LoAnn Mai M.D.</td>
<td>Physician and Surgeon</td>
<td>62820</td>
<td>03/31/2018</td>
<td>17</td>
</tr>
<tr>
<td>Horrigan, Patrick Brendan M.D.</td>
<td>Physician and Surgeon</td>
<td>62821</td>
<td>02/28/2018</td>
<td>18</td>
</tr>
<tr>
<td>Jaykel, Timothy John M.D.</td>
<td>Physician and Surgeon</td>
<td>62822</td>
<td>08/31/2018</td>
<td>19</td>
</tr>
<tr>
<td>Kenny, Karen Sue M.D.</td>
<td>Physician and Surgeon</td>
<td>62823</td>
<td>07/31/2018</td>
<td>20</td>
</tr>
<tr>
<td>Kingsley, Joanne Ruth M.D.</td>
<td>Physician and Surgeon</td>
<td>62824</td>
<td>02/28/2018</td>
<td>21</td>
</tr>
<tr>
<td>Kurtz Elkevik, Lucy Jeanne D.O.</td>
<td>Physician and Surgeon</td>
<td>62825</td>
<td>05/31/2018</td>
<td>22</td>
</tr>
<tr>
<td>Lambert, Megan Pierce M.D.</td>
<td>Physician and Surgeon</td>
<td>62826</td>
<td>12/31/2018</td>
<td>23</td>
</tr>
<tr>
<td>Langeveld, Andrea Peacock M.D.</td>
<td>Physician and Surgeon</td>
<td>62827</td>
<td>11/30/2018</td>
<td>24</td>
</tr>
<tr>
<td>Maclntire, Michael Brian-Anderson M.D.</td>
<td>Physician and Surgeon</td>
<td>62828</td>
<td>11/30/2018</td>
<td>25</td>
</tr>
<tr>
<td>Marion, Joseph Thomas M.D.</td>
<td>Physician and Surgeon</td>
<td>62829</td>
<td>03/31/2018</td>
<td>26</td>
</tr>
<tr>
<td>Mullikin, Trey Carlton M.D.</td>
<td>Physician and Surgeon</td>
<td>62830</td>
<td>11/30/2018</td>
<td>27</td>
</tr>
<tr>
<td>Nault, Ashley Marie M.D.</td>
<td>Physician and Surgeon</td>
<td>62831</td>
<td>08/31/2018</td>
<td>28</td>
</tr>
<tr>
<td>Orandi, Amir Behzad M.D.</td>
<td>Physician and Surgeon</td>
<td>62832</td>
<td>12/31/2018</td>
<td>29</td>
</tr>
<tr>
<td>Ortiz, David Leonard M.D.</td>
<td>Physician and Surgeon</td>
<td>62833</td>
<td>02/28/2018</td>
<td>30</td>
</tr>
<tr>
<td>Patel, Seeta Lalit M.D.</td>
<td>Physician and Surgeon</td>
<td>62834</td>
<td>04/30/2018</td>
<td>31</td>
</tr>
<tr>
<td>Peterson, Jess Friedrich M.D.</td>
<td>Physician and Surgeon</td>
<td>62835</td>
<td>05/31/2018</td>
<td>32</td>
</tr>
<tr>
<td>Roach, Donald Glenn M.D.</td>
<td>Physician and Surgeon</td>
<td>62836</td>
<td>02/28/2018</td>
<td>33</td>
</tr>
<tr>
<td>Robinette, Alison Marie M.D.</td>
<td>Physician and Surgeon</td>
<td>62837</td>
<td>12/31/2018</td>
<td>34</td>
</tr>
<tr>
<td>Tillinghast, Guy Warren M.D.</td>
<td>Physician and Surgeon</td>
<td>62838</td>
<td>03/31/2018</td>
<td>35</td>
</tr>
<tr>
<td>Wallis, Denise Desiree</td>
<td>Physician and Surgeon</td>
<td>62839</td>
<td>12/31/2018</td>
<td>36</td>
</tr>
<tr>
<td>Wu, Andrew Geli M.D.</td>
<td>Physician and Surgeon</td>
<td>62840</td>
<td>01/31/2018</td>
<td>37</td>
</tr>
<tr>
<td>Ziegler, Jacob Daniel M.D.</td>
<td>Physician and Surgeon</td>
<td>62841</td>
<td>08/31/2018</td>
<td>38</td>
</tr>
<tr>
<td>Geisinger, James Gary M.D. (Emeritus)</td>
<td>Physician and Surgeon</td>
<td>19008</td>
<td>09/30/2017</td>
<td>39</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Poethke, Jennifer Nicole</td>
<td>12489</td>
<td>06/30/2018</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Schiltz, Laura Beth</td>
<td>12490</td>
<td>06/30/2018</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Sudbeck, Adam William</td>
<td>12491</td>
<td>06/30/2018</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Wallace, Lindsey Anne</td>
<td>12492</td>
<td>06/30/2018</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Wilson, Michele McNalley</td>
<td>12493</td>
<td>06/30/2018</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Wypysznaki, Alexis Mae</td>
<td>12494</td>
<td>06/30/2018</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

License Type: Physician Assistant
<table>
<thead>
<tr>
<th>Name</th>
<th>License Type: Respiratory Therapist</th>
<th>License #</th>
<th>Expire Date</th>
<th>Seq #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam , Firaoli A BS</td>
<td></td>
<td>4513</td>
<td>06/30/2018</td>
<td>46</td>
</tr>
<tr>
<td>Lean , Evelyn Leda BS</td>
<td></td>
<td>4514</td>
<td>06/30/2018</td>
<td>47</td>
</tr>
<tr>
<td>Moua , Panhia BS</td>
<td></td>
<td>4515</td>
<td>06/30/2018</td>
<td>48</td>
</tr>
<tr>
<td>Olesiak , Kelsey Ann AAS</td>
<td></td>
<td>4516</td>
<td>06/30/2018</td>
<td>49</td>
</tr>
<tr>
<td>Swanstrom , Stephen Michael AAS</td>
<td></td>
<td>4517</td>
<td>06/30/2018</td>
<td>50</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Athletic Trainer</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Bendtsen, Decker Keith</td>
<td>NATA Approved</td>
<td>3013</td>
<td>06/30/2018</td>
<td>51</td>
</tr>
<tr>
<td>Berg, Jenna Norene</td>
<td>NATA Approved</td>
<td>3014</td>
<td>06/30/2018</td>
<td>52</td>
</tr>
<tr>
<td>Church, Brandon Louis</td>
<td>NATA Approved</td>
<td>3015</td>
<td>06/30/2018</td>
<td>53</td>
</tr>
<tr>
<td>Defries, Jaran Scott</td>
<td>NATA Approved</td>
<td>3016</td>
<td>06/30/2018</td>
<td>54</td>
</tr>
<tr>
<td>Differding, Jesse Adam</td>
<td>NATA Approved</td>
<td>3017</td>
<td>06/30/2018</td>
<td>55</td>
</tr>
<tr>
<td>Greeder, Brittany Nicole</td>
<td>NATA Approved</td>
<td>3018</td>
<td>06/30/2018</td>
<td>56</td>
</tr>
<tr>
<td>Jentink, Brandon Scott</td>
<td>NATA Approved</td>
<td>3019</td>
<td>06/30/2018</td>
<td>57</td>
</tr>
<tr>
<td>Kusick, Owen Payne</td>
<td>NATA Approved</td>
<td>3020</td>
<td>06/30/2018</td>
<td>58</td>
</tr>
<tr>
<td>Miles, Alyssa Mary</td>
<td>NATA Approved</td>
<td>3021</td>
<td>06/30/2018</td>
<td>59</td>
</tr>
<tr>
<td>Schultz, Zane Anthony</td>
<td>NATA Approved</td>
<td>3022</td>
<td>06/30/2018</td>
<td>60</td>
</tr>
<tr>
<td>Venne, Tiffany Anne</td>
<td>NATA Approved</td>
<td>2051</td>
<td>06/30/2018</td>
<td>61</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Medical Faculty Physician</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------</td>
</tr>
<tr>
<td>Rangel-Castilla, Leonardo</td>
<td></td>
<td>1005</td>
<td>11/30/2018</td>
<td>62</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Al-Lami, Mustafa S Khoder M.B., Ch.B.</td>
<td>62843</td>
<td>02/28/2018</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Alapati, Deepak M.B., B.S.</td>
<td>62844</td>
<td>10/31/2018</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Anderson, Molly Marie M.D.</td>
<td>62845</td>
<td>12/31/2018</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Bohn, Bradley Aaron M.D.</td>
<td>54051</td>
<td>05/31/2018</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Carroll, Jason John M.D.</td>
<td>62846</td>
<td>09/30/2018</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Chandrasekhar, Vinay M.D.</td>
<td>62847</td>
<td>06/30/2018</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Chang, Melanie M.D.</td>
<td>62848</td>
<td>03/31/2018</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Chinnadurai, Sivakumar M.D.</td>
<td>49691</td>
<td>10/31/2018</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Connor, Brynna M.D.</td>
<td>62849</td>
<td>09/30/2018</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>De la Garza, Julia Carmen M.D.</td>
<td>62850</td>
<td>09/30/2018</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Heurung, Ashley Rose M.D.</td>
<td>62851</td>
<td>12/31/2018</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Hinderaker, Katie Elizabeth M.D.</td>
<td>62852</td>
<td>09/30/2018</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Jensen, Joseph Christopher M.D.</td>
<td>62853</td>
<td>09/30/2018</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Ji, Lu M.D.</td>
<td>62854</td>
<td>08/31/2018</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Kiberenge, Roy Kagumba M.D.</td>
<td>62855</td>
<td>11/30/2018</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Loch, Spencer Joseph M.D.</td>
<td>62856</td>
<td>06/30/2018</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Malik, Ayaz Ul-Haque M.B., B.S.</td>
<td>62857</td>
<td>10/31/2018</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>McCormick-Deaton, Catherine Monica D.O.</td>
<td>62858</td>
<td>08/31/2018</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Morrical, Ethan Braden M.D.</td>
<td>62859</td>
<td>04/30/2018</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Murar, Jozef M.D.</td>
<td>62860</td>
<td>03/31/2018</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>O'Shaughnessy, Matthew John M.D.</td>
<td>62861</td>
<td>01/31/2018</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Pagali, Sandeep Reddy M.B., B.S.</td>
<td>57031</td>
<td>10/31/2018</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Prisco, Anthony Robert M.D.</td>
<td>62862</td>
<td>01/31/2018</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Sayad-Shah, Mehria M.D.</td>
<td>62863</td>
<td>02/28/2018</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Smith, Jacquelyn Rae M.D.</td>
<td>62864</td>
<td>06/30/2018</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Supik, David Allen D.O.</td>
<td>62865</td>
<td>06/30/2018</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Twogood, Todd Allen M.D.</td>
<td>62866</td>
<td>04/30/2018</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Urbach, Jonathan Aaron M.D.</td>
<td>62867</td>
<td>01/31/2018</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Lindeman, Raymond Jacob M.D.</td>
<td>11429</td>
<td>06/30/2017</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Hall, Nathanael Sean</td>
<td>12495</td>
<td>06/30/2018</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Nelson, Ryan Alexander</td>
<td>12496</td>
<td>06/30/2018</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Pool, Elin Christine</td>
<td>12497</td>
<td>06/30/2018</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Truong, Melissa Minh Nguyet</td>
<td>12498</td>
<td>06/30/2018</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Auch, Amy Marie BS</td>
<td></td>
<td>4518</td>
<td>06/30/2018</td>
<td>34</td>
</tr>
<tr>
<td>Binsfield, Brittany Ann AAS</td>
<td></td>
<td>4519</td>
<td>06/30/2018</td>
<td>35</td>
</tr>
<tr>
<td>Cabdirahman, Abdiwali Bashir AAS</td>
<td></td>
<td>4520</td>
<td>06/30/2018</td>
<td>36</td>
</tr>
<tr>
<td>Dennis, Francelia Gbole BS</td>
<td></td>
<td>4521</td>
<td>06/30/2018</td>
<td>37</td>
</tr>
<tr>
<td>Kinzel, Madison Lee BS</td>
<td></td>
<td>4522</td>
<td>06/30/2018</td>
<td>38</td>
</tr>
<tr>
<td>Kuretich, Kaelin Tunnell AAS</td>
<td></td>
<td>4523</td>
<td>06/30/2018</td>
<td>39</td>
</tr>
<tr>
<td>Miller, Jenna Lynne Whitchurch BS</td>
<td></td>
<td>4524</td>
<td>06/30/2018</td>
<td>40</td>
</tr>
<tr>
<td>Samatar, Yasmin Elmi BS</td>
<td></td>
<td>4525</td>
<td>06/30/2018</td>
<td>41</td>
</tr>
<tr>
<td>Skadsberg, Jenny Dalene AAS</td>
<td></td>
<td>4526</td>
<td>06/30/2018</td>
<td>42</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Athletic Trainer</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Bosshard, Laura Ann</td>
<td>NATA Approved</td>
<td>3023</td>
<td>06/30/2018</td>
<td>43</td>
</tr>
<tr>
<td>Funk, Colton David</td>
<td>NATA Approved</td>
<td>3024</td>
<td>06/30/2018</td>
<td>44</td>
</tr>
<tr>
<td>May, Allison Renee</td>
<td>NATA Approved</td>
<td>3025</td>
<td>06/30/2018</td>
<td>45</td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------</td>
<td>---------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Ahrens, Mary Ellen-Jarvis M.S.</td>
<td>1001</td>
<td>07/31/2018</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Bower, Matthew Aaron M.S.</td>
<td>1002</td>
<td>11/30/2018</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Douglas, Shari Rae M.S.</td>
<td>1003</td>
<td>06/30/2018</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Earnes, Anna Miesen M.S.</td>
<td>1004</td>
<td>10/31/2018</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Essendrup, Anna Alyse M.S.</td>
<td>1005</td>
<td>07/31/2018</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Hall, Beth Ann Conrad M.S.</td>
<td>1006</td>
<td>01/31/2018</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Kne, Alyssa Rose M.S.</td>
<td>1007</td>
<td>11/30/2018</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Kotzer, Katrina Elizabeth M.S.</td>
<td>1008</td>
<td>09/30/2018</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Michel, Olivia Jeannine M.S.</td>
<td>1009</td>
<td>10/31/2018</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Mitchell, Elyse Beth M.S.</td>
<td>1010</td>
<td>04/30/2018</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Rust, Laura Michelle M.S.</td>
<td>1011</td>
<td>11/30/2018</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Schema, Lynn Susan M.S.</td>
<td>1012</td>
<td>12/31/2018</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------</td>
<td>---------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Bakken, Bjorn M.D.</td>
<td>62869</td>
<td>02/28/2018</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Buchholz, Jonathan Paul M.D.</td>
<td>62870</td>
<td>07/31/2018</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Choi, Jonathan Dale M.D.</td>
<td>62871</td>
<td>02/28/2018</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Flug, Jonathan Alan M.D.</td>
<td>62872</td>
<td>08/31/2018</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Fox, Michael Gregory M.D.</td>
<td>62873</td>
<td>09/30/2018</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Friedman, Saul Nathan M.D.</td>
<td>62874</td>
<td>10/31/2018</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Ikeda, Sara Catherine M.D.</td>
<td>62875</td>
<td>11/30/2018</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Janiczak, Daniel Brandt M.D.</td>
<td>62876</td>
<td>08/31/2018</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Kligman, Brad Evan M.D.</td>
<td>62877</td>
<td>12/31/2018</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Lawrence, Adrian Christopher M.D.</td>
<td>62878</td>
<td>06/30/2018</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Mahan, Kathleen Suzanne M.D.</td>
<td>62879</td>
<td>10/31/2018</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Nahas, Ziad M.D.</td>
<td>62880</td>
<td>06/30/2018</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Olteanu, Horatiu</td>
<td>62881</td>
<td>03/31/2018</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Porter, Steven Bradley M.D.</td>
<td>62882</td>
<td>06/30/2018</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Steger, Brandon Daniel M.D.</td>
<td>62883</td>
<td>07/31/2018</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Stoy, Sean Patrick M.D.</td>
<td>55796</td>
<td>04/30/2018</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Taylor, Jeremy James M.D.</td>
<td>62884</td>
<td>06/30/2018</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Teekamdas, Roma M.B., B.S.</td>
<td>62885</td>
<td>04/30/2018</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Winter, Stuart Sheldon M.D.</td>
<td>62886</td>
<td>11/30/2018</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Vickers, John Frederick M.D. (Emeritus)</td>
<td>42467</td>
<td>08/31/2017</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Ahrendt, Seth Gregory</td>
<td>Physician and Surgeon</td>
<td>62890</td>
<td>08/31/2018</td>
<td>1</td>
</tr>
<tr>
<td>Alagappan, Priya</td>
<td>M.D.</td>
<td>62891</td>
<td>07/31/2018</td>
<td>2</td>
</tr>
<tr>
<td>Carlson, Kathleen Persoon</td>
<td>M.D.</td>
<td>62892</td>
<td>12/31/2018</td>
<td>3</td>
</tr>
<tr>
<td>Covington, Tristan Neal</td>
<td>M.D.</td>
<td>62893</td>
<td>06/30/2018</td>
<td>4</td>
</tr>
<tr>
<td>Dasso, Edwin Joseph</td>
<td>M.D.</td>
<td>62894</td>
<td>06/30/2018</td>
<td>5</td>
</tr>
<tr>
<td>Dreger, Tina Kay</td>
<td>M.D.</td>
<td>62895</td>
<td>02/28/2018</td>
<td>6</td>
</tr>
<tr>
<td>Elgallab, Janet</td>
<td>M.D.</td>
<td>62896</td>
<td>11/30/2018</td>
<td>7</td>
</tr>
<tr>
<td>Ellis, Michelle Claire</td>
<td>M.D.</td>
<td>62897</td>
<td>06/30/2018</td>
<td>8</td>
</tr>
<tr>
<td>Fewer, Thomas Lyle</td>
<td>M.D.</td>
<td>62898</td>
<td>09/30/2018</td>
<td>9</td>
</tr>
<tr>
<td>Hall, Allison Barbara</td>
<td>M.D.</td>
<td>62899</td>
<td>04/30/2018</td>
<td>10</td>
</tr>
<tr>
<td>Herstad, Sara Christine</td>
<td>D.O.</td>
<td>62900</td>
<td>06/30/2018</td>
<td>11</td>
</tr>
<tr>
<td>Hollatz, Andrew Allan</td>
<td>M.D.</td>
<td>62901</td>
<td>05/31/2018</td>
<td>12</td>
</tr>
<tr>
<td>Huggins, Laura Davis</td>
<td>M.D.</td>
<td>62902</td>
<td>01/31/2018</td>
<td>13</td>
</tr>
<tr>
<td>Joshi, Dhruv M.B., B.S.</td>
<td>M.D.</td>
<td>62903</td>
<td>06/30/2018</td>
<td>14</td>
</tr>
<tr>
<td>Leonard, Christopher Scott</td>
<td>M.D.</td>
<td>62904</td>
<td>05/31/2018</td>
<td>15</td>
</tr>
<tr>
<td>Lyerly, Kristin Marie</td>
<td>M.D.</td>
<td>62905</td>
<td>12/31/2018</td>
<td>16</td>
</tr>
<tr>
<td>Marsh, Ketzel Jacobowitz</td>
<td>M.D.</td>
<td>62906</td>
<td>02/28/2018</td>
<td>17</td>
</tr>
<tr>
<td>Nguyen, Tony Huy Tien</td>
<td>M.D.</td>
<td>62907</td>
<td>03/31/2018</td>
<td>18</td>
</tr>
<tr>
<td>Pasha, Maarya M.D.</td>
<td>M.D.</td>
<td>62908</td>
<td>01/31/2018</td>
<td>19</td>
</tr>
<tr>
<td>Schlabach, Renee Ann</td>
<td>M.D.</td>
<td>46405</td>
<td>04/30/2018</td>
<td>20</td>
</tr>
<tr>
<td>Schroeder, Lindsay Baye</td>
<td>D.O.</td>
<td>62909</td>
<td>06/30/2018</td>
<td>21</td>
</tr>
<tr>
<td>Stevenson-King, Allyson</td>
<td>D.O.</td>
<td>62910</td>
<td>12/31/2018</td>
<td>22</td>
</tr>
<tr>
<td>Vyas, Krishna Subhash</td>
<td>B.M., B.Ch.</td>
<td>62911</td>
<td>10/31/2018</td>
<td>23</td>
</tr>
<tr>
<td>Yuan, Kenneth Win</td>
<td>D.O.</td>
<td>62912</td>
<td>05/31/2018</td>
<td>24</td>
</tr>
<tr>
<td>Name</td>
<td>License#</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Biebl, Cindy Kokesch MSPA</td>
<td>12502</td>
<td>06/30/2018</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Davis, Sarah Rusciano MSPA</td>
<td>12503</td>
<td>06/30/2018</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Kasel, Brian Joseph MSPA</td>
<td>12504</td>
<td>06/30/2018</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Lunford, Rebecca Ann MSPA</td>
<td>12505</td>
<td>06/30/2018</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Mach, Jacob Timothy MSPA</td>
<td>12506</td>
<td>06/30/2018</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Spindler-Ebensperger, Lynn Therese MSPA</td>
<td>12507</td>
<td>06/30/2018</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Webb, Kristen Marie MSPA</td>
<td>12508</td>
<td>06/30/2018</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Hulegaard, Amie Nichole</td>
<td>AAS</td>
<td>4531</td>
<td>06/30/2018</td>
<td>32</td>
</tr>
<tr>
<td>Jacquart, Katelyn Marie</td>
<td>AS</td>
<td>4532</td>
<td>06/30/2018</td>
<td>33</td>
</tr>
<tr>
<td>Kunitz, Kimberly Ann</td>
<td>AAS</td>
<td>4533</td>
<td>06/30/2018</td>
<td>34</td>
</tr>
<tr>
<td>Reisdorf, Richard William</td>
<td>AAS</td>
<td>4534</td>
<td>06/30/2018</td>
<td>35</td>
</tr>
<tr>
<td>Ruchti, Susan Michelle</td>
<td>AAS</td>
<td>4535</td>
<td>06/30/2018</td>
<td>36</td>
</tr>
<tr>
<td>Stewart, Jenna Rae</td>
<td>AAS</td>
<td>4536</td>
<td>06/30/2018</td>
<td>37</td>
</tr>
<tr>
<td>Name</td>
<td>License Type</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Brown, Shae Lynn</td>
<td>NATA Approved</td>
<td>3031</td>
<td>06/30/2018</td>
<td>38</td>
</tr>
<tr>
<td>Johnson, Tanner Dane</td>
<td>NATA Approved</td>
<td>3032</td>
<td>06/30/2018</td>
<td>39</td>
</tr>
<tr>
<td>Kruger, Jennie-Beth</td>
<td>NATA Approved</td>
<td>3033</td>
<td>06/30/2018</td>
<td>40</td>
</tr>
<tr>
<td>Kuntz, Rachel Marie</td>
<td>NATA Approved</td>
<td>3034</td>
<td>06/30/2018</td>
<td>41</td>
</tr>
<tr>
<td>Lounsbury, Caroline Anne</td>
<td>NATA Approved</td>
<td>3035</td>
<td>06/30/2018</td>
<td>42</td>
</tr>
<tr>
<td>Marcus, Benjamin Leonard</td>
<td>NATA Approved</td>
<td>3036</td>
<td>06/30/2018</td>
<td>43</td>
</tr>
<tr>
<td>Name</td>
<td>License Type: Genetic Counselor</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------</td>
<td>-----------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>Bakke , Angela Marie M.S.</td>
<td></td>
<td>1017</td>
<td>02/28/2018</td>
<td>44</td>
</tr>
<tr>
<td>Bertsch , Nicole Louise Sophia M.S.</td>
<td></td>
<td>1018</td>
<td>03/31/2018</td>
<td>45</td>
</tr>
<tr>
<td>Crabb , Beau Amadeus M.S.</td>
<td></td>
<td>1019</td>
<td>11/30/2018</td>
<td>46</td>
</tr>
<tr>
<td>Eilers , Margaret Laura M.S.</td>
<td></td>
<td>1020</td>
<td>11/30/2018</td>
<td>47</td>
</tr>
<tr>
<td>Hibbs , Kathleen Ann M.S.</td>
<td></td>
<td>1021</td>
<td>05/31/2018</td>
<td>48</td>
</tr>
<tr>
<td>Kunz , Barbara Jo M.S.</td>
<td></td>
<td>1022</td>
<td>05/31/2018</td>
<td>49</td>
</tr>
<tr>
<td>Lee , Whiwon M.S.</td>
<td></td>
<td>1023</td>
<td>11/30/2018</td>
<td>50</td>
</tr>
<tr>
<td>Long , Catherine Weindel M.S.</td>
<td></td>
<td>1024</td>
<td>07/31/2018</td>
<td>51</td>
</tr>
<tr>
<td>Lorentz , Cindy Diem-Uyen Pham M.S.</td>
<td></td>
<td>1025</td>
<td>01/31/2018</td>
<td>52</td>
</tr>
<tr>
<td>Murphree , Marine Isabelle M.S.</td>
<td></td>
<td>1026</td>
<td>09/30/2018</td>
<td>53</td>
</tr>
<tr>
<td>Powers , Amy Lee Radak M.S.</td>
<td></td>
<td>1027</td>
<td>11/30/2018</td>
<td>54</td>
</tr>
<tr>
<td>Schoonveld , Kay Cheri M.S.</td>
<td></td>
<td>1028</td>
<td>05/31/2018</td>
<td>55</td>
</tr>
<tr>
<td>Steyermark , Joan Marie M.S.</td>
<td></td>
<td>1029</td>
<td>02/28/2018</td>
<td>56</td>
</tr>
<tr>
<td>Truelson , Melissa Renee M.S.</td>
<td></td>
<td>1030</td>
<td>09/30/2018</td>
<td>57</td>
</tr>
<tr>
<td>Tryon , Rebecca Kim M.S.</td>
<td></td>
<td>1031</td>
<td>07/31/2018</td>
<td>58</td>
</tr>
<tr>
<td>Waltman , Lindsey Ann M.S.</td>
<td></td>
<td>1032</td>
<td>04/30/2018</td>
<td>59</td>
</tr>
<tr>
<td>Wiesman , Chana Elisheva M.S.</td>
<td></td>
<td>1033</td>
<td>10/31/2018</td>
<td>60</td>
</tr>
</tbody>
</table>
REQUESTED ACTION:

Approve the actions of the Licensure Committee.

MOTION BY: ____________________  SECOND: ____________________

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

BACKGROUND:

See attached August 1 and August 10, 2017, Licensure Committee Meeting Minutes.
LICENSURE COMMITTEE MEETING
Minnesota Board of Medical Practice
University Park Plaza, 2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246

August 1, 2017

FINAL MINUTES

An ad hoc teleconference meeting was held and a roll call vote was acted on by the Licensure Committee (“Committee”) relating to one matter of business on August 1, 2017 at 12:00 p.m.

Committee Members Present for the Teleconference: Patricia J. Lindholm, M.D., FAAFP; Christopher Burkle, M.D., J.D., FCLM; Allen Rasmussen, M.A.; and Kimberly Spaulding, M.D., M.P.H.

Others Present In-Person: Molly Schwanz, Ruth Martinez and Randi Shimota, Board staff; Gerald Kaplan, M.A., L.P., Board President; and Greg Schaefer, Assistant Attorney General

Additional Meeting Dates for 2017, Scheduled at 1:00 p.m., are:
- August 10
- October 12
- December 14

DISCUSSION:

Athletic Trainer Registration Requirements:
A motion was made and a unanimous vote passed to include the Board of Certification for the Athletic Trainer as a nationally recognized accreditation agency for athletic training programs approved by the Board, pursuant to Minnesota Statutes §148.7808, Subd. 1, (2).
The Licensure Committee (“Committee”) met on August 1, 2017, at 1:00 p.m. in the Board of Medical Practice conference room.

Committee Members Present: Christopher Burkle, M.D., J.D., FCLM; Kathryn D. Lombardo, M.D.; Allen Rasmussen, M.A.; and Kimberly Spaulding, M.D., M.P.H.

Others Present: Molly Schwanz, Elizabeth Larson, Paul Luecke, Ruth Martinez and Kate Van Etta-Olson, Board staff; and Greg Schaefer, Assistant Attorney General

Additional Meeting Dates for 2017, Scheduled at 1:00 p.m., are:
- October 12
- December 14

Physicians Requesting Resigned/Inactive Status: For information only, the Committee was provided with the list of 56 requests.

Physician Assistant Requesting Resigned/Inactive Status: For information only, the Committee was provided with the list of one (1) request.

Respiratory Therapists Requesting Resigned/Inactive Status: For information only, the Committee was provided with the list of two (2) requests.

ADVISORY COUNCIL APPOINTMENTS:
Registered Naturopathic Doctor Advisory Council Appointments: The Committee agreed to recommend the following applications to the Board in September, 2017:
- Lee Aberle, N.D.
- Michael Green, M.D.
- Amy Johnson-Grass, N.D.
- Dionne Reinhart, N.D.
- Helen Soley, N.D.
- Karen Thullner
APPLICATION REVIEWS:
REDACTED: The Committee reviewed Dr. REDACTED application and approved issuance of a license, granting an extension to the number of attempts permitted to pass the United States Medical Licensing Examination, pursuant to Minnesota Statutes §147.02, Subd. 1b. (Mr. Rasmussen abstained).

REDACTED: The Committee reviewed Dr. REDACTED application and approved issuance of a license upon formal referral to the Health Professionals Services Program.

DISCUSSION:
Policy Issues Including:
- SF 2310
- Interstate Medical Licensure Compact
- Prescription Monitoring Program
- Opioid Legislation
DATE: September 23, 2017
SUBJECT: Registered Naturopathic Doctor Advisory Council Appointments

SUBMITTED BY: Licensure Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:
Re-appoint the following persons to two-year terms on the Registered Naturopathic Doctor Advisory Council, with terms ending July, 2019:

• Lee Aberle, N.D.
• Michael Green, M.D.
• Amy Johnson-Grass, N.D.
• Dionne Reinhart, N.D.
• Helen Soley, N.D.
• Karen Thullner

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

BACKGROUND:
Registered Naturopathic Doctor Advisory Council members are appointed to two-year terms (Minnesota Statutes §147E.35). The following Council member's terms expired on July 31, 2017:

<table>
<thead>
<tr>
<th>Council Member</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lee Aberle</td>
<td>Naturopathic Doctor Member</td>
</tr>
<tr>
<td>Michael Green</td>
<td>Licensed Physician Member</td>
</tr>
<tr>
<td>Amy Johnson-Grass</td>
<td>Naturopathic Doctor Member</td>
</tr>
<tr>
<td>Dionne Reinhart</td>
<td>Naturopathic Doctor Member</td>
</tr>
<tr>
<td>Helen Soley</td>
<td>Naturopathic Doctor Member</td>
</tr>
<tr>
<td>Karen Thullner</td>
<td>Public Member</td>
</tr>
<tr>
<td>Leslie Vilensky</td>
<td>Naturopathic Doctor Member</td>
</tr>
</tbody>
</table>

Four applications have been received for the registered naturopathic doctor member positions, one for the physician member position, and two for the public member position. Applications have been received from the following:

• Lee Aberle, N.D.
• Michelle Conley
• Michael Green, M.D.
• Amy Johnson-Grass, N.D.
• Dionne Reinhart, N.D.
• Helen Soley, N.D.
• Karen Thullner

The Licensure Committee is recommending re-appointment of Lee Aberle, Michael Green, Amy Johnson-Grass, Dionne Reinhart, Helen Soley and Karen Thullner.

See attached applications.
Application for the position Registered Naturopathic Doctor

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council
Position: Registered Naturopathic Doctor

Part II: Applicant Information

Name: Lee Aberle
Phone:
Mailing Address:
Email:
County: Stearns
Felony Conviction: No
Mn House District: 13B
US House District: 6
Recommended by the Appointing Authority: True

Part III: Appending Documentation

Cover Letter and Resume

<table>
<thead>
<tr>
<th>Type</th>
<th>File Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover Letter</td>
<td>application/vnd.openxmlformats-officedocument.wordprocessingml.document</td>
</tr>
<tr>
<td>Resume</td>
<td>application/vnd.openxmlformats-officedocument.wordprocessingml.document</td>
</tr>
</tbody>
</table>

Additional Documents (.doc, .docx, .pdf, .txt)

<table>
<thead>
<tr>
<th>Type</th>
<th>File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>No additional documents found.</td>
<td></td>
</tr>
</tbody>
</table>

Part IV: Optional Statistical Information

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

https://commissionsandappointments.sos.state.mn.us/ApplicationAdditionalDocument/ApplicationFinal/10728
Part V: Signature

Signature: Lee Aberle
Date: 8/2/2017 6:14:29 PM
Application for the position Public Member

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council  
Position: Public Member

Part II: Applicant Information

Name: Michelle Conlev  
Phone:  
Mailing Address:  
Email:  
County: Dakota  
Felony Conviction: No  
Mn House District: 51A  
US House District: 3  
Recommended by the Appointing Authority: False

Part III: Appending Documentation

Cover Letter and Resume

<table>
<thead>
<tr>
<th>Type</th>
<th>File Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resume</td>
<td>application/vnd.openxmlformats-officedocument.wordprocessingml.document</td>
</tr>
</tbody>
</table>

Additional Documents (.doc, .docx, .pdf, .txt)

<table>
<thead>
<tr>
<th>Type</th>
<th>File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No additional documents found.</td>
</tr>
</tbody>
</table>

Part IV: Optional Statistical Information

Gender: Female  
Disability: No  
Age: 60  
Political Affiliation: Democratic-Farm-Labor  
Ethnicity: White or Caucasian  
Hispanic, Latino or Spanish origin: No

Part V: Signature

https://commissionsandappointments.sos.state.mn.us/ApplicationAdditionalDocument/ApplicationFinal/11738
Application for the position Lic. Physician Or Osteopath

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council
Position: Lic. Physician Or Osteopath

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

<table>
<thead>
<tr>
<th>Type</th>
<th>File Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resume</td>
<td>application/pdf</td>
</tr>
</tbody>
</table>

Additional Documents (.doc, .docx, .pdf, .txt)

<table>
<thead>
<tr>
<th>Type</th>
<th>File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No additional documents found.</td>
</tr>
</tbody>
</table>

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

https://commissionsandappointments.sos.state.mn.us/ApplicationAdditionalDocument/ApplicationFinal/7948
Application for the position Registered Naturopathic Doctor

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council
Position: Registered Naturopathic Doctor

Part II: Applicant Information

Name: Amy Johnson-grass
Phone: 
Mailing Address: 
Email: 
County: Ramsey
Felony Conviction: No
Mn House District: 65A
US House District: 4
Recommended by the Appointing Authority: True

Part III: Appending Documentation

Cover Letter and Resume

<table>
<thead>
<tr>
<th>Type</th>
<th>File Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover Letter</td>
<td>application/pdf</td>
</tr>
<tr>
<td>Resume</td>
<td>application/pdf</td>
</tr>
</tbody>
</table>

Additional Documents (.doc, .docx, .pdf, .txt)

<table>
<thead>
<tr>
<th>Type</th>
<th>File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>No additional documents found.</td>
<td></td>
</tr>
</tbody>
</table>

Part IV: Optional Statistical Information

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

https://commissionsandappointments.sos.state.mn.us/ApplicationAdditionalDocument/ApplicationFinal/8056
Part V: Signature

Signature: Amy Johnson-Grass
Date: 6/16/2017 12:22:28 AM

AGENCY DETAILS

© 2017 Office of the Minnesota Secretary of State - Terms & Conditions
Application for the position Registered Naturopathic Doctor

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council
Position: Registered Naturopathic Doctor

Part II: Applicant Information

Name: Dionne Reinhart
Phone:
Mailing Address:
Email:
County: Ramsey
Felony Conviction: No
Mn House District: 65B
US House District: 4
Recommended by the Appointing Authority: True

Part III: Appending Documentation

Cover Letter and Resume

Type | File Type
--- | ---
Cover Letter | application/vnd.openxmlformats-officedocument.wordprocessingml.document

Additional Documents (.doc, .docx, .pdf, .txt)

Type | File Name
--- | ---
No additional documents found.

Part IV: Optional Statistical Information

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

Part V: Signature
Application for the position Registered Naturopathic Doctor

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council
Position: Registered Naturopathic Doctor

Part II: Applicant Information

Name: Helen Soley (Healy)
Phone: 
Mailing Address: 
Email: 
County: Dakota
Felony Conviction: No
Mn House District: 52A
US House District: 2
Recommended by the Appointing Authority: True

Part III: Appending Documentation

Cover Letter and Resume

File Type

Additional Documents (.doc, .docx, .pdf, .txt)

File Name

No additional documents found.

Part IV: Optional Statistical Information

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

Part V: Signature

Signature: Helen C. Soley
Application for the position Public Member

Part I: Position Sought

Agency Name: Registered Naturopathic Doctor Advisory Council
Position: Public Member

Part II: Applicant Information

Name: Karen Thullner
Phone: 
Mailing Address: 
Email: 
County: Ramsey
Felony Conviction: No
Mn House District: 54B
US House District: 4
Recommended by the Appointing Authority: False

Part III: Appending Documentation

Cover Letter and Resume

<table>
<thead>
<tr>
<th>Type</th>
<th>File Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover Letter</td>
<td>application/msword</td>
</tr>
<tr>
<td>Resume</td>
<td>application/vnd.openxmlformats-officedocument.wordprocessingml.document</td>
</tr>
</tbody>
</table>

Additional Documents (.doc, .docx, .pdf, .txt)

<table>
<thead>
<tr>
<th>Type</th>
<th>File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>No additional documents found.</td>
<td></td>
</tr>
</tbody>
</table>

Part IV: Optional Statistical Information

Gender: Female
Disability: No
Age: 
Political Affiliation: Democratic-Farm-Labor
Ethnicity: White or Caucasian
Hispanic, Latino or Spanish origin: No Answer
Part V: Signature

Signature: Karen S. Thullner
Date: 5/24/2017 9:08:10 AM
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Policy & Planning Committee.

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

BACKGROUND:
Policy & Planning Committee Report:
   a. August 9, 2017, Policy & Planning Committee Meeting Minutes
   b. August 9, 2017, Policy & Planning Committee Agenda
The Committee, chaired by Allen Rasmussen, M.A., and attended by Patrick Townley, M.D., J.D., and William Parham, M.D., F.A.C.P., F.C.C.P., met at 2:30 p.m. at the Board offices. Also in attendance was Board President Gerald Kaplan, M.A., L.P. The Committee was assisted by Board staff Ruth Martinez, Elizabeth Huntley, Molly Schwanz and Kate Van Etta-Olson. Members of the public also attended. The Committee considered the following items:

1. **In the matter of a presentation by Dr. Olga Steffens:** Dr. Steffens presented her credentials and experience as a physician from the Republic of Belarus. She reviewed her education, foreign and domestic training, licensing examination and specialty certifications. Dr. Steffens described her personal challenges in obtaining United States or Canadian accredited clinical training, and her interest in becoming licensed to practice in Minnesota or another U.S. jurisdiction. Dr. Steffens encouraged Minnesota to consider alternate pathways to licensure for international medical graduates who lack U.S. or Canadian accredited clinical training.

The Committee thanked Dr. Steffens for the information.

2. **In the matter of a presentation by Senator Jim Abeler:** Senator Abeler discussed the State’s struggle with health care disparities of geography and race. He emphasized the need for a sufficient quality and quantity of health care practitioners. Senator Abeler reviewed 2017 S.F. 2310, which he introduced during the 2017 legislative session as a placeholder to address the health care provider shortages in rural and underserved areas. He responded to questions from the Committee and invited collaboration toward solutions that would not require further legislation, but suggested that a legislative solution could also be considered. Senator Abeler expressed support for Dr. Steffens and encouraged the Board to consider ways to license similarly qualified international medical graduates.

The Committee thanked Senator Abeler and expressed its willingness to continue to examine minimum requirements for licensure.

3. **In the matter of opioid initiatives:** The Committee reviewed several initiatives.
   a. **Prescription Monitoring Program (PMP):** Board staff reviewed the requirements for and implementation of mandatory PMP account registration for physicians and physician assistants, beginning on July 1, 2017. Staff noted that the Board’s embedded link to PMP account registration in the on-line renewal process was very helpful to licensees, many of whom had already registered accounts during previous renewal cycles. Staff also identified some obstacles relative to mandatory account registration including:
      - Inactive PMP accounts
      - Confusion about the statutory intent regarding DEA registration
      - Discrepancies in identification of licensees among licensing boards, DEA and PMP databases
      - Required registration for non-prescribers

b. **2018 Legislation:** The Committee considered possible opioid-related legislation, including:
• Housekeeping changes in PMP language to clarify requirements for mandatory account registration
• Mandatory PMP use
• Opioid specific mandatory continuing medical education (CME)

c. The Committee reviewed Board engagement, including:
  • Endorsing Attorney General Swanson’s *Dose of Reality* website
  • Exhibiting at the MN Medical Association Annual Meeting on September 23, 2017; disseminating opioid-related information/resources
  • Creating access on the Board website to opioid-related resources such as the MN Medical Association website with free CME/Maintenance of Certification (MOC) programs and opioid-related guidance documents and articles
  • Board contributions to presentations and articles

The Committee recognized the need to continue internal and external conversations regarding the Board’s role and responsibility in addressing opioid issues and will make the discussion a standard item on future agendas.

4. **In the matter of obsolete rules:** The Committee deferred discussion of obsolete rules until its October 2017 meeting.

5. **In the matter of the Interstate Medical Licensure Compact (Compact):** Board staff updated the Committee on recently enacted statutory changes to the Medical Practice Act and the FBI’s July 2017 determination that the changes still do not satisfy federal requirements for the Board to receive criminal background check data for the purpose of qualifying Minnesota licensed physicians to participate in the Compact. Minnesota is participating in the Compact as a member state which may issue expedited licenses to incoming applicants through the Compact process. Further legislation, although invited by the FBI, does not appear to create good law. Minnesota’s commissioners will work with state and national stakeholders in the Compact process, including but not limited to member states in the Compact, regional healthcare systems, telehealth advocates, congressional representatives, the National Governor’s Association, and others, to strategize about next steps.

No action was required.

There being no other business, the meeting was adjourned.
1. Dr. Olga Steffens: Presentation on International Medical Graduate Qualifications

2. Senator Jim Abeler: Presentation on S.F. 2310
   a. S.F. 2310 (attached): A bill for an act relating to health care; authorizing the Board of Medical Practice to issue a limited license to practice medicine in rural or underserved communities for international medical graduates; proposing coding for new law in Minnesota Statutes, chapter 147.
   b. Medical Practice Act, Licensing Sections 147.02 – 147.0375 (attached)

3. Opioids:
   a. Mandatory Prescription Monitoring Program (PMP) Registration (Minn. Stat. 152.126, Subd. 6(c) attached)
   b. Possible Upcoming Legislation:
      • Mandatory CME on Opioids
      • Mandatory PMP Use
   c. MMIC Summer 2017 Brink, the Opioid Dilemma (attached)

4. Obsolete Rule: Repeal of Minn. Rules Chapter 5615
   a. Rule 5615 (attached)
   b. Contested Case Procedures:
      • Minn. Rules 1400.5100 – 1400.8400 (attached)
      • Minn. Stat. 214.10 (attached) and
      • Minn. Stat. 214.103 (attached)

5. Interstate Medical Licensure Compact (IMLC)
   a. New Language H.F. 474 (attached)
   b. FBI Background Check Legislation Minn. Stat. 214.075 (attached)

6. Other Business
I grew up in Belarus and Germany. Daughter of a military officer.

Belarus has 80.1 million sq. miles. Minnesota has 86.9 million sq. miles. Belarus population is 9.5 million. Minnesota population is 5.2 million. Belarus is at 54 Degrees Latitude. Minnesota is at 45 Degrees Latitude.
Education

Chernobyl’s Affects on Belarus

Confiscated/Closed Zone
Greater than 40 curies per square kilometer (Ci/km²) of Cesium-137

Permanent Control Zone
15 to 40 Ci/km² of Cesium-137

Periodic Control Zone
6 to 15 Ci/km² of Cesium-137

Unnamed zone
1 to 15 Ci/km² of Cesium-137
Belarus Thyroid Cancer Rates After Chernobyl

Yellow = Adults
Blue = Adolescents
Red = Children
Post Graduate Education

- M.D. Internship in Internal Medicine / Oncology & Emergency Medicine. Grodno State Medical University / Brest Reginal Cancer Center. Grodno and Brest, Belarus. 2002 - 2003
- Fellowship in Oncology with Research & Teaching Components. N. N. Alexandrov National Cancer Center & Medical Academy of Post-Graduate Education. Minsk, Belarus. 2007 - 2011
Belarus Certifications.

- Board Certification Internship Exam: “Internal Medicine / Oncology”. Certificate # 45. 2003
- Board Certification Residency Exam: “Surgical Oncology.” Certificate # 589. 2007
- Board Certification Fellowship Exam: “Oncology”. Certificate # 0528780. 2011
Belarus Research Awards

1. Patent License: Method of Photodynamic Treatment of Malignant Tumors of Oropharyngeal Zone and Premalignant Tumors of Oropharyngeal Zone. 10/2012

2. Patent license: Method of Differential Photodynamic Diagnosis of Pre-malignant and Malignant Tumors of the Oropharyngeal Zone. 09/2013

Belarus Member of Faculty

- Associate Professor / Lead Researcher.
- N.N. Alexandrov National Cancer Center & Medical Academy of Post-Graduate Education.
- Academic lectures.
- Trained residents.
- Trained practicing physicians.
1 Year U.S. Clinical Experience

2. Clinical Rotation in Internal Medicine. Avalon University School of Medicine. Youngstown, Ohio. 11/2015
3. Clinical Rotation in Psychiatry. Avalon University School of Medicine. Cleveland, Ohio. 01/2016
5. Clinical Rotation in Cardiology & Interventional Cardiology. Avalon University School of Medicine. Beckley, West Virginia. 03/2016
United States Exams / Certifications

- USMLE Step 1. 10/2013
- USMLE Step 2 CK. 06/2014
- USMLE Step 2 CS. 09/2015
- ECFMG Certification; Number 0-859-527-4. 10/2015
- USMLE Step 3. 9/2016
- Basic Life Support. 12/2016
- Pediatric Advanced Life Support. 01/2017
- Advanced Cardiac Life Support. 01/2017
Belarus, Exporter of Physicians

List of countries where my peers from my class practice.

- Italy
- Germany
- Spain
- Great Britain
- Poland
- Canada
- Australia
- Saudi Arabia
- United Arabic Emirates
- Qatar
- Iran
- Angola
- Nigeria
- India
- South Africa
Great Britain

- International medical graduate doctors can apply for two types of registration: provisional registration with a license to practice and full registration with a license to practice. If you have completed an acceptable internship either overseas or in the UK you can only apply for full registration with a license to practice.
- Medical school listed in the World Directory of Medical Schools or International Medical Education Directory.
- Must pass English language exam, IELTS.
- Give details of your registration or licensing for all the medical regulatory authorities of any countries where you have practiced.
- Will need a Certificate of Good Standing.
- Pass PLAB exam.
- Sponsorship by an approved sponsor.

http://www.gmc-uk.org/doctors/before_you_apply/imgs.asp
Germany

- Pass a German language test.
- Apply to clinics in Germany to get a post as a guest doctor.
- Apply to the State department for medical practice to obtain a temporary license of medical practice.
- Within the period of the 2 years pass the medical knowledge exam
- Apply to clinics for a paid job as a doctor in training with the aim to become a specialist after 5 years.
- [https://www.praktischarzt.de/arzt/international-doctors-medical-students/#nonEU](https://www.praktischarzt.de/arzt/international-doctors-medical-students/#nonEU)
Manitoba, Canada

- Must pass a Practice Ready Assessment
- Physicians do not require an offer of employment to submit an application for registration to the College.
- Be a graduate of an approved Faculty of Medicine in World Directory of Medical Schools or of the International Medical Education Directory.
- Have completed of the following postgraduate clinical training: 2 years of postgraduate clinical training to the Physicians & Surgeons of Manitoba OR 1 year postgraduate clinical training and 3 years of family practice.

http://cpsm.mb.ca/international-medical-graduates-application-guide-for-registration-family-practice
Texas Faculty Temporary License

- The sponsoring institution must be an accredited Texas medical school.
- Hold an M.D., D.O., or equivalent degree.
- Completed at least two years of postgraduate residency outside U.S.
- Pass the Texas Medical Jurisprudence examination.
- Hold a salaried faculty position equivalent to an assistant professor.
- Not have a medical license that has been subject to disciplinary action.
- Not have a medical license that is under an investigation.
- Not have a prosecution pending for any offense.
- The FTL is issued for a period of one year. An applicant may apply for one or more successive FTLs. There is no limit.
- Each year under an FTL is considered the equivalent of one year of approved postgraduate training in U.S.

http://www.tmb.state.tx.us/page/licensing-faculty-temporary-licenses
Florida Medical Faculty Certificate

- Graduated from an accredited medical school list with the World Health Organization.
- Hold a valid current license to practice medicine in another jurisdiction.
- Completed an approved residency or fellowship of at least one year or received training which has been determined by the Board to be equivalent to the one year requirement.
- Been offered and accepted a full-time faculty appointment to teach in a program of medicine.

http://flboardofmedicine.gov/licensing/medical-faculty-certificate/
Pennsylvania Intuitional License

- An applicant shall be a graduate of an unaccredited (International) medical college who has attained, through professional growth and teaching experience, the status of teacher in a particular area of medicine or
- Has achieved outstanding medical skills in a particular area of medicine and surgery and wishes to practice, demonstrate, or teach in that area, but not otherwise licensed to do so.
- If you have current ECFMG certification and ECFMG verified your medical education you DO NOT need to provide the verification of medical education outlined above.

New York Limited Permit

- Practice medicine only under the supervision of a New York State licensed and currently registered physician.
- Have satisfied all requirements for a license as a physician except those relating to examination and citizenship or permanent residence status in the U.S. OR
- International Medical Graduate (IMG) who has met the education requirement and holds a standard certificate from ECFMG.
- Limited permits are granted for an initial period of two years and may be renewed for up to two additional years only.

http://www.op.nysed.gov/prof/med/medlic.htm#limit
What's IMG Biggest Challenge?

- The largest challenge that I see for me in the American system of medicine will be learning the U.S. system of medical insurance.

- We have more similarities then you think.
  - Anatomy and physiology are the same.
  - Standards of treatment are the same.
  - The medical equipment is the same.
Summary

- 4 years Nursing school
- 6 years medical school
- 5 years residency.
- 4 years of fellowship.
- 1 year laser treatment training
- 1 year U.S. clinical rotations.
- 2 MD degrees
Thank you!

Questions?
A bill for an act

relating to health care; authorizing the Board of Medical Practice to issue a limited license to practice medicine in rural or underserved communities for international medical graduates; proposing coding for new law in Minnesota Statutes, chapter 147.

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

Section 1. [147.0373] LIMITED LICENSE TO PRACTICE MEDICINE IN RURAL OR UNDERSERVED COMMUNITIES FOR INTERNATIONAL MEDICAL GRADUATES.

Subdivision 1. Requirements. (a) The board shall issue a limited license to practice medicine within a rural or underserved community to an applicant who:

(1) satisfies the requirements in section 147.037, subdivision 1, paragraphs (a), (b), (c), and (e);

(2) submits evidence satisfactory to the board of the completion of at least one year of postgraduate clinical medical training in the country in which the applicant received their medical education, or of successfully practicing medicine in another country for a period of at least five years;

(3) submits evidence of Minnesota residency for a period of at least three years prior to the date of application; and

(4) submits an employment contract or other satisfactory evidence indicating employment and acknowledging that the applicant is employed or will be employed upon the issuance of a limited license under this section to practice medicine in primary care in a setting located in a rural or underserved community.
(b) For purposes of this section, "rural" and "underserved community" are defined under section 144.1911, subdivision 2.

Subd. 2. **Limited licensure.** (a) The board shall issue a limited license to practice medicine to an applicant eligible for licensure under this section only if the application for the limited license is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid. The limited license issued under this section shall limit the practice of medicine to primary care within the employment setting described under subdivision 1, paragraph (a), clause (4).

(b) If a person holding a limited license under this section changes employment, the person must notify the board in writing no later than 30 days after termination of employment. The new employment contract must be submitted to the board with the notification. If notification and a new employment contract is not submitted to the board within this time period, or the new employment contract does not meet the requirements in subdivision 1, the board shall immediately revoke the limited license issued under this section.

Subd. 3. **Limitation of practice.** (a) A person issued a limited license under this section may only practice medicine within the primary care setting of the limited licensee's employer, and shall only practice medicine under a collaborative agreement and under a physician's supervision.

(b) The collaborative agreement between the limited licensee and the supervising physician must affirm the supervisory relationship and define the limited licensee's scope of practice. The agreement must describe the scope and nature of the supervision and must specify the categories of drugs, controlled substances, and medical devices that the supervising physician delegates to the limited licensee to prescribe. The agreement must be prepared and signed by the supervising physician and the limited licensee, must be kept on file at the limited licensee's place of employment, and must be made available to the board upon request. The agreement must be reviewed after one year and may be updated or changed for the next year.

(c) For purposes of this section, "supervision" means overseeing the activities of, and accepting responsibility for, the medical services performed by the limited licensee. The scope and nature of the supervision shall be defined by the collaborative agreement between the limited licensee and the supervising physician. For purposes of this section, "supervising physician" means a Minnesota licensed physician who accepts full medical responsibility for the performance, practice, and activities of the limited licensee under the collaborative agreement as described in this subdivision.

Section 1.
Subd. 4. Licensure expiration. A limited license issued under this section shall expire after two years and may be renewed for an additional two years. Upon expiration, the limited licensee may apply for a license without limitations according to section 147.037 if the licensee has practiced for a period of two years in a rural or underserved community. The clinical medical training requirement under section 147.037, subdivision 1, paragraph (d), shall be deemed met upon the applicant maintaining a limited license under this section for a period of two years.

Subd. 5. Representation of professional status. In making representations of professional status, a limited licensee must indicate or state that the limited licensee is practicing under a limited license.

Subd. 6. Standard of practice. A licensee with a limited license issued under this section must conduct all professional activities in accordance with sections 147.091; 147.092; 147.111; 147.121; 147.131; 147.141; 147.231; and 147.37.

Subd. 7. Revocation of limited license. The board may immediately revoke the limited license of any licensee who violates a requirement of this section. A licensee whose limited license is revoked must immediately return the limited license to the board.
(d) The board shall upon request furnish to a person who made a complaint, or the alleged victim of a violation of section 147.091, subdivision 1, paragraph (i), or both, a description of the activities and actions of the board relating to that complaint, a summary of the results of an investigation of that complaint, and the reasons for actions taken by the board.

(e) A probable cause hearing held pursuant to section 147.092 shall be closed to the public, except for the notices of hearing made public by operation of section 147.092.

(f) Findings of fact, conclusions, and recommendations issued by the administrative law judge, and transcripts of oral arguments before the board pursuant to a contested case proceeding in which an administrative law judge found a violation of section 147.091, subdivision 1, paragraph (i), are public data.

Subd. 5. Expenses; staff. The Board of Medical Practice shall provide blanks, books, certificates, and such stationery and assistance as is necessary for the transaction of the business pertaining to the duties of such board. The expenses of administering this chapter shall be paid from the appropriations made to the Board of Medical Practice. The board shall employ an executive director subject to the terms described in section 214.04, subdivision 2a.

Subd. 6. [Repealed, 1997 c 225 art 2 s 63]

Subd. 7. Physician application fee. The board may charge a physician application fee of $200. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

History: (5706) RL s 2295; 1921 c 68 s 1; 1927 c 188 s 1; 1963 c 45 s 1; 1967 c 416 s 1; 1969 c 927 s 1; 1973 c 638 s 6; 1975 c 136 s 5; 1976 c 2 s 65; 1976 c 222 s 32; 1976 c 239 s 53; 1984 c 588 s 1; 1985 c 247 s 1-3,25; 1986 c 444; 1Sp1986 c 3 art 1 s 22; 1987 c 86 s 1; 1990 c 576 s 1-3; 1991 c 105 s 1; 1991 c 106 s 6; 1991 c 199 art 1 s 40; 1992 c 513 art 7 s 9; 1Sp1993 c 1 art 5 s 6; 1995 c 186 s 44; 1995 c 207 art 9 s 38; 1996 c 334 s 3; 2000 c 284 s 2; 2004 c 270 s 1; 2004 c 279 art 11 s 2; 2012 c 278 art 2 s 8; 2013 c 44 s 2; 2016 c 119 s 1,2

147.011 DEFINITION.

For the purpose of this chapter, "regulated person" or "person regulated by the board" means a person licensed, registered, or regulated in any other manner by the Board of Medical Practice.

History: 1995 c 18 s 1

147.012 OVERSIGHT OF ALLIED HEALTH PROFESSIONS.

The board has responsibility for the oversight of the following allied health professions: physician assistants under chapter 147A; acupuncture practitioners under chapter 147B; respiratory care practitioners under chapter 147C; traditional midwives under chapter 147D; registered naturopathic doctors under chapter 147E; and athletic trainers under sections 148.7801 to 148.7815.

History: 2013 c 44 s 5

147.02 EXAMINATION; LICENSING.

Subd. 1. United States or Canadian medical school graduates. The board shall issue a license to practice medicine to a person not currently licensed in another state or Canada and who meets the requirements in paragraphs (a) to (i).
(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic medical school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed an examination as described in clause (1) or (2).

(1) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the National Board of Medical Examiners, the Federation of State Medical Boards, the Medical Council of Canada, the National Board of Osteopathic Examiners, or the appropriate state board that the board determines acceptable. The board shall by rule determine what constitutes a passing score in the examination.

(2) The applicant taking the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must have passed steps or levels one, two, and three. Step or level three must be passed within five years of passing step or level two, or before the end of residency training. The applicant must pass each of steps or levels one, two, and three with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts. The applicant taking combinations of Federation of State Medical Boards, National Board of Medical Examiners, and USMLE may be accepted only if the combination is approved by the board as comparable to existing comparable examination sequences and all examinations are completed prior to the year 2000.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization.

(e) The applicant may make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a fee established by the board by rule. The fee may not be refunded. Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs; and

(2) clearly identify to the applicant the payment schedule of additional costs.

(g) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(h) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing
that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(i) If the examination in paragraph (c) was passed more than ten years ago, the applicant must either:

(1) pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(2) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

Subd. 1a. Examination extension; active military service. The board may grant an extension to the time period required to pass the United States Medical Licensing Examination (USMLE) as specified in subdivision 1, paragraph (c), clause (2), if an applicant is mobilized into active military service, as defined in section 190.05, subdivision 5, during the process of taking the USMLE, but before passage of all steps. Proof of active military service must be submitted to the board on the forms and according to the timelines of the board.

Subd. 1b. Examination extension; medical reasons. The board may grant an extension to the time period and to the number of attempts permitted to pass the United States Medical Licensing Examination (USMLE) as specified in subdivision 1, paragraph (c), clause (2), if an applicant has been diagnosed with a medical illness during the process of taking the USMLE but before passage of all steps, or fails to pass a step within three attempts due to the applicant's medical illness. Proof of the medical illness must be submitted to the board on forms and according to the timelines of the board.

Subd. 2. [Repealed, 1985 c 247 s 26]

Subd. 2a. Temporary permit. The board may issue a temporary permit to practice medicine to a physician eligible for licensure under this section only if the application for licensure is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the physician's application for licensure.

Subd. 3. [Repealed, 1971 c 485 s 6]

Subd. 4. [Repealed, 1984 c 432 art 2 s 55]

Subd. 5. Procedures. The board shall adopt a written statement of internal operating procedures describing procedures for receiving and investigating complaints, reviewing misconduct cases, and imposing disciplinary actions.

Subd. 6. Disciplinary actions must be published. At least annually, the board shall publish and release to the public a description of all disciplinary measures taken by the board. The publication must include, for each disciplinary measure taken, the name and business address of the licensee, the nature of the misconduct, and the disciplinary measure taken by the board.

Subd. 6a. Exception to publication requirement. The publication requirement does not apply to disciplinary measures by the board which are based exclusively upon grounds listed in section 147.091, subdivision 1, clause (l) or (r).

History: (5707) RL s 2296; 1909 c 474 s 1; 1927 c 188 s 2; 1937 c 203 s 1; 1953 c 290 s 1; 1959 c 346 s 1; 1963 c 45 s 2; 1967 c 416 s 2; 1969 c 6 s 25; 1969 c 927 s 2; 1971 c 485 s 2; 1973 c 638 s 7; 1974 c
147.025 EVIDENCE OF PAST SEXUAL CONDUCT.

In a proceeding for the suspension or revocation of a license or other disciplinary action for unethical or unprofessional conduct involving sexual contact with a patient or former patient, the board or administrative law judge shall not consider evidence of the patient’s previous sexual conduct nor shall any reference to this conduct be made during the proceedings or in the findings, except by motion of the complainant, unless the evidence would be admissible under the applicable provisions of section 609.347, subdivision 3.

History: 1984 c 556 s 1; 1984 c 640 s 32

147.03 LICENSURE BY ENDORSEMENT; RECIPROCITY; TEMPORARY PERMIT.

Subdivision 1. Endorsement; reciprocity. (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to (f).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada and, if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

(i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.
(d) The applicant shall pay a fee established by the board by rule. The fee may not be refunded.

(e) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(f) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (e). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

(g) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

Subd. 2. Temporary permit. The board may issue a temporary permit to practice medicine to a physician eligible for licensure under this section only if the application for licensure is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the physician's application for licensure.

Subd. 3. Exception. Notwithstanding subdivision 2, the board may issue a temporary permit to practice medicine to an applicant who has not satisfied the requirements of subdivision 1, paragraph (c), clause (2), item (i) or (ii), but has satisfied all other requirements for licensure under this section, and has paid a nonrefundable fee set by the board. The permit remains valid for six months.

History: (5709) 1905 c 236 s 1; 1913 c 139 s 1; 1919 c 251 s 1; 1927 c 188 s 3; 1953 c 290 s 2; 1963 c 43 s 3; 1975 c 92 s 1; 1977 c 7 s 1; 1985 c 247 s 8; 1986 c 444; 1991 c 105 s 1; 1992 c 513 art 6 s 28; 1993 c 19 s 1; 1993 c 21 s 4; 1999 c 33 s 2; 2004 c 268 s 12; 2004 c 288 art 7 s 5; 2006 c 188 s 2; 2008 c 189 s 3; 2016 c 119 s 4

147.031 [Repealed, 2016 c 158 art 1 s 215]

147.032 INTERSTATE PRACTICE OF TELMIDICINE.

Subdivision 1. Requirements; registration. (a) A physician not licensed to practice medicine in this state may provide medical services to a patient located in this state through interstate telemedicine if the following conditions are met:

(1) the physician is licensed without restriction to practice medicine in the state from which the physician provides telemedicine services;

(2) the physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction;

(3) the physician does not open an office in this state, does not meet with patients in this state, and does not receive calls in this state from patients; and

(4) the physician annually registers with the board, on a form provided by the board.

(b) To register with the board, a physician must:

(1) state the physician's intention to provide interstate telemedicine services in this state;

(2) provide complete information on:
(i) all states and jurisdictions in which the physician is currently licensed;
(ii) any states or jurisdictions in which the physician was previously licensed;
(iii) any negative licensing actions taken previously against the physician in any state or jurisdiction;
and
(iv) other information requested by the board; and

(3) pay a registration fee of $75 annually and an initial application fee of $100.

(c) A physician registered to provide interstate telemedicine services under this section must immediately notify the board of restrictions placed on the physician's license to practice in any state or jurisdiction.

(d) In registering to provide interstate telemedicine services to state residents under this section, a physician agrees to be subject to state laws, the state judicial system, and the board with respect to providing medical services to state residents.

(e) For the purposes of this section, telemedicine means the practice of medicine as defined in section 147.081, subdivision 3, when the physician is not in the physical presence of the patient.

Subd. 2. Exemptions from registration. A physician who is not licensed to practice medicine in this state, but who holds a valid license to practice medicine in another state or jurisdiction, and who provides interstate telemedicine services to a patient located in this state is not subject to the registration requirement of subdivision 1, paragraph (a), clause (4), if:

(1) the services are provided in response to an emergency medical condition. For the purposes of this section, an emergency medical condition means a condition, including emergency labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any body organ or part;

(2) the services are provided on an irregular or infrequent basis. For the purposes of this section, a person provides services on an irregular or infrequent basis if the person provides the services less than once a month or provides the services to fewer than ten patients annually; or

(3) the physician provides interstate telemedicine services in this state in consultation with a physician licensed in this state and the Minnesota physician retains ultimate authority over the diagnosis and care of the patient.

Subd. 3. Notification to other states. The board shall obtain confirmation of licensure from all states and jurisdictions in which a physician registered under subdivision 1 has ever been licensed to verify statements made by the physician and to be notified if any future adverse action is taken against the physician's license in another state or jurisdiction. This requirement does not replace the reporting obligation under section 147.111.

Subd. 4. Health records. A physician who provides interstate telemedicine services to a patient located in this state must comply with sections 144.291 to 144.298 with respect to the provision of those services.

History: 2002 c 361 s 1; 2007 c 147 art 10 s 15
147.035 MALPRACTICE HISTORY.

Subdivision 1. Submission. A person desiring to practice medicine in this state who has previously practiced in another state shall submit the following additional information with the license application for the five-year period of active practice preceding the date of filing such application:

(a) The name and address of the person’s professional liability insurer in the other state.

(b) The number, date, and disposition of any medical malpractice settlement or award made to the plaintiff relating to the quality of medical treatment.

Subd. 2. Board action. The board shall give due consideration to the information submitted pursuant to section 147.03 and this section. An applicant who willfully submits incorrect information shall be subject to disciplinary action pursuant to section 147.091.

History: 1976 c 222 s 35; 1985 c 247 s 25; 1986 c 444

147.037 LICENSING OF FOREIGN MEDICAL SCHOOL GRADUATES; TEMPORARY PERMIT.

Subdivision 1. Requirements. The board shall issue a license to practice medicine to any person who satisfies the requirements in paragraphs (a) to (g).

(a) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (e), (f), (g), and (h).

(b) The applicant shall present evidence satisfactory to the board that the applicant is a graduate of a medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data. If the applicant is a graduate of a medical or osteopathic program that is not accredited by the Liaison Committee for Medical Education or the American Osteopathic Association, the applicant may use the Federation of State Medical Boards’ Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses this service as allowed under this paragraph, the physician application fee may be less than $200 but must not exceed the cost of administering this paragraph.

(c) The applicant shall present evidence satisfactory to the board that the applicant has been awarded a certificate by the Educational Council for Foreign Medical Graduates, and the applicant has a working ability in the English language sufficient to communicate with patients and physicians and to engage in the practice of medicine.

(d) The applicant shall present evidence satisfactory to the board of the completion of two years of graduate, clinical medical training in a program located in the United States, its territories, or Canada and accredited by a national accrediting organization approved by the board. This requirement does not apply:

(1) to an applicant who is admitted as a permanent immigrant to the United States on or before October 1, 1991, as a person of exceptional ability in the sciences according to Code of Federal Regulations, title 20, section 656.22(d);

(2) to an applicant holding a valid license to practice medicine in another country and issued a permanent immigrant visa after October 1, 1991, as a person of extraordinary ability in the field of science or as an outstanding professor or researcher according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary nonimmigrant visa as a person of extraordinary ability in the field of science according to Code of Federal Regulations, title 8, section 214.2(o),

Copyright © 2017 by the Revisor of Statutes, State of Minnesota. All Rights Reserved.
provided that a person under clause (1) or (2) is admitted pursuant to rules of the United States Department of Labor; or

(3) to an applicant who is licensed in another state, has practiced five years without disciplinary action in the United States, its territories, or Canada, has completed one year of the graduate, clinical medical training required by this paragraph, and has passed the Special Purpose Examination of the Federation of State Medical Boards within three attempts in the 24 months before licensing.

(e) The applicant must:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the United States Medical Licensing Examination program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2), or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or country and, if the examination in clause (1) was passed more than ten years ago, either:

   (i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

   (ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

   (i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

   (ii) is currently licensed in another state; and

   (iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(f) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (f). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

Subd. 1a. Temporary permit. The board may issue a temporary permit to practice medicine to a physician eligible for licensure under this section only if the application for licensure is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the physician's application for licensure.
11 MINNESOTA STATUTES 2017 147.0375  

Subd. 2. Medical school review. The board may contract with any qualified person or organization for the performance of a review or investigation, including site visits if necessary, of any medical or osteopathic school prior to approving the school under section 147.02, subdivision 1, paragraph (b), or subdivision 1, paragraph (b), of this section. To the extent possible, the board shall require the school being reviewed to pay the costs of the review or investigation.

History: 1985 c 247 s 9; 1986 c 444; 1991 c 106 s 2; 1993 c 21 s 5,6,13; 1994 c 433 s 1; 1995 c 18 s 2; 1999 c 33 s 3; 2004 c 270 s 2; 2007 c 123 s 6; 2008 c 189 s 4; 2016 c 119 s 5

147.0375 MEDICAL FACULTY LICENSE.

Subdivision 1. Requirements. The board shall issue a license to practice medicine to any person who satisfies the requirements in paragraphs (a) to (d).

(a) The applicant must satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (e), (f), (g), and (h).

(b) The applicant must present evidence satisfactory to the board that the applicant is a graduate of a medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data. If the applicant is a graduate of a medical or osteopathic program that is not accredited by the Liaison Committee for Medical Education or the American Osteopathic Association, the applicant may use the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses this service as allowed under this paragraph, the physician application fee may be less than $200 but must not exceed the cost of administering this paragraph.

(c) The applicant must present evidence satisfactory to the board of the completion of two years of graduate, clinical medical training in a program located in the United States, its territories, or Canada and accredited by a national accrediting organization approved by the board. This requirement does not apply:

(1) to an applicant who is admitted as a permanent immigrant to the United States on or before October 1, 1991, as a person of exceptional ability in the sciences according to Code of Federal Regulations, title 20, section 656.22 (d);

(2) to an applicant holding a valid license to practice medicine in another state or country and issued a permanent immigrant visa after October 1, 1991, as a person of extraordinary ability in the field of science or as an outstanding professor or researcher according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary nonimmigrant visa or status as a person of extraordinary ability in the field of science according to Code of Federal Regulations, title 8, section 214.2(o); or

(3) to an applicant who is licensed in another state, has practiced five years without disciplinary action in the United States, its territories, or Canada, has completed one year of the graduate, clinical medical training required by this paragraph, and has passed the Special Purpose Examination of the Federation of State Medical Boards within three attempts in the 24 months before licensing.

(d) The applicant must present evidence satisfactory to the board that the applicant has been appointed to serve as a faculty member of a medical school accredited by the Liaison Committee of Medical Education or an osteopathic medical school accredited by the American Osteopathic Association.

Subd. 2. Medical school review. The board may contract with any qualified person or organization for the performance of a review or investigation, including site visits if necessary, of any medical or osteopathic school prior to approving the school under section 147.02, subdivision 1, paragraph (b), or subdivision 1,
paragraph (b), of this section. To the extent possible, the board shall require the school being reviewed to pay the costs of the review or investigation.

Subd. 3. Resignation or termination for medical faculty position. If a person holding a license issued under this section resigns or is terminated from the academic medical center in which the licensee is employed as a faculty member, the licensee must notify the board in writing no later than 30 days after the date of termination or resignation. Upon notification of resignation or termination, the board shall terminate the medical license.

Subd. 4. Reporting obligation. A person holding a license issued under this section is subject to the reporting obligations of section 147.111.

Subd. 5. Limitation of practice. A person issued a license under this section may only practice medicine within the clinical setting of the academic medical center where the licensee is an appointed faculty member or within a physician group practice affiliated with the academic medical center.

Subd. 6. Continuing education. The licensee must meet the continuing education requirements under Minnesota Rules, chapter 5605.

Subd. 7. Expiration. This section expires July 1, 2018.

_History_: 2016 c 179 s 26
Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(5) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

(6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);
(8) federal, state, and local-law enforcement authorities acting pursuant to a valid search warrant;

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

(10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (i);

(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.

For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(f) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

(h) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section,
and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

(i) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

(j) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.
Brink

THE OPIOID DILEMMA
WELCOME TO OUR SUMMER ISSUE.

You may not be surprised to find this issue of *Brink* focused on the nation's opioid epidemic and the problems it presents for health care providers. Every day brings new media stories on the subject, new challenges for our policyholders trying to balance effective pain treatment and patient safety, and ongoing risks to organizations whose health care practitioners themselves may become ensnared in the misuse of opioids.

What may surprise you is the richness of viewpoints on the problem, the many ways to approach solutions (and their sometimes unintended consequences), and evolving research on the effectiveness of both traditional and emerging treatments. We've tried to approach the issue in a thoughtful manner that respects these different starting points while driving toward effective suggestions to help you engage more fully with the problem in your own practice.

A broader discussion we encourage is how to rethink pain management, the subject of our educational program, "Rethinking Pain Management for Community Health and Safety," which we're delivering to our policyholders at various sites throughout our coverage territory this year. We share highlights of this program on page 6 of this issue, including findings from our claim data related to opioids and recommendations for safer care. In our claim review on page 18, we provide excellent chronic pain management resources, including assessment tools.

We also focus on the problem of health professionals and opioid addiction, considering factors like stress, burnout, isolation and access to medications that can play a role in the problem. We advocate a compassionate and therapeutic approach and offer resources that can help.

As part of our decades-long commitment to helping healers with addictions get help themselves, MMIC has co-sponsored, since 1981, a Minnesota program called Physicians Serving Physicians (PSP). It's a discreet resource that provides peer support, assessment, consultation, and referrals for physicians, their families and colleagues who are affected by addiction.

As we point out in our "Rethinking Pain Management" educational program, opioid use disorder is a community problem, and it will take all of us working together to make lasting inroads on the problem.

We welcome your feedback on this issue and encourage you to reach out if we can help you or a colleague in any way.

All my best,

Bill McDonough
President and CEO, Constellation
ENHANCED CYBER COVERAGE IN 2017

MMIC, UMIA and Arkansas Mutual are enhancing cyber coverage throughout 2017 and 2018 to include the following coverages for eligible policyholders:

- BrandGuard® coverage for lost income resulting from an adverse media report or customer notification of a privacy or security breach
- PCI DSS Assessments coverage for defense costs and fines/assessments levied by credit card associations or acquiring banks for non-compliance with the PCI DSS resulting from a privacy or security breach
- Cyber crime coverage for certain losses resulting from financial fraud, telecommunications fraud or phishing attacks
- Privacy response breach costs coverage extended to proactive public relations expenses and voluntary notification
- Medefense Plus® coverage for governmental and commercial payer billing audits and investigations as well as EMTALA, Stark and HIPAA proceedings
- EMTALA coverage for independent living and outpatient facilities with revenues less than $250 million and medical professional liability deductibles less than $250,000.

Up to $10 million in limits are available. More information will be provided directly to policyholders regarding this coverage and effective dates.

*Eligible policyholders include independently owned and operated physician practices, hospitals, senior living and outpatient facilities with revenues less than $250 million and medical professional liability deductibles less than $250,000.

CONTACT YOUR INSURANCE AGENT OR COMPANY UNDERWRITER FOR MORE INFORMATION

NEW WEBSITE IMPROVED FOR YOUR PHONE OR TABLET

MMICgroup.com now resizes to fit your phone or tablet. We’ve also refreshed our site with:

- Easy navigation, iconography and condensed content—to find what you need fast
- New client and broker login experience

LONG-TERM CARE VENTURES INTO SOCIAL MEDIA

On Wednesday, October 18, Kristi Eldredge, RN, JD, CPHRM, senior patient safety consultant at MMIC, will present her talk, “Best Practices for Social Media in the LTC Environment: Facebook, Twitter and Snapchat … Oh My!” at the AHCA/NCAL Annual Convention & Expo in Las Vegas.

Eldredge will discuss the risks and benefits of social media usage for both residents and facilities, such as resident well-being and privacy, HIPAA, medical malpractice, employee behavior and training, and reputation monitoring.

LEARN MORE AT EVENTSCRIBE.COM/2017/AHCANCAL/INDEX.ASP

FALL CONFERENCE ON RURAL EMERGENCY CARE

The 4th CALS Conference on Rural Emergency Care is scheduled for Friday, September 29 at the University of Minnesota campus in St. Paul, MN. CALS stands for Comprehensive Advanced Life Support, an educational program designed for emergency medical training needs of rural health care teams.

Physicians, nurses, NPs, paramedics and administrators will come together for hands-on workshops. Constellation’s chief medical officer, Laurie Drill-Mellum, MD, will present on diagnostic error.

SUMMER/FALL SPEAKING EVENTS WITH CMO AND PATIENT SAFETY LEADERS

Laurie Drill-Mellum, MD, MPH
Chief Medical Officer, Constellation
9/20 Hutchinson Health’s Annual Primary Care Nursing Conference, Hutchinson, MN: “The Case for Empathy: Improving the Patient & Clinician Experience One Encounter at a Time” and “Who Heals the Healers?”


10/17 SIDM Diagnostic Error in Medicine Conference, Boston: Laurie Drill-Mellum, MD will speak in the panel discussion, “Building-up Your Team”

11/12 AMA Forum for Medical Affairs, Honolulu: “Reclaiming Joy in Medical Life: Personal Practices and Systemic Approaches for Success”

Trish Lugtu, BS, CPHIMS
Senior Manager, Advanced Analytic Solutions, Constellation

10/17 ASHRM Annual Conference, Seattle: “Closing the Loop on Diagnosis with Health IT Risk Management”

Emily Clegg, JD, MBA, CPHRM
Manager and Senior Consultant, UMIA
8/10 Utah Osteopathic Association Annual Conference, Salt Lake City: “Advanced Practice Providers: Roles and Risks”

10/17 ASHRM Annual Conference, Seattle: “Evolving Models of Care: Eight Risks in Telemedicine”

Visit CyberNet®, the newly enhanced website for CyberSolutions® policyholders. Find great resources:

- Sample policies and best practice guidelines
- Training modules and webinars
- Guidance for handling data breaches
- Quarterly newsletters and instant alerts

LOG IN TO MMICGROUP.COM TO BROWSE WHAT CYBERNET OFFERS
Powerful Medicine
Talking to patients is the most effective diagnostic tool.

In her new book, "What Patients Say, What Doctors Hear," Danielle Ofri, MD, claims, much as Sir William Osler, MD, did more than a century ago, that the conversation between doctor and patient is still the single most powerful diagnostic tool.

That's both reassuring and unnerving. Unnerving because it's a lot to ask from today's brief, distracted and often mutually unsatisfying medical encounters. Reassuring because basic communication chops seem to be (at least potentially) within most every clinician's skill set.

Dr. Ofri explores both angles in her book, weaving together compelling stories of physician-patient pairs who share the frustrations and rewards of their relationships, and research from linguists and other scientists who are gaining new insights into what makes medical interactions effective and how to train clinicians to use communication more effectively.

What she also includes, and this grounds the book nicely, are candid accounts of her experiments incorporating various recommendations in her own practice. Her frankness and good humor shine throughout.

We see her vow to go for one day without interrupting a single patient as they explain the reason for their visit (she measures their talk time on a stopwatch in her pocket). She encourages them to get all their issues on the table: "Each time [they] paused, I asked gamely, 'Anything else?'"

No spoilers, but her results don't lend support to those who claim, "We could never do that here."

We see her resist her urge to harangue patients about their chronic conditions, mindful of research that shows repetition isn't effective because most patients are very knowledgeable about their conditions. Instead, she asks what their biggest challenges are in dealing with their condition. "Nine times out of ten, that question yields the most important kernel of the medical visit," she says.

What emerges is a heartening look at how approaching medical interactions with curiosity, respect, humility and courage is the basis for building a trusting relationship with patients.

Language matters
In one chapter, Dr. Ofri explores how the words physicians use can make it sound as though patients are responsible for clinical outcomes. As an example, she describes a patient as having failed chemotherapy, refused radiation and been non-compliant with her medications.

"We could just as easily say that [her] cancer is resistant to chemotherapy, she has declined radiation treatment because of low efficacy, and the side effects of her diabetes meds outweigh the benefits."

This more careful and respectful use of language acknowledges both "the very hard work of being a patient and the tremendous challenges of being a physician."

Listening matters, too
In a particularly interesting chapter, Dr. Ofri explores research that points up how meaning is co-created by speaker and listener — each responding to the other's moves — and how inattentive listening can lead to a drop in the quality of the speaker's story. That's a problem when the story is the patient's history — that vital key to diagnosis.

The book has much to offer both physicians and patients. As Dr. Ofri notes, cultivating good communication can "enhance our lives on both sides of the stethoscope."

LYNN WELCH
Senior Strategic Communications Consultant
Constellation
Lynn.Welch@ConstellationMutual.com
The Data Mine

Opioids and Malpractice Claims

Opioid malpractice risk hotspots

An examination of malpractice risks in pain management offers a unique perspective within the general discourse of the opioid epidemic. For this analysis, MMIC identified 41 professional liability claims asserted 2010 through 2015 involving opioids, excluding treatment involved in managing cancer-related or acute care pain. One striking insight from the study is that medication administration allegations occur with the same frequency regardless of whether opioids are involved; however, outcomes in cases involving opioids are commonly more severe, highlighting the need for stronger diligence during medication administration processes.

What allegations are involved?
The majority of allegations involving opioids are medication-related regardless of setting, such as the administration or ordering of wrong medication or dose. Second highest are medical treatment-related allegations, including improper management of treatment course. The third most frequent are allegations of failure to ensure safety from falls.

The top issues vary between inpatient and outpatient claims. Whereas inpatient issues tend to involve more medication administration errors or behavior issues involving nursing, outpatient claims tend to involve more ordering errors by physicians or patient factors, such as non-compliance with medication or treatment regimen. Outpatient claims also involve more communication issues between patients and providers regarding the risks of medication.

Conclusion
Increasing awareness, training, and diligence for medication ordering and administration is paramount to preventing the avoidable high severity outcomes found in opioid cases. In addition, fall safety measures must be implemented for patients medicated with opioids, and effort must be made to prevent, identify and respond to drug diversion occurring within the health care workplace (see page 21 for strategies for preventing diversion).

This analysis was made possible through MMIC’s partnership with CRICO Strategies and use of their comprehensive risk intelligence platform.

TRISH LUGTU, BS, CPHIMS
Senior Manager, Advanced Analytics Solutions
Constellation
Trish.Lugtu@ConstellationMutual.com

Opioids were involved in 41 PL cases accounting for $3.1 million over a six-year period

Major Allegation Categories Involving Opioids

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>68%</td>
</tr>
<tr>
<td>Medical Treatment</td>
<td>20%</td>
</tr>
<tr>
<td>Safety</td>
<td>10%</td>
</tr>
<tr>
<td>Provider Behaviors</td>
<td>2%</td>
</tr>
</tbody>
</table>
Opioids Most Involved

Medication combination resulting in the highest indemnity
- fentanyl and oxycodone

Opioids most often involved
- Dilaudid® (29%)
- methadone (21%)
- oxycodone (14%)

Injury Severity

All Settings

The most frequent injury was adverse reaction in 29% of cases.

Death was the outcome in 22% of all cases.

NAIC Clinical Severity Scale
HIGH: Death, Perm Grave/Major/Significant
MED: Perm Minor, Temp Major/Minor
LOW: Temp Insignificant, Emotional/Legal Only

Top Issues Vary Across Settings

Cases by Claimant Type

Top issues in inpatient claims
Nursing (67%)
- Administration of incorrect/inappropriate dose
- Drug diversion

General medicine (22%)
- Family med/internal practice
- Improper management of treatment course

Top issues in outpatient claims
Family medicine (45%)
- Improper medication regimen management
- Ordering wrong dose or medication

Nursing (20%)
- Administration of wrong dose
- Fall safety
Rethinking Pain Management

Toward increased patient safety with opioid prescriptions.

By Lori Atkinson, RN, BSN, CPHRM, CPPS

Treating patients with chronic pain is complex and challenging. Many clinicians express concern about how to safely manage the needs of an increasing number of pain patients in an environment of federal and state initiatives aimed at reducing opioid prescriptions.

MMIC, UMIA and Arkansas Mutual have responded to policyholder concerns with an education program, “Rethinking Pain Management for Community Health and Safety.” This one-hour in-person education program uses findings from an analysis of malpractice claims and identifies strategies and training to empower clinicians and team members to support this complex issue while managing the emerging risks. The following is a high-level overview of the program and recommended risk mitigation strategies.

Scope of the opioid problem
The Centers for Disease Control and Prevention (CDC) notes that over the past 25 years there has been a dramatic increase in the use of prescription opioids for the treatment of chronic, non-cancer pain. The CDC estimates that 20 percent of patients presenting to physician offices with pain receive an opioid prescription.1 At the same time, the increasing use of opioids for the treatment of chronic pain has resulted in unintended consequences. The CDC has declared that our nation is in the midst of an unprecedented opioid epidemic, with more than 33,000 people killed by opioids (including prescription opioids and heroin) in 2015. Nearly half of all opioid overdose deaths involve a prescription opioid.1

In a 2016 study, 91 percent of patients who survived an opioid overdose received more opioid prescriptions upon discharge. The researchers identified this as a missed opportunity to diagnose and treat substance abuse.2 In another study of more than 35,000 hospitalizations for opioid abuse and overdose, only 16.7 percent of patients received medication-assisted treatment (MAT) for substance abuse in the 30 days following discharge.3

Opioid use disorder (OUD) is a substance use disorder identified and described in the DSM-5. OUD and opioid addiction are two terms that are often used interchangeably to describe a chronic, relapsing disease, not a lifestyle choice—one of the common myths surrounding addiction (see page 13, Addiction Myths).

Every community is different in terms of patients, clinicians, prescription opioid use and OUD. According to the CDC, “Prescribing rates for opioids vary widely across different states and regions with clinicians in the highest-prescribing state writing almost three times as many opioid prescriptions per person in 2012 as those in the lowest prescribing states.”4 In 2016, the CDC released the “CDC Guideline for Prescribing Opioids for Chronic Pain” aimed at changing these unsafe prescribing patterns to ensure the safest and most effective chronic pain treatment.

Risks to patients and health care providers
Treating chronic pain with prescription opioids involves risks for patients, clinicians and health care organizations, including:

- Adverse outcomes, including addiction, overdose and death
- Licensing actions for improper prescribing
- Drug diversion on the part of the patient or health care professional. Drug diversion is the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for illicit use.
- DEA criminal prosecution for prescribing without a legitimate medical purpose
- Medication-related malpractice claims

Licensing actions
Rules and regulations relating to pain management are found in nearly every state outlining clinician education requirements, treatment plans, informed consent, patient examination and screening for substance abuse, patient referral to specialists,
limitations on prescribing schedule II and III controlled substances, and regulation of pain clinics and treatment programs. Many states also require clinicians to access their state’s prescription drug monitoring program to determine whether a patient is receiving prescription controlled substances from other clinicians.

When clinicians and licensed health care professionals don’t follow these rules and regulations, state licensing boards can take actions that may include public warnings, fines, practice restrictions, remedial education, probation, and suspension or revocation of license.

Medication-related malpractice claims
An analysis of MMIC medication-related malpractice claims involving chronic pain and opioids revealed that the contributing factors in the outpatient setting were often related to selection and management of therapy. The claims involved patients with high numbers of refills combined with a lack of pain and function assessments, unsafe drug combinations, inadequate assessment for comorbidities, lack of opioid risk stratification and undiagnosed opioid use disorder.

In the outpatient setting, patient noncompliance and ineffective communication regarding the risks of opioids were also factors, while diversion by health care professionals and a lack of policy and procedures contributed to the allegations in the inpatient setting.

Organizations should begin immediately to assess their prescribing practices and policies and implement strategies to protect their communities and stem the tide of the growing opioid epidemic.

References

LORI ATKINSON, RN, BSN, CPHRM, CPPS
Research & Education Manager
MMIC
Lori.Atkinson@MMICgroup.com

Reducing risk, increasing safety
These three strategies can help reduce risks inherent in prescription opioid use and enhance patient safety.

1. Incorporate evidence-based guidelines into practice. Federal, state and specialty-based clinical treatment guidelines can be used as resources to develop chronic pain management policies to ensure consistent evidence-based practice. Most of these clinical guidelines are voluntary and based on emerging evidence, so when writing policies, be sure to allow for patient-specific treatment plans based on the patient’s condition, risks and unique needs. State requirements such as prescribing and refill limits should be incorporated as well, so policies need frequent review and updates.

2. Implement reliable patient management processes to assess, monitor and communicate.

- Assess. Standard tools and algorithms (e.g., PEG, ORT, ICSI Pain Assessment Algorithm) should be used to assess and document a patient’s pain intensity, functional status, quality-of-life impact, opioid addiction risk, behavioral health co-morbidities and aberrant drug-related behaviors (e.g., early refill requests, falsification of a prescription, illegal drug use) to ensure consistent care across your organization.

- Communicate. Motivational interviewing and shared decision-making are patient-centered ways to facilitate communication. When assessments reveal that opioids are doing more harm than good, a respectful conversation with the patient is in order (see “When You Need To Say No,” page 23). Clinicians need to use empathetic communication skills to discuss the behaviors revealed on the assessments and engage patients in revisiting the treatment plan.

3. Provide training, tools and education.
Research indicates that although clinicians are in need of additional training on pain management and prescription opioids, the majority are in support of clinical and regulatory strategies to reduce the harm caused by opioids.

Education and training should focus on:
- Acute and chronic pain pathophysiology
- Pain treatment modalities including non-opioids, opioids and non-pharmacologic treatments
- Pain and function assessment tools; risk stratification tools
- Evidence-based guidelines and policies
- Monitoring for adverse effects and aberrant behavior
- Opioid use disorder and medication-assisted treatment (MAT)
- Empathetic communication skills
The American College of Physicians issued a policy statement in March emphasizing that substance use disorders are chronic medical conditions and should be treated that way.

It's the way Mark Willenbring, MD, a psychiatrist and addiction specialist practicing in St. Paul, MN, has thought about substance use disorders for years, including during a stint as director of the Division of Treatment and Recovery Research of the National Institute on Alcohol and Alcohol Abuse.

Over time, Dr. Willenbring grew increasingly impressed by the "pristine research" being done on the effectiveness of medication-assisted treatment (MAT) models, and increasingly frustrated that that research "never gets to the people [the public] who paid for it." Instead, the treatment landscape has been overwhelmingly based on 12-step models that, in Dr. Willenbring's view, lack the scientific rigor and evidence of effectiveness that guide treatment advances for other chronic conditions.

"Twenty years ago, I was more diplomatic in how I talked about it," Dr. Willenbring says. Now, with the explosion in the number of opioid and heroin overdoses, the stakes are higher. He is quick to point out that abstinence-based models can not only fail their patients, but kill them. "Substance use disorder is a relapsing disorder," he explains. "When relapses occur, patients who have spent time off the substance tend to start using at the same level they did before entering treatment, and they overdose."

Individualized care

When Dr. Willenbring opened Alltyr Clinic five years ago, his outpatient-based, medication-assisted treatment model enabled patients to get help without unnecessarily disrupting their lives, and without losing their dignity—factors that have no doubt contributed to the growth of the practice.

One patient, a police officer injured in the line of duty, began taking opioids for multiple physical symptoms and became dependent on them. He first sought help from his GP, who worked with him to create a taper plan, "but I just couldn't stick to it," he said. He then entered treatment at Hazelden, a nationally recognized rehab facility in Minnesota, but something in him resisted the message he got there, he says, that "You can never be normal again."

"I just never believed that," he said. "I was normal for 35 years! Bad stuff happened. I self-medicated. I got addicted." He needed help from an expert who acknowledged that.

Seeking out Dr. Willenbring enabled him to recover a sense of normalcy, a fact for which he credits both Dr. Willenbring and "an amazing therapist" (patients see both at Alltyr). Together, the three created a customized, medication-assisted treatment plan. Today, the patient is pursuing studies in criminal justice and raising his 11-year-old daughter. "She's an A student. I'm an A student," he smiles. "Thank God I'm here for it. I almost wasn't."

Expanding access

Access to medication-assisted treatment is still a problem as doctors must be specifically credentialed and are limited in the number of patients they can treat. It will likely be a while before treatment rates for people with substance use disorders, currently 18 percent of those who need it, according to the ACP paper, approach those for other chronic conditions (above 70 percent).

Dr. Willenbring believes opioid use disorder will eventually be treated by primary care physicians, much like depression is today. In his view, treatment with Suboxone and similar drugs is a valuable addition to the physician's tool bag. "There are very few treatments in all of health care with this kind of dramatic and rapid improvement," he says.

Reference


LYNN WELCH
Senior Strategic Communications Consultant
Constellation
Lynn.Welch@Constellation Mutual.com
Tough Talk
How clear, evidence-based patient education can disrupt the cycle of chronic pain and opioid addiction.
By Liz Lacey-Gotz

Years before the evidence started rolling in and the media exploded with staggering statistics, Bret Haake, MD, had been giving talks on a better way to treat chronic pain without opioids, which confuse the brain and inhibit the ability to improve, both physiologically and psychologically. “If someone comes to me with chronic pain and they’re on opioids,” Dr. Haake says, “I describe to them that the best way to get rid of their pain is to stop the opioids.”

Research has shown that opioids are not very effective for chronic pain, and long-term use—defined as greater than three months—poses the greatest risk for addiction and overdose. In 2016, the CDC released long-awaited guidelines for treating chronic pain, recommending non-pharmacologic therapies, such as exercise and cognitive behavioral therapy, and non-opioid pharmacologic therapies. Now it’s widely acknowledged: it’s critical to get patients off opioids as soon as possible.

The straight dope
Dr. Haake is the medical director of neuroscience for HealthPartners and chief medical officer at Regions Hospital in St. Paul, MN. He doesn’t prescribe opioids for chronic pain, but he often gets new patients already on them. “When you give a single dose of an opioid medicine, you get an immediate relief of your pain. But then as the opioid wears off, you get a tail of hyperalgesia for 72 hours after the pill has worn off. That prompts people to take a second pill, then a third pill, then a fourth pill. With every subsequent pill, however, it works less well and the period of hyperalgesia gets longer and longer. It’s an extremely slippery slope in which people get habituated very fast.”

To assess his new patients already on opioids, Dr. Haake takes a good history, listens to their story, and does a thorough examination to rule out other diagnoses, such as a pathology that is progressive. “And then we discuss their current strategy and how it is not working for them. Because patients with chronic pain on opioids—every one of them—will tell you they’re in severe pain and the pain is getting worse over time. They just haven’t made the connection that it is because of the opioids they’re using.”

It can be a delicate situation to help patients understand. “I’ll say, ‘This may be new to you today, but I want to present to you another way that you can have less pain in the future, by
taking a different approach to your pain. In that initial visit, there's some level of dissonance because they are hearing something they haven't heard before. At the same time, they've had a sense that something is wrong. "It's interesting the amount of openness people will have to a discussion about the idea that they need to come off of the opioids," says Dr. Haake. What evidence can convince them further? Dr. Haake explains, "If you do a PET scan of someone's brain, you can see the areas active with pain, and you can see what areas of the brain make compounds to relieve pain. People that are given opioids for their pain, they don't make their own natural pain relieving compounds anymore; in fact, they are relying on the medication to get that pain relief. It's only coming off the opioids—sometimes months later—that their brain starts to make their own feel-good compounds again."

**Weaning and alternative treatments**
Alternative treatments, concurrent with weaning, are always part of the plan and can include behavioral therapy, physical therapy, and sleep and exercise regimens. Patients need to understand and have confidence in their treatment plan. According to Dr. Haake, positive thought is extremely important, because the treatment is not easy and it's not quick. "Patients need to be warned that as they wean off the opioids, their pain will actually get worse and that will persist for several weeks after they are off the opioids—until they start to make their own pain relieving compounds again," says Dr. Haake.

For those who stick with Dr. Haake's program, the initial time coming off the opioids, and then for about six weeks off of the opioids, is not fun since the pain can be as bad or worse during that time. A few weeks later, though, they start to feel better. "By that third month off the opioids, they're thrilled with their care. Then 6-12 months later, they feel better than they have in years, and they become strong advocates for this kind of work," says Dr. Haake.

But not all patients follow through with weaning. "For patients who are addicted, it actually hijacks their brain, and they will do whatever it takes to get more medication. If I suggest to start the patient on their current dose, and then begin to wean off 10 percent, and the patient refuses to be weaned, first line is asking them if they know why they are here to see me. Sometimes they do, if they've been prepped. If they say, 'No,' then I'll say, 'My name is Anne Pylkas and I'm an addiction specialist and just because you're here doesn't mean you are necessarily addicted to anything; this is an open and non-judgmental place to talk about addiction.' I explain that I'm here to help people get off pain medications."

Dr. Pylkas notes that a lot of patients don't know what addiction means. "Addiction means there's a behavioral disorder. There's a fine line between physical dependence and addiction—physical dependence means, 'If I stop it, I will go through withdrawal,' which is true for anyone on opioids. With addiction there's also behavioral dysregulation including use of a substance despite known harm. Harm can be anything from legal issues to relationship issues to medical issues." Dr. Pylkas has found that patients are quick to diagnose themselves as addicts because they realize they rely on the drugs for pain, even if they're frustrated with the diminishing effects over time, which may have caused them to take more and more to feel relief. If they weren't prepped well, or if they don't know why they're here, it can be difficult to navigate the conversation. "Patients worry that anytime we say 'addiction' it automatically means they need to go to treatment. I address this upfront, letting them know that just because they're here doesn't mean we're going to lock them away."

**Hyperalgesia is "a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli."**

---

"Patients with chronic pain on opioids—every one of them—will tell you they're in severe pain and the pain is getting worse over time."

that's usually the first flag that there's a stronger issue than just physical tolerance. If they go to an ER and ask for more medication, or game your colleague down the hall for more, then it's clear there's an addiction issue."

**The addiction conversation**
Anne Pylkas, MD, a physician and addiction medicine specialist, handles referrals needing special treatment for addiction or dependence. She explains the initial patient conversation: "My

---

"No, then I'll say, 'My name is Anne Pylkas and I'm an addiction specialist and just because you're here doesn't mean you are necessarily addicted to anything; this is an open and non-judgmental place to talk about addiction.' I explain that I'm here to help people get off pain medications."

Dr. Pylkas notes that a lot of patients don't know what addiction means. "Addiction means there's a behavioral disorder. There's a fine line between physical dependence and addiction—physical dependence means, 'If I stop it, I will go through withdrawal,' which is true for anyone on opioids. With addiction there's also behavioral dysregulation including use of a substance despite known harm. Harm can be anything from legal issues to relationship issues to medical issues." Dr. Pylkas has found that patients are quick to diagnose themselves as addicts because they realize they rely on the drugs for pain, even if they're frustrated with the diminishing effects over time, which may have caused them to take more and more to feel relief. If they weren't prepped well, or if they don't know why they're here, it can be difficult to navigate the conversation. "Patients worry that anytime we say 'addiction' it automatically means they need to go to treatment. I address this upfront, letting them know that just because they're here doesn't mean we're going to lock them away."

---

"Not everyone is ready" Dr. Pylkas recognizes that some people just aren't ready for treatment. "For those people," she says, "it depends on how dangerous their behavior is. If they're frequently overdosing, or they're getting it from the street, or they're injecting, then I would say, 'You have three options. You can go on Suboxone® (buprenorphine) with me—and I explain that it's a medication for addiction—you can use this other medication, or you can use abstinence.'"

Still, she remains clear when telling them, "Because the opioids interfere with how your brain feels pain, it's impossible to treat your pain until we treat your addiction first." For high-risk patients who refuse the treatment options, Dr. Pylkas lets them know she is available to talk more if they come back, but that she will not be prescribing any opioids.

The majority of patients, however, are open to treatment that includes weaning, while also engaging in other treatments, including physical therapy, pain psychology, and injections if needed. "The first thing they'll say is, 'I've done all these
"things," Dr. Pylkas says, "but the reality is that when you are on opioids and you’re addicted or you’re headed to addiction, you can try all those things and they’re not going to work."

The longer they’ve been taking opioids, the longer it can take for the brain to recover from the effects of the drugs. Often, it can take a year or even two, making it a long journey back to a healthy approach to their chronic condition.

"Opioids totally disengage you from what your body is feeling," says Dr. Pylkas. At some point, people don’t know what they’re feeling anymore, and they haven’t felt anything for a very long time because they can just take a pill whenever they’re going to start to feel anything. So I do really long, slow tapers—like over a year or two. If they’re high risk, then I will speed up the taper."

The good news, according to Dr. Pylkas, is that “after a while, they start understanding that this was never helpful, and it never will be helpful, and these other things that we’re doing are much more helpful.”

LIZ LACEY-GOTZ
Brink Editor
Constellation
Liz.Lacey-Gotz@ConstellationMutual.com

**Addiction Myths**

What we don’t know (or what we falsely believe) can hurt our patients

<table>
<thead>
<tr>
<th>Myths and Misconceptions</th>
<th>Truth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction is simply a set of bad choices.</td>
<td>The risk of opioid addiction varies substantially among persons.</td>
</tr>
<tr>
<td>30% of providers believed addiction is a lifestyle choice</td>
<td>Genetic vulnerability accounts for 35-40% of the risk associated with addiction</td>
</tr>
<tr>
<td>30% of providers believed addiction is a lifestyle choice</td>
<td>Patients who are prescribed opioids can become addicted</td>
</tr>
<tr>
<td>Pain protects patients from addiction to their opioids.</td>
<td>even if they take their medicine as directed.</td>
</tr>
<tr>
<td>Only long-term use of certain opioids can cause addiction.</td>
<td>All opioid use can lead to addiction.</td>
</tr>
<tr>
<td>Only patients with certain characteristics are vulnerable to addiction.</td>
<td>U.S. medical schools allot fewer than 11 teaching hours to pain management and addiction</td>
</tr>
<tr>
<td>57% of providers viewed low income as causal/contributory to addiction.</td>
<td>Although some patients are more vulnerable than others, no patient is immune to opioid addiction.</td>
</tr>
<tr>
<td>Medication-assisted therapies are just substitutes for heroin or opioids.</td>
<td>Opioid-agonist medications such as buprenorphine have slower pharmacokinetics that help stabilize physiologic processes, and they help protect against abuse while facilitating recovery.</td>
</tr>
</tbody>
</table>

**References**


Health Professionals and Opioid Addiction
Reframing the problem with a compassionate and therapeutic approach.
By Anne Geske

Just like airline pilots, the ability of health professionals to place public safety first, doing their job well and unimpaired, is essential. Health professionals are keenly aware of their ethical and moral responsibilities. But through the lens of addicted thinking, an individual may rationalize that their use of opioids won’t lead to impaired judgement. That their diversion—appropriating patients’ prescription medication—won’t affect patient safety or lead to malpractice claims.

Unique factors and risks
Generally speaking, health professionals experience chemical dependency at the same rate as the rest of the population. But when the substance is opioids, unique factors and risks come into play for people in the health professions.

First, there can be extreme stress on the job. Physicians have a much higher risk of depression and burnout (emotional exhaustion, depersonalization, and a low sense of personal accomplishment) compared to the general population! Marc Myer, MD, works at Hazelden Betty Ford as medical director for Adult Services Minnesota, as well as the Health Care Professionals Program. According to Dr. Myer, for the health professional population subset, addiction to opioids frequently does not begin after long-term use of opioids prescribed for pain, but as a coping mechanism—a way to self-medicate stress.

Second, there’s access. When stress leads health professionals to reach for a substance as a coping mechanism, access to opioids is there, especially for those who administer anesthesia and medications. Third, physicians’ and nurses’ very knowledge about disease and medication can lead them to intellectualize their substance use behavior, thinking “I know how they work, so I’ll be able to control their use.”

And then there’s shame and isolation. Dr. Myer believes that addiction is a disease driven by shame. “I find that health care professionals are riddled with shame at a much greater degree even than the general population because,” he says, “due to their substance use, they oftentimes violate their own ethical and moral standards. And then they end up becoming isolated because of fear of retribution or loss of licensure, loss of income, stress, and burnout.”

Stressful work environments, burnout, access, intellectualization, and isolation may create a unique set of risks.
Addiction Self-Assessment

☐ I continue my addictive behavior after experiencing serious consequences.
☐ I regret my behavior.
☐ I can't stop my addictive behavior whenever I want.
☐ Others express concern about me.
☐ I'm worried about my behaviors.
☐ I don't limit my behaviors to certain times of the day or to certain places.
☐ I get into arguments with family members or friends about my behavior.
☐ My behavior causes me shame and embarrassment.
☐ I use my behavior to make me feel better.
☐ My work is in jeopardy because of my addictive behaviors.
☐ I have had financial difficulties because of my behaviors.
☐ I engage in addictive behaviors to boost my self-confidence or self-esteem.
☐ I would be concerned if my clients knew about my behaviors.
☐ I have put my family in embarrassing or potentially dangerous situations.
☐ I have lied about or minimized my addictive behaviors.
☐ I have changed my circle of friends/acquaintances in order to more easily engage in my behavior.
☐ I have not been aware of the needs and well-being of my family.
☐ I celebrate good news by engaging in my addictive behaviors.
☐ I have considered suicide because of my behavior.
☐ I am preoccupied with my past, present or future behaviors.

See Resources in this article for where to find help in your state.

Adapted with permission. Physicians Serving Physicians, Edina, MN. http://psp-mn.com/

loss of career. So it puts them in a very difficult position to reach out and seek help.”

Stressful work environments, burnout, access, intellectualization, and isolation may create a unique set of risks for health professionals, but the results of opioid use disorder (OUD) are every bit as deadly. “The scary thing for me,” says Dr. Myer, “is that those folks out there who are deep in the throes of addiction feel alone, like they can’t reach out. And many will die of their addiction before they get to treatment. So I hope that as a society we focus our approach more on a therapeutic intervention to a chronic disease rather than a punitive one. That doesn’t mean that physicians and other health care professionals shouldn’t take responsibility for their actions, but it should be considered within the context of their state of mind while addicted.”

Compassion, not punishment

Employers of health care professionals know they have a responsibility to the public. How much do they also have a stake in the success, well-being and careers of their employees? Laurie Drill-Mellum, MD, chief medical officer of Constellation, says, “We have to make sure that people are treated fairly, with dignity and respect. We see the effects of addiction and how it can land on patient care and safety, which we all care about—including the people who struggle with this issue.”

A compassionate, not punitive, model of chemical dependency treatment is known to be most effective. To that end, most states have a confidential program for medical professionals that operates outside of the state licensing board. Participants can seek help without risk of losing their license if they follow the program. Once enrolled, their adherence is monitored. If they’re noncompliant, they could lose their license.

One such successful program is South Dakota’s Health Professionals Assistance Program (SDHPAP), which monitors health professionals identified as having a substance abuse disorder. Craig Uthe, MD, a family medicine physician and
medical adviser to SDHPAP, states that the two cornerstones of the program are accountability and consequences. "We have a personal plan of action that's individualized for every participant, using guidelines and policies that are generally followed by the Federation of State Physician Health Programs," says Uthe. "Addiction is a disease. It was recognized that physicians wouldn't acknowledge [admit or seek treatment for] their disease if the result was going to be punishment. So many states, including South Dakota, have created trusted, confidential and protected programs away from board disclosure if the individual is willing to get treatment for their disease and not be a risk to the public's health."

Dr. Myer believes such programs make a positive difference. He says, "It's very clear that when health professionals are able to reach out to a non-punitive program, they will self-report and get help earlier at much greater rates than if they have to go straight through a licensing board. We know from this model that the earlier they get help—and the more support they get—the better the outcomes."

The good news is that after completing treatment and obtaining ongoing support, the five-year success rate for physicians is greater than 80 percent—much higher than the general population.3

Awareness and communication
Administrators of medical facilities and owners of private practices will want to evaluate awareness and planning around their employees and OUD. What can a medical facility do to update efforts around awareness and communication? First, understand that there's no need to reinvent the wheel. Ruth Martinez, executive director at the Minnesota Board of Medical Practice, says she has seen groups "examining this issue in silos, redundantly going through processes without bringing their information together and aggregating information in a way that more broadly communicates a message." Each state's medical board has its own list of resources.

Policyholders of MMIC, UMIA, and Arkansas Mutual have access to online resources and phone consultations. When necessary, phone consultants refer policyholders to Walt Flynn, a human resources consultant at W.J. Flynn and Associates, LLC. Flynn frequently talks to small- and medium-sized practices about employees suspected of using substances. "Broadly speaking," he says, "the best practice is to actually confront the behavior. You'd be amazed at how many times things go unevaluated because people are afraid to confront or call out the behavior."

Nurses and other staff see physicians as holding a position of power within the organization, and they might be afraid to report. "I'm always impressed with how courageous people are in being willing to deal with this," says Flynn. "If you're an administrator for a physician group, and one of the physicians is a partner or owner of the practice, it's a lot to step up and confront. Basically, you're going to the owner of your group and calling them out. I've seen many situations where that's exactly what's occurred, and thank goodness." Flynn also makes referrals as necessary for impairment assessment, drug testing, and fitness-for-duty exams. Physicians require confidentiality, so often referrals will be made to out-of-town resources.

Dr. Drill-Mellum acknowledges that OUD in health professionals poses significant risks, and reiterates that competent, legal, and compassionate intervention is what works. "We are a company that was formed by and for physicians," she says. "We recognize this is a problem, and we offer services to help mitigate these issues, whether it's potential patient litigation or stress-related dependency. We try our best to be of service to our colleagues and peers."

References

Resources
Federation of State Physician Health Programs lists programs by state for physicians and other health professionals: http://www.fsphp.org/state-programs

Physicians Serving Physicians, co-sponsored by MMIC, is a confidential Minnesota organization that helps physicians with addiction issues: http://psp-mn.com/

ANNE GESKE
Health Care Feature Writer

Confronting impairment:
Starting the conversation

"We want organizations to have safe, competent physicians who are not impaired taking care of our patients," says Walt Flynn, HR consultant. Here are three basic steps that Flynn uses to broach the subject of potential impairment.

1. Explain why you're having this conversation.
   "Here's what we've seen, can you help explain what's going on?" Talk about observed behavior or verbalizations that have been out of the norm.

2. Help them understand why there's a concern.
   "Here's why we're concerned." Discuss potential patient safety concerns, how coworkers are affected, and risks to the organization.

3. Talk about steps toward remediation.
   "Where do we go from here?" Come prepared with what next steps might look like depending upon the direction the conversation takes.

Brink / Summer 2017 / 17
Failure to Provide Appropriate Pain Treatment

After violating his opioid treatment agreement and no longer able to obtain his prescription pain medication, a patient suffering from opioid addiction and withdrawal symptoms overdoses on heroin and is hospitalized.

Facts of case
A family physician (FP) treated a 57-year-old man with an extensive history of work-related injuries for seven years with muscle relaxants and opioids for complaints of chronic pain. Over the years, the patient requested and received many refills prior to his next scheduled appointment without a physical examination. After the clinic initiated a new chronic pain treatment policy, the patient was required to sign an opioid treatment agreement mandating routine urine drug testing.

Several months later when the patient’s urine drug test was positive for amphetamines, the clinic sent him a letter indicating that he was in violation of the treatment agreement and would no longer be prescribed pain medication. He was advised to see a pain specialist.

Two weeks later, the patient called complaining of severe withdrawal symptoms, and a nurse advised him to go to the emergency room. Two months later, the patient was found at home unresponsive due to an overdose of heroin and was hospitalized.

The patient filed a malpractice claim against the FP alleging improper pain treatment resulting in opioid addiction.

Disposition of case
The case was settled against the FP.

Patient safety and risk management perspective
The experts who reviewed this case were critical of the FP for a lack of documented pain and function assessments, lack of treatment goal planning, refills without exams and assessments, failure to treat opioid withdrawal symptoms and failure to diagnose and treat opioid use disorder. The patient testified he sought relief for his opioid withdrawal symptoms by using heroin. The malpractice case was settled with a payment on behalf of the FP and his clinic. The state licensing board also fined the physician for failing to provide appropriate pain treatment.
Chronic Pain Management Resources

Links to these resources can be found on the MMIC and UMIA websites by navigating as follows: www.MMICgroup.com or www.UMIA.com Login > Risk Management > Bundled Solutions > Chronic Pain Management

Academy of Integrative Pain Management http://www.aapainmanage.org/
American Academy of Pain Medicine http://www.painmed.org/
American Pain Society http://americanpainsociety.org/
American Society for Pain Management Nursing http://www.aspmn.org
American Society of Addiction Medicine http://www.asam.org/asam-home-page
CDC: Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 https://tinyurl.com/cdcopioidschronicpain
CDC: Guideline Resources: Clinical Tools https://www.cdc.gov/drugoverdose/clinical-tools.html
CDC: Opioid Overdose https://www.cdc.gov/drugoverdose/index.html
ICSI: Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management https://tinyurl.com/icsipainguidelines
Physicians for Responsible Opioid Prescribing http://www.supportprop.org/
SAMHSA Managing Chronic Pain in Adults With or In Recovery From Substance Use Disorders. Appendix B Assessment Tools and Resources https://www.ncbi.nlm.nih.gov/books/NBK92056/
Turn the Tide: The Surgeon General's Call to End the Opioid Crisis http://turntheid.org/

LORI ATKINSON, RN, BSN, CPHRM, CPPS
Research & Education Manager
MMIC
Lori.Atkinson@MMICgroup.com

Key strategies for patient safety and risk management

Create and maintain policies
- Enlist a multidisciplinary team to provide coordinated care across the continuum.
- Develop a chronic pain management policy using evidence-based resources (e.g., CDC, ICSI, AAPA) to outline chronic pain therapy modalities, when to initiate or continue opioids for chronic pain, opioid selection, dosage, duration, follow-up, tapering and discontinuing opioid treatment.
- Incorporate state-specific prescribing rules (e.g., limits on refills, numbers of pills, informed consent, treatment plan) into the chronic pain management policy.
- Evaluate your chronic pain practice using a risk management self-assessment tool.

Assess patients
- Assess the risk of addiction prior to initiating opioid therapy and during treatment using standard risk stratification tools.
- Query the state prescription drug monitoring program to review the patient's controlled substance prescription history prior to initiating opioid therapy and routinely during therapy.
- Use standard tools and algorithms to assess pain, function, behavioral health co-morbidities and aberrant drug-related behaviors.
- Evaluate aberrant drug-related behaviors (unintended behaviors involving acquisition or use of prescribed opioids such as early refill requests, falsification of a prescription, use of illegal drugs), establish a differential diagnosis list (e.g., uncontrolled pain, progressive disease/condition, tolerance to opioids, poor coping skills, behavioral health co-morbidities, diversion, opioid use disorder) and reassess opioid therapy to determine whether opioids are causing more harm than good.

Monitor and communicate with patients
- Obtain informed consent for opioid therapy outlining benefits and risks, including addiction and overdose.
- Utilize a patient dashboard to monitor pain and function status, opioid risk and progress towards treatment goals.
- Use treatment agreements for long-term opioid therapy to clarify expectations and responsibilities, outline the refill and monitoring process, and discontinuation therapy.

Educate your team and patients
- Educate clinicians and team members on the use of empathetic communication skills, motivational interviewing and shared decision-making for informed consent to opioid therapy.
- Educate clinicians and team members on pain management, assessment tool use, evidence-based guidelines, risk stratification tool use, opioid use disorder and medication-assisted treatment.
- Educate patients and families about the risks of opioids, safe storage of opioids in the home and safe disposal of unused opioids.
Diversion of Controlled Substances

After a series of patients developed unusual infections during their hospitalizations, an extensive investigation revealed a nurse diverted IV opioids for personal use and contaminated the IV bags.

Facts of case
A physician admitted a 62-year-old man with a longstanding history of low back pain to the hospital for pain control and opioid withdrawal symptoms when his intrathecal pump malfunctioned. While waiting for the pump to be replaced, the physician prescribed IV Dilaudid. A week into the patient's hospitalization, his temperature rose to 102 degrees. The physician ordered blood cultures that were positive for a gram-negative bacteria. The patient was treated with antibiotics and discharged after his intrathecal pump was replaced.

After a series of patients were found to have unusual bacterial bloodstream infections during their hospitalizations, the hospital began an extensive investigation and concluded that all were cared for on the same hospital unit, all had received IV pain medication and all were cared for by the same nurse. The nurse admitted to numerous occasions of withdrawing controlled substance pain medication from patient IV bags, replacing it with saline to make it appear that nothing had been taken and injecting it for personal use. The investigators concluded that the IV bags were contaminated when the nurse withdrew the pain medication.

The hospital suspended the nurse and a criminal investigation was initiated. A review of the controlled substance access logs indicated that nurse had access rates several times greater than any other nurse for over six months. The nurse later pled guilty in federal court to a felony of obtaining a controlled substance by fraud. Multiple patients filed malpractice claims against the hospital alleging improper treatment resulting in an infection, negligent hiring and supervision, and failure to prevent and detect drug diversion.

Disposition of case
The malpractice cases were settled against the hospital.

Patient safety and risk management perspective
The experts who reviewed the cases were critical of the hospital's detection and response to the infection outbreak and drug diversion, noting the hospital had not been routinely reviewing the controlled substance access logs, did not immediately pull all potentially contaminated IV pain medication bags from service, did not objectively investigate the health care professional and did not immediately report the theft to federal and state authorities.
Controlled substance diversion
The Centers for Disease Control and Prevention (CDC) cites the epidemic of opioid addiction as a major driver of drug diversion. Sales of prescription opioids in the United States nearly quadrupled from 1999 to 2014, which increased the availability of opioids for diversion. Diversion is one way to get opioids—both for addicted patients and addicted health care professionals—especially now, when physicians have cut back drastically on prescribing opioids with the new CDC guidelines. When health care professionals divert controlled substances, the risks to patient safety include unsafe care delivered by an impaired health care professional, untreated pain, and exposure to infectious disease from contamination. Health care organizations face regulatory and legal risk, fraudulent billing claims, professional liability, claims and damage to their reputation in the community. Health care organizations have a duty to protect patients from potential harm related to controlled substance diversion and must have a strong program to prevent, detect, respond, investigate and report drug diversion.

References

Diversion Prevention Resources
Links to these resources can be found on the MMIC and UMIA websites by navigating as follows: www.MMICgroup.com or www.UMIA.com Login > Risk Management > Bundled Solutions > Chronic Pain Management

Key strategies to ensure patient safety and prevent diversion

Create and implement policies

- Implement a controlled substance diversion prevention program administered by a multidisciplinary team.
- Include and enforce zero tolerance for drug diversion in the provider and employee substance abuse policy.
- Run background checks and drug testing on potential employees/clinicians as a condition of employment/medical staff privileges.
- Implement a Fitness for Duty policy, including for-cause drug testing and return to work criteria.
- Implement a controlled substance handling and administration policy that includes controlled substance counts; wastes, storage, access, security, discrepancies, and waste retrieval system monitoring; and surveillance systems audits.
- Ensure organizational policies comply with federal and state requirements including reporting to local law enforcement, DEA and applicable licensing boards.

Assess and monitor locations, inventory, and processes for diversion risk points

- Perform diversion risk assessments of high risk areas (e.g., surgery, anesthesia, pharmacy, emergency departments) and high risk processes (e.g., known diversion points) to identify and mitigate diversion risk.
- Use automated technology such as automated dispensing and diversion monitoring software to assist in the management of controlled substance inventory, documentation of removal, administration, waste, billing and auditing.
- Review automated dispensing reports at least monthly to compare automated dispensing activity with medication administration records to detect unusual patterns.

Monitor patients for infection and pain relief

- Utilize an infection surveillance system to review and analyze infection data regularly.
- Conduct random patient interviews to verify that patients receiving pain medication obtain adequate pain relief.

Provide education and training

- Provide clinician and team member education and training on how to prevent, recognize and report impairment or diversion.
Seniors and Pain Management
Prescribing opioids for seniors requires special considerations.

Opioid use among older adults can provide health care professionals with challenging considerations, especially for chronic pain conditions. Clinicians should consider certain factors before ordering and managing opioid therapy for seniors.

The aging process can cause many of the human organ systems to slow or to change in ways that impact the absorption, motility, and excretion of medications—including opioids. In aging adults, the liver and kidneys go through a decrease in mass and blood flow, reducing their ability to remove wastes from the body. While muscle mass decreases, the proportion of body fat typically increases. These processes increase the potential for harm for older adults who use opioids.

Some reports indicate a higher number of grandparents caring for grandchildren in recent years, including children born addicted to opioids or other substances. Grandparents may be caring for grandchildren because one or both parents is jailed or has overdosed from opioid addiction. In this situation, the grandparent’s legitimately prescribed medication may be at risk from theft by relatives or acquaintances. Opioid-addicted relatives may view their elders as easy targets for exploitation, exposing them to the potential of physical, emotional or financial abuse.

Reducing risks for seniors
Opioids should not be the first line of treatment for pain in seniors. Depending on the individual, using nonpharmacological techniques such as physical therapy or other alternative therapies may be a better alternative. In addition to following best practices for all adults, practitioners should consider additional guidelines for seniors:
- Review all medications to determine possible drug interactions.
- Conduct physical exams, including lab tests for renal and liver functions. Evidence shows that opioids should be prescribed at doses 25–50 percent lower than the typical adult dose! Smaller quantities of pills should be prescribed, and more frequent assessments conducted.
- Assess seniors for signs of increased injuries to determine if they have been a victim of abuse. Increased injuries could also indicate the possibility of misuse, adverse reactions, or abuse of opioid medications.
- Be aware that symptoms associated with aging may mask signs of opioid abuse. Ask about changes in appetite, balance and social habits.
- Be cognizant of requests for early refills and frequently reporting lost or stolen medications. Demands for prescriptions at office visits are a potential indicator of abuse.
- Proper opioid management in seniors can be even more complex than in younger adults. Comorbidities, the aging process, polypharmacy, and multiple care providers contribute to the potential harm of opioid use in this at-risk population.

Health care professionals need to be alert to the potential risk of prolonged or mismanaged opioid use.

Reference

D. MICHELLE KINNEER, RN, MSN, JD, CPHRM, CHPC, CHC
Senior Risk and Patient Safety Consultant
MMIC
michelle.kinneer@MMICgroup.com

Reducing Risk
- Consider alternatives
- Prescribe in lower doses
- Prescribe in small quantities
- Require frequent follow-ups
- Avoid time ranges in prescription dosing instructions
- Avoid symptom bias in assessments
- Utilize prescription monitoring drug programs
When You Need to Say No
Getting beyond the fear of a patient's dissatisfaction just might save their life.

Conversations about opioids are sometimes about more than symptoms and treatment. There can be unspoken fears and motivations swirling beneath the surface if the patient feels entitled to opioids, or feels frightened by the prospect of coping without them. The patient may be dishonest, overly emotional, or even aggressive. The provider may fear backlash from the patient if the answer is no, but also knows that saying no could save a life.

Dan O'Connell, PhD, is a clinical psychologist who trains, coaches and consults with health care professionals on improving communication and patient relationships. He uses his psychology background to help clinicians through tough conversations about pain management and opioids.

Dr. O'Connell promotes a simple mantra: Patients are not the problem. The provider is not the problem. The problem is the problem. "Namely," he says, "the problem that opioids may be causing more harm than good." It's not the patient's fault they're struggling with psychological cravings, but the provider saying "no" isn't the bad guy either. The problem is the problem.

Talking points for saying no
Sometimes the answer needs to be "no." Algorithms and assessment tools are available to help screen for risks, alcohol and substance abuse, or depression.

A conversation, however, is the place to start. Dr. O'Connell promotes three key talking points for those conversations: drug safety, drug effectiveness, and (balancing those two), is the drug doing more harm than good?

These talking points will help to open the dialogue.

Safety
Probe about tolerance, addiction, or diversion, drawing out the patient's own understanding of the safety. Then educate to fill in gaps.

Questions to ask:
/ Do you find yourself needing more and more?
/ How would you know if you were becoming addicted?
/ Can you account for every pill?

Effectiveness
Reflect the patient's own complaints back to them.

Questions to ask:
/ If opioids were really the most effective way to help, I would expect them to be making more of a difference. Instead, I'm hearing...
/ It sounds like you're struggling with stress and lack of sleep. Opioids are not the most effective treatments for those. Let me propose a more effective approach.

Balancing safety and effectiveness
Reframe the conversation as balancing necessity vs. risk:
/ I'm open to considering any plan we both agree is the safest and most effective way to help your pain, and which we are both certain could not do more harm than good.

Concluding the conversation
After following this format, clinicians need to present a clear conclusion. Some examples:
/ I've come to the conclusion that the way you're using opioids is causing more harm than good and we need to agree to a different plan.

Dr. O'Connell advises, "Be soft on the people, but be hard on the problem."
/ I'm willing to prescribe opioids if we can agree to a contract that includes the elements we need to watch for safety and effectiveness, and to be sure they are not causing more harm than good. Let me describe those, and you decide if you can commit to each one.

If a patient grows angry or disagrees, Dr. O'Connell suggests using a defusing technique such as getting a second opinion or the input of a specialist.

It's important for clinicians to remember the mantra that the patient is not the problem, but neither are you. The problem is the problem. Dr. O'Connell advises, "Be soft on the people, but be hard on the problem."

EMILY CLEGG, JD, MBA, CPHRM
Manager & Senior Consultant
UMIA
eclegg@UMIA.com
Like all patients, opioid-dependent patients deserve physician best practices.

Most of us who were drawn to medicine were enticed by the opportunity to serve people requiring medical care. Yet the emphasis in medical education has been greatly biased toward the technical parts of the profession: general anatomy, embryology, histology, physiology, pathology, pharmacology, pathophysiology, microbiology, diagnosis and treatment.

Many of us didn’t receive much training in listening, empathy, and compassion; perhaps there was an assumption we didn’t need it, or that such skills weren’t that important. As it turns out, these habits of engaging with people can separate the “good enough” physician from the great physician, and might be what our patients remember most about their time with us. They can increase diagnostic accuracy and efficiency and decrease the chance that adverse outcomes will develop into malpractice claims.

Sadly, by the time many of us have endured the challenges of medical school and the demands of specialty training, remnants of the idealistic yearnings we expressed in our medical school applications may be hard to trace. Less well documented is their effect on our patients. Take our attitudes toward patients who are dependent on opioids, whom many of us reflexively dismiss as “drug seekers,” though we (the “big We”) have surely played a role in creating the problem, just a bit downstream from Big Pharma and the push to make pain the fifth vital sign. I have witnessed how the labeling and judgment can land on a patient and their family.

Several years ago, a friend had both knees replaced. She experienced tremendous post-operative pain and was seen by a pain management specialist. She was treated aggressively for her pain, and during her convalescence became physiologically dependent on the prescribed opioids; this, in turn, impacted her mood, her spirit, her sleep patterns, and of course, her bowels. When she requested help from her primary physician, my friend was told: “Go back to whoever put you on these meds; I didn’t create this problem and I’m not going to be the one to fix it.”

I felt awful for my friend, who hadn’t done anything wrong, and a sense of indictment toward our current disjointed practice of medicine. I guided my friend to a colleague with the knowledge, skills and compassion necessary to wean her from the opioids.

How can we do better? I hope we have given you both good data and good ideas for reflection on the vexing problem of opioid use and abuse. We are interested in continuing the conversation.

Be kind, for everyone you meet is fighting a hard battle.

—author unknown
o•pi•oids noun
a class of drugs that includes the illicit drug heroin as well as the legal prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.¹

80% OF WORLDWIDE OPIOID CONSUMPTION IS FROM THE UNITED STATES WHICH REPRESENTS ONLY 5% OF THE WORLD'S POPULATION²

STEEP SITUATION
Of patients taking opioids longer than one month, NEARLY 30% will still be on them a year later.³

1 in 7 people who got a refill or second prescription were on opioids a year later.³

A George Washington University study showed patients with chronic wounds who never receive opioids heal faster than those who do.⁴

DEADLY COMBINATIONS⁵
Nearly 60% of patients taking opioid prescriptions for long-term conditions were also prescribed potentially dangerous mixtures of medications during the same time period.

OF THESE PATIENTS:
2/3 were prescribed the drugs by two or more physicians.
27% were taking multiple opiate pain treatments simultaneously.
Nearly 40% filled their prescriptions at more than one pharmacy.
Nearly 1 in 3 patients were on an opiate and a benzodiazepine, a combination that is the most common cause of multiple-drug overdose deaths.

Calendar

UPCOMING WEBINARS ON WEDNESDAYS
To register for a webinar, go to MMICgroup.com > News & Events
All webinars are presented noon-1 CST and are available on demand at MMICgroup.com after the initial presentation.

<table>
<thead>
<tr>
<th>JULY</th>
<th>AUGUST</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>NAVIGATING THE JOURNEY: HIPAA PRIVACY AUDITING</td>
<td>REMAINING INDEPENDENT OR SELLING YOUR PRACTICE</td>
</tr>
<tr>
<td>Presenter: D. Michelle Kinneer, RN, MSN, JD, CPHRM, CHFC, CHC, MMIC Senior Risk &amp; Patient Safety Consultant</td>
<td>Presenter: Ryan S. Johnson, Shareholder, Fredriksen &amp; Byron</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEPTEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
</tr>
<tr>
<td>ADVANCED PRACTICE PROVIDERS: ENHANCING THEIR ROLES, REDUCING THEIR RISKS</td>
</tr>
<tr>
<td>Presenter: Robert S. Thompson, RT, JD, MBA, LLM, AIC, ARM, ARE, RPLU, CPCU, MMIC Business Development Consultant, Strategic Relationships</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OCTOBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
</tr>
<tr>
<td>CREATING A JUST CULTURE OF ACCOUNTABILITY</td>
</tr>
<tr>
<td>Presenters: Betty VanWoert, RN, BSN, CCM, CPHRM, MMIC Senior Risk and Patient Safety Consultant and Kristi Eldredge, RN, JD, CPHRM, MMIC Senior Risk and Patient Safety Consultant</td>
</tr>
</tbody>
</table>

RISK MANAGEMENT EDUCATION
MMIC experts will share a day of insights you can use to help support better patient safety.
Topics include:
- Rethinking Pain Management for Community Health and Safety
- Evolving Models of Care: Eight questions to ask before diving into telemedicine
- Driving with Ambulatory Data: Harnessing practice intelligence for improved outcomes

Thursday, August 17
10:30 a.m. to 2:45 p.m.
MMIC, Edina, MN

For more information contact Marian Hagerman at Marian.Hagerman@ConstellationMutual.com

Contact MMIC
7701 France Avenue South
Suite 500
Minneapolis, MN 55435
support@MMICgroup.com
952.838.6700 | 800.328.5532
Fax: 952.838.6808
Policyholder technical support
800.328.5532
CHAPTER 5615
BOARD OF MEDICAL PRACTICE
HEARINGS BEFORE THE BOARD

5615.0100 DEFINITIONS.
5615.0200 ACCUSATION.
5615.0300 STATEMENT OF ISSUES.
5615.0400 SERVICE OF ACCUSATION.
5615.0500 TIME AND PLACE OF HEARING.
5615.0600 NOTICE OF HEARING.
5615.0700 DEPOSITIONS.
5615.0800 CONDUCT OF HEARING.
5615.0900 EVIDENCE.
5615.1000 DECISION IN CONTESTED CASE.
5615.1100 FORM OF DECISION AND FINDINGS.
5615.1200 EFFECTIVE DATE OF DECISION.
5615.1300 REVIEW OF DECISION IN CONTESTED CASE.

5615.0100 DEFINITIONS.

Subpart 1. Scope. For the purposes of parts 5615.0100 to 5615.1300, the terms defined in this part have the following meanings.

Subp. 2. Board. "Board" means the Minnesota Board of Medical Practice or any member or members thereof authorized by law to adjudicate contested cases.

Subp. 3. Contested case. "Contested case" means a proceeding before the board in which the legal rights, duties, or privileges of specific parties under the provisions of any statute granting jurisdiction to the board are required by law or constitutional right to be determined after a board hearing.

Subp. 4. Party. "Party" includes the board, the respondent, and any person, other than a member of the board in the member's official capacity, who has been permitted to appear in the proceeding.

Subp. 5. Respondent. "Respondent" means any person or professional corporation against whom an accusation or charge has been filed pursuant to any statute granting jurisdiction to the board, or any person or professional corporation which is subject to a dispute concerning any legal rights, duties, or privileges granted or conferred thereby.

Statutory Authority: MS s 147.01

History: 17 SR 1279; L 1991 c 106 s 6

Published Electronically: June 11, 2008

5615.0200 ACCUSATION.

A hearing to determine whether a right, license, certificate, registration, or privilege should be revoked, suspended, qualified, restricted, limited, or conditioned, shall be initiated by the issuance of an accusation by the board. The accusation shall be a written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the respondent is charged and shall be in sufficient detail
to enable the respondent to prepare a defense. It shall specify the statutes and rules which the respondent is alleged to have violated. The accusation may also include any additional information which the board deems appropriate. The accusation shall be verified by a member of the board. The verification may be on information and belief.

Statutory Authority: **MS s 147.01**

History: **17 SR 1279**

Published Electronically: June 11, 2008

### 5615.0300 STATEMENT OF ISSUES.

Subpart 1. **Initiation of hearing.** A hearing to determine whether a right, license, certificate, registration, or privilege should be granted, issued, or renewed shall be initiated either by the board or by the applicant by filing a statement of issues. The statement of issues shall be a written statement specifying the statutes and rules with which the applicant must show compliance by producing proof at the hearing and, in addition, any additional matters which have come to the attention of the initiating party and which would bear upon the issues presented.

Subp. 2. **Verification.** The statement of issues shall be verified by the initiating party. The verification may be on information and belief.

Subp. 3. **Service of statement of issues.** If the board is the initiating party, the statement of issues shall be served in the same manner as an accusation, and shall be accompanied by a notice of hearing substantially in the form set forth in part 5615.0600. If the applicant is the initiating party, the statement of issues shall be served on the board by registered or certified mail, addressed to the board at its office in St. Paul, Minnesota, and such service shall be deemed a request for hearing.

Subp. 4. **Notice of hearing.** Within ten days after such service, the board shall deliver or mail to the applicant a notice of hearing, substantially in the form set forth in part 5615.0600.

Subp. 5. **Time of hearing.** In either case, the hearing shall be held not less than 20 days nor more than 120 days after service of the statement of issues.

Subp. 6. **Place of hearing.** Hearings shall be held in St. Paul, Minnesota, at a place designated by the board, unless the parties, by agreement, select another place within the state of Minnesota.

Statutory Authority: **MS s 147.01**

Published Electronically: June 11, 2008

### 5615.0400 SERVICE OF ACCUSATION.

Upon the issuance of an accusation, the board shall serve a copy thereof on the respondent as provided in this part.

If the respondent is a resident of the state of Minnesota and can be found therein, the accusation and all accompanying information shall be served upon respondent personally in the manner provided by law for the service of a summons in a civil action.

If the respondent is not a resident of the state of Minnesota, or if the respondent is a resident of the state of Minnesota but cannot be found therein, the accusation and all accompanying information shall be served upon respondent by registered or certified mail, addressed to the most recent address theretofore
furnished by the respondent to the board, and the same shall be deemed received by respondent five days after having been deposited in the United States mail, postage prepaid, addressed to such address.

The appearance of respondent in the proceeding shall constitute a waiver of any defect in such service.

Service may be proved by the affidavit of the person making the same.

Statutory Authority: MS s 147.01

Published Electronically: June 11, 2008

5615.0500 TIME AND PLACE OF HEARING.

The board shall determine the time and place of the hearing on the accusation which shall be held not less than 20 days nor more than 120 days after service of the accusation upon the respondent. The hearing shall be held in St. Paul, Minnesota, at a place designated by the board, unless the parties, by agreement, select another place within the state of Minnesota.

Statutory Authority: MS s 147.01

Published Electronically: June 11, 2008

5615.0600 NOTICE OF HEARING.

A notice of hearing on the accusation shall be served by the board upon respondent at the same time and in the same manner as the service of the accusation. The notice of hearing shall be substantially in the following form:

You are hereby notified that a hearing will be held before the Minnesota Board of Medical Practice at ______ on ____________, ______, at the hour of _____ M., o'clock, upon the charges made in the accusation served upon you. You may be present at the hearing; may be, but need not be, represented by counsel of your own choosing; may present any relevant evidence on your own behalf and will be given full opportunity to cross-examine all witnesses who testify therein. If you fail to appear at the time and place above set forth, such failure will constitute a waiver of your right to a hearing and the Minnesota Board of Medical Practice may proceed upon the accusation with or without a hearing.

Statutory Authority: MS s 147.01

History: L 1991 c 106 s 6; L 1998 c 254 art I s 107

Published Electronically: June 11, 2008

5615.0700 DEPOSITIONS.

On request of the respondent, or upon notice from the board to the respondent, the board may permit the testimony of any material witness, residing within or without the state, to be taken for use as evidence in the hearing, by deposition in the manner prescribed by law for such depositions in civil actions. The request or notice shall set forth the nature of pending proceedings; the name and address of the witness whose testimony is desired; a showing of the materiality of the testimony; a showing that the witness will be unable to attend; and the board shall, thereupon, forward a request to the witness to appear and testify before an officer named in the request.
5615.0800 CONDUCT OF HEARING.

Subpart 1. Role of board members. Every hearing in a contested case shall be presided over by a member of the board. A case may be heard by six or more members of the board.

Subp. 2. Legal counsel. The attorney for the board shall advise the member or members of the board concerning the conduct of the hearing and rulings on the admission or exclusion of evidence and other matters of law.

Subp. 3. Disqualification of board member. Any member of the board shall voluntarily disqualify himself or herself and withdraw from any case in which the member cannot accord a fair and impartial hearing or consideration. Any party may request the disqualification of any board member by filing an affidavit, prior to the taking of evidence at a hearing, stating with particularity the grounds upon which it is claimed that a fair and impartial hearing cannot be accorded. The issue shall be determined by the other members of the board. No board member shall withdraw voluntarily or be subject to disqualification if the disqualification would prevent the existence of a quorum qualified to act in a particular case.

Subp. 4. Record of hearings. All proceedings at the hearing shall be reported in writing, and the board shall prepare an official record, which shall include testimony and exhibits in each contested case, but it shall not be necessary to transcribe the record unless requested for purposes of rehearing or court review.

Statutory Authority: MS s 147.01
History: 17 SR 1279
Published Electronically: June 11, 2008

5615.0900 EVIDENCE.

Subpart 1. Oath. All evidence shall be taken only on oath or affirmation.

Subp. 2. Rights of parties. Each party shall have the right to call and examine witnesses, to introduce exhibits, to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in direct examination, to impeach any witness regardless of which party first called that witness to testify, and to rebut the evidence against that party. If the respondent does not testify in the respondent's own behalf, she or he may be called and examined as if under cross-examination.

Subp. 3. Admissible evidence. The board may admit and give probative effect to relevant evidence which possesses probative value and shall not be bound by the technical rules relating to evidence and witnesses; provided, however, that the board shall give effect to the rules of privilege recognized by law. Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence but shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. All evidence including records and documents, except tax returns and tax reports, in the possession of the board of which it desires to avail itself shall be offered and made a part of the record in the case. Documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference.
5615.1000 DECISION IN CONTESTED CASE.

Subpart 1. Votes required. No right, license, or privilege shall be granted, issued, renewed, revoked, suspended, limited, qualified, restricted, or conditioned except upon the affirmative vote of at least six members of the board.

Subp. 2. Exceptions and argument before the board. Whenever, in a contested case, a member of the board who has not participated in the hearing votes in the decision of the case, a final decision, if adverse to the respondent, shall not be made until a proposed decision, including the statement of reasons therefor, has been served on the respondent, and opportunity has been afforded to file exceptions and present argument to all of the members of the board who are to render the final decision.

Subp. 3. Respondent's argument and evidence. The respondent shall have the opportunity to present either oral or written argument and to present additional newly discovered evidence after the close of the record but prior to final decision.

Subp. 4. Informal dispositions. Informal disposition of a contested case may be made in the manner prescribed by law.

Statutory Authority: MS s 147.01

Published Electronically: June 11, 2008

5615.1100 FORM OF DECISION AND FINDINGS.

Every decision and order adverse to a party to the proceeding shall be in writing and, except when such decision or order is made pursuant to stipulation with or the consent of the respondent, shall contain a statement of findings or reasons, a determination of the issues presented and the penalty, if any, or decision of the board. The findings shall consist of a statement of the conclusions upon each contested issue of fact necessary to the decision. Parties to the proceedings shall be notified of the decision and order in person or by mail. A copy of the decision and order and accompanying statement of reasons together with proof of service shall be delivered or mailed, upon request, to the respondent or to the respondent's attorney of record.

Statutory Authority: MS s 147.01

History: 17 SR 1279

Published Electronically: June 11, 2008

5615.1200 EFFECTIVE DATE OF DECISION.

The decision or order of the board shall become effective immediately upon its service on respondent; provided, however, that the board may, in its discretion, stay the enforcement of its decision pending appeal or reconsideration within 30 days after said service.
5615.1300 REVIEW OF DECISION IN CONTESTED CASE.

The board may, upon its own motion or upon petition by respondent, reconsider or grant a rehearing of any decision rendered in a contested case or may condition any such decision upon just and reasonable grounds.

The filing of a petition for review shall not automatically stay the enforcement of the board's decision.

Statutory Authority: MS s 147.01
Published Electronically: June 11, 2008
14.57 INITIATION; DECISION; AGREEMENT TO ARBITRATE.

(a) An agency shall initiate a contested case proceeding when one is required by law. Unless otherwise provided by law, an agency shall decide a contested case only in accordance with the contested case procedures of the Administrative Procedure Act. Upon initiation of a contested case proceeding, an agency may, by order, provide that the report or order of the administrative law judge constitutes the final decision in the case.

(b) As an alternative to initiating or continuing with a contested case proceeding, the parties, subsequent to agency approval, may enter into a written agreement to submit the issues raised to arbitration by an administrative law judge according to sections 572B.01 to 572B.31.

History: 1957 c 806 s 8; 1976 c 68 s 3; 1980 c 615 s 14; 1982 c 424 s 130; 2002 c 251 s 1; 2013 c 125 art 1 s 6
14.58 NOTICE AND HEARING.

In any contested case all parties shall be afforded an opportunity for hearing after reasonable notice. The notice shall state the time, place and issues involved, but if, by reason of the nature of the case, the issues cannot be fully stated in advance of the hearing, or if subsequent amendment of the issues is necessary, they shall be fully stated as soon as practicable, and opportunity shall be afforded all parties to present evidence and argument with respect thereto. Prior to assignment of a case to an administrative law judge as provided by sections 14.48 to 14.56, all papers shall be filed with the agency. Subsequent to assignment of the case, the agency shall certify the official record to the Office of Administrative Hearings, and thereafter, all papers shall be filed with that office. The agency and any other party to a contested case may file all necessary notices, documents, and other necessary information with the Office of Administrative Hearings by any reliable method of electronic transmission in the manner approved by that office. The Office of Administrative Hearings shall maintain the official record which shall include subsequent filings, testimony and exhibits. All filings are deemed effective upon receipt. The record shall contain a written transcript of the hearing only if preparation of a transcript is requested by the agency, a party, or the chief administrative law judge. The agency or party requesting a transcript shall bear the cost of preparation. When the chief administrative law judge requests preparation of the transcript, the agency shall bear the cost of preparation. Upon issuance of the administrative law judge's report, the official record shall be certified to the agency.

History: 1957 c 806 s 8; 1976 c 68 s 3; 1980 c 615 s 14; 1982 c 424 s 130; 1984 c 640 s 32; 2015 c 63 s 7
14.59 INFORMAL DISPOSITION.

Informal disposition may also be made of any contested case by arbitration, stipulation, agreed settlement, consent order or default.

History: 1957 c 806 s 8; 1976 c 68 s 3; 1980 c 615 s 14; 1982 c 424 s 130; 2002 c 251 s 2
14.60 EVIDENCE IN CONTESTED CASE HEARINGS.

Subdivision 1. Admissibility. In contested cases agencies may admit and give probative effect to evidence which possesses probative value commonly accepted by reasonable prudent persons in the conduct of their affairs. They shall give effect to the rules of privilege recognized by law. They may exclude incompetent, irrelevant, immaterial and repetitious evidence.

Subd. 2. Made part of record. All evidence, including records and documents containing information classified by law as not public, in the possession of the agency of which it desires to avail itself or which is offered into evidence by a party to a contested case proceeding, shall be made a part of the hearing record of the case. No factual information or evidence shall be considered in the determination of the case unless it is part of the record. Documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference. When the hearing record contains information which is not public, the administrative law judge or the agency may conduct a closed hearing to discuss the information, issue necessary protective orders, and seal all or part of the hearing record.

Subd. 3. Cross-examination of witnesses. Every party or agency shall have the right of cross-examination of witnesses who testify, and shall have the right to submit rebuttal evidence.

Subd. 4. Official notice. Agencies may take notice of judicially cognizable facts and in addition may take notice of general, technical, or scientific facts within their specialized knowledge. Parties shall be notified in writing either before or during hearing, or by reference in preliminary reports or otherwise, or by oral statement in the record, of the material so noticed, and they shall be afforded an opportunity to contest the facts so noticed. Agencies may utilize their experience, technical competence, and specialized knowledge in the evaluation of the evidence in the hearing record.

History: 1957 c 806 s 9; 1980 c 615 s 15-17; 1982 c 424 s 130; 1984 c 640 s 32
14.61 FINAL DECISION IN CONTESTED CASE.

Subdivision 1. Filing of exceptions. In all contested cases the decision of the officials of the agency who are to render the final decision shall not be made until the report of the administrative law judge as required by sections 14.48 to 14.56, has been made available to parties to the proceeding for at least ten days and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to a majority of the officials who are to render the decision. This section does not apply to a contested case under which the report or order of the administrative law judge constitutes the final decision in the case.

Subd. 2. Closure of record. In all contested cases where officials of the agency render the final decision, the contested case record must close upon the filing of any exceptions to the report and presentation of argument under subdivision 1 or upon expiration of the deadline for doing so. The agency shall notify the parties and the presiding administrative law judge of the date when the hearing record closed. In all contested cases where the report or order of the administrative law judge constitutes the final decision in the case, the hearing record must close as ordered in writing by the presiding administrative law judge.

History: 1957 c 806 s 10; 1975 c 380 s 7; 1982 c 424 s 130; 1984 c 640 s 32; 1995 c 264 art 9 s 1; 2002 c 251 s 3
14.62 DECISIONS, ORDERS.

Subdivision 1. Writing required. Every decision and order rendered by an agency in a contested case shall be in writing, shall be based on the record and shall include the agency's findings of fact and conclusions on all material issues. A decision or order that rejects or modifies a finding of fact, conclusion, or recommendation contained in the report of the administrative law judge required under sections 14.48 to 14.56, must include the reasons for each rejection or modification. A copy of the decision and order shall be served upon each party or the party's representative and the administrative law judge by first class mail.

Subd. 2. [Repealed, 2002 c 251 s 7]

Subd. 2a. Administrative law judge decision final; exception. Unless otherwise provided by law, the report or order of the administrative law judge constitutes the final decision in the case unless the agency modifies or rejects it under subdivision 1 within 90 days after the record of the proceeding closes under section 14.61. When the agency fails to act within 90 days on a licensing case, the agency must return the record of the proceeding to the administrative law judge for consideration of disciplinary action. In all contested cases where the report or order of the administrative law judge constitutes the final decision in the case, the administrative law judge shall issue findings of fact, conclusions, and an order within 90 days after the hearing record closes under section 14.61. Upon a showing of good cause by a party or the agency, the chief administrative law judge may order a reasonable extension of either of the two 90-day deadlines specified in this subdivision.

Subd. 3. Award of fees and other expenses. Fees and expenses must be awarded as provided in sections 15.471 to 15.474.

Subd. 4. Applicability. This section does not apply to a contested case under which the report or order of the administrative law judge constitutes the final decision in the case.

History: 1957 c 806 s 11; 1980 c 615 s 18; 1982 c 424 s 130; 1983 c 247 s 8; 1984 c 640 s 32; 1986 c 377 s 6; 1986 c 444; 1995 c 264 art 9 s 2; 1997 c 7 art 2 s 68; 2002 c 251 s 4.5; 2005 c 16 s 5.
CHAPTER 1400
OFFICE OF ADMINISTRATIVE HEARINGS

CONTESTED CASE HEARINGS 1400.5100 - 1400.8400

1400.5100 DEFINITIONS.
1400.5275 DOCUMENTS FILED.
1400.5300 REQUEST FOR ADMINISTRATIVE LAW JUDGE.
1400.5400 ASSIGNMENT OF ADMINISTRATIVE LAW JUDGE.
1400.5500 DUTIES OF ADMINISTRATIVE LAW JUDGE.
1400.5550 SERVICE AND FILING PROCEDURE.
1400.5600 NOTICE AND ORDER FOR HEARING.
1400.5700 NOTICE OF APPEARANCE.
1400.5800 RIGHT TO COUNSEL.
1400.5900 CONSENT ORDER, SETTLEMENT, OR STIPULATION.
1400.5950 MEDIATION.
1400.6000 DEFAULT.
1400.6100 TIME.
1400.6200 INTERVENTION IN PROCEEDINGS AS PARTY.
1400.6350 CONSOLIDATION OF CASES.
1400.6400 ADMINISTRATIVE LAW JUDGE DISQUALIFICATION.
1400.6500 PREHEARING CONFERENCE.
1400.6550 SETTLEMENT CONFERENCE.
1400.6600 MOTIONS.
1400.6700 DISCOVERY.
1400.6800 REQUESTS FOR ADMISSION OF FACTS OR OPINIONS.
1400.6900 DEPOSITIONS TO PRESERVE TESTIMONY.
1400.6950 EXCHANGE OF WITNESS LISTS AND EXHIBITS.
1400.7000 SUBPOENAS.
1400.7050 SANCTIONS IN DISCRIMINATION CASES.
1400.7100 RIGHTS AND RESPONSIBILITIES OF PARTIES.
1400.7150 RIGHTS AND RESPONSIBILITIES OF NONPARTIES.
1400.7200 WITNESSES.
1400.7300 RULES OF EVIDENCE.
1400.7400 HEARING RECORD.
1400.7500 CONTINUANCES.
1400.7600 CERTIFICATION OF MOTIONS TO AGENCY.
1400.7700 ADMINISTRATIVE LAW JUDGE'S CONDUCT.
1400.7800 CONDUCT OF HEARING.
1400.7900 PARTICIPATION BY AGENCY.
1400.8000 DISRUPTION OF HEARING.
1400.8100 ADMINISTRATIVE LAW JUDGE'S REPORT.
1400.8200 AGENCY DECISION.
1400.8300 RECONSIDERATION OR REHEARING.
1400.8400 EMERGENCY PROCEDURES NOT PREEMPTED.
CONTESTED CASE HEARINGS

1400.5010 SCOPE.
The procedures in parts 1400.5010 to 1400.8400 govern all contested cases conducted by the office under Minnesota Statutes, chapter 14.

1400.5100 DEFINITIONS.

Subpart 1. Administrative law judge or judge. "Administrative law judge" or "judge" means the person or persons assigned by the chief administrative law judge pursuant to Minnesota Statutes, section 14.50, to hear the contested case.

Subp. 2. Agency. "Agency" means the state or public agency for whom a contested case hearing is being conducted.

Subp. 3. Chief judge. "Chief judge" means the chief administrative law judge of the Office of Administrative Hearings.

Subp. 3a. Filing. "Filing" means transmission of a document to the Office of Administrative Hearings by mail, delivery, fax, or licensed overnight express mail service.

Subp. 4. [Repealed, 15 SR 1595]

Subp. 5. [Repealed, 15 SR 1595]


Subp. 7. Party. "Party" means each person named as a party by the agency in the notice of and order for hearing, or persons granted permission to intervene pursuant to part 1400.6200. The term "party" shall include the agency except when the agency participates in the contested case in a neutral or quasi-judicial capacity only.

Subp. 8. Person. "Person" means any individual, business, nonprofit association or society, or governmental entity.

Subp. 9. Service; serve. "Service" or "serve" means personal service or, unless otherwise provided by law, service by first class United States mail or a licensed overnight express mail service.
1400.5275 DOCUMENTS FILED.

Forms, documents, or written materials prepared specifically for and used or filed in contested proceedings before the office must be on standard size 8-1/2-inch by 11-inch paper.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.5300 REQUEST FOR ADMINISTRATIVE LAW JUDGE.

Before issuing a notice of and order for hearing, an agency must first file with the docket coordinator a request for assignment of an administrative law judge. The request must include a proposed time, date, and place for the hearing or prehearing conference.

In proposing a hearing location, the requesting agency must take into account the location of known parties, witnesses, and other participants so as to maximize convenience and minimize costs.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.5400 ASSIGNMENT OF ADMINISTRATIVE LAW JUDGE.

Within ten days of the receipt of a request pursuant to part 1400.5300, the chief judge shall assign a judge to hear the case and set the time, date, and place for hearing or prehearing conference, taking into account the agency's request. The agency shall issue the notice of and order for hearing, unless the substantive law requires it to be issued otherwise.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.5500 DUTIES OF ADMINISTRATIVE LAW JUDGE.

Consistent with law, the judge shall perform the following duties:

A. grant or deny a demand for a more definite statement of charges;

B. grant or deny requests for discovery including the taking of depositions;
C. receive and recommend action upon requests for subpoenas where appropriate and consistent with part 1400.7000;
D. hear and rule on motions;
E. preside at the contested case hearing;
F. administer oaths and affirmations;
G. grant or deny continuances;
H. examine witnesses as necessary to make a complete record;
I. prepare findings of fact, conclusions, and recommendations or a final order where required by law;
J. make preliminary, interlocutory, or other orders as deemed appropriate;
K. recommend a summary disposition of the case or any part thereof where there is no genuine issue as to any material fact or recommend dismissal where the case or any part thereof has become moot or for other reasons;
L. permit testimony, upon the request of a party or upon his or her own motion to be prefilled in whole or in part where the prefiling will expedite the conduct and disposition of the case without imposing an undue burden on any party;
M. grant or deny a request to substitute initials or numbers for proper names in the hearing record or in findings of fact, conclusions, and recommendations or order;
N. appoint an interpreter where necessary to provide a fair hearing;
O. set a reasonable limit on the time allowed for testimony after considering the requests of the parties;
P. change the location of the hearing based upon the request of a party where necessary to provide a fair hearing;
Q. do all things necessary and proper to the performance of the foregoing; and
R. in his or her discretion, perform such other duties as may be delegated by the agency ordering the hearing.

Statutory Authority: MS 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276; 26 SR 391

Published Electronically: August 6, 2013

1400.5550 SERVICE AND FILING PROCEDURE.

Subpart 1. Certificate of service. A certificate of service must be made by the person making the service. A certificate of service must bear the name of the person certifying that service has been made, but need not be signed or notarized.

Subp. 2. Service by mail. Service by mail or licensed overnight express mail service is effective upon placing the item to be served in the mail or delivering it to the authorized agent of the express mail service. Postage must be prepaid. Mail to a person other than a state agency shall be addressed to the last
known address of the person. Agencies of the state of Minnesota may also deposit the document with the state of Minnesota's central mail system for United States mail.

Subp. 3. Personal service. Personal service may be accomplished by either delivering the document to the person or by leaving the document at the person's home or place of business with someone of suitable age and discretion who resides in the same house or who is located at the same business address as the person to be served.

Subp. 4. Service upon a confined person. If a person is confined to a federal or state institution, a copy of the document must also be served upon the chief executive officer of the institution.

Subp. 5. Filing by facsimile and other means. Any paper relating to hearings conducted by an administrative law judge under Minnesota Statutes, chapter 14, may be filed with the office by fax transmission. Filings are effective on the date that the office receives the fax transmission if the transmission is begun before 4:30 p.m. on that date. The filing of a fax has the same force and effect as the filing of the original document. Filings made by other means described in part 1400.5100, subpart 3a, are effective on the date the office receives the filing.

Statutory Authority: MS s 14.51; 15.474

History: 26 SR 391

Published Electronically: August 6, 2013

1400.5600 NOTICE AND ORDER FOR HEARING.

Subpart 1. Commencing a contested case. A contested case is commenced, subsequent to the assignment of a judge, by the service of a notice of and order for hearing by the agency.

Subp. 2. Contents of notice and order. Unless otherwise provided by law, a notice of and order for hearing, which shall be a single document, shall be served upon all parties, shall be filed with the office and shall contain, among other things, the following:

A. The time, date, and place for the hearing or a prehearing conference, or a statement that the matter has been referred to the office and that a hearing or prehearing time, date, and place will be set by the judge;

B. Name, address, and telephone number of the judge;

C. A citation to the agency's statutory authority to hold the hearing and to take the action proposed;

D. A statement of the allegations or issues to be determined together with a citation to the relevant statutes or rules allegedly violated or which control the outcome of the case;

E. Notification of the right of the parties to be represented by an attorney, by themselves, or by a person of their choice if not otherwise prohibited as the unauthorized practice of law;

F. A citation to parts 1400.5100 to 1400.8400, to any applicable procedural rules of the agency, and to the contested case provisions of Minnesota Statutes, chapter 14, and notification of how copies may be obtained in print or online;

G. A brief description of the procedure to be followed at the hearing;

H. A statement advising the parties to bring to the hearing all documents, records, and witnesses they need to support their position;
I. A statement that subpoenas may be available to compel the attendance of witnesses or the production of documents, referring the parties to part 1400.7000 relating to subpoenas;

J. A statement advising the parties of the name of the agency official or member of the attorney general's staff to be contacted to discuss informal disposition pursuant to part 1400.5900 or discovery pursuant to parts 1400.6700 and 1400.6800;

K. A statement advising the parties that a notice of appearance must be filed with the judge within 20 days of the date of service of the notice of and order for hearing if a party intends to appear at the hearing unless the hearing date is less than 20 days from the issuance of the notice of and order for hearing;

L. A statement advising existing parties that failure to appear at a prehearing conference, settlement conference, or the hearing, or failure to comply with any order of the judge may result in the allegations of the notice of and order for hearing being taken as true, or the issues set out being deemed proved, and a statement that explains the possible results of the allegations being taken as true or the issues proved;

M. A statement advising the parties that state agencies are required by law to keep some data not public, that parties are required to advise the judge if not public data is offered into the record, and that if not public data is admitted into evidence it may become public unless a party objects and asks for relief under Minnesota Statutes, sections 14.60, subdivision 2;

N. A statement advising the parties and counsel that the office conducts contested case proceedings in accordance with the Minnesota Rules of Professional Conduct and the Professionalism Aspirations adopted by the Minnesota State Bar Association;

O. Notification that the agency will, upon request, make an accommodation so that the hearing is accessible and will appoint a qualified interpreter if necessary; and

P. A statement advising the parties that if an interpreter is needed the judge must be promptly notified.

Subp. 3. Service. Unless otherwise provided by law, the notice of and order for hearing shall be served and filed not less than 30 days prior to the hearing. Provided, however, that a shorter time may be allowed, where it can be shown to the chief judge that a shorter time is in the public interest and that interested persons are not likely to be prejudiced.

Subp. 4. [Repealed, 26 SR 391]

Subp. 5. Amendment. At any time prior to the start of the evidentiary hearing, the agency may file and serve an amended notice of and order for hearing, provided that, should the amended notice and order raise new issues or allegations, the parties shall have a reasonable time to prepare to meet the new issues or allegations if requested. Amendments sought after the start of the hearing must be approved by the judge.

Subp. 6. Alternative documents and procedures. With the prior written concurrence of the chief judge, an agency may substitute other documents and procedures for the notice of and order for hearing provided that the documents and procedures inform actual and potential parties of the information contained in subpart 2.

Subp. 7. Department of Human Rights hearings. After receipt of a request for a hearing forwarded by the commissioner of the Department of Human Rights under Minnesota Statutes, section 363A.29, subdivision 2, and the assignment of a judge to the case, the judge shall prepare and issue a notice of and order for hearing. The notice shall incorporate the charge or charges filed by the charging party and
shall state that an answer to the charges must be served and filed by the respondent within 20 days after service of the notice.

Statutory Authority: MS s 3.764; 14.06; 14.131; 14.51; 15.474; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 11 SR 1385; 15 SR 1595; 26 SR 391

Published Electronically: August 6, 2013

1400.5700 NOTICE OF APPEARANCE.

Each party intending to appear at a contested case hearing shall file with the judge and serve upon all other known parties a notice of appearance which shall advise the judge of the party's intent to appear and shall indicate the title of the case, the agency ordering the hearing, the party's current address and telephone number, and the name, office address, and telephone number of the party's attorney or other representative. The notice of appearance shall be filed and served within 20 days of the date of service of the notice of and order for hearing, except that, where the hearing or prehearing conference date is less than 20 days from the commencement of the contested case, the notice of appearance shall be filed as soon as possible. The failure to file and serve a notice may, in the discretion of the judge, result in a continuance of the hearing if the party failing to file appears at the hearing. A notice of appearance form shall be included with the notice of and order for hearing for use by the party served. After an attorney has filed a notice of appearance, withdrawal is effective only if a notice of withdrawal is promptly served on all parties and filed with the judge. The notice of withdrawal must include the address and telephone number of the party. Withdrawal of counsel does not create any right to a continuance.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 15 SR 1595; 26 SR 391

Published Electronically: August 6, 2013

1400.5800 RIGHT TO COUNSEL.

Parties may be represented by an attorney throughout the proceedings in a contested case, by themselves, or by a person of their choice if not otherwise prohibited as the unauthorized practice of law. Persons appearing in contested case proceedings in a representative capacity must conform to the standards of professional conduct required of attorneys before the courts of Minnesota. If any representative fails to conform to these standards, the judge may exclude the person from the proceeding.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276; 26 SR 391

Published Electronically: August 6, 2013

1400.5900 CONSENT ORDER, SETTLEMENT, OR STIPULATION.

Informal disposition may be made of any contested case or any issue therein by stipulation, agreed settlement, or consent order at any point in the proceedings. Parties may enter into these agreements on their own or may utilize the mediation procedures in part 1400.5950 or the settlement conference procedures in
1400.5950 MEDIATION.

Subpart 1. Definition. "Mediation" is a voluntary process where parties to a dispute jointly explore and resolve all or a part of their differences with the assistance of a neutral person. The mediator's role is to assist the parties in resolving the dispute themselves. The mediator has no authority to impose a settlement.

Subp. 2. Office to provide. The office will provide mediation services to any state agency, court, or political subdivision in a contested case proceeding or other contested matter other than labor relation disputes which are within the jurisdiction of the Bureau of Mediation Services. For purposes of this part only, "agency" means either a state agency, court, or political subdivision of the state.

Subp. 3. Initiating mediation. Mediation may be initiated in the following ways:

A. Prior to the initiation of a contested case proceeding, an agency may propose mediation by filing a written request for mediation services with the chief judge. A copy of the request shall be served upon all persons whom the agency would name as parties in the notice of and order for hearing.

B. Subsequent to the initiation of a contested case proceeding, the agency, a party to a contested case, or the judge assigned to the contested case may propose that the case be mediated by filing a request for mediation services with the chief judge. A copy of the request must be served upon the agency, the judge, and all parties.

C. Upon receipt of a request for mediation, the chief judge or designee shall contact, either orally or in writing, the agency and all parties to determine whether they are willing to participate in mediation. No matter shall be ordered for mediation if the agency or any party is opposed.

D. If the chief judge determines that no party or the agency is opposed to mediation, the chief judge shall appoint a mediator and issue an order for mediation, which shall set forth:

   (1) the name, address, and telephone number of the mediator; and
   (2) a date by which the mediator must initiate the mediation proceedings.

The order shall be served upon the agency, the parties, and the judge assigned to the contested case, if any.

E. The mediator must initiate the mediation proceedings by contacting the agency and each party no later than the date set forth in the order for mediation.

Subp. 4. Confidentiality. The mediator shall not communicate, either directly or indirectly, regarding any facts or issues in the mediation with any person not participating in the mediation unless authorized to do so by the parties to the mediation.

Subp. 5. Termination. The mediation process shall terminate when all parties are, or the agency is, unwilling to continue mediation; or a settlement agreement is signed setting forth the resolution of the disputed issues.
Upon termination, the mediator shall either forward the signed settlement agreement to the agency or the judge, if applicable, for appropriate action; or inform the agency or the judge, if applicable, that the mediation has been terminated without agreement.

Subp. 6. Admissibility. Any offers to compromise or evidence of conduct or statements made during mediation are not admissible.

Subp. 7. Unsuccessful mediation. The person appointed to mediate a dispute shall not be assigned to hear any portion of the case should mediation terminate unsuccessfully.

Statutory Authority: MS s 14.06; 14.131; 14.51; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 15 SR 1595

Published Electronically: August 6, 2013

1400.6000 DEFAULT.

The agency or the judge, where authorized, may dispose of a contested case adverse to a party which defaults. Upon default, the allegations of or the issues set out in the notice of and order for hearing or other pleading may be taken as true or deemed proved without further evidence. A default occurs when a party fails to appear without the prior consent of the judge at a prehearing conference, settlement conference, or a hearing or fails to comply with any interlocutory orders of the judge.

Statutory Authority: MS s 14.06; 14.131; 14.51; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 15 SR 1595

Published Electronically: August 6, 2013

1400.6100 TIME.

Subpart 1. Computation. In computing any period of time prescribed by parts 1400.5100 to 1400.8400 or the procedural rules of any agency, the day of the last act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday, or a legal holiday.

Subp. 2. Extra time: service by mail. Whenever a party has the right or is required to do some act or take some action within a prescribed period after the service of a notice or other paper upon the party, or whenever service is required to be made within a prescribed period before a specified event, and the notice or paper is served by mail, three days shall be added to the prescribed period. In the event an agency chooses to utilize the Central Mailing Section, Publications Division, Department of Administration, four days shall be added to the prescribed period.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.6200 INTERVENTION IN PROCEEDINGS AS PARTY.

Subpart 1. Petition. Any person not named in the notice of hearing who desires to intervene in a contested case as a party shall submit a timely written petition to intervene to the judge and shall serve
the petition upon all existing parties and the agency. Timeliness will be determined by the judge in each case based on circumstances at the time of filing. The petition shall show how the petitioner's legal rights, duties, or privileges may be determined or affected by the contested case; shall show how the petitioner may be directly affected by the outcome of that petitioner's participation is authorized by statute, rule, or court decision; shall set forth the grounds and purposes for which intervention is sought; and shall indicate petitioner's statutory right to intervene if one should exist. The agency may, with the consent of the judge, and where good reason appears thereafter, specify in the notice of and order for hearing or prehearing the final date upon which a petition for intervention may be submitted to the judge.

Subp. 2. Objection. Any party may object to the petition for intervention by filing a written notice of objection with the judge within seven days of service of the petition if there is sufficient time before the hearing. The notice shall state the party's reasons for objection and shall be served upon all parties, the person petitioning to intervene and the agency. If there is insufficient time before the hearing for a written objection, the objection may be made orally at the hearing.

Subp. 2a. Hearing on petition. Where necessary to develop a full record on the question of intervention, the judge shall conduct a hearing on the petition to determine specific standards that will apply to each category of intervenor, and to define the scope of intervention.

Subp. 3. Order. The judge shall allow intervention upon a proper showing pursuant to subpart 1 unless the judge finds that the petitioner's interest is adequately represented by one or more parties participating in the case. An order allowing intervention shall specify the extent of participation permitted the petitioner and shall state the judge's reasons. A petitioner may be allowed to:

A. file a written brief without acquiring the status of a party;
B. intervene as a party with all the rights of a party; or
C. intervene as a party with all the rights of a party but limited to specific issues and to the means necessary to present and develop those issues.

Subp. 4. By agency in a neutral capacity. Where the agency participates in the hearing in a neutral or quasi-judicial capacity, the agency staff, or a portion of the agency staff, may petition to intervene under the rule.

Subp. 5. Participation by public. The judge may, in the absence of a petition to intervene, nevertheless hear the testimony and receive exhibits from any person at the hearing, or allow a person to note that person's appearance, or allow a person to question witnesses, but no person shall become, or be deemed to have become, a party by reason of such participation. Persons offering testimony or exhibits may be questioned by parties to the proceeding.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276; 26 SR 391

Published Electronically: August 6, 2013

1400.6300 [Repealed, 9 SR 2276]

Published Electronically: August 6, 2013

Copyright ©2015 by the Revisor of Statutes, State of Minnesota. All Rights Reserved.
1400.6350 CONSOLIDATION OF CASES.

Subpart 1. Standards for consolidation. Whenever two or more separate contested cases present substantially the same issues of fact and law, that a holding in one case would affect the rights of parties in another case, that consolidating the cases for hearing would save time and costs, and that consolidation would not prejudice any party, the cases may be consolidated for hearing under this part.

Subp. 2. Agency consolidation. Subject to a motion for severance as provided in subpart 7, prior to referring cases to the office for hearing an agency may consolidate two or more cases for hearing.

Subp. 3. Service of petition. A party requesting consolidation shall serve a petition for consolidation on all parties to the cases to be consolidated, on the agency if the agency is not a party, and shall file the original with the judge assigned to the cases, together with a proof of service showing service as required herein. Any party objecting to the petition shall serve and file their objections within ten calendar days following service of the petition for consolidation.

Subp. 4. Determination of petition. When more than one judge is assigned to the cases which are the subject of the petition for consolidation, the petition will be determined by the judge assigned to the first case submitted to the office.

Subp. 5. Order. Upon determining whether cases should be consolidated, the judge shall serve a written order on all parties and the agency, if the agency is not a party. The order shall contain, among other things, a description of the cases for consolidation, the reasons for the decision, and notification of a consolidated prehearing conference if one is being scheduled.

Subp. 6. Stipulations. Nothing contained in this part shall be deemed to prohibit parties from stipulating and agreeing to a consolidation which shall be granted upon submission of a written stipulation, signed by all parties, to the judge. A judge may consolidate two or more cases presently pending before that judge on the judge's own motion, applying the standards in subpart 1.

Subp. 7. Petition for severance. Following receipt of a notice of or order for consolidation, any party may petition for severance by serving it on all other parties and the agency, if the agency is not a party, and filing it with the judge at least seven business days prior to the first scheduled hearing date. If the judge finds that the consolidation will prejudice the petitioner, the judge shall order the severance or other relief which will prevent the prejudice from occurring.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.6400 ADMINISTRATIVE LAW JUDGE DISQUALIFICATION.

The judge shall withdraw from participation in a contested case at any time if he or she deems himself or herself disqualified for any reason. Upon the filing in good faith by a party of an affidavit of prejudice, the chief judge shall determine the matter as a part of the record provided the affidavit shall be filed no later than five days prior to the date set for hearing. A judge must be removed upon an affirmative showing of prejudice or bias. A judge may not be removed merely because of rulings on prior cases.
1400.6550 APA PROCEEDINGS; EXPENSES AND ATTORNEY FEES

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28
History: 9 SR 2276; 26 SR 391
Published Electronically: August 6, 2013

1400.6500 PREHEARING CONFERENCE.

Subpart 1. Purpose. The purpose of the prehearing conference is to simplify the issues to be determined, to consider amendment of the agency’s order if necessary, to obtain stipulations in regard to foundation for testimony or exhibits, to obtain stipulations of agreement on nondisputed facts or the application of particular laws, to consider the proposed witnesses for each party, to consider how the hearing will be recorded and whether a transcript will be prepared, to consider whether an interpreter or other accommodation is needed, to identify and exchange documentary evidence intended to be introduced at the hearing, to determine deadlines for the completion of any discovery, to consider a reasonable limit on the time allowed for presenting evidence, to establish hearing dates and locations if not previously set, to determine whether the issues in the case are susceptible to mediation, to consider such other matters that may be necessary or advisable and, if possible, to reach a settlement without the necessity for further hearing.

Subp. 2. Procedure. Upon the request of any party or upon his or her own motion, the judge may, in his or her discretion, hold a prehearing conference prior to each contested case hearing. A prehearing conference may be held by telephone. The judge may require the parties to file a prehearing statement prior to the prehearing conference which shall contain such items as the judge deems necessary to promote a useful prehearing conference. A prehearing conference shall be an informal proceeding conducted expeditiously by the judge. Agreements on the simplification of issues, amendments, stipulations, or other matters may be entered on the record or may be made the subject of an order by the judge.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28
History: 9 SR 2276; 26 SR 391
Published Electronically: August 6, 2013

1400.6550 SETTLEMENT CONFERENCE.

Subpart 1. Purpose. A settlement conference is for the primary purpose of assisting the parties in resolving disputes and for the secondary purpose of narrowing the issues and preparing for hearing as in part 1400.6500, subpart 1.

Subp. 2. Scheduling. Upon the request of any party or the judge, the chief judge shall assign the case to another judge for the purpose of conducting a settlement conference. Unless both parties and the judge agree, a unilateral request for a settlement conference will not constitute good cause for a continuance. The conference shall be conducted at a time and place agreeable to all parties and the judge. It shall be conducted by telephone if any party would be required to travel more than 50 miles to attend, unless that party agrees to travel to the location set for the conference. If a telephone conference is scheduled, the parties must be available by telephone at the time of the conference. Where mediation between the parties has previously occurred, a settlement conference will not be ordered unless all parties agree.

Subp. 3. Procedures at conference. All parties shall attend or be represented at a settlement conference. Parties or their representatives attending a settlement conference shall be prepared to participate in meaningful settlement discussions.
Subp. 4. Preconference discussions. The parties shall discuss the possibility of settlement before a settlement conference if they believe that a reasonable basis for settlement exists.

Subp. 5. Information provided. At the settlement conference, the parties shall be prepared to provide the information and to discuss all matters required by part 1400.6500, subpart 1.

Subp. 6. Orders. If, following a settlement conference, a settlement has not been reached but the parties have reached an agreement on any facts or other issues, the judge presiding over the settlement conference shall issue an order confirming and approving, if necessary, those matters agreed upon. The order is binding on the judge who is assigned to hear the case.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28
History: 9 SR 2276
Published Electronically: August 6, 2013

1400.6600 MOTIONS.

Any application to the judge for an order shall be by motion which, unless made during a hearing, shall be made in writing, shall state with particularity the grounds therefor, and shall set forth the relief or order sought. Motions provided for in parts 1400.5100 to 1400.8400 shall be served on all parties, the agency, if it is not a party, and the judge. The written motion shall advise other parties that should they wish to contest the motion they must file a written response with the judge and serve copies on all parties, within ten working days after it is received. No memorandum of law submitted in connection with a motion may exceed 25 pages, except with the permission of the judge. If any party desires a hearing on the motion, they shall make a request for a hearing at the time of the submission of their motion or response. A response shall set forth the nonmoving party's objections. A hearing on a motion will be ordered by the judge only if it is determined that a hearing is necessary to the development of a full and complete record on which a proper decision can be made. Motions may be heard by telephone. All orders on such motions, other than those made during the course of the hearing, shall be in writing and shall be served upon all parties of record and the agency if it is not a party. In ruling on motions where parts 1400.5100 to 1400.8400 are silent, the judge shall apply the Rules of Civil Procedure for the District Court for Minnesota to the extent that it is determined appropriate in order to promote a fair and expeditious proceeding.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28
History: 9 SR 2276; 26 SR 391
Published Electronically: August 6, 2013

1400.6700 DISCOVERY.

Subpart 1. Witnesses; statement by parties or witnesses. Each party shall, within ten days of a written demand by another party, disclose the following:

A. The names and addresses of all witnesses that a party intends to call at the hearing, along with a brief summary of each witness' testimony. All witnesses unknown at the time of said disclosure shall be disclosed as soon as they become known.

B. Any relevant written or recorded statements made by the party or by witnesses on behalf of a party. The demanding party shall be permitted to inspect and reproduce any such statements.
C. All written exhibits to be introduced at the hearing. The exhibits need not be produced until one week before the hearing unless otherwise ordered.

D. Any party unreasonably failing upon demand to make the disclosure required by this subpart may, in the discretion of the judge, be foreclosed from presenting any evidence at the hearing through witnesses or exhibits not disclosed or through witnesses whose statements are not disclosed.

Subp. 2. Discovery of other information. Any means of discovery available pursuant to the Rules of Civil Procedure for the District Court of Minnesota is allowed. If the party from whom discovery is sought objects to the discovery, the party seeking the discovery may bring a motion before the judge to obtain an order compelling discovery. In the motion proceeding, the party seeking discovery shall have the burden of showing that the discovery is needed for the proper presentation of the party's case, is not for purposes of delay, and that the issues or amounts in controversy are significant enough to warrant the discovery. In ruling on a discovery motion, the judge shall recognize all privileges recognized at law.

Subp. 3. Noncompliance. Upon the failure of a party to reasonably comply with an order of the judge made pursuant to subpart 2, the judge may make a further order as follows:

A. an order that the subject matter of the order for discovery or any other relevant facts shall be taken as established for the purposes of the case in accordance with the claim of the party requesting the order;

B. an order refusing to allow the party failing to comply to support or oppose designated claims or defenses, or prohibiting that party from introducing designated matters in evidence.

Subp. 4. Protective orders. The judge may issue a protective order as justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense due to a discovery request. When a party is asked to reveal material considered to be proprietary information or trade secrets, or not public data, that party may bring the matter to the attention of the judge, who shall make such protective orders as are reasonable and necessary or as otherwise provided by law.

Subp. 5. Filing. Copies of a party's request for discovery as well as the responses to those requests and copies of discovery depositions shall not be filed with the office unless otherwise ordered by the judge or unless they are filed in support of any motion or unless they are introduced as evidence in the hearing.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 15 SR 1595; 26 SR 391

Published Electronically: August 6, 2013

1400.6800 REQUESTS FOR ADMISSION OF FACTS OR OPINIONS.

A party may serve upon any other party a written request for the admission of relevant facts or opinions, or of the application of law to relevant facts or opinions, including the genuineness of any document. The request must be served at least 15 days prior to the hearing, and it shall be answered in writing by the party to whom the request is directed within ten days of receipt of the request. The written answer shall either admit or deny the truth of the matters contained in the request or shall make a specific objection thereto. Failure to make a written answer within ten days will result in the subject matter of the request being deemed admitted unless it can be shown that there was a justifiable excuse for failing to respond.
1400.6900 DEPOSITIONS TO PRESERVE TESTIMONY.

Upon the request of any party, the judge may order that the testimony of any witness be taken by deposition to preserve that witness' testimony in the manner prescribed by law for depositions in civil actions. The request shall indicate the relevancy of the testimony and shall make a showing that the witness will be unable or cannot be compelled to attend the hearing or show other good cause.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.6950 EXCHANGE OF WITNESS LISTS AND EXHIBITS.

Subpart 1. Order. Prior to the hearing the judge may, upon a party's request or at the judge's own motion, order the parties by a date certain to:

A. exchange a list of all witnesses to be called at the hearing. The list must include the witness' occupation and address; and

B. exchange all written exhibits to be offered at the hearing.

Subp. 2. Objection to foundation. Any party objecting to the foundation for any written exhibit received under subpart 1 must notify both the offering party and the judge in writing at least two working days before the hearing or the foundation objection is waived.

Statutory Authority: MS s 14.51; 15.474

History: 26 SR 391

Published Electronically: August 6, 2013

1400.7000 SUBPOENAS.

Subpart 1. Written request. Requests for subpoenas for the attendance of witnesses or the production of documents, either at a hearing or for the purpose of discovery, shall be made in writing to the judge, shall contain a brief statement demonstrating the potential relevance of the testimony or evidence sought, shall identify any documents sought with specificity, shall include the full name and home or business address of all persons to be subpoenaed and, if known, the date, time, and place for responding to the subpoena.

Subp. 2. Service. A subpoena shall be served in the manner provided by the Rules of Civil Procedure for the District Courts of Minnesota unless otherwise provided by law. The cost of service, fees, and expenses of any witnesses subpoenaed shall be paid by the party at whose request the witness appears. The person serving the subpoena is not required to make proof of service by filing the subpoena with the judge. However, a filing with an affidavit of service will be required with the motion of a party seeking an order imposing sanctions for failure to comply with any subpoena issued under parts 1400.5100 to 1400.8400.
Subp. 3. Objection to subpoena. Any person served with a subpoena who has an objection to it may file an objection with the judge. The objection shall be filed promptly, and in any event at or before the time specified in the subpoena for compliance. The judge shall cancel or modify the subpoena if it is unreasonable or oppressive, taking into account the issues or amounts in controversy, the costs or other burdens of compliance when compared with the value of the testimony or evidence sought for the presentation of a party's case, and whether or not there are alternative methods of obtaining the desired testimony or evidence. Modification may include requiring the party requesting the subpoena to pay reasonable costs of producing documents, books, papers, or other tangible things.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.7050 SANCTIONS IN DISCRIMINATION CASES.

Subpart 1. Precomplaint procedure. If, at any time prior to the issuance of a complaint in any matter pending before the Minnesota Department of Human Rights, the charging party or the respondent believes that the other is intentionally and frivolously delaying any precomplaint proceedings, it may petition the chief judge for an order imposing sanctions. For the purpose of this subpart, a respondent is any person against whom a charge has been filed. The sanctions and the procedures are as follows:

A. A party requesting the imposition of sanctions shall file a petition with the chief judge which shall include proof that a copy of the petition has been served on the other party.

B. A petition for the imposition of sanctions shall state, with specificity, the acts of the other party which are alleged to be intentional and frivolous delay; the sanctions requested; whether an oral hearing is requested; and shall include sworn affidavits of persons having first-hand knowledge of the alleged acts.

C. The party against whom sanctions are sought shall have ten working days following receipt of the petition to file an objection to the petition. The objection shall respond to each alleged act of delay with specificity; shall include sworn affidavits of persons having first-hand knowledge of the alleged acts; and shall state whether an oral hearing is requested. Objections are timely filed only if received by the office at or before 4:30 p.m. of the tenth working day. The objection shall include proof that it was served on the other party.

D. Upon receipt of a petition and objection under this part, the chief judge shall either determine the matter or assign it to a judge for determination. If either party has requested an oral hearing, it shall be conducted no earlier than ten calendar days following the receipt of a notice of the hearing.

E. Intentional and frivolous delay occurs when a party deliberately delays proceedings for immaterial, meritless, trivial, or unjustifiable reasons. In determining whether intentional and frivolous delay has occurred, the judge shall also give consideration to the number of issues and amount of damages in controversy, any pattern of similar acts by the party, and effects of the delay.

F. If it is determined that intentional and frivolous delay has occurred, the judge shall enter an order requiring the offending party to cease and desist from the act; compelling cooperation in all phases of the proceedings; or imposing any other sanctions, other than fines, deemed necessary to compel expeditious cooperation and completion of the investigation.
G. In the event the investigation results in a finding of probable cause and issuance of a complaint, the determination of intentional and frivolous delay and compliance with any orders issued under item F shall be taken into consideration in awarding damages and attorney's fees, where applicable.

Subp. 2. Procedure during proceedings. If during the pendency of a contested case before the office either the charging party or the respondent believe that the other is intentionally and frivolously delaying the proceedings, they may bring a motion before the judge by following the procedures in part 1400.6600. If the judge determines, using the criteria in subpart 1, item E, that intentional and frivolous delay has occurred, the judge shall issue an order containing any of the following:

A. that the party shall cease and desist from the acts;
B. compelling cooperation during further pendency of the case;
C. dismissing any or all charges or defenses to charges, whichever may be appropriate;
D. foreclosing the testimony of specified witnesses or the presentation of evidence on specified issues;
E. that the delay will be taken into consideration in awarding damages or attorney's fees; or
F. any sanctions available in civil cases in the district courts of Minnesota.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.7100 RIGHTS AND RESPONSIBILITIES OF PARTIES,

Subpart 1. Generally. All parties shall have the right to present evidence, rebuttal testimony, and argument with respect to the issues, and to cross-examine witnesses.

Subp. 2. Necessary preparation. A party shall have all evidence to be presented, both oral and written, available on the date for hearing. Requests for subpoenas, depositions, or continuances shall be made within a reasonable time after their need becomes evident to the requesting party. In cases where the hearing time is expected to exceed one day, the parties shall be prepared to present their evidence at the date and time ordered by the judge or as agreed upon at a prehearing conference. Parties shall have enough copies of exhibits so that they can provide a copy to each other party at the time the exhibit is introduced, unless that other party has already obtained a copy through discovery.

Subp. 3. Responding to orders. If the judge orders that parties do an act or not do an act, the parties shall comply with the order. If a party objects to an order, the objection shall be stated in advance of the order as part of the record. If the party had no advance knowledge that the order was to be issued, any objection shall be made as part of the record as soon as the party becomes aware of the order.

Subp. 4. Copies. The judge shall send copies of all orders or decisions to all parties simultaneously. Any party sending a letter, exhibit, brief, memorandum, subpoena request, or other document to the judge shall simultaneously send a copy to all other parties.

Subp. 5. Representation by attorney. A party need not be represented by an attorney. If a party has notified other parties of that party's representation by an attorney, all communications shall be directed to that attorney.
Subp. 6. Communication with judge. No party or attorney may communicate with the judge on the merits of the case unless all parties have the opportunity to participate.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 15 SR 1595; 26 SR 391

Published Electronically: August 6, 2013

1400.7150 RIGHTS AND RESPONSIBILITIES OF NONPARTIES.

Subpart 1. Offering evidence. With the approval of the judge, any person may offer testimony or other evidence relevant to the case. Any nonparty offering testimony or other evidence may be questioned by parties to the case and by the judge.

Subp. 2. Questioning witnesses. The judge may allow nonparties to question witnesses if deemed necessary for the development of a full and complete record.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.7200 WITNESSES.

Any party may be a witness and may present witnesses on the party’s behalf at the hearing. All oral testimony at the hearing shall be under oath or affirmation. At the request of a party or upon the judge’s own motion, the judge shall exclude witnesses from the hearing room so that they cannot hear the testimony of other witnesses.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.7300 RULES OF EVIDENCE.

Subpart 1. Admissible evidence. The judge may admit all evidence which possesses probative value, including hearsay, if it is the type of evidence on which reasonable, prudent persons are accustomed to rely in the conduct of their serious affairs. The judge shall give effect to the rules of privilege recognized by law. Evidence which is incompetent, irrelevant, immaterial, or unduly repetitious shall be excluded.

Subp. 2. Evidence part of record. All evidence to be considered in the case, including all records and documents in the possession of the agency or a true and accurate photocopy, shall be offered and made a part of the record in the case. No other factual information or evidence shall be considered in the determination of the case.

Subp. 3. Documents. Documentary evidence in the form of copies or excerpts may be received or incorporated by reference in the discretion of the judge or upon agreement of the parties. Copies of a document shall be received to the same extent as the original document unless a genuine question is raised as to the accuracy or authenticity of the copy or, under the circumstances, it would be unfair to admit the copy in lieu of the original.
Subp. 4. **Official notice of facts.** The judge may take notice of judicially cognizable facts but shall do so on the record and with the opportunity for any party to contest the facts so noticed.

Subp. 5. **Burden of proof.** The party proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence, unless the substantive law provides a different burden or standard. A party asserting an affirmative defense shall have the burden of proving the existence of the defense by a preponderance of the evidence. In employee disciplinary actions, the agency or political subdivision initiating the disciplinary action shall have the burden of proof.

Subp. 6. **Examination of adverse party.** A party may call an adverse party or a managing agent, or employees or an officer, director, managing agent, or employee of the state or any political subdivision thereof or of a public or private corporation or of a partnership or association or body politic which is an adverse party, and interrogate that party by leading questions and contradict and impeach that party on material matters in all respects as if that party had been called by the adverse party. The adverse party may be examined by that party's counsel upon the subject matter of that party's examination in chief under the rules applicable to direct examination, and may be cross-examined, contradicted, and impeached by any other party adversely affected by the testimony.

**Statutory Authority:** MS s 14.06; 14.131; 14.51; 363.06; 363A.28

**History:** 9 SR 2276

**Published Electronically:** August 6, 2013

---

**1400.7400 HEARING RECORD.**

Subpart 1. **Content.** The judge shall maintain the official record in each contested case until the issuance of the judge's final report, at which time the record, except for the audiomagnetic recordings of the hearing, shall be sent to the agency. The audiomagnetic recordings shall be retained by the office for five years from the date that the record is returned to the agency. Unless an agency requests a longer retention period for a specific case, the recordings may be erased or otherwise destroyed at the end of the five-year period.

The record in a contested case shall contain all pleadings, motions, and orders; evidence offered or considered; offers of proof, objections, and rulings thereon; the judge's findings of fact, conclusions, and recommendations; all memoranda or data submitted by any party in connection with the case; and the transcript of the hearing, if one was prepared.

Subp. 2. **Transcript.** The verbatim record shall be transcribed if requested by the agency, a party, or in the discretion of the chief judge. The agency or party requesting a transcript is responsible for the cost. The parties may agree to divide the cost. When the chief administrative law judge requests a transcript the agency is responsible for the cost.

**Statutory Authority:** MS s 14.06; 14.131; 14.51; 15.474; 116C.66; 216E.16; 363.06; 363A.28

**History:** 9 SR 2276; 15 SR 1595; 26 SR 391

**Published Electronically:** August 6, 2013

---

**1400.7500 CONTINUANCES.**

Requests for a continuance of a hearing shall be granted upon a showing of good cause. Unless time does not permit, a request for continuance of the hearing shall be made in writing to the judge and shall
be served upon all parties of record and the agency if it is not a party. In determining whether good cause exists, due regard shall be given to the ability of the party requesting a continuance to effectively proceed without a continuance. A request for a continuance filed within five business days of the hearing shall be denied unless the reason for the request could not have been earlier ascertained.

"Good cause" shall include: death or incapacitating illness of a party, representative, or attorney of a party; a court order requiring a continuance; lack of proper notice of the hearing; a substitution of the representative or attorney of a party if the substitution is shown to be required; a change in the parties or pleadings requiring postponement; and agreement for a continuance by all parties provided that it is shown that more time is clearly necessary to complete authorized discovery or other mandatory preparation for the case and the parties and the judge have agreed to a new hearing date, or, the parties are engaged in serious settlement negotiations or have agreed to a settlement of the case which has been or will likely be approved by the final decision maker.

"Good cause" shall not include: intentional delay; unavailability of counsel or other representative due to engagement in another judicial or administrative proceeding unless all other members of the attorney's or representative's firm familiar with the case are similarly engaged, or if the notice of the other proceeding was received subsequent to the notice of the hearing for which the continuance is sought; unavailability of a witness if the witness' testimony can be taken by deposition; and failure of the attorney or representative to properly utilize the statutory notice period to prepare for the hearing.

During a hearing, if it appears in the interest of justice that further testimony should be received and sufficient time does not remain to conclude the testimony, the judge shall either order the additional testimony be taken by deposition or continue the hearing to a future date and oral notice on the record shall be sufficient.

A continuance shall not be granted when to do so would prevent the case from being concluded within any statutory deadline.

Statutory Authority: MS s 14.06; 14.131; 14.51; 116C.66; 216E.16; 363.06; 363A.28
History: 9 SR 2276; 15 SR 1595
Published Electronically: August 6, 2013

1400.7600 CERTIFICATION OF MOTIONS TO AGENCY.

No motions shall be made directly to or be decided by the agency subsequent to the assignment of a judge and prior to the completion and filing of the judge's report unless the motion is certified to the agency by the judge. No motions will be certified in cases where the judge's report is binding on the agency. Uncertified motions shall be made to and decided by the judge and considered by the agency in its consideration of the record as a whole subsequent to the filing of the judge's report. Any party may request that a pending motion or a motion decided adversely to that party by the judge before or during the course of the hearing, other than rulings on the admissibility of evidence or interpretations of parts 1400.5100 to 1400.8400, be certified by the judge to the agency. In deciding what motions should be certified, the judge shall consider the following:

A. whether the motion involves a controlling question of law as to which there is substantial ground for a difference of opinion; or
B. whether a final determination by the agency on the motion would materially advance the ultimate termination of the hearing; or
C. whether or not the delay between the ruling and the motion to certify would adversely affect the prevailing party; or

D. whether to wait until after the hearing would render the matter moot and impossible for the agency to reverse or for a reversal to have any meaning; or

E. whether it is necessary to promote the development of the full record and avoid remanding; or

F. whether the issues are solely within the expertise of the agency.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.7700 ADMINISTRATIVE LAW JUDGE'S CONDUCT.

Subpart 1. Communication with parties. The judge shall not communicate, directly or indirectly, in connection with any issue of fact or law with any person or party including the agency concerning any pending case, except upon notice and opportunity for all parties to participate. When these rules authorize communications contrary to this part, the communications shall be limited to only those matters permitted by these rules. The judge may respond to questions relating solely to procedures for the hearing without violating this part.

Subp. 2. Ex parte communication. Where circumstances require, ex parte communications for scheduling, administrative purposes, or emergencies that do not deal with substantive matters or issues on the merits are authorized, provided;

A. the judge reasonably believes that no party will gain a procedural or tactical advantage as a result of the ex parte communication; and

B. the judge makes provisions promptly to notify all other parties of the substance of the ex parte communication and allows an opportunity to respond.

Subp. 3. Other communication. The administrative law judge may:

A. obtain the advice of a disinterested expert on the law applicable to a proceeding before the judge if the judge gives prior notice to the parties of the person to be consulted and an opportunity to object. If the advice is obtained, the judge shall notify the parties of the substance of the advice and afford the parties a reasonable opportunity to respond;

B. consult with other judges and with office personnel whose function is to aid the judge in carrying out the judge's adjudicative responsibilities;

C. if the parties consent, confer separately with the parties and/or their representatives in an effort to mediate or settle matters pending before the judge, subject to part 1400.5950, subpart 7; and

D. initiate or consider any ex parte communication when expressly authorized by law to do so.

Subp. 4. Code of conduct. Administrative law judges are subject to the provisions of the Code of Judicial Conduct.
1400.7800 CONDUCT OF HEARING.

In the absence of a specific provision mandating or permitting a closed hearing, all contested case hearings are open to the public. Unless the judge determines that the public interest will be equally served otherwise, the hearing shall be conducted substantially in the following manner:

A. The judge shall open the hearing by reading the title of the case, asking the parties or counsel to note their appearances, and explaining the hearing procedure to unrepresented parties.

B. After opening the hearing, the judge shall, unless all parties are represented by counsel or are otherwise familiar with the procedures, state the procedural rules for the hearing including the following:

   (1) All parties may present evidence and argument with respect to the issues and cross-examine witnesses.

   (2) All parties have a right to be represented by an attorney at the hearing.

   (3) The rules of evidence in part 1400.7300, subpart 1.

C. Any stipulations, settlement agreements, or consent orders entered into by any of the parties prior to the hearing shall be entered into the record.

D. The party with the burden of proof may make an opening statement. All other parties may make statements in a sequence determined by the judge.

E. After any opening statements, the party with the burden of proof shall begin the presentation of evidence unless the parties have agreed otherwise or the administrative law judge determines that requiring another party to proceed first would be more expeditious and would not jeopardize the rights of any other party. It shall be followed by the other parties in a sequence determined by the judge.

F. Cross-examination of witnesses shall be conducted in a sequence and in a manner determined by the judge to expedite the hearing while ensuring a fair hearing. At the request of a party whose witness is being cross-examined, the judge shall make rulings as are necessary to prevent argumentative, repetitive, or irrelevant questioning and to expedite the cross-examination to the extent consistent with the disclosure of all relevant testimony and information.

G. Any party may be a witness or may present other persons as witnesses at the hearing. All evidentiary testimony presented to prove or disprove a fact at issue shall be under oath or affirmation.

H. When all parties and witnesses have been heard, opportunity shall be offered to present oral final argument, in a sequence determined by the judge. Final argument may, in the discretion of the judge, be in the form of written memoranda or oral argument, or both. Final argument need not be recorded, in the discretion of the judge. Written memoranda may, in the discretion of the judge, be submitted simultaneously or sequentially and within time periods as the judge may prescribe. The judge may limit the length of written memoranda.

I. After final argument, the hearing shall be closed unless a continuance has been ordered under part 1400.7500. If continued, it shall be either: continued to a certain time and day, announced at the time
of the hearing and made a part of the record; or continued to a date to be determined later, which must be
upon not less than five days' written notice to the parties.

J. The record of the contested case proceeding shall be closed upon receipt of the final written
memorandum, transcript, if any, or late filed exhibits which the parties and the judge have agreed should be
received into the record, whichever occurs latest.

Statutory Authority: MS s 14.06; 14.131; 14.51; 15.474; 363.06; 363A.28

History: 9 SR 2276; 26 SR 391

Published Electronically: August 6, 2013

1400.7900 PARTICIPATION BY AGENCY.

An agency which is a party to a contested case may only participate in the hearing by the giving
of testimony and through its designated representative or counsel. Where the agency is not a party and
participates in the hearing in a neutral or quasi-judicial capacity, the agency head or a member of the
governing body of the agency or designee may engage in examination of witnesses as the judge deems
appropriate.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.8000 DISRUPTION OF HEARING.

Subpart 1. Cameras. Television, newsreel, motion picture, still, or other cameras, and mechanical
recording devices may be operated in the hearing room during the course of the hearing after permission is
obtained from the judge and then only pursuant to any conditions the judge may impose to avoid disruption
of the hearing.

Subp. 2. Other conduct. Pursuant to and in accordance with Minnesota Statutes, section 624.72,
no person shall interfere with the free, proper, and lawful access to or egress from the hearing room. No
person shall interfere with the conduct of, disrupt, or threaten interference with or disruption of the hearing.
In the event of interference, disruption, or threat, the judge shall read this subpart to those persons causing
such interference or disruption and thereafter proceed as deemed appropriate, which may include ordering
the disruptive person to leave or be removed from the hearing.

Statutory Authority: MS s 14.06; 14.131; 14.51; 363.06; 363A.28

History: 9 SR 2276

Published Electronically: August 6, 2013

1400.8100 ADMINISTRATIVE LAW JUDGE'S REPORT.

Subpart 1. Based on record. No factual information or evidence which is not a part of the record
shall be considered by the judge or the agency in the determination of a contested case.
1400.8300 APA PROCEEDINGS; EXPENSES AND ATTORNEY FEES

Subp. 2. **Administrative notice.** The judge and agency may take administrative notice of general, technical, or scientific facts within their specialized knowledge in conformance with Minnesota Statutes, section 14.60.

Subp. 3. **Completion and distribution.** Following the close of the record, the judge shall make a report pursuant to Minnesota Statutes, section 14.50, and, upon completion, a copy of the report shall be served upon all parties by personal service, by first class mail, or by depositing it with the Central Mailing Section, Publications Division, Department of Administration.

**Statutory Authority:** MS s 14.06; 14.131; 14.51; 363.06; 363A.28

**History:** 9 SR 2276

**Published Electronically:** August 6, 2013

1400.8200 AGENCY DECISION.

Following receipt of the judge's report, the agency shall proceed to make its final decision in accordance with Minnesota Statutes, sections 14.61 and 14.62 and shall serve a copy of its final order upon the office by first class mail.

**Statutory Authority:** MS s 14.06; 14.131; 14.51; 363.06; 363A.28

**History:** 9 SR 2276

**Published Electronically:** August 6, 2013

1400.8300 RECONSIDERATION OR REHEARING.

Once a judge has issued a report, unless that report is binding on the agency, the judge loses jurisdiction to amend the report except for clerical or mathematical errors. Unless the report is a final order, binding on the agency, petitions for reconsideration or rehearing must be filed with the agency.

Where the judge's decision is binding on the agency, a petition for reconsideration or rehearing shall be filed with the judge. The petition must be filed within a reasonable time but not after an appeal is taken nor more than one year after the decision was issued. Pursuant to Minnesota Statutes, section 14.64, a petition for reconsideration must be filed within ten days after the decision in order to toll the time for appeal to the Court of Appeals. A notice of and order for rehearing shall be served on all parties in the same manner prescribed for the notice of and order for hearing provided that the judge may permit service of the notice and order for rehearing less than 30 days prior to rehearing. The rehearing shall be conducted in the same manner prescribed for a hearing.

In ruling on a motion for reconsideration or rehearing in cases where the judge's decision is binding on the agency, the judge shall grant reconsideration or rehearing if it appears that to deny it would be inconsistent with substantial justice and any one of the following has occurred:

A. irregularity in the proceedings whereby the moving party was deprived of a fair hearing;

B. accident or surprise that could not have been prevented by ordinary prudence;

C. material evidence newly discovered that with reasonable diligence could not have been found and produced at hearing;

D. fraud upon the hearing process;
E. mistake, inadvertence, or excusable neglect; or

F. the decision is not justified by the evidence, or is contrary to law; but unless it be so expressly stated in the order granting rehearing, it shall not be presumed, on appeal, to have been made on the ground that the decision was not justified by the evidence.

Statutory Authority: MS s 14.06; 14.131; 14.51; 116C.66; 216E.16; 363.06; 363A.28

History: 9 SR 2276; 15 SR 1595

Published Electronically: August 6, 2013

1400.8400 EMERGENCY PROCEDURES NOT PREEMPTED.

Nothing contained in these rules is intended to preempt, repeal, or be in conflict with any rule or statute which provides for acts by the agency in an emergency or procedure for conduct by the agency in such a situation.

Statutory Authority: MS s 14.51

Published Electronically: August 6, 2013
214.10 COMPLAINT, INVESTIGATION, AND HEARING.

Subdivision 1. Receipt of complaint; notice. The executive director or executive secretary of a board, a board member or any other person who performs services for the board who receives a complaint or other communication, whether oral or written, which complaint or communication alleges or implies a violation of a statute or rule which the board is empowered to enforce, shall promptly forward the substance of the communication on a form prepared by the attorney general to the designee of the attorney general responsible for providing legal services to the board. Before proceeding further with the communication, the designee of the attorney general may require the complaining party to state the complaint in writing on a form prepared by the attorney general. Complaints which relate to matters within the jurisdiction of another governmental agency shall be forwarded to that agency by the executive director or executive secretary. An officer of that agency shall advise the executive director or executive secretary of the disposition of that complaint. A complaint received by another agency which relates to a statute or rule which a licensing board is empowered to enforce shall be forwarded to the executive director or executive secretary of the board to be processed in accordance with this section. No complaint alleging a matter within the jurisdiction of the board shall be dismissed by a board unless at least two board members have reviewed the matter. If a board makes a determination to investigate a complaint, it shall notify a licensee who is the subject of an investigation that an investigation has been initiated at a time when such notice will not compromise the investigation.

Subd. 2. Investigation and hearing. The designee of the attorney general providing legal services to a board shall evaluate the communications forwarded by the board or its members or staff. If the communication alleges a violation of statute or rule which the board is to enforce, the designee is empowered to investigate the facts alleged in the communication. In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director, executive secretary, or, if the board determines, a member of the board who has been appointed by the board to assist the designee. The designee may also consult with or seek the assistance of any other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation. The executive director, executive secretary, or the consulted board member may attempt to correct improper activities and redress grievances through education, conference, conciliation and persuasion, and in these attempts may be assisted by the designee of the attorney general. If the attempts at correction or redress do not produce satisfactory results in the opinion of the executive director, executive secretary, or the consulted board member, or if after investigation the designee providing legal services to the board, the executive director, executive secretary, or the consulted board member believes that the communication and the investigation suggest illegal or unauthorized activities warranting board action, the person having the belief shall inform the executive director or executive secretary of the board who shall schedule a contested case hearing in accordance with chapter 14. Before directing the holding of a contested case hearing, the executive director, executive secretary, or the designee of the attorney general shall have considered the recommendations of the consulted board member. Before scheduling a contested case hearing, the executive director or executive secretary must have received a verified written complaint from the complaining party. A board member who was consulted during the course of an investigation may participate at the hearing but may not vote on any matter pertaining to the case. The executive director or executive secretary of the board shall promptly inform the complaining party of the final disposition of the complaint. Nothing in this section shall preclude the board from scheduling, on its own motion, a contested case hearing based upon the findings or report of the board's executive director or executive secretary, a board member or the designee of the attorney general assigned to the board. Nothing in this section shall preclude a member of the board, executive director, or executive secretary from initiating a complaint.

Subd. 2a. Proceedings. A board shall initiate proceedings to suspend or revoke a license or shall refuse to renew a license of a person licensed by the board who is convicted in a court of competent jurisdiction.
of violating section 609.2231, subdivision 8, 609.23, 609.231, 609.2325, 609.233, 609.2335, 609.234, 609.465, 609.466, 609.52, or 609.72, subdivision 3.

Subd. 3. **Discovery; subpoenas.** In all matters pending before it relating to its lawful regulation activities, a board may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the board or by a subpoena of the board to do so may, upon application to the district court in any district, be ordered to comply therewith; provided that in matters to which the Peace Officers Standards and Training Board is a party, application shall be made to the district court having jurisdiction where the event giving rise to the matter occurred. The chair of the board acting on behalf of the board may issue subpoenas and any board member may administer oaths to witnesses, or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon any person named therein, anywhere within the state by any officer authorized to serve subpoenas or other process or paper in civil actions, with the same fees and mileage and in the same manner as prescribed by law for service of process issued out of the district court of this state. Fees and mileage and other costs shall be paid as the board directs.

Subd. 4. [Repealed, 1993 c 326 art 7 s 22]

Subd. 5. [Repealed, 1993 c 326 art 7 s 22]

Subd. 6. [Repealed, 1993 c 326 art 7 s 22]

Subd. 7. [Repealed, 1993 c 326 art 7 s 22]

Subd. 8. **Special requirements for health-related licensing boards.** In addition to the provisions of this section that apply to all examining and licensing boards, the requirements in this subdivision apply to all health-related licensing boards, except the Board of Veterinary Medicine.

(a) If the executive director or consulted board member determines that a communication received alleges a violation of statute or rule that involves sexual contact with a patient or client, the communication shall be forwarded to the designee of the attorney general for an investigation of the facts alleged in the communication. If, after an investigation it is the opinion of the executive director or consulted board member that there is sufficient evidence to justify disciplinary action, the board shall conduct a disciplinary conference or hearing. If, after a hearing or disciplinary conference the board determines that misconduct involving sexual contact with a patient or client occurred, the board shall take disciplinary action. Notwithstanding subdivision 2, a board may not attempt to correct improper activities or redress grievances through education, conciliation, and persuasion, unless in the opinion of the executive director or consulted board member there is insufficient evidence to justify disciplinary action. The board may settle a case by stipulation prior to, or during, a hearing if the stipulation provides for disciplinary action.

(b) A board member who has a direct current or former financial connection or professional relationship to a person who is the subject of board disciplinary activities must not participate in board activities relating to that case.

(c) Each health-related licensing board shall establish procedures for exchanging information with other Minnesota state 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. The procedures must provide for the forwarding to other regulatory bodies...
of all information and evidence, including the results of investigations, that are relevant to matters within
that licensing body's regulatory jurisdiction. Each health-related licensing board shall have access to any
data of the Department of Human Services relating to a person subject to the jurisdiction of the licensing
board. The data shall have the same classification under chapter 13, the Minnesota Government Data Practices
Act, in the hands of the agency receiving the data as it had in the hands of the Department of Human Services.

(d) Each health-related licensing board shall establish procedures for exchanging information with other
states regarding disciplinary actions against licensees. The procedures must provide for the collection of
information from other states about disciplinary actions taken against persons who are licensed to practice
in Minnesota or who have applied to be licensed in this state and the dissemination of information to other
states regarding disciplinary actions taken in Minnesota. In addition to any authority in chapter 13 permitting
the dissemination of data, the board may, in its discretion, disseminate data to other states regardless of its
classification under chapter 13. Before transferring any data that is not public, the board shall obtain reasonable
assurances from the receiving state that the data will not be made public.

Subd. 9. Acts against minors. (a) As used in this subdivision, the following terms have the meanings
given them.

(1) "Licensed person" means a person who is licensed under this chapter by the Board of Nursing, the
Board of Psychology, the Social Work Licensing Board, the Board of Marriage and Family Therapy, the
Board of Unlicensed Mental Health Service Providers, the Board of Behavioral Health and Therapy, or the
Board of Teaching.

(2) "Crime against a minor" means conduct that constitutes a violation of section 609.185, 609.19,
609.195, 609.20, 609.205, 609.2112, 609.2113, 609.2114, 609.215, 609.221, 609.222, 609.223, 609.342,
609.343, 609.345, or a felony violation of section 609.377.

(b) In any license revocation proceeding, there is a rebuttable presumption that a licensed person who
is convicted in a court of competent jurisdiction of committing a crime against a minor is unfit to practice
the profession or occupation for which that person is licensed.

Subd. 10. Board of Peace Officers Standards and Training; receipt of complaint. Notwithstanding
the provisions of subdivision 1 to the contrary, when the executive director or any member of the Board of
Peace Officer Standards and Training produces or receives a written statement or complaint that alleges a
violation of a statute or rule that the board is empowered to enforce, the executive director shall designate
the appropriate law enforcement agency to investigate the complaint and shall order it to conduct an inquiry
into the complaint's allegations. The investigating agency must complete the inquiry and submit a written
summary of it to the executive director within 30 days of the order for inquiry.

Subd. 11. Board of Peace Officers Standards and Training; reasonable grounds determination.
(a) After the investigation is complete, the executive director shall convene a three-member committee of
the board to determine if the complaint constitutes reasonable grounds to believe that a violation within the
board's enforcement jurisdiction has occurred. At least two members of the committee must be board members
who are peace officers. No later than 30 days before the committee meets, the executive director shall give
the licensee who is the subject of the complaint and the complainant written notice of the meeting. The
executive director shall also give the licensee a copy of the complaint. Before making its determination,
the committee shall give the complaining party and the licensee who is the subject of the complaint a reasonable
opportunity to be heard.
(b) The committee shall, by majority vote, after considering the information supplied by the investigating agency and any additional information supplied by the complainant or the licensee who is the subject of the complaint, take one of the following actions:

(1) find that reasonable grounds exist to believe that a violation within the board's enforcement jurisdiction has occurred and order that an administrative hearing be held;

(2) decide that no further action is warranted; or

(3) continue the matter.

The executive director shall promptly give notice of the committee's action to the complainant and the licensee.

(c) If the committee determines that a complaint does not relate to matters within its enforcement jurisdiction but does relate to matters within another state or local agency's enforcement jurisdiction, it shall refer the complaint to the appropriate agency for disposition.

Subd. 12. Board of Peace Officers Standards and Training; administrative hearing; board action. (a) Notwithstanding the provisions of subdivision 2 to the contrary, an administrative hearing shall be held if ordered by the committee under subdivision 11, paragraph (b). After the administrative hearing is held, the administrative law judge shall refer the matter to the full board for final action.

(b) Before the board meets to take action on the matter and the executive director must notify the complainant and the licensee who is the subject of the complaint. After the board meets, the executive director must promptly notify these individuals and the chief law enforcement officer of the agency employing the licensee of the board's disposition.

Subd. 13. Board of Peace Officers Standards and Training; definition. As used in subdivisions 10 to 12, "appropriate law enforcement agency" means the law enforcement agency assigned by the executive director and the chair of the committee of the board convened under subdivision 11.

Subd. 14. Complementary and alternative health care practitioners. This section shall not apply to complementary and alternative health care practitioners practicing under chapter 146A. Complaints and disciplinary actions against complementary and alternative health care practitioners shall be conducted in accordance with chapter 146A.

History: 1976 c 222 s 5; 1977 c 326 s 10; 1979 c 117 s 1-5; 1981 c 310 s 15; 1982 c 424 s 130; 1985 c 247 s 22,23,25; 1986 c 444; 1987 c 384 art 2 s 1; 1988 c 557 s 5; 1991 c 265 art 9 s 62; 1993 c 326 art 7 s 4-7; 1995 c 164 s 33; 1995 c 229 art 4 s 10; 1Sp1997 c 3 s 25; 1999 c 227 s 22; 2000 c 284 s 7; 2003 c 118 s 21; 2014 c 180 s 9; 2016 c 125 s 11-13
214.103 HEALTH-RELATED LICENSING BOARDS; COMPLAINT, INVESTIGATION, AND HEARING.

Subdivision 1. Application. For purposes of this section, "board" means "health-related licensing board" and does not include the non-health-related licensing boards. Nothing in this section supersedes section 214.10, subdivisions 2a, 3, 8, and 9, as they apply to the health-related licensing boards.

Subd. 1a. Notifications and resolution. (a) No more than 14 calendar days after receiving a complaint regarding a licensee, the board shall notify the complainant that the board has received the complaint and shall provide the complainant with the written description of the board's complaint process. The board shall periodically, but no less than every 120 days, notify the complainant of the status of the complaint consistent with section 13.41.

(b) Except as provided in paragraph (d), no more than 60 calendar days after receiving a complaint regarding a licensee, the board must notify the licensee that the board has received a complaint and inform the licensee of:

(1) the substance of the complaint;
(2) the sections of the law that have allegedly been violated;
(3) the sections of the professional rules that have allegedly been violated; and
(4) whether an investigation is being conducted.

(c) The board shall periodically, but no less than every 120 days, notify the licensee of the status of the complaint consistent with section 13.41.

(d) Paragraphs (b) and (c) do not apply if the board determines that such notice would compromise the board's investigation and that such notice cannot reasonably be accomplished within this time.

(e) No more than one year after receiving a complaint regarding a licensee, the board must resolve or dismiss the complaint unless the board determines that resolving or dismissing the complaint cannot reasonably be accomplished in this time and is not in the public interest.

(f) Failure to make notifications or to resolve the complaint within the time established in this subdivision shall not deprive the board of jurisdiction to complete the investigation or to take corrective, disciplinary, or other action against the licensee that is authorized by law. Such a failure by the board shall not be the basis for a licensee's request for the board to dismiss a complaint, and shall not be considered by an administrative law judge, the board, or any reviewing court.

Subd. 2. Receipt of complaint. The boards shall receive and resolve complaints or other communications, whether oral or written, against regulated persons. Before resolving an oral complaint, the executive director or a board member designated by the board to review complaints shall require the complainant to state the complaint in writing or authorize transcribing the complaint. The executive director or the designated board member shall determine whether the complaint alleges or implies a violation of a statute or rule which the board is empowered to enforce. The executive director or the designated board member may consult with the designee of the attorney general as to a board's jurisdiction over a complaint. If the executive director determines that it is necessary, the executive director may seek additional information to determine whether the complaint is jurisdictional or to clarify the nature of the allegations by obtaining records or other written material, obtaining a handwriting sample from the regulated person, clarifying the alleged facts with the complainant, and requesting a written response from the subject of the
complaint. The executive director may authorize a field investigation to clarify the nature of the allegations and the facts that led to the complaint.

Subd. 3. **Referral to other agencies.** The executive director shall forward to another governmental agency any complaints received by the board which do not relate to the board's jurisdiction but which relate to matters within the jurisdiction of another governmental agency. The agency shall advise the executive director of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule which a board is empowered to enforce must be forwarded to the executive director of the board to be processed in accordance with this section. Governmental agencies shall coordinate and conduct joint investigations of complaints that involve more than one governmental agency.

Subd. 4. **Role of attorney general.** The executive director or the designated board member shall forward a complaint and any additional information to the designee of the attorney general when the executive director or the designated board member determines that a complaint is jurisdictional and:

(1) requires investigation before the executive director or the designated board member may resolve the complaint;

(2) that attempts at resolution for disciplinary action or the initiation of a contested case hearing is appropriate;

(3) that an agreement for corrective action is warranted; or

(4) that the complaint should be dismissed, consistent with subdivision 8.

Subd. 5. **Investigation by attorney general.** (a) If the executive director or the designated board member determines that investigation is necessary before resolving the complaint, the executive director shall forward the complaint and any additional information to the designee of the attorney general. The designee of the attorney general shall evaluate the communications forwarded and investigate as appropriate.

(b) The designee of the attorney general may also investigate any other complaint forwarded under subdivision 3 when the designee of the attorney general determines that investigation is necessary.

(c) In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director or the designated board member. The designee may also consult with or seek the assistance of other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation.

(d) Upon completion of the investigation, the designee shall forward the investigative report to the executive director with recommendations for further consideration or dismissal.

Subd. 6. **Attempts at resolution.** (a) At any time after receipt of a complaint, the executive director or the designated board member may attempt to resolve the complaint with the regulated person. The available means for resolution include a conference or any other written or oral communication with the regulated person. A conference may be held for the purposes of investigation, negotiation, education, or conciliation. Neither the executive director nor any member of a board's staff shall be a voting member in any attempts at resolutions which may result in disciplinary or corrective action. The results of attempts at resolution with the regulated person may include a recommendation to the board for disciplinary action, an agreement between the executive director or the designated board member and the regulated person for corrective action, or the dismissal of a complaint. If attempts at resolution are not in the public interest, a contested case hearing may be initiated.
(1) The designee of the attorney general shall represent the board in all attempts at resolution which the executive director or the designated board member anticipate may result in disciplinary action. A stipulation between the executive director or the designated board member and the regulated person shall be presented to the board for the board's consideration. An approved stipulation and resulting order shall become public data.

(2) The designee of the attorney general shall represent the board upon the request of the executive director or the designated board member in all attempts at resolution which the executive director or the designated board member anticipate may result in corrective action. Any agreement between the executive director or the designated board member and the regulated person for corrective action shall be in writing and shall be reviewed by the designee of the attorney general prior to its execution. The agreement for corrective action shall provide for dismissal of the complaint upon successful completion by the regulated person of the corrective action.

(b) Upon receipt of a complaint alleging sexual contact or sexual conduct with a client, the board must forward the complaint to the designee of the attorney general for an investigation. If, after it is investigated, the complaint appears to provide a basis for disciplinary action, the board shall resolve the complaint by disciplinary action or initiate a contested case hearing. Notwithstanding paragraph (a), clause (2), a board may not take corrective action or dismiss a complaint alleging sexual contact or sexual conduct with a client unless, in the opinion of the executive director, the designated board member, and the designee of the attorney general, there is insufficient evidence to justify disciplinary action.

Subd. 7. Contested case hearing. If the executive director or the designated board member determines that attempts at resolution of a complaint are not in the public interest, the executive director or the designated board member, after consultation with the designee of the attorney general, and the concurrence of a second board member, may initiate a contested case hearing under chapter 14. The designated board member or any board member who was consulted during the course of an investigation may participate at the contested case hearing. A designated or consulted board member may not deliberate or vote in any proceeding before the board pertaining to the case.

Subd. 8. Dismissal and reopening of a complaint. (a) A complaint may not be dismissed without the concurrence of at least two board members and, upon the request of the complainant, a review by a representative of the attorney general's office. The designee of the attorney general must review before dismissal any complaints which allege any violation of chapter 609, any conduct which would be required to be reported under section 626.556 or 626.557, any sexual contact or sexual conduct with a client, any violation of a federal law, any actual or potential inability to practice the regulated profession or occupation by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental or physical condition, any violation of state medical assistance laws, or any disciplinary action related to credentialing in another jurisdiction or country which was based on the same or related conduct specified in this subdivision.

(b) The board may reopen a dismissed complaint if the board receives newly discovered information that was not available to the board during the initial investigation of the complaint, or if the board receives a new complaint that indicates a pattern of behavior or conduct.

Subd. 9. Information to complainant. A board shall furnish to a person who made a complaint a written description of the board's complaint process, and actions of the board relating to the complaint.
Subd. 10. **Prohibited participation by board member.** A board member who has actual bias or a current or former direct financial or professional connection with a regulated person may not vote in board actions relating to the regulated person.

**History:** 1Sp1993 c 1 art 9 s 70; 1994 c 465 art 1 s 26; 1995 c 164 s 34; 2005 c 147 art 5 s 24; 2007 c 123 s 129,130; 2009 c 157 art 1 s 15; 2012 c 278 art 4 s 2; 2014 c 291 art 4 s 48,49
A bill for an act

relating to health occupations; authorizing criminal background checks by the
Board of Medical Practice; exempting certain physicians from criminal background
checks under the Interstate Medical Licensure Compact; amending Minnesota
Statutes 2016, section 147.381.

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

Section 1. Minnesota Statutes 2016, section 147.381, is amended to read:

147.381 APPLICATION OF INTERSTATE MEDICAL LICENSURE COMPACT
TO EXISTING LAWS.

(a) Uniform rules developed by the Interstate Commission established under section
147.38 shall not be subject to the provisions of sections 14.05 to 14.389.

(b) Complaints against physicians licensed in Minnesota under the expedited licensure
process in section 147.38 shall be handled as provided in sections 214.10 and 214.103.

(c) All provisions of section 147.38 authorizing or requiring the board to provide data
to the Interstate Commission are authorized by section 214.10, subdivision 8, paragraph
(d).

(d) The provisions of sections 214.17 to 214.25 apply to physicians licensed in Minnesota
through the provisions of section 147.38 when the practice involves direct physical contact
between the physician and a patient.

(e) According to uniform rules developed by the Interstate Commission established
under section 147.38, the board is authorized to require a physician who has designated
Minnesota as the state of principal license to submit to a national criminal background
check. The criminal background check shall be conducted as provided in section 214.075.
The board shall use the criminal background check data to evaluate a physician's eligibility for a letter of qualification pursuant to section 147.38, and shall not disseminate this data to the Interstate Commission. A physician seeking expedited licensure in Minnesota under section 147.38 who has not designated Minnesota as the state of principal license is exempt from the requirements of section 214.075 if the state of principal license has required a criminal background check for the physician within the last 12 months.

EFFECTIVE DATE. This section is effective the day following final enactment.
214.075 HEALTH-RELATED LICENSING BOARDS; CRIMINAL BACKGROUND CHECKS.

Subdivision 1. Applications. (a) By January 1, 2018, each health-related licensing board, as defined in section 214.01, subdivision 2, shall require applicants for initial licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse in licensure, as defined by the individual health-related licensing boards, to submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI).

(b) An applicant must complete a criminal background check if more than one year has elapsed since the applicant last submitted a background check to the board.

Subd. 2. Investigations. If a health-related licensing board has reasonable cause to believe a licensee has been charged with or convicted of a crime in this or any other jurisdiction, the health-related licensing board may require the licensee to submit to a criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI.

Subd. 3. Consent form; fees; fingerprints. (a) In order to effectuate the federal and state level, fingerprint-based criminal background check, the applicant or licensee must submit a completed criminal history records check consent form and a full set of fingerprints to the respective health-related licensing board or a designee in the manner and form specified by the board.

(b) The applicant or licensee is responsible for all fees associated with preparation of the fingerprints, the criminal records check consent form, and the criminal background check. The fees for the criminal records background check shall be set by the BCA and the FBI and are not refundable. The fees shall be submitted to the respective health-related licensing board by the applicant or licensee as prescribed by the respective board.

(c) All fees received by the health-related licensing boards under this subdivision shall be deposited in dedicated accounts in the special revenue fund and are appropriated to health-related licensing boards to pay for the criminal background checks conducted by the Bureau of Criminal Apprehension and Federal Bureau of Investigation.

Subd. 4. Refusal to consent. (a) The health-related licensing boards shall not issue a license to any applicant who refuses to consent to a criminal background check or fails to submit fingerprints within 90 days after submission of an application for licensure. Any fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent to the criminal background check or fails to submit the required fingerprints.

(b) The failure of a licensee to submit to a criminal background check as provided in subdivision 3 is grounds for disciplinary action by the respective health-related licensing board.

Subd. 5. Submission of fingerprints to the Bureau of Criminal Apprehension. The health-related licensing board or designee shall submit applicant or licensee fingerprints to the BCA. The BCA shall perform a check for state criminal justice information and shall forward the applicant's or licensee's fingerprints to the FBI to perform a check for national criminal justice information regarding the applicant or licensee. The BCA shall report to the board the results of the state and national criminal justice information checks.

Subd. 6. Alternatives to fingerprint-based criminal background checks. The health-related licensing board may require an alternative method of criminal history checks for an applicant or licensee who has submitted at least three sets of fingerprints in accordance with this section that have been unreadable by the BCA or the FBI.
Subd. 7. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary action against an applicant or a licensee based on a criminal conviction, the health-related licensing board shall provide the applicant or the licensee an opportunity to complete or challenge the accuracy of the criminal history information reported to the board. The applicant or licensee shall have 30 calendar days following notice from the board of the intent to deny licensure or to take disciplinary action to request an opportunity to correct or complete the record prior to the board taking disciplinary action based on the information reported to the board. The board shall provide the applicant up to 180 days to challenge the accuracy or completeness of the report with the agency responsible for the record. This subdivision does not affect the right of the subject of the data to contest the accuracy or completeness under section 13.04, subdivision 4.

Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in collaboration with the commissioner of human services and the BCA, shall establish a plan for completing criminal background checks of all licensees who were licensed before the effective date requirement under subdivision 1. The plan must seek to minimize duplication of requirements for background checks of licensed health professionals. The plan for background checks of current licensees shall be developed no later than January 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI in which any new crimes that an applicant or licensee commits after an initial background check are flagged in the BCA's or FBI's database and reported back to the board. The plan shall include recommendations for any necessary statutory changes.

**History:** 2013 c 108 art 10 s 9; 2016 c 189 art 21 s 26
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

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 August 8, 2017, HPSP Program Committee meeting.
The Health Professional Services Program (HPSP) Program Committee met on August 8, 2017, at 10:00 a.m. Twelve of the seventeen Minnesota Health Related Licensing Boards (HLBs) were represented (August 8, 2017, minutes attached).

HPSP Program Director Monica Feider, Executive Director of the Minnesota Board of Medical Practice Ruth Martinez and HPSP Program Chair Allen Rasmussen provided a health care worker burnout presentation (attached).

Discussion of what Minnesota Health Licensing Boards should do with the burnout information followed the presentation resulting in the suggestion that the presentation material and data should be made available to all HLBs who should encourage employer burnout support groups.

Executive Director of the Board of Marriage and Family Therapy and the Chairperson of the Executive Directors’ (ED) Forum Janet Mohlenhoff, provided an overview and information update of the Forum.

Ms. Feider presented a brief overview of the HPSP Fiscal Year 2017 Report (attached).

The HPSP Program Committee will meet Tuesday, November 14, 2017. A presentation is scheduled by the Minnesota Department of Health, Office of Medical Cannabis, Research Manager, Dr. Tom Arneson.

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 Rano</td>
<td>Chiropractic Examiners</td>
<td>X</td>
</tr>
<tr>
<td>Bridgett Anderson</td>
<td>Dentistry</td>
<td>X</td>
</tr>
<tr>
<td>Patricia Jo Forberg</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>

P.C. Member | Board                        | Present |
-------------|------------------------------|---------|
Randy Snyder | Nursing Home Administ         | X       |
Randy Snyder | Optometry                    | X       |
James Blalke | Pharmacy                      | X       |
Kathy Polhamus(Vice Chair) | Physical Therapy         | X       |
Margaret Schreiner | Podiatric Medicine        | X       |
Samuel Sands | Psychology                    | X       |
Kathi Zacher-Pale | Social Work                  | X       |
Julia Wilson  | Veterinary Medicine           | X       |

OTHERS IN ATTENDANCE: Monica Feider, Tracy Erfourth, Kimberly Zillmer, Marilyn Miller, Audrey Grossman (HPSP staff), Ruth Martinez (Executive Director, Board of Medical Practice/HPSP Administering Board) and Shirley Brekken (Executive Director, Board of Nursing)

AGENDA:

I. Convene and Introductions: Allen Rasmussen convened the meeting at 10:03 am. Introductions were made.

II. Minutes & Agenda: The May minutes were approved. A report from Jennifer Mohlenhoff about the Executive Director’s Forum was added to the agenda.

III. State Logo Changes: Monica Feider informed Committee members that HPSP is adopting the State’s new logo and it is being incorporated into documents.

IV. Burnout in Healthcare: Allen Rasmussen, Ruth Martinez, and Monica Feider provided an overview of a joint presentation of the Federation of State Medical Boards and the Federation of State Physician Health Programs regarding Burnout. Key points to the presentation included:

- Fifty percent of physicians experience at least one symptom of burnout (regardless of age)
- Healthy practitioners provide better care
- There are individual drivers of burnout (i.e. perfectionism, difficulty setting boundaries, and intellectualization)
- There are environmental drivers of burnout (i.e. lack of autonomy, workload constraints, culture of incivility, inefficiencies and loss of meaning).

The Mayo Clinic has done considerable research on burnout. Mayo outlined key organizational strategies for addressing burnout.

A robust discussion ensued regarding burnout among different professions and how factors outside of the organization (i.e. insurance) contribute to both organizational directives (i.e. productivity) and personal performance. While the boards cannot address organizational issues, they often see the impact of burnout on practitioners. It was recommended to maintain an awareness of the impact of burnout on practitioners.

V. Executive Director’s Forum: Jennifer Mohlenhoff, the Chair of the Executive Director’s Forum provided an overview of the Forum. She explained that the Forum includes the executive directors of the 17 health licensing/quasi-health licensing boards, the director of EMSRB and HPSP, lead staff from the Administrative Services Unit, and the boards’ legal counsel. Others attend based on specific agenda items. The Forum meets monthly and works collaboratively to share information and develop best practices. This promotes consistent services among boards and shared resources and expertise. She emphasized that there are specific statutes that all of the boards must follow and the Forum
provides boards with a collaborative approach to addressing shared issues. The following agenda items are reviewed at every meeting:
- Office of the Attorney General – David Cullen, Deputy Director – provides an overview of shared board/legal issues.
- HPSP – Monica Feider – Provides an update on HPSP.
- Administrative Services Unit – Juli Vangness provides updates on financial matters and Cindy Greenlaw-Benton provides information on contracting and human resource issues.
- MN.IT / IT Governance – Rick Bostrom provides an update on technology issues and the IT Governance chair provides an update on IT strategic planning and implementation issues.
- Continuity of Operations Planning (COOP) – Thora Fisko, Executive Director of the Board of Barber Examiners, is the COOP liaison and provides updates on the state’s emergency and disaster preparedness plans.
- Policy Committee – Ruth Martinez, Executive Director of the Board of Medical Practice, chairs the Committee and provides updates on legislative and statutory issues impacting the HLBs.
- Management Committee – This committee addresses issues regarding HLB shared services, including staffing and funding of ASU, operation of ED Forum and related committees, and other issues impacting operations.

VI. **HPSP Fiscal Year 2017 Report:** Monica Feider provided a brief overview of the report. The report will not be reviewed in the minutes, as it was distributed in full to Committee members and is found on the HPSP website.

VII. **Future Meetings:** Allen Rasmussen suggested that the Committee have a presentation on medical cannabis at the November meeting. He also suggested that the Committee review the frequency and content of meetings. Margaret Schreiner suggested that Monica Feider provide dates where action may be needed by the Committee.

VIII. **Adjourn** – Meeting adjourned at 11:35 am.

*Thank you for your participation on the Program Committee. Minutes respectfully submitted by the staff of the HPSP.*
Physician Burnout

A Presentation at a joint session of the Federation of State Medical Boards (FSMB) and the Federation of State Physician Health Programs (FSPHP)

The following is a summary of a presentation by Chris Bundy, MD, MPH, Medical Director of the Washington Physicians Health Program
INTRODUCTION TO PHYSICIAN BURNOUT
(This can pertain to any profession)

Healthy Physicians Give Better Care
- Decreased medical errors
- Increased patient satisfaction
- Better treatment recommendations
- Increased treatment adherence
- Lower malpractice risk
- Better attitudes toward work
- Higher team functioning
- Lower turnover

Individual Drivers of Physician Burnout
- Perfectionism
- High achievement orientation
- Difficulty setting boundaries
- Intellectualization
- Delay of gratification
- Compartmentalization
- Materialism
Environmental Drivers of Physician Burnout

- Workload and time constraints
- Inefficiencies/frustration (EHR)
- Lack of autonomy/control
- Ineffective leadership
- Mission/values mismatch (loss of meaning)
- Culture of incivility
- Perception of fairness and respect
- Diminished rewards

Individual Wellness: Key Targets

- Awareness
- Self-Care
- Resilience
- Engagement
PREVALENCE


Research over the last 10 years has shown that burnout – the particular constellation of emotional exhaustion, detachment and a low sense of accomplishment – is widespread among medical students and doctors-in-training. Nearly half of these aspiring doctors end up becoming burned out over the course of their schooling, quickly losing their sense of empathy for others and succumbing to unprofessional behavior like lying and cheating.

Now, in what is the first study of burnout among fully trained doctors from a wide range of specialties, it appears that the young are not the only ones who are vulnerable. Doctors who have been practicing anywhere from a year to several decades are just as susceptible to becoming burned out as students and trainees. And the implications of their burnout — unlike that of their younger counterparts, who are often under supervision — may be more devastating and immediate.

Analyzing questionnaires sent to more than 7,000 doctors, researchers found that almost half complained of being emotionally exhausted, feeling detached from their patients and work or suffering from a low sense of accomplishment.
Results Of 27,276 physicians who received an invitation to participate, 7,288 (26.7%) completed surveys. When assessed using the Maslach Burnout Inventory, 45.8% of physicians reported at least 1 symptom of burnout. Substantial differences in burnout were observed by specialty, with the highest rates among physicians at the front line of care access (family medicine, general internal medicine, and emergency medicine). Compared with a probability-based sample of 3,442 working US adults, physicians were more likely to have symptoms of burnout (37.9% vs 27.8%) and to be dissatisfied with work-life balance (40.2% vs 23.2%) (P < .001 for both). Highest level of education completed also related to burnout in a pooled multivariate analysis adjusted for age, sex, relationship status, and hours worked per week. Compared with high school graduates, individuals with an MD or DO degree were at increased risk for burnout (odds ratio [OR], 1.36; P < .001), whereas individuals with a bachelor's degree (OR, 0.80; P = .048), master's degree (OR, 0.71; P = .01), or professional or doctoral degree other than an MD or DO degree (OR, 0.64; P = .04) were at lower risk for burnout.

Conclusions: Burnout is more common among physicians than among other US workers. Physicians in specialties at the front line of care access seem to be at greatest risk.
PREVENTION

How Do You Prevent Burnout?

• Accept shared responsibility for burnout
• Elevate personal wellness to a core professional value, starting in medical school
• Make wellness and satisfaction a quality outcome and incentivize it accordingly
• Muster the will to address burnout generators and ask for help
• Create opportunities for peer support and decrease isolation
• Nurture the brain through meditation and application of mindful practice to clinical work

RESOURCES

Washington Physician Health Program:  http://wphp.org/cct/

Indiana State Medical Association:
http://www.ismanet.org/doctoryourspirit/

• http://www.ismanet.org/doctoryourspirit/BurnoutSolutions.html
• http://www.ismanet.org/doctoryourspirit/BurnoutChallenge.html
• http://www.ismanet.org/doctoryourspirit/HealthWellnessChallenge.html
• http://www.ismanet.org/doctoryourspirit/CivilityChallenge.html

Stanford School of Medicine: The center for Compassion and Altruism Research and Education

• http://ccare.stanford.edu/
Headspace: https://www.headspace.com/
Welcome to Calm: https://www.calm.com/
The Schwartz Center for Compassionate Healthcare: http://www.theschwartzcenter.org/
Implications of Physician Burnout

FIGURE 1. Personal and professional repercussions of physician burnout.
A Shared Responsibility

FIGURE 2. Key drivers of burnout and engagement in physicians.
Key Drivers of Burnout and Engagement in Physicians
<table>
<thead>
<tr>
<th>Drivers of burnout and engagement in physicians</th>
<th>Individual factors</th>
<th>Work unit factors</th>
<th>Organization factors</th>
<th>National factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workload and job demands</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td>Productivity expectations</td>
<td>Productivity targets</td>
<td>Structure reimbursement</td>
</tr>
<tr>
<td>Practice location</td>
<td></td>
<td>Team structure</td>
<td>Method of compensation</td>
<td>- Medicare/Medicaid</td>
</tr>
<tr>
<td>Decision to increase work</td>
<td></td>
<td>Efficiency</td>
<td>Salary</td>
<td>- Bundled payments</td>
</tr>
<tr>
<td>to increase income</td>
<td></td>
<td>Use of allied health professionals</td>
<td>Productivity based</td>
<td>- Documentation requirements</td>
</tr>
<tr>
<td><strong>Efficiency and resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td></td>
<td>Availability of support staff and their experience</td>
<td>Integration of care</td>
<td>Integration of care</td>
</tr>
<tr>
<td>Ability to prioritize</td>
<td></td>
<td>Patient check-in</td>
<td>Use of patient portal</td>
<td>- Requirements for:</td>
</tr>
<tr>
<td>Personal efficiency</td>
<td></td>
<td>efficiency/process</td>
<td>Institutional efficiency:</td>
<td>- Electronic prescribing</td>
</tr>
<tr>
<td>Organizational skills</td>
<td></td>
<td>Use of scribes</td>
<td>- EHR</td>
<td>- Medication reconciliation</td>
</tr>
<tr>
<td>Willingness to delegate</td>
<td></td>
<td>Team huddles</td>
<td>- Appointment system</td>
<td>- Meaningful use of EHR</td>
</tr>
<tr>
<td>Ability to say &quot;no&quot;</td>
<td></td>
<td>Use of allied health professionals</td>
<td>Ordering systems</td>
<td>- Certification agency facility regulations (JCAHO)</td>
</tr>
<tr>
<td><strong>Meaning in work</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-awareness of most</td>
<td></td>
<td>Match of work to talents and interests of</td>
<td>Organizational culture</td>
<td>Evolving supervisory role of physicians (potentially less direct patient contact)</td>
</tr>
<tr>
<td>personally meaningful aspect of work</td>
<td></td>
<td>individuals</td>
<td>Practice environment</td>
<td>- Reduced funding</td>
</tr>
<tr>
<td>Ability to shape career to focus on interests</td>
<td></td>
<td>Opportunities for involvement</td>
<td>Opportunities for professional development</td>
<td>- Research</td>
</tr>
<tr>
<td>Doctor-patient relationships</td>
<td></td>
<td>- Education</td>
<td>- Leadership</td>
<td>- Education</td>
</tr>
<tr>
<td>Personal recognition of positive events at work</td>
<td></td>
<td>- Research</td>
<td></td>
<td>- Regulations that increase clerical work</td>
</tr>
<tr>
<td><strong>Culture and values</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal values</td>
<td></td>
<td>Behavior of work unit leader</td>
<td>Organization’s mission</td>
<td>System of coverage for uninsured</td>
</tr>
<tr>
<td>Professional values</td>
<td></td>
<td>Work unit norms and expectations</td>
<td>Service/quality vs profit</td>
<td>- Structure reimbursement</td>
</tr>
<tr>
<td>Level of altruism</td>
<td></td>
<td>Equity/fairness</td>
<td>Organization’s values</td>
<td>- What is rewarded</td>
</tr>
<tr>
<td>Moral compass/ethics</td>
<td></td>
<td></td>
<td>Behavior of senior leaders</td>
<td>- Regulations</td>
</tr>
<tr>
<td>Commitment to organization</td>
<td></td>
<td></td>
<td>Communication/</td>
<td></td>
</tr>
<tr>
<td><strong>Control and flexibility</strong></td>
<td></td>
<td></td>
<td>messaging</td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td></td>
<td></td>
<td>Organizational norms and expectations</td>
<td></td>
</tr>
<tr>
<td>Assertiveness</td>
<td></td>
<td></td>
<td>Just culture</td>
<td></td>
</tr>
<tr>
<td>Intentionality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social support and community at work</strong></td>
<td></td>
<td>Colleaguality in practice environment</td>
<td>System for</td>
<td></td>
</tr>
<tr>
<td>Personality traits</td>
<td></td>
<td>Physical configuration of work unit space</td>
<td>Oversight of the</td>
<td>Support and community created by Medical/Specialty societies</td>
</tr>
<tr>
<td>Length of service</td>
<td></td>
<td>Social gatherings to promote community</td>
<td>Physician lounge</td>
<td>- Requirements for:</td>
</tr>
<tr>
<td>Relationship-building skills</td>
<td></td>
<td>Team structure</td>
<td>Strategies to build community</td>
<td>- Maintenance certification</td>
</tr>
<tr>
<td><strong>Work-life integration</strong></td>
<td></td>
<td></td>
<td>Social gatherings</td>
<td>- Licensing</td>
</tr>
<tr>
<td>Priorities and values</td>
<td></td>
<td></td>
<td></td>
<td>- Regulations that increase clerical work</td>
</tr>
<tr>
<td>Personal characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse/partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children/dependents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call schedule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structure night/weekend coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-coverage for time away</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectations/role models</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FIGURE 3.</strong> Drivers of burnout and engagement with examples of individual, work unit, organization, and national factors that influence each driver. EHR = electronic health record; JCAHO = Joint Commission on the Accreditation of Healthcare Organizations. Adapted from Mayo Clin Proc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Mayo Clinic Experience
FIGURE 5. Organizational strategies to reduce burnout and promote physician engagement. *Often will focus on improving efficiency and reducing clerical burden but should focus on whichever driver dimension (Figure 1) deemed most important by members of the work unit (Figure 3).
CONTENTS

OVERVIEW ......................................................................................................................... 1
PARTICIPATION ................................................................................................................... 2
REFERRALS ........................................................................................................................ 2
DISCHARGES .................................................................................................................... 6
CASELOAD ........................................................................................................................ 10
ILLNESSES MONITORED ............................................................................................... 13
GENERAL ILLNESS DATA ............................................................................................ 13
DIVERSION OF CONTROLLED SUBSTANCES .......................................................... 14
BUDGET .......................................................................................................................... 16
FUNDING ........................................................................................................................ 16
EXPENSES ...................................................................................................................... 16
HIGHLIGHTS .................................................................................................................... 17
STRATEGIC PLANNING ................................................................................................. 17
PARTICIPATION AGREEMENTS ................................................................................... 18
PROGRAM COMMITTEE GOALS ................................................................................... 19
COMMITTEE MEMBERS AND STAFF .......................................................................... 22
PROGRAM COMMITTEE MEMBERS ........................................................................... 22
ADMINISTERING BOARD ............................................................................................ 22
ADVISORY COMMITTEE MEMBERS ........................................................................... 23
HPSP STAFF .................................................................................................................... 23

Gratitude: Special appreciation for assistance in the development of this report goes to Mark Chu of MN.IT, Ruth Martinez, Executive Director of the Minnesota Board of Medical Practice, Mark Stensgard, IT Consultant, and HPSP staff.

Questions or comments about this report should be directed to Monica Feider at 612-317-3060 or Monica.Feider@state.mn.us.
OVERVIEW

The Health Professionals Services Program (HPSP) is a program of the Minnesota health related licensing boards that provides monitoring services to health professionals with illnesses that may impact their ability to practice safely. HPSP promotes public safety in health care by implementing Participation Agreements that oversee the participants’ illness management and professional practice, both of which are tied to patient safety. A Participation Agreement may include the participant’s agreement to comply with continuing care recommendations, practice restrictions, random drug screening, work site monitoring, and support group participation. A summary of HPSP’s primary functions are described below.

FUNCTIONS

1. 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/or 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 and monitoring that promotes public safety

2. Create and implement Participation Agreements:
   - Specify requirements for appropriate treatment and continuing care
   - Determine illness-specific and practice-related limitations or conditions

3. Monitor the continuing care and compliance of 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 or inadequate treatment, or symptom exacerbation

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

Participant Exit Survey Comments

HPSP sends exit surveys to all participants who engaged in monitoring. Most participant comments about the benefits of monitoring related to drug screens, accountability and case manager support. The following is a sampling:

- Monitoring/drug screens kept me thinking of the importance of compliance, which comes only from me and my sobriety.
- Structure. Reminders. Support and understanding.
- Case manager was kind, respectful and professional – did not feel judged or less of a human being.
- Work site monitor reports were a good thing.

Participant comments about how HPSP can improve include:

- Possibly be more visible to people who want help.
- More support for depression.
- On Saturdays, it was impossible to work days and get to collection site before it closed.

All identifying information were removed from comments above.
PARTICIPATION

REFERRALS

Definitions of Referral Sources

HPSP's intake process is fairly consistent, regardless of how licensees are referred for monitoring. The program is responsible for evaluating the licensee's eligibility for services and whether they have an illness that warrants monitoring. When it is determined that a licensee has an illness that warrants monitoring, a Participation Agreement is developed and monitoring is initiated.

Licensees can be referred to HPSP in the following ways:

1. **Self-Referrals**
   Licensees refer themselves directly to the program. Licensees report themselves to HPSP at various points during an illness/recovery. Some call directly from a hospital or treatment center, while others call after they have been sent home from work for exhibiting illness-related behavior.

2. **Third-Party Referrals**
   Third party referrals come from persons concerned about a licensee's ability to practice safely by reason of illness. The most common third party referrals are from treatment providers and employers. The identity of all third party reporters is confidential. Reports by third parties are subject to immunity if the report is made in good faith.

3. **Board Referrals**
   Participating boards have three options for referring licensees 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 licensee has an illness and refers the licensee to HPSP for monitoring of the illness.
   - **Discipline** (Board Discipline): The board has determined that there is an illness to monitor and refers the licensee to HPSP as part of a disciplinary measure (i.e.: Stipulation and Order). The Order may dictate monitoring requirements.

   For the purposes of this report, the two voluntary board referral sources (**Determine Eligibility** and **Follow-Up to Diagnosis and Treatment**) are combined.

---

**First Referral Source**

The term *first referral source* refers to the initial way practitioners are referred to HPSP. For example, a practitioner may self-report (first referral source) and while actively being monitored, HPSP may receive a report from their board, which is considered a *second referral source*. If the practitioner is discharged from HPSP and later is referred back to HPSP by a board without discipline, the first referral source for their second admission to the program would be *determine eligibility* or *follow-up to diagnosis and treatment*. 
Referrals by First Referral Source and Board

In fiscal year 2017 (July 1, 2016 to June 30, 2017), 460 health professionals were referred to HPSP. The table below shows the number of health professionals referred to HPSP by board and first referral source for the past four fiscal years.

<table>
<thead>
<tr>
<th>Board</th>
<th>Nursing Home Administrators</th>
<th>Behavioral Health &amp; Therapy</th>
<th>Chiropractic Examiners</th>
<th>Dentistry</th>
<th>Department of Health</th>
<th>Dietetics and Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Board Voluntary</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Board Discipline</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Self</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Third Party</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>SUM</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board</th>
<th>Emergency Medical Services</th>
<th>Marriage &amp; Family Therapy</th>
<th>Medical Practice</th>
<th>Nursing</th>
<th>Optometry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Board Voluntary</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Board Discipline</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Self</td>
<td>7</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Third Party</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>SUM</td>
<td>17</td>
<td>16</td>
<td>12</td>
<td>23</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board</th>
<th>Physical Therapy</th>
<th>Podiatric Medicine</th>
<th>Psychology</th>
<th>Social Work</th>
<th>Veterinary Medicine</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Board Voluntary</td>
<td>1</td>
<td>13</td>
<td>9</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Board Discipline</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Self</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Third Party</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>SUM</td>
<td>5</td>
<td>16</td>
<td>11</td>
<td>16</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Referrals by First Referral Source

The chart below shows the percentage of referrals to HPSP by first referral source from July 1, 2016 to June 30, 2017;
Referral Trends
The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2006 through fiscal year 2017. Self-referrals slightly increased and exceeded board voluntary referrals. Third party referrals also increased slightly. Self and third party referrals made up 56% of all referrals by first referral source to HPSP in fiscal year 2017.

Self-Referrals – How did licensees learn about HPSP?
Practitioners learn about HPSP from many sources. The following data shows how the 174 practitioners who self-referred to HPSP in fiscal year 2017 learned about the program:

The majority of people who self-referred in fiscal year 2017 learned about HPSP through their treatment providers. Treatment providers often include HPSP participation and compliance in continuing care planning. This reflects treatment providers’ positive impression of the benefits of HPSP services.

The majority of illnesses HPSP monitors are chronic illnesses which persist over one’s lifespan with periods of remission and symptom exacerbation. Therefore, HPSP anticipates that more persons who had previously been enrolled will refer themselves back to the program.

Other referral sources include but are not limited to mutual support groups, and HPSP’s brochure and website.
Third Party Referrals – Who referred licensees to HPSP?

When HPSP receives a third party report about a licensee, the licensee typically receives a letter directing them to contact HPSP within ten days to follow-up on the report. In fiscal year 2017, HPSP decreased the timeframe in which licensees are required to contact the program from two weeks to ten days. In cases where immediate public safety is at risk, HPSP calls the licensee upon receipt of the report. If the licensee fails to contact HPSP in response to the report, HPSP closes the case as no contact. If the licensee fails to cooperate with the intake process, the licensee is discharged for non-cooperation. HPSP provides the licensee’s board with a redacted copy of the third party report when HPSP discharges due to no contact or non-cooperation. Treatment providers not only tell their patients about HPSP (as seen in self-referrals), they are also the most common source of third party referrals.

Third Party Referent Information

The chart below shows the sources of fiscal year 2017 third party reports to HPSP:

![Pie chart showing sources of third party reports]

Treatment providers are the most common source of third party referrals. However, work-related referrals represent 59% of referrals when supervisor/employer, employee health and colleagues are combined.

Fiscal Year 2017 Additional Referral Sources

The previous data showed how health practitioners were referred to HPSP in fiscal year 2017 by first referral source. The following data shows subsequent referral sources for the same admission:

<table>
<thead>
<tr>
<th>First Referral Source</th>
<th>Second Referral Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self (#174)</td>
<td>• 19 Third Party</td>
</tr>
<tr>
<td></td>
<td>• 10 Board Voluntary</td>
</tr>
<tr>
<td></td>
<td>• 7 Board Disciplinary</td>
</tr>
<tr>
<td>Third Party (#81)</td>
<td>• 5 Self-Reports</td>
</tr>
<tr>
<td></td>
<td>• 4 Third Party</td>
</tr>
<tr>
<td></td>
<td>• 3 Board Voluntary</td>
</tr>
<tr>
<td>Board Voluntary (#150)</td>
<td>• 2 Board Disciplinary</td>
</tr>
<tr>
<td></td>
<td>• 1 Third Party</td>
</tr>
</tbody>
</table>

Self and third party reports for the same person often arrive on the same day or week. Employers or treatment providers recommend licensees report to HPSP and follow-up by making third party reports.
DISCHARGES

Definitions of Discharge Categories:
When licensees are discharged from HPSP, the reason for the discharge is listed as one of the following:

1. **Completion**
   Program completion occurs when the licensee satisfactorily completes the terms of the Participation Agreement.

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

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

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

5. **Ineligible Not Monitored**
   At time of intake, it is determined that licensee is not eligible for program services as defined in statute; the case manager closes the case and files report with licensee's board. Sub-categories of this include:
   - Ineligible Not Monitored - Illness too severe
   - Ineligible Not Monitored - License suspended/revoked
   - Ineligible Not Monitored - License went inactive
   - Ineligible Not Monitored - No active Minnesota license (not reported to board because not regulated in Minnesota)
   - Ineligible Not Monitored - Violation of practice act
   - Ineligible Not Monitored - Previously discharged to the board

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

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

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

*Discharge results in report to board and providing data.
### Discharges by Discharge Category and Board

The table below shows the number of persons discharged from HPSP by board and discharge category over the past four fiscal years.

<table>
<thead>
<tr>
<th>Board</th>
<th>Nursing Home Administrators</th>
<th>Behavioral Health &amp; Therapy</th>
<th>Chiropractic Examiners</th>
<th>Dentistry</th>
<th>Department of Health</th>
<th>Dietetics and Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion</td>
<td>0 0 1 0</td>
<td>6 5 2 3</td>
<td>3 5 3 3</td>
<td>7 6 6 8</td>
<td>0 0 0 2</td>
<td>0 0 0 2</td>
</tr>
<tr>
<td>Voluntary Withdraw</td>
<td>0 0 0 0</td>
<td>0 2 1 1</td>
<td>1 1 0 0</td>
<td>0 3 0 1</td>
<td>0 1 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>0 0 0 0</td>
<td>6 5 6 9</td>
<td>2 0 2 2</td>
<td>6 10 6 4</td>
<td>1 0 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Deceased</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Ineligible Monitored</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>2 0 0 0</td>
<td>1 3 3 3</td>
<td>14 16 10 13</td>
<td>55 58 39 19</td>
<td>1 1 2 1</td>
<td>0 0 1 0</td>
</tr>
<tr>
<td>SUM</td>
<td>14 15 16 0</td>
<td>20 25 18 28</td>
<td>24 24 16 20</td>
<td>80 92 59 43</td>
<td>5 4 4 4</td>
<td>0 0 1 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board</th>
<th>Emergency Medical Services</th>
<th>Marriage &amp; Family Therapy</th>
<th>Medical Practice</th>
<th>Nursing</th>
<th>Optometry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion</td>
<td>2 3 4 4</td>
<td>1 2 0 1</td>
<td>34 41 27 26</td>
<td>91 102 85 93</td>
<td>0 0 0 0</td>
<td>3 10 1 1</td>
</tr>
<tr>
<td>Voluntary Withdraw</td>
<td>1 2 2 1</td>
<td>0 0 0 0</td>
<td>5 1 2 0</td>
<td>18 15 15 13</td>
<td>0 0 0 0</td>
<td>0 1 0 1</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>3 1 3 0</td>
<td>0 0 0 0</td>
<td>1 0 0 0</td>
<td>74 50 39 12</td>
<td>0 0 0 0</td>
<td>4 2 3 2</td>
</tr>
<tr>
<td>Deceased</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>1 0 1 1</td>
<td>0 0 0 3</td>
<td>0 0 0 0</td>
<td>0 1 0 0</td>
</tr>
<tr>
<td>Ineligible Monitored</td>
<td>0 1 1 0</td>
<td>0 1 0 0</td>
<td>11 6 6 5</td>
<td>14 15 20 20</td>
<td>0 1 0 0</td>
<td>0 0 0 1</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>1 0 0 0</td>
<td>1 0 0 0</td>
<td>1 0 1 3</td>
<td>12 17 1 3</td>
<td>0 0 0 0</td>
<td>0 0 1 1</td>
</tr>
<tr>
<td>No Contact</td>
<td>1 1 1 5</td>
<td>0 0 0 0</td>
<td>1 3 2 3</td>
<td>11 12 11 11</td>
<td>0 0 0 0</td>
<td>3 4 1 1</td>
</tr>
<tr>
<td>Non-Cooperation</td>
<td>2 4 3 2</td>
<td>1 1 3 0</td>
<td>2 4 1 2</td>
<td>22 26 24 32</td>
<td>0 0 0 0</td>
<td>2 1 2 3</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>5 4 3 5</td>
<td>3 1 2 3</td>
<td>11 11 9 10</td>
<td>19 23 20 32</td>
<td>0 0 0 0</td>
<td>0 2 0 3</td>
</tr>
<tr>
<td>SUM</td>
<td>15 16 18 17</td>
<td>7 4 5 5</td>
<td>70 66 49 50</td>
<td>261 260 215 219</td>
<td>0 1 0 0</td>
<td>12 21 8 23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board</th>
<th>Physical Therapy</th>
<th>Podiatric Medicine</th>
<th>Psychology</th>
<th>Social Work</th>
<th>Veterinary Medicine</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion</td>
<td>1 6 3 3</td>
<td>0 0 0 0</td>
<td>1 3 2 4</td>
<td>6 2 4 6</td>
<td>0 3 1 1</td>
<td>155 188 139 168</td>
</tr>
<tr>
<td>Voluntary Withdraw</td>
<td>0 1 0 1</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>2 0 2 2</td>
<td>0 0 0 0</td>
<td>27 27 23 20</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>2 2 0 2</td>
<td>0 0 0 0</td>
<td>2 2 0 0</td>
<td>2 1 2 3</td>
<td>1 1 0 0</td>
<td>104 74 61 34</td>
</tr>
<tr>
<td>Deceased</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 2 2 4</td>
</tr>
<tr>
<td>Ineligible Monitored</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 2 1</td>
<td>1 0 1 0</td>
<td>33 24 33 29</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Ineligible Not Monitored</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>No Contact</td>
<td>0 1 1 0</td>
<td>0 0 0 0</td>
<td>0 0 0 0</td>
<td>1 0 1 0</td>
<td>0 0 0 0</td>
<td>21 35 19 29</td>
</tr>
<tr>
<td>Non-Cooperation</td>
<td>0 1 1 2</td>
<td>0 1 0 0</td>
<td>0 0 0 0</td>
<td>1 2 4 1</td>
<td>2 1 0 0</td>
<td>46 54 47 55</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>2 7 4 5</td>
<td>0 0 0 0</td>
<td>0 1 0 0</td>
<td>1 6 0 6</td>
<td>3 1 1 1</td>
<td>117 134 94 101</td>
</tr>
<tr>
<td>SUM</td>
<td>5 18 9 13</td>
<td>0 1 0 1</td>
<td>3 7 3 6</td>
<td>15 14 15 21</td>
<td>9 6 3 3</td>
<td>528 559 424 455</td>
</tr>
</tbody>
</table>

Note: Discharge categories highlighted in blue represent categories of persons who did not engage in monitoring.
Discharges by Category

The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2017.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineligible Not Monitored</td>
<td>3%</td>
</tr>
<tr>
<td>Non-Cooperation</td>
<td>12%</td>
</tr>
<tr>
<td>No Contact</td>
<td>6%</td>
</tr>
<tr>
<td>Ineligible Monitored</td>
<td>6%</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>8%</td>
</tr>
<tr>
<td>Completed</td>
<td>37%</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>22%</td>
</tr>
<tr>
<td>Deceased</td>
<td>1%</td>
</tr>
</tbody>
</table>

Of persons discharged in fiscal year 2017, 43% did not engage in monitoring, which is reflected in the table on the left (includes the categories of non-jurisdictional, non-cooperation, no contact, and ineligible-not monitored), which skews the overall completion rate to 33%. The most common reason that persons did not engage in monitoring is that HPSP did not identify an illness that warranted monitoring.

Discharges by Category for Those Monitored

The table below shows the discharge categories of persons who engaged in monitoring and were discharged from HPSP in fiscal year 2017.

<table>
<thead>
<tr>
<th>Ineligible Monitored</th>
<th>12%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Compliance</td>
<td>14%</td>
</tr>
<tr>
<td>Voluntary Withdraw</td>
<td>8%</td>
</tr>
<tr>
<td>Completed</td>
<td>66%</td>
</tr>
</tbody>
</table>

The completion rate of 66% reflects only persons that engaged in monitoring.

Discharges Due to Ineligibility for Monitoring

Forty-five (45) health professionals were discharged in fiscal year 2017 because they were not eligible for program services; 29 were monitored and 16 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (29)
- 26 were discharged because their licenses were suspended, revoked, became inactive or they chose to give up their license;
- 2 were discharged because their illnesses were too severe to warrant continued monitoring; and
- 1 was discharged because of a practice act violation.

Not-monitored and discharged as ineligible (15)
- 7 were discharged because their license was suspended, revoked, became inactive or their application for licensure was not granted;
- 5 were discharged because of a practice act violation;
- 2 were discharged because their illnesses were too severe to warrant monitoring; and
- 1 was discharged because of a previous discharge to their board (board was still investigating prior HPSP discharge).
Discharges for Non-Compliance (34)

The sub-categories of the 34 persons discharged for non-compliance in fiscal year 2017 are as follows:
- 15 were discharged for non-compliance with Monitoring Plan (i.e. relapse and refusing evaluations);
- 15 were discharged for problem toxicology screen results (i.e. not providing screens as requested or providing dilute specimens); and
- 4 were discharged for non-compliance with treatment.

Discharges by First Referral Source for Those Monitored

The charts below show licensees monitored by first referral source and percent of discharge category in fiscal year 2017. The completion rate is highest among persons referred under a disciplinary order and lowest among those referred by third parties. The actual number of persons who self-referred and were discharged out-paced any other referral source.
Length of Monitoring

Successful Completion: In fiscal year 2017, the average length of monitoring of practitioners who successfully completed monitoring was two years and five months. The shortest length just under two months and the longest was six years and six months.

HPSP satisfactorily discharges persons based on the following protocols: (1) The individual is in sustained remission after a period of monitoring (usually the case for substance use disorders); (2) there is new information indicating the diagnosis has changed, or (3) the participant is deemed to be appropriately managing the illness after a period of monitoring (usually the case in chronic health or mental health illnesses).

Unsatisfactory Completion: In fiscal year 2017, the average length of monitoring for persons who were monitored but did not complete monitoring was just under twelve months (330 days). The shortest length was 11 days, and the longest was four years and three months. The majority, 63%, were discharged in the first year of monitoring, followed by 22% in the second year, 14% in the third year, and 1% in the fourth or greater years of monitoring.

CASELOAD

Open Cases at End of Fiscal Year
The following chart shows the number of open cases at the end of each of the last 18 fiscal years.
**Rate of Participation by Board**

The following table shows the number of persons regulated by each board, the number of persons active in HPSP on July 12, 2017, and the ratio of persons monitored by board per 1,000 regulated. The Number Active in HPSP represents persons in the enrollment phase as well as those with signed Participation Agreements. The Number Licensed or Regulated includes only individuals who are licensed or regulated by the board (some boards regulate facilities or agencies).

<table>
<thead>
<tr>
<th>Board</th>
<th>Number Licensed or Regulated</th>
<th>Number Active in HPSP</th>
<th>Number Active in HPSP per 1,000 Licensed or Regulated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Podiatric Medicine*</td>
<td>263</td>
<td>2</td>
<td>7.60</td>
</tr>
<tr>
<td>Board of Behavioral Health &amp; Therapy</td>
<td>5,302</td>
<td>26</td>
<td>4.90</td>
</tr>
<tr>
<td>Board of Medical Practice**</td>
<td>23,523</td>
<td>84</td>
<td>3.57</td>
</tr>
<tr>
<td>Board of Nursing</td>
<td>129,418</td>
<td>329</td>
<td>2.54</td>
</tr>
<tr>
<td>Board of Physical Therapy</td>
<td>7,185</td>
<td>16</td>
<td>2.23</td>
</tr>
<tr>
<td>Board of Veterinary Medicine</td>
<td>2,977</td>
<td>5</td>
<td>1.67</td>
</tr>
<tr>
<td>Board of Social Work</td>
<td>14,938</td>
<td>24</td>
<td>1.61</td>
</tr>
<tr>
<td>Board of Psychology *</td>
<td>3,797</td>
<td>6</td>
<td>1.58</td>
</tr>
<tr>
<td>Board of Dentistry</td>
<td>17,531</td>
<td>23</td>
<td>1.31</td>
</tr>
<tr>
<td>Board of Dietetics and Nutrition Practice</td>
<td>1,817</td>
<td>2</td>
<td>1.10</td>
</tr>
<tr>
<td>Board of Pharmacy</td>
<td>20,742</td>
<td>18</td>
<td>0.87</td>
</tr>
<tr>
<td>Department of Health***</td>
<td>7,167</td>
<td>6</td>
<td>0.83</td>
</tr>
<tr>
<td>Board of Marriage and Family Therapy</td>
<td>2,571</td>
<td>2</td>
<td>0.78</td>
</tr>
<tr>
<td>Emergency Medical Services Regulatory Board</td>
<td>29,378</td>
<td>18</td>
<td>0.61</td>
</tr>
<tr>
<td>Board of Chiropractic Examiners *</td>
<td>9,486</td>
<td>4</td>
<td>0.42</td>
</tr>
<tr>
<td>Board of Optometry*</td>
<td>1,097</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Board of Exam. of Nursing Home Admin.</td>
<td>866</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299,734</strong></td>
<td><strong>565</strong></td>
<td><strong>1.88 per 1,000</strong></td>
</tr>
</tbody>
</table>

*Represents number regulated based on the Health-Related Licensing Board’s Biennial Report, July 1, 2014 to June 30, 2016
**Represents number regulated from the Boards’ website on 7/17/18
***Represents number regulated per data received July 2016

All other data obtained from Board Office Managers from 7/18/17-7/20/17
**Active Caseload by Board and Profession**

The chart below shows the number of licensees active with HPSP on July 12, 2017 by Board and Profession. It includes persons in the enrollment phase as well as those with signed Participation Agreements.

<table>
<thead>
<tr>
<th>Board</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Behavioral Health &amp; Therapy</td>
<td>26</td>
</tr>
<tr>
<td>LPC</td>
<td>1</td>
</tr>
<tr>
<td>LPCC</td>
<td>3</td>
</tr>
<tr>
<td>LADC</td>
<td>22</td>
</tr>
<tr>
<td>Board of Chiropractic Examiners</td>
<td>4</td>
</tr>
<tr>
<td>Board of Dentistry</td>
<td>23</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>7</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>6</td>
</tr>
<tr>
<td>Dentists</td>
<td>10</td>
</tr>
<tr>
<td>Department of Health</td>
<td>6</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>5</td>
</tr>
<tr>
<td>Occupational Therapy Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Board of Dietetics and Nutrition Practice</td>
<td>2</td>
</tr>
<tr>
<td>Board of Exam. of Nursing Home Admin.</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Medical Services Regulatory Board</td>
<td>12</td>
</tr>
<tr>
<td>CMPA</td>
<td>1</td>
</tr>
<tr>
<td>EMT1</td>
<td>9</td>
</tr>
<tr>
<td>EMTP</td>
<td>7</td>
</tr>
<tr>
<td>Board of Marriage and Family Therapy</td>
<td>2</td>
</tr>
<tr>
<td>Board of Medical Practice</td>
<td>84</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>7</td>
</tr>
<tr>
<td>Physician</td>
<td>67</td>
</tr>
<tr>
<td>Respiratory Care Practitioner</td>
<td>7</td>
</tr>
<tr>
<td>Resident</td>
<td>3</td>
</tr>
<tr>
<td>Board of Nursing</td>
<td>329</td>
</tr>
<tr>
<td>RN</td>
<td>268</td>
</tr>
<tr>
<td>LPN</td>
<td>61</td>
</tr>
<tr>
<td>Board of Optometry</td>
<td>0</td>
</tr>
<tr>
<td>Board of Pharmacy</td>
<td>18</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>13</td>
</tr>
<tr>
<td>Technician</td>
<td>5</td>
</tr>
<tr>
<td>Board of Physical Therapy</td>
<td>16</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>11</td>
</tr>
<tr>
<td>Physical Therapist Assistant</td>
<td>5</td>
</tr>
<tr>
<td>Board of Podiatric Medicine</td>
<td>2</td>
</tr>
<tr>
<td>Board of Psychology</td>
<td>6</td>
</tr>
<tr>
<td>Board of Social Work</td>
<td>24</td>
</tr>
<tr>
<td>LGSW</td>
<td>11</td>
</tr>
<tr>
<td>LICSW</td>
<td>6</td>
</tr>
<tr>
<td>LISW</td>
<td>1</td>
</tr>
<tr>
<td>LSW</td>
<td>6</td>
</tr>
<tr>
<td>Board of Veterinary Medicine</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>565</td>
</tr>
</tbody>
</table>

Of the 565 active cases on July 12, 2017, 518 had signed Participation Agreements and 47 were in the enrollment process.

Nurses make up the greatest number of HPSP participants (58%).
ILLNESSES MONITORED

GENERAL ILLNESS DATA

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 14, 2017, there were 515 health professionals enrolled in HPSP with signed Participation Agreements. Many were monitored for more than one illness. The following data identifies the illnesses for which participants were being monitored.

<table>
<thead>
<tr>
<th>Illness Category</th>
<th>Number of participants</th>
<th>Percent of 515 participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders</td>
<td>436</td>
<td>85%</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td>365</td>
<td>71%</td>
</tr>
<tr>
<td>Medical Disorders</td>
<td>57</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Single and Co-occurring Illnesses</th>
<th>Number of participants</th>
<th>Percent of 515 participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Only</td>
<td>140</td>
<td>27%</td>
</tr>
<tr>
<td>Psychiatric Only</td>
<td>61</td>
<td>12%</td>
</tr>
<tr>
<td>Medical Only</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>Substance and Psychiatric</td>
<td>257</td>
<td>50%</td>
</tr>
<tr>
<td>Substance and Medical</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Psychiatric and Medical</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Substance, Psychiatric &amp; Medical</td>
<td>35</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use Disorders (SUD)</th>
<th>Number of participants with SUD: 436</th>
<th>Percent of 515 participants</th>
<th>Percent of 436 with a SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>352</td>
<td>68%</td>
<td>81%</td>
</tr>
<tr>
<td>Prescription</td>
<td>125</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>13</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Barbiturate</td>
<td>3</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>31</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Opiate</td>
<td>99</td>
<td>19%</td>
<td>23%</td>
</tr>
<tr>
<td>Sedative/Hypnotic</td>
<td>11</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>I illicit</td>
<td>58</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>39</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Heroin</td>
<td>6</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>13</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Over the Counter</td>
<td>1</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric Disorders</th>
<th>Number of participants with psychiatric diagnosis: 365</th>
<th>Percent of 515 participants</th>
<th>Percent of 365 with a psychiatric diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and/or Depression</td>
<td>328</td>
<td>63%</td>
<td>90%</td>
</tr>
<tr>
<td>Attention Deficit</td>
<td>24</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>40</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>PTSD</td>
<td>45</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>15</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Disorders</th>
<th>Number of participants with medical disorders: 57</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

The majority of persons (>75%) monitored for a medical disorder have a pain-related condition (i.e., degenerative disc disease, fibromyalgia, migraines, chronic pain). Other medical conditions monitored include but are not limited to diabetes, neurological disorders, and seizure disorders. Some are monitored for more than one medical illness.
DIVERSION OF CONTROLLED SUBSTANCES

HPSP Definition of Diversion
The HPSP working definition of diversion is the inappropriate acquisition of controlled or other potentially abusable substances. Note the term “diversion” is umbrella terminology in which stealing drugs from the workplace is included. Methods of diversion vary greatly, as does the impact and potential impact on patients.

Monitoring Conditions
Standard monitoring conditions for work-related diversion include a minimum of twelve months of no access to, handling of, or responsibility for, controlled and mood altering substances at work. In some professions and work situations, access to drugs must be supervised after the restriction is lifted. The length of monitoring is also extended.

Prescription Drug Abuse and Diversion
On July 14, 2017, a total of 515 health professionals had signed Participation Agreements. Of the 515 health professionals with signed agreements, 125 (24%) were addicted to prescription medications. Of the 125 addicted to prescription medications, 77 (62%) engaged in diversion (15% of total engaged in monitoring). Of the 77 who engaged in diversion, 49 (63%) engaged in work-related diversion and 46 (60%) engaged in non-work related diversion. Also, 18 (23%) engaged in both work related and non-work related diversion.

Diversion by Board
The table below shows the number of participants with signed Participation Agreements on July 14, 2017, who diverted by Board and whether the diversion took place at work. Some participants diverted in more than one way. The data is based on participant self-report of diversion, employer report of diversion and Board data (i.e. data provided to HPSP by the Board via a disciplinary order).

<table>
<thead>
<tr>
<th>Board</th>
<th>Number of persons who diverted by board</th>
<th>Diversion took place at work</th>
<th>Diversion did not take place at work</th>
<th>Percent in HPSP by board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>49</td>
<td>31*</td>
<td>34*</td>
<td>15%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>8</td>
<td>8**</td>
<td>1**</td>
<td>44%</td>
</tr>
<tr>
<td>Medical Practice</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Dentistry</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>19%</td>
</tr>
<tr>
<td>Other Boards</td>
<td>6***</td>
<td>2</td>
<td>4</td>
<td>8%***</td>
</tr>
<tr>
<td>Totals</td>
<td>77</td>
<td>49</td>
<td>46</td>
<td>15% total</td>
</tr>
</tbody>
</table>

*Represents 16 persons regulated by the Board of Nursing engaged in work and non-work related diversion.
**Represents 1 person regulated by the Board of Pharmacy engaged in work and non-work related diversion.
***Represents 6 persons regulated by the Board of Behavioral Health and Therapy (2), the Department of Health (1), the Emergency Services Regulatory Board (1), the Board of Social Work (1) and the Board of Veterinary Medicine (1).
Methods of Diversion
The tables below show more specific data about the methods of diversion among the 77 who diverted (some used more than one method of diversion, which is shown in the data).

<table>
<thead>
<tr>
<th>Diversion took place at work</th>
<th>49 participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took from inventory</td>
<td>20</td>
</tr>
<tr>
<td>Took from waste</td>
<td>19</td>
</tr>
<tr>
<td>Withdrew more than patient needed and kept extra for self</td>
<td>9</td>
</tr>
<tr>
<td>Wrote prescription for patient and filled for self</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>Diversion did not take place at work (53%)</td>
<td>46 participants</td>
</tr>
<tr>
<td>Took from family or friends</td>
<td>41</td>
</tr>
<tr>
<td>Ordering off the internet</td>
<td>3</td>
</tr>
<tr>
<td>Wrote prescription for self</td>
<td>2</td>
</tr>
<tr>
<td>Wrote prescription for fake patient</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note: HPSP does not currently track participants who buy medications from illegitimate sources.*

Some of the other forms of diversion included substituting medications, taking medications that patients brought to the hospital, and altering prescriptions. Persons who engaged in substitution of medications and falsifying prescriptions were referred to HPSP by their Boards or reported to their Board per HPSP statutory reporting requirements.

**Referral Sources of Persons who Diverted by First Referral Source:**
The referral sources of HPSP participants who diverted medications include are described below:

- 39 (51%) self-referred (12 were later Board referred, 10 with discipline and 2 without discipline)
- 30 (39%) were board referred with discipline
- 4 (5%) were board referred without discipline (voluntary)
- 4 (5%) were third party referred

**Trends**

**Diversion at Work**
Access to controlled substances is a risk factor for diverting the drugs. This is evidenced by the rate of diversion among professions. For example, pharmacists have the greatest access to controlled substances and the highest rate of diversion among HPSP participants.

**Diversion from Other Sources**
The most common form of non-work-related diversion is taking (or receiving) medications from family members or friends, which is increasing across health professions. This demonstrates the need for greater education for patients who are prescribed controlled substances regarding risks associated with sharing medications and proper disposal of unused medications.
BUDGET

HPSP is committed to providing quality services that contribute to public safety in health care in the most cost effective manner possible. HPSP appreciates the boards' recognition that adequate funding is essential to HPSP's success.

FUNDING

The health licensing boards and the Department of Health fund HPSP. Each board pays an annual $1,000 fee and a pro-rata share of program expenses to HPSP based on the number of the board's participants in the program at the end of each month. No additional fees are collected by HPSP for program participation from licensees.

HPSP sought additional funding in the 2018-2019 biennium for database enhancements and to address inflation in salaries, benefits, rent and other expenses. Both were granted.

EXPENSES

HPSP's operating budget in fiscal year 2017 was $864,000, increased to $903,000 after moving $39,000 of unspent money forward from fiscal year 2016 to fiscal year 2017. The majority of savings came from salary savings.

Similar to the health licensing boards, the majority of HPSP's expenses are directed toward salaries and benefits (77%). The next largest expense was rent. HPSP utilized additional salary savings during fiscal year 2017 to purchase updated equipment and furniture for specific work areas. HPSP stayed within its spending authority and retained $50,000 for database upgrades.

Rent Projections

HPSP office space is located at Energy Park Place, 1380 Energy Lane, Suite 202, St. Paul, Minnesota and consists of 2,279 square feet. HPSP's lease will expire on January 31, 2018. The Minnesota Department of Administration will negotiate HPSP's updated lease.

<table>
<thead>
<tr>
<th>Lease Period</th>
<th>Annual Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/16 to 6/30/17</td>
<td>$36,283.20</td>
</tr>
<tr>
<td>7/1/17 to 1/31/18</td>
<td>$21,150.75*</td>
</tr>
</tbody>
</table>

*Represents 6 months of rent. so HPSP's lease timeframe will be consistent with the Health Licensing Boards.
HIGHLIGHTS

STRATEGIC PLANNING

Documents Updated
HPSP focused on improving forms, authorizations, letters and most importantly, the Participation Agreement (contract) that participants sign. It is anticipated that participants will find the new letters and forms easier to understand.

Outreach
HPSP staff presented to 15 different stakeholder groups (i.e. schools, professional associations, employers); interfacing with over 500 individuals in fiscal year 2017. This exceeded fiscal year 2016 numbers by an estimated 111 contacts.

As the boards and HPSP work together to protect the public, HPSP thanks the Boards of Dentistry and Nursing for including information about HPSP in board newsletters. Some other boards include information about HPSP in renewal packets. Additionally, HPSP offers each board the opportunity to have HPSP present to their board annually. This promotes board member understanding of HPSP services.

Program Committee
A sub-committee of the Program Committee met to review whether the Program Committee’s role warranted change. After several meetings and robust discussions, the sub-committee brought a recommendation to the full Program Committee for review. The Program Committee voted to retain its current structure and roles.

The Program Committee voted unanimously to accept HPSP’s proposal for a new Participation Agreement template.

Advisory Committee
HPSP worked with the Advisory Committee to identify opportunities for outreach and education. Advisory Committee members took an active role in providing information to their membership and professional schools about professional support groups, addiction and HPSP. HPSP had the opportunity to present to several groups in collaboration with Advisory Committee members.

HPSP staff collaborated with the Advisory Committee to compare HPSP’s work site monitor report form to forms used in other states. The form was modified based on input from the Advisory Committee.
PARTICIPATION AGREEMENTS

HPSP strives to have Participation Agreements signed within 60 days of participant contact with the program. Despite the timeframe allowed for participants to sign Participation Agreements, an intervention takes place during the initial intake interview, which protects the public.

In fiscal year 2017, 210 Participation Agreements were signed. Of these, 94% were signed within 60 days of the individual's contact with the program. The average timeframe was 31 days. Delays in obtaining appropriate assessments was the most common factor causing the timeframe to exceed 60 days. More specifically, assessments by neuropsychologists, neurologists, and pain management physicians are challenging to schedule in a timely manner. The chart below shows the number of days between the dates licensees contacted the program and the dates their Participation Agreements were signed.

Days from Participant Contact to Date Participation Agreement Signed
PROGRAM COMMITTEE GOALS

In 1999, the Program Committee worked with a consultant to develop five goals to outline the Committee’s responsibilities. These goals have remained consistent since that time. HPSP staff is committed to meeting these goals. Many quantifiable measures of how HPSP is addressing the goals are listed earlier in this document. Additional examples are listed below.

GOAL 1: ENSURE THE PUBLIC IS PROTECTED

HPSP’s protection of the public is multifaceted. Some of the examples listed below will be quantified in future reports.

- HPSP works collaboratively with board staff to ensure monitoring is consistent with board expectations, national norms and available science
- Self and third party reporting of illness made up 56% of referrals in fiscal year 2017 (this is up 6% from fiscal year 2016)
- HPSP implements practice restrictions when appropriate
- HPSP refers health professionals for appropriate assessments and evaluations
- HPSP requires participants to follow their treatment recommendations
- HPSP tracks participants’ compliance with treatment
- HPSP intervenes when participants have exacerbations of symptoms
- HPSP serves as a liaison between employers and treatment providers
- HPSP reports health professionals who are not compliant with monitoring to their licensing boards
- HPSP educates employers and the medical community about professional impairment
- HPSP encourages early intervention through its outreach and reputation

GOAL 2: ENSURE INDIVIDUAL CLIENTS ARE TREATED WITH RESPECT

Showing respect in a complex interaction is essential when providing any type of service. Beyond HPSP’s day-to-day involvement with participants, the following HPSP procedures and activities demonstrate respect for clients:

- Maintaining a simple process for reporting to the program
- Developing and utilizing monitoring guidelines that are based on research and national norms
- Providing a consistent service to all health professionals
- Maintaining motivated, competent staff who are proficient in substance and psychiatric disorders as well as case management
- Collecting and reviewing feedback from participants on a regular basis
- Incorporating participant feedback as deemed appropriate
- Finding accessible collection sites for participants and posting them on our website
- Maintaining a user-friendly website that includes participant, treatment provider and work site monitor information and forms
GOAL 3: ENSURE THE PROGRAM IS WELL MANAGED

Identifying how HPSP is well managed includes the above items in addition to a broad range of actions, including:

- HPSP collaborates with board staff and seeks input regarding the monitoring process and guidelines
- HPSP holds quarterly meetings with board staff to review program processes and board concerns
- HPSP is staffed with competent employees who are invested in the program's mission
- The program manager hires competent case managers who provide quality intake, case management monitoring services
- The program manager performs annual performance reviews of employees
- The program manager surveys executive directors annually to obtain input on program services
- The program manager submits monthly billing reports to the Administrative Services Unit on a timely basis
- The program manager meets with the Administering Board Executive Director and the Administrative Services Unit's Chief Financial Officer to review spending on a regular basis
- The program manager follows all state requirements for hiring and managing personnel
- The program manager ensures all staff review relevant state policies upon hire and in even numbered years (i.e. data practices, code of ethics, respectful workplace, electronic communications and others)
- The program manager reviews policy and other issues with the Administering Board Executive Director as needed
- The program manager seeks legal advice when needed
- HPSP is recognized nationally as having a quality program
- HPSP utilizes highly specialized consultants to assist in developing monitoring plan conditions for complex cases

GOAL 4: ENSURE THE PROGRAM IS FINANCIALLY SECURE

The funding source of HPSP is defined in statute and is established by the Legislature on a biennial basis. HPSP has sought increases when deemed necessary to address program growth and needs. For example, HPSP requested increases for the 2018-2019 biennium to support improving technology, which will result in more efficient services and the ability to sustain current staffing levels.

HPSP consistently spends within its allotted budget. HPSP has regular budget meetings with the Administrative Services Unit Chief Financial Officer and the Administering Board Executive Director to track spending.

The majority of HPSP costs are related to staffing. All expenses are tracked and reconciled with reports from the Administrative Services Unit. The Administrative Services Unit also performs audits.

GOAL 5: ENSURE THE PROGRAM IS OPERATING CONSISTENT WITH ITS STATUTE

HPSP understands and appreciates the benefits and constraints of its enabling legislation. HPSP consistently operates within the parameters of its enabling legislation. HPSP utilizes the Office of the Attorney General as legal questions arise regarding the program's authority.

In fiscal year 2017, HPSP utilized the Office of the Attorney General to improve several documents, including the Participation Agreement, Tennessee Warning, and Authorizations.
SUMMARY

HPSP is committed to protecting the public by providing monitoring services to regulated health professionals whose illnesses may impact their ability to practice safely. Monitoring is multifaceted and focuses on reviewing the professional's illness management and professional practice. To this end, HPSP obtains reports from participants' work site monitors, treatment providers and other sources.

HPSP is also committed to providing services in an effective and efficient manner that supports participant cooperation and success, as well as board satisfaction. HPSP accomplishes this by seeking input from a variety of sources; including participants, boards and professional associations; as well as by keeping current on monitoring programs in other states and on national developments in healthcare, impairment and recovery.

As a program of the Minnesota Health Related Licensing Boards, HPSP benefits from collaborating with regulators in an ongoing assessment of program effectiveness, communications, and monitoring processes to assure public protection and board satisfaction.
COMMITTEE MEMBERS AND STAFF

PROGRAM COMMITTEE MEMBERS

The Program Committee consists of one member from each health licensing board. By law, the Program Committee provides HPSP with guidance to ensure the direction of HPSP is in accord 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 consistent with its statute.

<table>
<thead>
<tr>
<th>Board</th>
<th>Member Name</th>
<th>Term Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health and Therapy</td>
<td>Yvonne Hundshamer</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Chiropractic Examiners</td>
<td>Nestor Riano</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Bridgett Anderson</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Catherine Lloyd</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Dietetics and Nutritionists</td>
<td>Margaret Schreiner</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>Matthew Simpson</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>Kathryn Graves</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Medical Practice</td>
<td>Allen Rasmussen</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Nursing</td>
<td>Christine Norton</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Nursing Home Administrators</td>
<td>Randy Snyder</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Optometry</td>
<td>Michelle Falk</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Joseph Stanek (through 6/12/17)</td>
<td>1/1/2018</td>
</tr>
<tr>
<td></td>
<td>James Bialke (effective 6/13/17)</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Kathy Polhamus, Vice Chair</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Podiatric Medicine</td>
<td>Margaret Schreiner</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Psychology</td>
<td>Angelina Barnes (through 4/4/17)</td>
<td>1/1/2018</td>
</tr>
<tr>
<td></td>
<td>Samuel Sands (effective 7/19/17)</td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td>Rosemary Kassekert (through 7/17/17)</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Veterinary Medicine</td>
<td>Julia Wilson</td>
<td>1/1/2018</td>
</tr>
</tbody>
</table>

ADMINISTERING BOARD

HPSP is not an independent State agency. By statute, the Program Committee designates one of the health licensing boards to administer the program. The Board of Medical Practice is serving as HPSP’s Administering Board. HPSP is grateful to the Board of Medical Practice for accepting the responsibility to serve as HPSP’s Administering Board.
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>Professional Association</th>
<th>Member</th>
<th>Term Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>MN Pharmacists Assoc.</td>
<td>Jim Alexander</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Health Systems Pharmacists</td>
<td>S. Bruce Benson</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Assoc. of Social Workers</td>
<td>Pam Berkwitz</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Veterinary Assoc.</td>
<td>Marcia Brower</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Psychological Assoc.</td>
<td>Lois Cochrane-Schlutter</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Dental Assoc.</td>
<td>Stephen Gulbrandsen, Chair</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Nurses Assoc.</td>
<td>Jody Haggy</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Assoc. of Marriage &amp; Fam. Therapy</td>
<td>Eric Hansen</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Ambulance Assoc.</td>
<td>Megan Hartigan (Debbie Gillquist alt)</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Chiropractic Assoc.</td>
<td>Rick Heuffmeier</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Public Member</td>
<td>Abdiaziz Hirsi</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Academy of Physician Assist.</td>
<td>Tracy Keizer</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Medical Assoc.</td>
<td>Teresa Knoedler</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Academy of Nutrition and Dietetics</td>
<td>Sheryl Lundquist</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Nurse Peer Support Group</td>
<td>Marie Manthey</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Physicians Serving Physicians</td>
<td>Jeff Morgan</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Ad Hoc Member</td>
<td>Rose Nelson</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Occupational Therapy Assoc.</td>
<td>Karen Sames</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN Organization of Registered Nurses</td>
<td>Joseph Twitchell</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MN LPNA/AFSCME</td>
<td>Lisa Weed</td>
<td>1/1/2018</td>
</tr>
</tbody>
</table>

**HPSP STAFF**

<table>
<thead>
<tr>
<th>Staff Person</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monica Feider, MSW, LICSW</td>
<td>Program Manager</td>
</tr>
<tr>
<td>Tracy Erfourth, BA</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Marilyn Miller, MS, LICSW</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Audrey Grossman, MA, LADC</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Kurt Roberts, EdD, LADC</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Kimberly Zillmer, BA, LADC</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Daisy Chavez</td>
<td>Case Manager Assistant</td>
</tr>
<tr>
<td>Sheryl Jones</td>
<td>Office Manager</td>
</tr>
</tbody>
</table>
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For information only.

MOTION BY: ___________________ SECOND: ____________________

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

BACKGROUND:

a) 2018 Annual Meeting (see attached)
b) Call for Nominations (see attached)
c) Call for Amendment of the Bylaws (see attached)
August 15, 2017

Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039

Humayun J. Chaudhry, DO, MACP  Gregory B. Snyder, MD, DABR
President and Chief Executive Officer  Chair, Board of Directors

Subject: Request for exemption from state employee travel restrictions to North Carolina

Dear Dr. Chaudhry and Dr. Snyder:

In April 2016, Minnesota Governor Mark Dayton imposed a prohibition on nonessential state employee travel to North Carolina and Mississippi based on laws, commonly referred to as “bathroom bills” which blocked local governments from passing anti-discrimination rules related to gay, lesbian, bisexual and transgender women and men. In August 2016, Governor Dayton issued a continuation of the travel restrictions. The Minnesota Board of Medical Practice received notice of conditions upon which exceptions to the travel restrictions could be considered.

By letter dated July 17, 2017, the Minnesota Board of Medical Practice submitted a request on behalf of members for an exception that would allow Board members and Board staff to travel to North Carolina to participate in the Federation of State Medical Boards Annual Meeting in Charlotte, North Carolina, and to host the Minnesota Welcome Reception at the start of the Annual Meeting. On July 26, 2017, we received notice that our request had been denied.

Enclosed are copies of the notices of travel restrictions, the Board’s request for exception and the response to our request. Please contact me if you have any questions.

Sincerely,

Gerald Kaplan, President
Gerald.Kaplan@state.mn.us

Enclosures
Date: July 25, 2017

To: Gerald T. Kaplan, M.A., L.P. President
Minnesota Board of Medical Practice

From: Commissioner Myron Frans

Subject: Response to North Carolina Travel Request

Thank you for expressing your interest in attending the Federation of State Medical Boards Annual Meeting (FSMB) in Charlotte, North Carolina on April 25, 2018.

Governor Mark Dayton has directed all state employees to stop traveling to North Carolina for state business due to its discriminatory laws. This action is consistent with other states, companies, and organizations. Per an earlier memo, if travel requests do not meet one of the following three conditions, the travel request will be denied:

- Is travel required for the enforcement of Minnesota law?
- Is travel required to meet the state’s contractual or other legal obligations?
- Is travel required for the protection of public health, welfare, and/or safety?

MMB has considered your exception request and the attached conference agenda. We have determined your request does not meet the expressed conditions noted above. While we recognize the leadership connection, it does not appear that this FSMB educational event, and your hosting a welcome reception, is necessary to fulfill the boards mandate to protect the public’s health, welfare, and safety of Minnesotans.

In lieu of attending, perhaps members of the board can participate in some of these learning events online and/or receive the materials electronically.
July 18, 2017

Deputy Commissioner Edwin Hudson
Minnesota Management and Budget
658 Cedar Street
400 Centennial Office Building
Saint Paul, Minnesota 55155

Subject: Request for exemption from state employee travel restrictions to North Carolina

Dear Deputy Commissioner Hudson:

In follow up to our telephone conversation on July 11, 2017, the Minnesota Board of Medical Practice (Minnesota Board) respectfully requests an exemption from Governor Dayton’s prohibition on nonessential state employee travel to North Carolina to permit Minnesota Board members and senior staff to attend the Federation of State Medical Boards Annual Meeting in Charlotte, North Carolina, from April 25, 2018 through April 28, 2018. The Minnesota Board understands and respects Governor Dayton’s decision to impose travel restrictions to North Carolina and Mississippi and believes that attendance at the 2018 Federation of State Medical Boards Annual Meeting (FSMB Annual Meeting) is essential for the Minnesota Board to effectively carry out its statutory mandate to protect the public’s health, welfare and safety through its licensing and disciplinary procedures, and is necessary for the Minnesota Board to carry out its national leadership obligations.

The Federation of State Medical Boards (FSMB) represents 70 state medical and osteopathic boards within the United States, its territories and the District of Columbia in carrying out the mandate of protecting the public’s health, safety and welfare through proper licensing and regulation of physicians, physician assistants and other health care professionals. The Minnesota Board, the state agency responsible for licensing and regulating physicians, physician assistants and six other allied health professions in the State of Minnesota, is an active member of the FSMB. The current Chair of the FSMB Board of Directors is Dr. Gregory B. Snyder, a Minnesota physician who served eight years as an appointed member of the Minnesota Board, including as Chair of the Minnesota Board’s Complaint Review Committee and as Minnesota Board President. As Chair of the FSMB Board of Directors, Dr. Snyder is obligated to attend the FSMB Annual Meeting to coordinate and present the critical policy and advocacy initiatives that have advanced under his leadership.

The FSMB Annual Meeting is the FSMB’s premier educational event and includes the annual business meeting wherein guidelines and policies are considered and leadership elections held. The guidelines developed and adopted by the FSMB address important public health and protection issues and are influential as they have the imprimatur of the nation’s medical boards. The 2018 meeting will have policies addressing prescription drug monitoring programs (a result of a resolution from the Minnesota Board); regenerative medicine and stem cell therapies; disruptive physician behavior; and a newly revised model medical practice act. Additionally, the meeting offers continuing medical education for attendees on issues related to health professional regulation and the ability for board members and senior staff to share best practices to improve efficiencies in operations and the ability to fulfill the boards’ statutory mandate to protect the public.
Minnesota is recognized nationally for its quality healthcare and the Minnesota Board is recognized for its excellence and leadership, locally and nationally. Minnesota Board members affirm that attendance at the FSMB Annual Meeting significantly strengthens their effectiveness and functionality as members of a cohesive board. Engagement at the FSMB Annual Meeting in topic-specific breakout sessions expands participants’ awareness and understanding of patient safety initiatives, healthcare workforce issues, regulatory policy, and evolving trends such as telemedicine expansion and the opioid crisis. The knowledge gained by its attendees enables the Minnesota Board to proficiently perform licensing and enforcement activities that assure access to quality healthcare for all Minnesotans. The FSMB Annual Meeting also provides Minnesota Board members opportunities to serve on committees and work groups established by FSMB leadership. These committees and work groups meet throughout the year to advance important regulatory initiatives that directly impact public health, welfare and safety.

The Minnesota Board asked the FSMB whether it would consider moving the FSMB Annual Meeting to a location other than North Carolina. The FSMB responded that the Charlotte, North Carolina, meeting site was selected and contracted prior to the legislation that was the basis for the travel restriction. Once the legislation passed, the FSMB considered the political situation, including the potential for repeal in light of the election of a new governor, while exploring concomitantly the feasibility of getting released from its contractual duties under the hotel contract. Unfortunately, the cost of cancellation is prohibitive. The cost of the FSMB Annual Meeting is a significant budget commitment for the FSMB, in part, because it provides funding for two representatives from each of its 70 member medical and osteopathic boards to attend the meeting each year. The FSMB anticipates that it will webcast the Thursday morning plenary sessions as it has in the past few years. While a webcast may provide the opportunity to observe limited presentations, it does not afford the ability to actively engage in the comprehensive content of the full FSMB Annual Meeting.

As part of the FSMB Annual Meeting, the Minnesota Board serves as host to a Minnesota Welcome Reception that launches the Annual Meeting. The reception affords attendees an opportunity to network with one another, become better acquainted with peers, and to begin the conversations on healthcare initiatives that will continue throughout the days ahead. The Minnesota Board has hosted this event for many years and has been invited to host a reception in North Carolina on April 25, 2018.

Former Governors have exempted the Minnesota Board from previous travel restrictions and permitted attendance at the FSMB Annual Meeting, recognizing the value of this premier event. We sincerely hope that Governor Dayton agrees that travel to the 2018 FSMB Annual Meeting is essential for Minnesota Board members and senior staff.

Thank you for considering this request on behalf of the Minnesota Board. Please let us know if you have any questions.

Sincerely,

Gerald T. Kaplan, M.A., L.P.
President
Minnesota Board of Medical Practice
(612) 720-9747
Gerald.Kaplan@state.mn.us

Ruth M. Martinez, M.A., Executive Director
Minnesota Board of Medical Practice
(612) 548-2150
Ruth.Martinez@state.mn.us

Enclosures: Federation of State Medical Boards 2017 Annual Report
2016 and 2017 FSMB Annual Meeting agendas
April 2, 2016

Minnesota Management & Budget
ATTN: Minnesota State Employees
400 Centennial Building
658 Cedar Street
Saint Paul, Minnesota 55155

Dear Fellow Minnesota Employees:

As Governor, I take great pride in our state’s culture of inclusiveness and our continuing efforts to make Minnesota a state free from discrimination. As public servants, we strive to demonstrate this commitment every day in our work for the people of Minnesota. We all have a part in assuring that all of us can live our lives without discrimination on any basis.

You are probably aware that the State of North Carolina recently passed a so-called “Public Facilities Privacy and Security Act.” That law blocks local governments from passing anti-discrimination rules to grant protections to gay, lesbian, bisexual, and transgender women and men. It violates the values and the laws of our great state. In my view, it is destructive to the progress we have made to provide equal rights and protections to our LGBT community.

Therefore, I direct that all state employees cease all nonessential state business travel to North Carolina until further notice. The Department of Management and Budget will provide additional guidance.

This policy permits state-funded travel to North Carolina if it is necessary to protect the safety or other essential interests of our citizens. Please notify your agency’s Human Resources Office, in advance of any essential travel to North Carolina while this restriction is in place.

Thank you for your understanding and support.

Sincerely,

Mark Dayton
Governor
Date: April 6, 2016

To: Agency Heads, Agency Chief Financial Officers, and Agency Human Resources Directors

From: Myron Frans, Commissioner

Subject: Nonessential state employee travel to Mississippi prohibited until further notice

Governor Dayton has directed all state employees to stop all nonessential travel to Mississippi for state business until further notice. Nonessential state employee travel to North Carolina was prohibited on April 2. Attached is a copy of the Governor’s letter on April 2 regarding North Carolina travel restrictions.

For essential travel, employees should direct their travel requests to their agency human resources office. Factors that agencies should consider in determining whether travel is essential include:

- Is travel necessary for the enforcement of Minnesota law?
- Is travel necessary to meet the state’s contractual or other legal obligations?
- Is travel necessary for the protection of public health, welfare, and/or safety?

For nonessential travel that was arranged prior to the travel restriction, agencies may allow the travel if the state will incur significant costs or penalties if the travel is cancelled.

If you would like assistance in evaluating travel requests, please contact Deputy Commissioner Edwin Hudson at 651-201-8061.

cc: Edwin Hudson, Deputy Commissioner, MMB
Dear Colleagues:

FSMB Needs YOUR Leadership Skills.

One of the most rewarding experiences for members of state medical and osteopathic boards is the opportunity to serve on FSMB’s Board of Directors or its Nominating Committee, helping guide our organization’s vision and mission. Each year, FSMB’s Nominating Committee seeks capable and committed individuals for consideration as candidates, and we would like to hear from you.

Service in a leadership position brings many benefits, notably the opportunity to make a real impact in the direction and policy of a national organization with a vital role in health care.

Nominations by FSMB Member Medical Boards are open starting today and will close on December 29, 2017. Elections will be held at the FSMB’s April 28, 2018 House of Delegates annual business meeting. Details regarding the nomination process and eligibility requirements are attached.

We encourage you to make national service a part of your experience as an FSMB Fellow.

Sincerely yours,

Humayun J. Chaudhry, D.O., M.S., MACP, MACOI
President and Chief Executive Officer

Federation of State Medical Boards
1300 Connecticut Avenue NW | Suite 500 | Washington, DC 20036

400 Fuller Wiser Road | Suite 300 | Euless, Texas 76039

www.fsmb.org

Executive Administrative Associate: Sandy McAllister
DATE: September 12, 2017

TO: Member Medical Board Executive Directors/Secretaries and Current Board Members

FROM: Nominating Committee Chair Arthur S. Hengerer, MD, FACS
Nominating Committee Members Howard J. Falgout, MD, Jone Geimer-Flanders, DO, Marilyn J. Heine, MD, Stuart F. Mackler, MD, W. Michelle Terry, MD, and Carmela Torrelli, BBA

RE: FIRST Call for Nominations of Candidates for Elected Office

Nominations of Candidates for Elected Office

Arthur S. Hengerer, MD, FACS, Chair of the FSMB’s Nominating Committee, requests that FSMB Member Medical Boards submit names of individuals for the Nominating Committee to consider as candidates for elected office. Elections will be held at the FSMB’s April 28, 2018 House of Delegates annual business meeting. Nominees may include physicians as well as non-physicians who are Fellows of the FSMB. The FSMB Bylaws state: 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 months thereafter. Instructions for nominating candidates, including eligibility requirements, additional position-specific qualifications, and responsibilities of elected positions, are attached for your information. Please refer to this information when submitting your letters of nomination for consideration by the Nominating Committee.

Under the FSMB Bylaws, the Nominating Committee shall submit a roster of one or more candidates for each position. Nomination by the Nominating Committee or Nomination by Petition 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. Positions to be filled in 2018 are as follows:

- Chair-elect 1 Fellow, to be elected for 3 years: one year as chair-elect; one year as chair; and one year as immediate past chair
- Treasurer 1 Fellow, to be elected for a three-year term
- Board of Directors 3 Fellows, each to be elected for a three-year term**/
- Nominating Committee 3 Fellows, each to be elected for a two-year term***/****

The Nominating Committee requests that all nominations be submitted by December 29, 2017. No nominations will be accepted after end of business on Friday, December 29.

*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.” The term of one of the two current public/consumer members of the FSMB Board of Directors will expire in April 2018; therefore, the House of Delegates will be required to elect at least one non-physician or public/consumer member in April 2018.
**Should a current board member whose term does not expire until 2019 or 2020 be elected Chair-elect or Treasurer, then an additional candidate(s) will need to be elected to fill the remainder of that board member’s term.

***In accordance with the FSMB Bylaws, “At least one elected member of the Nominating Committee shall be a public member.” The Nominating Committee currently has one public member and the term of that public member will expire in 2018; therefore, the House of Delegates will be required to elect at least one public member in 2018.

****No two Nominating Committee members shall be from the same member board. Continuing members of the Committee will be from Alabama, Pennsylvania Medical and Washington Medical.

INSTRUCTIONS FOR NOMINATIONS OF CANDIDATES FOR FSMB ELECTED OFFICE

Eligibility

Any person who is or will be a Fellow of the FSMB at the time of the election on April 28, 2018 is eligible for nomination. The Bylaws of the FSMB define Fellows as: An individual member who as a result of appointment or confirmation is designated to be 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 months thereafter.

Core Competencies of Candidates

A candidate for elected office must:

➤ Have a clear understanding of (and enthusiastically support) the vision, mission and strategic goals of the FSMB;
➤ Possess a positive outlook on the role and function of state medical boards in the medical regulatory field;
➤ Bring a broad, national perspective to specific issues;
➤ Have adequate time and commitment necessary to fulfill the responsibilities of the office (please see “Responsibilities of Elected Positions” – pages 4-6); and,
➤ Demonstrate professionalism, personal integrity, and the ability to work effectively with others.

Additional qualifications are suggested but not mandatory by the time an individual is nominated for the following positions:

Chair-elect of the Board of Directors: One or more years’ experience on the FSMB Board of Directors and, if applicable, a commitment of time that may require reduction by one-third or more of patient care duties in medical practice.

Board of Directors and Nominating Committee: 1) One or more years on a State Medical or Osteopathic Board; 2) FSMB Committee or Task Force participation; and 3) prior attendance of at least one FSMB Annual Meeting.

Board of Directors: Significant experience on a non-profit Board of Directors or Foundation may be considered an equivalent for one of the recommendations stated above.

Letter of Nomination - Contents

The letter of nomination must come from the candidate’s state medical or osteopathic board to the Nominating Committee and should specify: (1) the name of the candidate to be considered; (2) the office for which the candidate is being recommended; (3) a description of the candidate’s ability to demonstrate the core competencies and/or additional position-specific qualifications stated above; (4) the candidate’s agreement to the submission of his/her name for potential nomination; (5) the candidate’s affirmation that he/she is aware of the time commitment required
for the position to which he/she may be elected; and (6) the candidate’s mailing address, daytime telephone number, fax number and email address.

**Attachments to State Medical Board’s Letter of Nomination**

The following materials should accompany the letter of nomination:

1. **Candidate’s photograph — color (jpg).** Copies of the photo will be included in the Nominating Committee meeting agenda book. If the candidate is selected, the photo will also be used in the Election Manual that is distributed at the Annual Meeting and placed on the Candidates Website. **Questions regarding photos should be directed to David Hooper, Sr. Director of Marketing, at 817-868-4070 or dhooper@fsmb.org.**

2. **Candidate’s Signatory Form (separate attachment).** The candidate **must submit a signed** confirmation that the candidate: 1) will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 28, 2018; 2) is aware of the time commitment required for the position to which he/she may be elected; and 3) is disclosing any potential conflict(s) of interest.

3. **Candidate’s Personal Statement in WORD version (sample on page 7) — (500 word limit).** The candidate should state why he/she wants to serve in the particular position for which he/she will be campaigning for election; how he/she fulfills the core competencies and/or additional position-specific qualifications of candidates, and what he/she will contribute to FSMB. The personal statement will be included in the Election Manual and placed on the Candidates Website.

4. **Electronic copy of the candidate’s curriculum vitae (CV) (maximum five (5) pages) and/or a one-page CV summary-bio.** The CV/bio should include the following relevant information:
   - **Education:** Undergraduate; Graduate/Medical School; Postgraduate; Area of Specialization
   - **Current Position**
   - **FSMB Activities:** Board of Directors; Committees, Workgroups, Advisory Panels, Task Forces; Other Activities
   - **Professional and/or Organizational Activities** (National, State or Local)
   - **Appointments, Honors and Awards**

Please note that **these documents will be PUBLISHED** on the Candidates Website; therefore, social security numbers and all other private information **must be removed** prior to submitting with the letter of nomination.

**Deadline for Submission of Letters and Materials**

The members of the Nominating Committee request that all nominations be submitted in writing by mail, fax or email to:

Arthur S. Hengerer, MD, FACS, Chair  
Nominating Committee  
c/o Pat McCarty, Director of Leadership Services  
Federation of State Medical Boards  
400 Fuller Wiser Road, Suite 300  
Euless, TX  76039-3855  
Fax: (817) 868-4167  
Email: pmccarty@fsmb.org

All letters of nomination and accompanying materials should be received at the Euless, TX office by end of business on **Friday, December 29, 2017. No nominations will be accepted after end of business December 29.**

A confirmation acknowledging receipt of nominations will be sent within one week. If you do not receive confirmation, please contact Pat McCarty at (817) 868-4067 or at the email above.
RESPONSIBILITIES OF ELECTED POSITIONS

Board of Directors

The FSMB Board of Directors is responsible for the control and administration of the FSMB and reports to the House of Delegates; the Board provides leadership in the development and implementation of the FSMB's Strategic Goals and the Board's Annual Action Plan; the Board is responsible for governing and conducting the business of the corporation, including supervising the President/CEO; and, under the leadership of the Chair and President/CEO, represents the FSMB to other organizations and promotes recognition of the FSMB as the premier organization concerned with medical licensure and discipline. The Board of Directors is the fiscal agent of the corporation.

GENERAL RESPONSIBILITIES

The Board of Directors is responsible for the following:

1. Setting goals, objectives and priorities necessary to achieve the FSMB Strategic Goals.
2. Setting goals, objectives and critical success factors for the President/CEO.
3. Ensuring effective management of the FSMB's financial resources.
4. Approving systems for assessing and addressing needs of Member Boards.
5. Implementing adopted Board of Directors professional development and self-assessment plans.
6. Promoting use of FSMB services among targeted customer groups.
7. Enhancing communication with and among Member Boards.
8. Enhancing support and education for Member Board executives and their staff.

TIME COMMITMENT

Board Meetings

The Board of Directors will meet five times during the FY 2019 fiscal year:

April 29, 2018 – Charlotte, NC (immediately following the Annual Meeting)
July 2018 – Dates and Site TBD
October 2018 – Dates and Site TBD
February 2019 – Dates and Site TBD
April 23-28, 2019 – Fort Worth, TX (in conjunction with the Annual Meeting)

New Directors Orientation

Newly-elected directors will be asked to participate in the New Directors Orientation scheduled June 24-25, 2018 at the FSMB Euless, TX Office.

Board of Directors State Medical Board Liaison Program

A director's participation in the Board of Directors State Medical Board Liaison Program may involve telephone communications with Member Board leadership (dependent upon the leadership's
availability) and/or travel to a Member Board location (i.e., “site visit”) in partnership with FSMB staff to meet with the Member Board representatives. New Directors may be asked to participate in one or two site visits during their first year on the Board of Directors, schedule permitting.

**Subcommittees of the Board of Directors**

All directors will be appointed to one subcommittee of the Board of Directors, which include the Awards, Governance and Planning Committees. Additionally, two directors will be elected by the Board to participate on the Executive, Compensation and Investment Committees with the officers of the Board.

**Nominating Committee**

**COMMITTEE CHARGE**

The charge of the Nominating Committee as currently set forth in the FSMB Bylaws is to submit a roster of one or more nominees for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates. The Committee will mail its roster of candidates to Member Boards not fewer than 60 days prior to the meeting of the House of Delegates.

Tasks of the Committee include:

1. Soliciting recommendations for candidates for elected positions from Member Board Executive Directors/Secretaries and active Fellows of the FSMB.
2. Assertively recruiting individuals who have the core competencies set forth on page 2 and who represent diversified backgrounds, experiences and cultures.
3. Educating potential candidates on the core competencies for FSMB leadership roles and the responsibilities associated with respective leadership positions.
4. Reviewing letters of recommendation and supporting material of each individual nominated or recruited as a candidate for election.
5. Verifying that candidates have the core competencies for FSMB leadership positions.
6. Verifying that queries of the FSMB Physician Data Center have been completed on physician candidates and physician assistant candidates and that no board actions have been reported that could call into question an individual’s fitness for FSMB leadership.
7. Affirming that all candidates for elected leadership have disclosed any potential conflicts of interest.
8. Considering the importance of public representation on the FSMB Board of Directors and assuring the roster of candidates provides for election of adequate/qualified public representation.
9. Selecting and narrowing the roster of candidates to those who best demonstrate the core competencies outlined, have the necessary qualifications and eligibility for a position, and bring valuable talents and perspectives to the FSMB.
10. Preparing a report to the House of Delegates, which includes a roster of nominees for positions to be filled by election at the House of Delegates annual business meeting.
11. Determining process for notifying candidates of the Nominating Committee’s decisions as soon as possible following the Committee’s winter meeting and providing the Nominating Committee report to the FSMB Board of Directors.
TIME COMMITMENT

Members of the Nominating Committee serve a single two-year term. The Committee will have a kick-off breakfast in Charlotte, NC on the morning of Sunday, April 29, 2018 immediately following the FSMB’s Annual Meeting. The Committee will meet again via teleconference in July or August 2018 and March 2019 (dates TBD) as well as in person (location TBD) in January 2019. In preparation for the January meeting, the Committee members will each interview three to five nominees. Members of the Committee will also receive scholarships to attend the FSMB’s 2019 Annual Meeting in Fort Worth, TX, so they can be onsite to solicit membership interest in elected and appointed positions.
SAMPLE PERSONAL STATEMENT [500 words or less]
*Please provide this document in WORD format*

NAME: ___________________________

CANDIDATE FOR: [Chair-elect, Treasurer, Board of Directors or Nominating Committee]

[SAMPLE TEXT – please describe your own experiences using your own words]

I am a candidate for [elected office]. Since beginning my medical career in a small rural town over 20 years ago, I have been involved in professionalism and upholding the higher standards of being a physician. Currently, I am the Chairman of the Department of [specialty] at the School of Medicine in [city].

My experiences with medical licensure began in 2005 when I was appointed to the advisory committee for athletic trainers of the [state medical or osteopathic board]. Subsequently, I was appointed as a member of the [state medical or osteopathic board] in 2015. I was elected Vice President in 2016 and have been serving as President since January 2017.

Since being appointed to the [state medical board], I have been serving the [state medical board] in a number of capacities, which have included [committee/workgroups, etc.].

Additionally, I have worked as [other professional experiences and associations].

It is with great anticipation that I am running for [elected office]. I have the energy, enthusiasm and experience to represent the FSMB. My qualifications are broad and strong, which will allow me to function well within a system that is focused on licensure, discipline and protection of the public.
STATE MEDICAL BOARD ACTIVITIES

On which state medical or osteopathic board are you currently serving?

If not serving, when did you leave the board?  Month:  Day:  Year:

How long have you served (did you serve) on your state medical or osteopathic board?

- I will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 28, 2018 and understand that only an individual who is a Fellow at the time of the individual's election shall be eligible for election. The Bylaws of the FSMB defines Fellow as:

  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 months thereafter.

- I am aware of the time commitment for the position I wish to be elected.

- I am disclosing any potential conflict(s) of interest.

SIGNATURE: __________________________

Potential Conflict(s) of Interest:
July 21, 2017

Dear Member Board Presidents/Chairs and Executive Directors,

The FSMB Bylaws Committee will meet on September 27-28 in Washington, D.C. to consider requests for amendments to the FSMB Bylaws. Bylaws Article XIV, Section A states:

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.

The deadline for submission of proposed changes is September 18, 2017. A copy of the Bylaws as amended by the 2017 House of Delegates is attached for your review.

Please submit your recommendations by mail, fax or email to:

    Bylaws Committee
    c/o Humayun J. Chaudhry, DO, MACP, President and CEO
    Secretary, Board of Directors
    Federation of State Medical Boards
    400 Fuller Wiser Road, Suite 300
    Euless, TX 76039-3855

The receipt of all recommendations will be confirmed within one week.

Sincerely yours,

Humayun J. Chaudhry, D.O., M.S., MACP, MACOI
President and Chief Executive Officer

Federation of State Medical Boards
July 21, 2017

Dear Member Board Presidents/Chairs and Executive Directors,

The FSMB Bylaws Committee will meet on September 27-28 in Washington, D.C. to consider requests for amendments to the FSMB Bylaws. Bylaws Article XIV, Section A states:

*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.*

The deadline for submission of proposed changes is **September 18, 2017**. A copy of the Bylaws as amended by the 2017 House of Delegates is attached for your review.

Please submit your recommendations by mail, fax or email to:

**Bylaws Committee**
c/o Humayun J. Chaudhry, DO, MACP, President and CEO  
Secretary, Board of Directors  
Federation of State Medical Boards  
400 Fuller Wiser Road, Suite 300  
Euless, TX 76039-3855

The receipt of all recommendations will be confirmed within one week.

Sincerely yours,

Humayun J. Chaudhry, D.O., M.S., MACP, MACOI  
President and Chief Executive Officer

**Federation of State Medical Boards**  
1300 Connecticut Avenue NW | Suite 500 | Washington, DC 20036  
202-463-4007 direct | 817-868-8888 fax  
400 Fuller Wiser Road | Suite 300 | Euless, Texas 76039

Executive Administrative Associate: Sandy McAllister
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 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.

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 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. 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 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 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 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. 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 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 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
DATE: September 23, 2017
SUBJECT: Executive Director’s Report

SUBMITTED BY: Ruth M. Martinez, M.A., Executive Director

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:
For information only.

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

BACKGROUND:
Attached is the Executive Director’s Report of activities since the last board meeting.
Engagement in Opioid Initiatives

Dose of Reality Campaign and Website:
At the July 8, 2017 Board meeting, the Board voted to support Attorney General Lori Swanson’s Dose of Reality Campaign and website. The Board is now listed on the website as a supporter. Please see the attachment. The Attorney General’s Office thanks the Board for its support.

Minnesota Department of Health Opioid Dashboard
On September 7, 2017, the Minnesota Department of Health (MDH) held a press conference to launch its Opioid Dashboard and to release 2016 drug overdose data. MDH Commissioner Dr. Ed Ehlinger and others addressed the audience and provided a demonstration of the Opioid Dashboard. A link to the Opioid Dashboard is posted on the Board’s website.

The dashboard may also be accessed at:
http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/

Meetings with the Attorney General’s Office
On July 21, 2017, staff of the Board’s of Medical Practice and Nursing met with representatives from the Attorney General’s Office to discuss data exchanges and investigative procedures related to opioid prescribing by physicians, physician assistants and advanced practice registered nurses. The Attorney General’s Office will begin to provide reports from the Hennepin County Coroner regarding opioid related deaths. The Boards and the Attorney General’s Health Occupations Division will continue to work closely to expeditiously process complaints involving allegations of inappropriate prescribing of opioid medications. The Attorney General’s Office has also offered to meet with staff of the Boards to educate and facilitate interpretation of prescription monitoring program data gathered in a complaint investigation.

IMPLEMENTATION OF CRIMINAL BACKGROUND CHECKS FOR NEW APPLICANTS
Board and MNiT staff have initiated the process for implementing criminal background checks for initial applicants for licensure. The Board has participated in meetings with other Health Licensing Boards (HLBs) and with the Health Licensing Board Criminal Background Check Program Director, Juanita Borton, to develop the process for implementation. Staff who will handle criminal history record information (CHRI) received from the Program have been fingerprinted and undergone a criminal background check, as required.

INTERSTATE MEDICAL LICENSURE COMPACT (IMLC) Update
The IMLC Commission (IMLCC) held a teleconference on September 13, 2017 to initiate further rulemaking. A public hearing on proposed rules will be held by teleconference on October 5, 2017. Comments may be submitted through October 13, 2017. The IMLCC will convene by teleconference to act on the proposed rules on October 17, 2017.

At the teleconference on September 13, 2017, IMLCC Chair Jon Thomas, MD, announced that the IMLCC has hired an Executive Director, Marshall Smith. Mr. Smith will be introduced to the IMLCC at its meeting in Phoenix, Arizona, on November 17, 2017.

Board staff continue to participate in monthly updates, debriefings and training sessions, held via teleconference and webinar.

Please refer to the IMLC website, the Board website or the license portability website for meeting agendas and minutes, committee reports, Bylaws and Rules, and other relevant information.

https://imlcc.org/
PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) MN UPDATE
The MMA provided an update on the POLST, endorsed by the Board of Medical Practice. Please see the attachment.

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

Meeting with Senator Jim Abeler, Anoka, Minnesota, July 11, 2017

Meeting with Representative of the Minnesota Medical Association, July 14, 2017

Meeting with Representative of the Minnesota Hospital Association, July 24, 2017

Meetings with Representatives of the Minnesota Drug Enforcement Administration (DEA)
On July 27 and September 14, 2017, representatives from the Minnesota DEA met with Board staff to discuss interactions between the Board and the DEA, exchange of data, and issues of mutual concern regarding controlled substance prescribing.

Center for Personalized Education for Physicians (CPEP) Visit, July 13, 2017
Bill O’Neill presented to Board members, staff and Attorney General’s staff on CPEP’s practice skills assessment and educational programming. He invited Board members to attend a CPEP Learning Summit to personally experience the assessment components.

Interstate Collaboration in Healthcare Conference Call, August 4, 2017
Stakeholders convened by teleconference and expressed support for the Interstate Medical Licensure Compact states experiencing challenges in securing FBI approval to receive criminal background check data.

Professional Firms: Information Sharing and Listening Session, August 8, 2017
Representatives from the Attorney General’s Office met with Board Executive Directors and staff to hear questions regarding application of the Professional Firms Act, chapter 319B of Minnesota statutes.

Meeting with Representative of the Legislative Revisor’s Office, August 15, 2017
Board staff met with the Revisor’s office to discuss potential legislation, the process for repealing sections of statutes and rules, and to seek guidance on making legislative changes during the 2018 session.

Minnesota Medical Association (MMA) Annual Meeting: September 23, 2017, Rochester, Minnesota
Board staff will attend the MMA Annual Meeting in Rochester and distribute information at the Board’s exhibit table.

Presentation to Legislative Staff, rescheduled from September 28 to October 18, 2017
The HLBs have been invited to provide an overview of the roles and responsibilities of health licensing boards to Minnesota Senate and House staff. Ruth Martinez from the Board of Medical Practice and Shirley Brekken from the Board of Nursing will present.

State Opioid Oversight Project (SOOP) Planning Retreats, October 2 and November 13, 2017
Strategic planning for future SOOP initiatives will be discussed and developed and two upcoming retreats in October and November.

Health Licensing Board executive directors continue to collaborate on:
- Upcoming legislative initiatives
Policy issues
Technology projects
Health Professional Services Program participation agreement/forms and renewal questions related to illness on Board renewal application forms

**ALIMS DATABASE UPDATE PROJECT**
A kick-off meeting for a multi-year project to update databases for the Boards of Medical Practice and Behavioral Health and Therapy was held on July 19, 2017. Participants included staff of the Boards, the ALIMS project manager, vendor representatives and MNiT system administrator for the Board. Regular meetings will be held as the project advances.

**Other Activities**

**Furniture Installation**
The Board utilized funds at the end of the biennium to purchase new furniture for some offices and to replace file cabinets. The installation was completed on September 12 – 13, 2017. The new furniture and storage units significantly improve storage space and efficiency.

**AV Installation**
An updated audio-visual recording system has been installed in the Board’s conference room.

**Other Business**
SUPPORTING AGENCIES

The following agencies support the message of DOSE OF REALITY and its goal of promoting proper use, storage, and disposal of prescription painkillers.
To: POLST MN Stakeholders

The purpose of this email is to provide a brief update on recent POLST MN activities.

1. **POLST MN Steering Committee.** Please note that the next meeting of the Steering Committee has been rescheduled from September 19 to **Tuesday, October 3, 6:00-8:00 pm** at the MMA. **Please reply to this email to confirm your ability to attend** – in person or via phone/webinar.

2. **Recap of June 27 POLST MN Steering Committee Meeting.** There was strong attendance at the June Steering Committee meeting. Highlights of the meeting are as follows:
   - POLST MN program updates were shared, including results of the stakeholder interest inventory, database updates, website updates, a new program logo, and new participants.
   - POLST MN leadership and staff met with leadership of the Benedictine Health System (BHS) to discuss the revised POLST MN form. The BHS leadership expressed interest in exploring a transition from the BHS-designed form to the new form. They also offered to help connect POLST MN leadership with MN Catholic Conference leadership to discuss the revised POLST form.
   - Dr. Rubins provided a brief demonstration of a form-fillable version of the POLST MN form that he developed. That version will be added to the POLST MN website soon.
   - There was a discussion about whether we should work to establish guidelines/standards for use of the POLST MN form. Some examples of customized versions of the POLST form were shared (e.g., organizations adding logos, bar codes, changing the layout). There was strong agreement among the Steering Committee that ideally there should be no changes to the POLST MN form in order to achieve as much uniformity across the state as possible. **Further consideration of this issue is currently underway and additional updates will be provided soon.**
   - A handful of minor changes/formatting adjustments to the form were discussed and supported. A slightly revised version of the form will be completed soon and additional updates will be forthcoming; in the meantime, note that prior versions of the form remain valid.
   - An education subcommittee was authorized to develop high-priority educational resources. The subcommittee held their first meeting on August 10 and expects to have resources available soon. **Stay tuned for updates on these resources.**
   - A handful of Steering Committee members agreed to explore potential grant funding from the state nursing home fines fund; this may be a source of funding to support development and/or dissemination of some targeted educational resources.
   - As a reminder, the MMA, the Board of Medical Practice, and the Emergency Medical Services Regulatory Board (EMSRB) have all endorsed the revised POLST MN form. Other potential endorsements were discussed, including MNA and the MN Nursing Home Social Workers Association.

3. **POLST MN Information & Resources.** Thank you to all POLST MN stakeholders for your support of POLST MN and for your work in helping to disseminate information and resources. To ensure accurate and consistent information, we would urge everyone that maintains POLST information on your website to **be sure to link directly to the POLST MN website**, rather than posting content separately. Some customized information or education is expected, but please do not generate content on behalf of POLST MN without permission or post the form directly on your website. The best way to make sure that POLST MN information is accurate and consistently
available is through our single program website. In addition, consistent information and uniformity of content is an important attribute of our program as we work to make progress toward national endorsement.

Please feel free to contact me with any questions or concerns. Enjoy the remaining weeks of summer!

Thanks,
Janet

Janet Silversmith | Director of Health Policy & Member Services
Minnesota Medical Association
REQUESTED ACTION:
For information only.

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

BACKGROUND:
The Executive Director’s Performance Evaluation was completed on August 31, 2017, and will be presented in Executive Session.
DATE: September 23, 2017            SUBJECT: Appointment of a Nominating Committee

SUBMITTED BY: Gerald T. Kaplan, M.A., L.P., Board President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The Board is asked to approve appointment of the following Board members to the Nominating Committee, as recommended by Board President Gerald T. Kaplan, MA, LP:

♦ Christopher Burkle, M.D., J.D., FCLM
♦ Jon V. Thomas, M.D., M.B.A.
♦ Gerald T. Kaplan, M.A., L.P.

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

BACKGROUND:

Election of Board Officers for the Year 2018 will take place at the regularly scheduled meeting of the Board on November 11, 2017.

It is customary for the current Board President to suggest appointments to the Nominating Committee for approval by the full Board.

The composition of the Nominating Committee has, historically, been two physicians and one public member, with one member near the end of Board service, one member near the beginning of Board service and one member as an out-going Board President.
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Check your calendars for the 2018 Board meetings.

MOTION BY:_____________________SECOND:______________________________
(  )   PASSED      (  )   PASSED AMENDED     (  )   LAYED OVER     (  )   DEFEATED

BACKGROUND:

The following dates are anticipated for Board meetings during calendar year 2018.

Please check your calendar, set aside these dates and, if there are conflicts, we will discuss and finalize at the November Board meeting.

REGULAR BOARD MEETINGS

January 13
March 10
May 12
July 14
September 8
November 10

CONTESTED CASE DATES

February 10
April 14
June 9
August 11
October 13
December 8
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.
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

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

BACKGROUND:

For your information only, attached are copies of Corrective or other Actions that were implemented between July 1, 2017, and September 11, 2017.
BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Kathryn V. Dobbs, M.D.
Year of Birth: 1972
License Number: 54,965

ORDER OF SUSPENSION

1. The Minnesota Board of Medical Practice ("Board") is authorized pursuant to Minn. Stat. §§ 147.001 through 147.381 (2016) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. §§ 214.10 and 214.103 (2016) to review complaints against physicians, to investigate such complaints, and to initiate appropriate disciplinary action.

2. Kathryn V. Dobbs, M.D. ("Respondent") has been and now is subject to the jurisdiction of the Board from which she holds a license to practice medicine and surgery in the State of Minnesota.

3. Pursuant to Minn. Stat. § 270C.72, subd. 1 (2016), the license of a physician must be revoked if the licensee owes the State delinquent taxes, penalties, or interest, and the Minnesota Commissioner of Revenue so notifies the Board.

4. On June 2, 2017, the Board received a Notice of License Revocation from the Minnesota Department of Revenue, which advised the Board of Respondent's outstanding tax liability, and under Minn. Stat. §§ 270C.72 and/or 16D.08, subd. 2 (2016), the Board must revoke Respondent's license to practice medicine and surgery in the State of Minnesota. The Department of Revenue has informed the Board that, for purposes of Minn. Stat. § 270C.72
(2016), the Department of Revenue deems the term “revoke” to mean that the taxpayer's license will be suspended until the tax obligation has been satisfied and the tax clearance certificate has been issued.

5. The authority to sign orders suspending licenses pursuant to Department of Revenue tax delinquency notices has been delegated to the Executive Director of the Board.

ORDER

1. IT IS HEREBY ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota shall be SUSPENDED pursuant to Minn. Stat. § 270C.72, subd. 1 (2016), effective July 3, 2017. During the period of suspension, Respondent shall not engage in the practice of medicine, as defined by Minn. Stat. § 147.081 (2016), in the State of Minnesota.

2. IT IS FURTHER ORDERED that within ten days of the date of this Order, Respondent shall provide the Board with a list of all hospitals and skilled nursing facilities at which Respondent currently has medical privileges, a list of all states in which Respondent is licensed or has applied for licensure, and the addresses and telephone numbers of Respondent's residences and all work sites. Within seven (7) days of any change, Respondent shall provide the Board with new address and telephone number information. The information shall be sent to Ruth M. Martinez, Minnesota Board of Medical Practice, University Park Plaza, 2829 University Avenue S.E., Suite 500, Minneapolis, Minnesota 55414-3246.
3. IT IS FURTHER ORDERED that Respondent's license shall be reinstated by the Board after Respondent has submitted to the Board a tax clearance certificate from the Minnesota Department of Revenue indicating that Respondent does not owe the State of Minnesota any uncontested delinquent taxes, penalties, or interest and has filed all required returns.

STATE OF MINNESOTA  
BOARD OF MEDICAL PRACTICE

Dated: July 3, 2017

RUTH M. MARTINEZ  
Executive Director
AFFIDAVIT OF SERVICE

Re: In the Matter of the Suspension of Kathryn V. Dobbs, M.D.
License No. 54,965

STATE OF MINNESOTA )
) ss.
COUNTY OF RAMSEY )

RACHAEL BERNARDINI, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on this 3rd day of
July, 2017, she caused to be served the attached ORDER OF SUSPENSION, by depositing in the
United States mail at said city and state, a true and correct copy thereof, properly enveloped,
with first-class postage prepaid, and addressed to:

Kathryn V. Dobbs, M.D.
P.O. Box 295
Park Rapids, MN 56470

Subscribed and sworn to before me
this 3rd day of July, 2017

NOTARY PUBLIC

JUDY R. SIGAL
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2020
In the Matter of the
Medical License of
Kathryn V. Dobbs, M.D.
Year of Birth: 1972
License Number: 54,965

ORDER FOR REINSTATEMENT

1. The Minnesota Board of Medical Practice ("Board") is authorized pursuant to
Minn. Stat. §§ 147.001 through 147.381 (2016) to license, regulate, and discipline persons who
apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and
is further authorized pursuant to Minn. Stat. §§ 214.10 and 214.103 (2016) to review complaints
against physicians, to investigate such complaints, and to initiate appropriate disciplinary action.

2. Kathryn V. Dobbs, M.D. ("Respondent") has been and now is subject to the
jurisdiction of the Board from which she holds a license to practice medicine and surgery in the
State of Minnesota.

3. Pursuant to Minn. Stat. § 270C.72, subd. 1 (2016), the license of a physician must
be revoked if the licensee owes the State delinquent taxes, penalties, or interest, and the Minnesota
Commissioner of Revenue so notifies the Board.

4. On June 2, 2017, the Board received a Notice of License Revocation from the
Minnesota Department of Revenue, which advised the Board of Respondent’s outstanding tax
liability, and under Minn. Stat. §§ 270C.72 and/or 16D.08, subd. 2 (2016), the Board must revoke
Respondent’s license to practice medicine and surgery in the State of Minnesota. The Department
of Revenue has informed the Board that, for purposes of Minn. Stat. § 270C.72 (2016), the
Department of Revenue deems the term “revoke” to mean that the taxpayer’s license will be suspended until the tax obligation has been satisfied and a tax clearance certificate has been issued.

5. On July 3, 2017, the Board issued an Order for Suspension and served it on Respondent, as required by Minn. Stat. §§ 270C.72 and/or 16D.08, subd. 2 (2016).

6. On July 6, 2017, the Board received notification from the Department of Revenue that Respondent had been issued a tax clearance certificate, effective July 6, 2017, under the authority of Minn. Stat. § 270C.72 (2016).

7. The authority to sign orders suspending licenses pursuant to Department of Revenue tax delinquency notices and reinstating licenses pursuant to Department of Revenue Clearance Certificates has been delegated by the Board to its Executive Director.

ORDER

IT IS HEREBY ORDERED that Respondent’s license to practice medicine and surgery in the State of Minnesota is REINSTATED, effective on July 6, 2017.

Dated: July 7, 2017

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE

RUTH M. MARTINEZ
Executive Director
AFFIDAVIT OF SERVICE BY U.S. MAIL & ELECTRONIC MAIL

Re: In the Matter of the Medical License of Kathryn V. Dobbs, M.D.
License No. 54,965

STATE OF MINNESOTA )
) ss.
COUNTY OF RAMSEY )

SANDRA D. HOWARD being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on July 7, 2017, she caused to be served the Order for Reinstatement via electronic mail at kdobbs200@yahoo.com and by depositing the same in the United States mail at said city and state, true and correct copy(ies) thereof, properly enveloped with prepaid first class postage, and addressed to:

PERSONAL AND CONFIDENTIAL

Kathryn V. Dobbs, M.D.
P.O. Box 295
Park Rapids, MN 56470

15970 Discovery Circle
Park Rapids, MN 56470

Subscribed and sworn to before me on July 7, 2017.

SANDRA D. HOWARD
NOTARY PUBLIC
DONNA M. ACKERMAN
NOTARY PUBLIC, MINNESOTA
My Commission Expires January 31, 2020
AGREEMENT FOR CORRECTIVE ACTION

This agreement is entered into by and between Glenn W. Vinton, R.T. ("Respondent"), and the Complaint Review Committee of the Minnesota Board of Medical Practice ("Committee") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (2016). Respondent has been advised by Board representatives that Respondent may choose to be represented by legal counsel in this matter. Although aware of this opportunity, Respondent has elected not to be represented by counsel. The Board was represented by Deputy Attorney General Karen Olson, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101, (651) 296-7575.

Respondent and the Committee hereby agree as follows:

FACTS

1. This agreement is based upon the following facts:
   b. By letter dated July 1, 2016, Respondent was notified by Board staff that he was subject to a continuing education audit for the period of July 1, 2014 to June 30, 2016 and Respondent was asked to submit documentation of the required 24 contact hours by July 31, 2016. Respondent failed to respond.
c. Respondent was sent two subsequent letters on January 26, 2017 and February 9, 2017 requesting a response. Respondent submitted a written response to the Board on March 10, 2017. In his response, Respondent stated he was unable to find a hard copy confirmation of his continuing education hours for the reporting period.

2. On July 13, 2017, Respondent met with the Committee to discuss the information set forth in paragraph 1, above. Based on the discussion, the Committee views Respondent's conduct as inappropriate under Minn. Stat. §§ 147C.25, subd. 1 (failure to complete continuing education), 147C.30, and 147.091, subd. 1 (a) (failure to satisfy the requirements for a license) and (u) (failure to cooperate with an investigation of the Board) (2016), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action under these statutes.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraph 1 by taking the following corrective action:

a. By June 30, 2018, Respondent shall provide the Committee proof of 48 contact hours of continuing education credits. Respondent may provide the Committee proof of up to 24 contact hours of continuing education for the dates of July 1, 2014, through June 30, 2016. The contact hours must be from programs that are approved as required by Minn. Stat. § 147C.25 (2016).

4. The agreement shall become effective upon execution by the Committee and shall remain in effect until Respondent successfully completes the terms of the agreement. Successful completion shall be determined by the Committee. Upon Respondent's signature and the Committee's execution of the Agreement for Corrective Action, the Committee agrees to close
the complaint resulting in the information referred to in paragraph 1. Respondent understands and further agrees that if, after the matter has been closed, the Committee receives additional complaints similar to the information in paragraph 1, the Committee may reopen the closed complaint.

5. If Respondent fails to complete the corrective action satisfactorily or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the Committee may, in its discretion, reopen the investigation and proceed according to Minn. Stat. Chs. 147, 147C, 214, and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minn. Stat. § 147.131. In any subsequent proceeding, the Committee may use as proof of the allegations of paragraphs 1 and 2 Respondent's agreements herein.

6. Respondent understands that this agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this agreement and any letter of satisfaction are classified as public data.

7. Respondent hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

Dated: 8-3-2017

GLENN W. VINTON, R.T.
Respondent

Dated: 8/9/2017

FOR THE COMMITTEE
AFFIDAVIT OF SERVICE BY U.S. MAIL

Re: In the Matter of the Respiratory Therapy License of Glenn W. Vinton, R.T. License No. 1,749

STATE OF MINNESOTA  )
                  ) ss.
COUNTY OF RAMSEY  )

ANGELA BRINDAMOUR, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on August 10, 2017, she caused to be served the attached AGREEMENT FOR CORRECTIVE ACTION, by depositing the same in the United States mail at said city and state, a true and correct copy thereof, properly enveloped with prepaid first class postage, and addressed to:

PERSONAL & CONFIDENTIAL

Glenn W. Vinton, R.T.
376 East Broadway Street
Winona, MN 55987

Subscribed and sworn to before me on August 10, 2017.

NOTARY PUBLIC
This Agreement for Corrective Action ("Agreement") is entered into by and between Taryn M. McEvoy, M.D. ("Respondent"), and the Complaint Review Committee of the Minnesota Board of Medical Practice ("Committee") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (2016). Respondent has been advised by Board representatives that Respondent may choose to be represented by legal counsel in this matter. Respondent has chosen to be represented by Richard Thomas, Burke & Thomas, PLLP, 3900 Northwoods Drive, Suite 200, Arden Hills, MN 55112, (651) 789-2208. The Board was represented by Deputy Attorney General, Karen Olson, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101, (651) 296-7575. Respondent and the Committee hereby agree as follows:

FACTS

1. This agreement is based upon the following facts:
   a. Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on May 9, 2009. Respondent is board-certified in obstetrics and gynecology.
   b. In February 2017, the Board received a complaint alleging that Respondent failed to evaluate a patient’s breast lump which resulted in a seven-month delay in the patient commencing treatment for breast cancer. The Board initiated an investigation of
Respondent’s care of the patient, which revealed concerns regarding Respondent’s care of the patient, including evaluation of the patient’s concerns, documentation, and follow-up with the patient.

2. On August 17, 2017, Respondent met with the Committee to discuss the information set forth in paragraph 1, above. Based on the discussion, the Committee views Respondent’s conduct as inappropriate under Laws of Minnesota 2017, Chapter 56, Sec. 3, subd. 1(g)(3) (disregard for the health or welfare of a patient), (k) (failure to conform to the minimal standards of acceptable and prevailing medical practice) and (o) (failure to maintain adequate medical records), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action under these statutes.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraph 1 by taking the following corrective action:

a. Respondent shall successfully complete a medical records management course, approved in advance by the Committee or its designee, within six months of the date of this Agreement.

b. Following the successful completion of the preapproved course and within six months of the date of this Agreement, Respondent shall write a paper for Committee approval detailing what Respondent has learned from the coursework, the importance of medical record keeping, how medical records can help her with patient follow-up, and how a similar situation will not occur again.

4. The agreement shall become effective upon execution by the Committee and shall remain in effect until Respondent successfully completes the terms of the agreement. Successful
completion shall be determined by the Committee. Upon Respondent's signature and the Committee's execution of the Agreement, the Committee agrees to close the complaint(s) resulting in the information referred to in paragraph 1. Respondent understands and further agrees that if, after the matter has been closed, the Committee receives additional complaints similar to the information in paragraph 1, the Committee may reopen the closed complaint(s).

5. If Respondent fails to complete the corrective action satisfactorily or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the Committee may, in its discretion, reopen the investigation and proceed according to Minn. Stat. chs. 147, 214, and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minnesota Statutes section 147.131. In any subsequent proceeding, the Committee may use as proof of the allegations of paragraphs 1 and 2 Respondent's agreements herein.

6. Respondent understands that this agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this agreement and any letter of satisfaction are classified as public data.

7. Respondent hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

Dated: 8/25/17

Taryn M. McEvoy, M.D.
Respondent

Dated: 9/1/17

[Signature]
FOR THE COMMITTEE
AFFIDAVIT OF SERVICE BY U.S. MAIL

Re: In the Matter of the Medical License of Taryn M. McEvoy, M.D.
License No. 51,755

STATE OF MINNESOTA )
COUNTY OF RAMSEY ) ss.

ANGELA BRINDAMOUR, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on September 5, 2017, she caused to be served the attached AGREEMENT FOR CORRECTIVE ACTION, by depositing the same in the United States mail at said city and state, a true and correct copy thereof, properly enveloped with prepaid first class postage, and addressed to:

CONFIDENTIAL

Richard J. Thomas, Esq.
Burke & Thomas, PLLP
3900 Northwoods Drive, Suite 200
St. Paul, MN 55112

Subscribed and sworn to before me on September 5, 2017.

NOTARY PUBLIC

RACHEL A TESS
COMM. #20395724
Notary Public
State of Minnesota
My Commission Expires 1/31/2019
This agreement is entered into by and between Mekonnen G. Kifle, R.T. ("Respondent"), and the Complaint Review Committee of the Minnesota Board of Medical Practice ("Committee") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (2016). Respondent has been advised by Board representatives that Respondent may choose to be represented by legal counsel in this matter. Although aware of this opportunity, Respondent has elected not to be represented by counsel. The Board was represented by Deputy Attorney General, Karen Olson, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101, (651) 296-7575.

Respondent and the Committee hereby agree as follows:

FACTS

1. This agreement is based upon the following facts:
   a. The Board accepted Respondent’s credentials to practice as a respiratory therapist in the State of Minnesota on September 12, 2009.
   
   b. By letter dated June 29, 2016, Respondent was notified by Board staff that he was subject to a continuing education audit for the period of July 1, 2014 to June 30, 2016. Respondent failed to respond.

   c. Respondent was sent two subsequent letters on January 25, 2017 and March 16, 2017 requesting a response. Respondent submitted a written response to the Board on
May 4, 2017. In his response, Respondent provided proof of 12 continuing education hours for
the audit time period. Respondent was unable to provide proof of the additional 12 continuing
education hours required to be completed during the reporting period.

2. On August 17, 2017, Respondent met with the Committee to discuss the
information set forth in paragraph 1, above. Based on the discussion, the Committee views
Respondent's conduct as inappropriate under Minn. Stat. §§ 147C.25, subd. 1 (failure to
complete continuing education), 147C.30, and 147.091, subd. 1 (a) (failure to satisfy the
requirements for a license) and (u) (failure to cooperate with an investigation of the Board)
(2016), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law
and fact to justify corrective action under these statutes.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraph 1 by taking
the following corrective action:

   a. By June 30, 2018, Respondent shall provide the Committee proof of
   36 contact hours of continuing education credits. The contact hours must be from programs that
   are approved as required by Minn. Stat. § 147C.25 (2016).

4. The agreement shall become effective upon execution by the Committee and shall
remain in effect until Respondent successfully completes the terms of the agreement. Successful
completion shall be determined by the Committee. Upon Respondent's signature and the
Committee's execution of the Agreement for Corrective Action, the Committee agrees to close
the complaint resulting in the information referred to in paragraph 1. Respondent understands
and further agrees that if, after the matter has been closed, the Committee receives additional
complaints similar to the information in paragraph 1, the Committee may reopen the closed complaint.

5. If Respondent fails to complete the corrective action satisfactorily or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the Committee may, in its discretion, reopen the investigation and proceed according to Minn. Stat. Chs. 147, 147C, 214, and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minn. Stat. § 147.131. In any subsequent proceeding, the Committee may use as proof of the allegations of paragraphs 1 and 2 Respondent's agreements herein.

6. Respondent understands that this agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this agreement and any letter of satisfaction are classified as public data.

7. Respondent hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

Dated: 09/05/17
MERONNEN G. KIFLE, R.T.
Respondent

Dated: 09/11/2017
FOR THE COMMITTEE
AFFIDAVIT OF SERVICE BY U.S. MAIL

Re: In the Matter of the Respiratory Therapy License of
Mekonnen G. Kifle, R.T.
License No. 3,579

STATE OF MINNESOTA  )
) ss.
COUNTY OF RAMSEY  )

ANGELA BRINDAMOUR, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on September 12, 2017, she caused to be served the attached AGREEMENT FOR CORRECTIVE ACTION, by depositing the same in the United States mail at said city and state, a true and correct copy thereof, properly enveloped with prepaid first class postage, and addressed to:

PERSONAL & CONFIDENTIAL

Mekonnen G. Kifle, R.T.
100 West 27th Street, #2B
Minneapolis, MN 55408

Subscribed and sworn to before me on September 12, 2017.

[Signature]
NOTARY PUBLIC

[Seal]