

**AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
BOARD MEETING THAT WILL BE HELD ON:
SEPTEMBER 10, 2016, 9:00 AM
AT:
DAN ABRAHAM HEALTH LIVING CENTER (DAHLC)
ROOM 6-101
565 1ST STREET SW
ROCHESTER, MN 55902
(612) 617-2130**

PUBLIC SESSION

President: Subbarao Inampudi, M.B., B.S., FACR

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MINNESOTA BOARD OF MEDICAL PRACTICE

ROLL CALL
September 10, 2016
BOARD MEETING

<u>NAME</u>	<u>CONGRESSIONAL DISTRICT</u>	<u>APPOINTMENT FROM</u>	<u>TO</u>
INAMPUDI, Subbarao, M.B., B.S., FACR (President)	3	4/27/09	1/17
KAPLAN, Gerald T., M.A., L.P. (Vice President)	3	3/29/11	1/19
JAFRI, Irshad H., M.B., B.S., FACP (Secretary)	2	10/15/12	1/19
BERGE, Keith H., M.D.	1	9/23/08	1/16
EGGEN, Mark A., M.D.	4	4/27/09	1/17
ELLA, V. John, J.D.	5	3/09/10	1/18
JOHNSON, Kelli, M.B.A.	4	3/09/10	1/18
LINDHOLM, Patricia J., M.D., FAAFP	7	10/30/13	1/16
RASMUSSEN, Allen G., M.A.	8	9/29/14	1/18
SPAULDING, Kimberly W., M.D., M.P.H.	6	6/06/16	1/20
STATTON, Maria K., M.D., Ph.D.	8	10/15/12	1/17
THOMAS, Jon V., M.D., M.B.A.	At large	3/09/10	1/18
TOWNLEY, Patrick R., M.D., J.D.	5	6/06/16	1/20
WILLETT, Joseph R., D.O., FACOI	7	3/29/11	1/19

DATE: September 10, 2016

SUBJECT: Approve the Minutes of the
July 9, 2016, Board Meeting

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

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the minutes of the July 9, 2016, Board Meeting as circulated.

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

BACKGROUND:

See attached Minutes.

**MINNESOTA BOARD OF MEDICAL PRACTICE
BOARD MEETING
2829 UNIVERSITY AVE. SE
MINNEAPOLIS, MN 55414-3246**

July 9, 2016

The Minnesota Board of Medical Practice met on July 9, 2016, at its offices in Minneapolis, Minnesota.

The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Subbarao Inampudi, M.B., B.S., FACR; Gerald T. Kaplan, M.A., L.P., Vice President; Irshad H. Jafri, M.B., B.S., FACP, Secretary; Mark A. Eggen, M.D.; V. John Ella, J.D.; Kelli Johnson, M.B.A.; Patricia J. Lindholm, M.D., FAAFP; Allen G. Rasmussen, M.A.; Kimberly W. Spaulding, M.D., M.P.H.; Maria K. Statton, M.D., Ph.D.; Jon V. Thomas, M.D., M.B.A.; Patrick R. Townley, M.D., J.D.; 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 Subbarao Inampudi, M.B., B.S., FACR. Roll call was taken by Board staff.

Agenda Item 2: Minutes of the May 14, 2016, Board Meeting

The minutes of the May 14, 2016, Board meeting were received and approved as circulated.

Dr. Inampudi introduced and welcomed new Board members Kimberly W. Spaulding, M.D., M.P.H., and Patrick R. Townley, M.D., J.D.

Dr. Spaulding has practiced family medicine with obstetrics from the St. Cloud Medical Group for the past 15 years. Dr. Spaulding received a BA in biology from St. Olaf College and a Master's of Public Health in Maternal and Child Health from the University of Minnesota School of Public Health. Dr. Spaulding completed medical school at the University of Minnesota – Minneapolis and residency at Park Nicollet/Methodist Hospital. Dr. Spaulding represents Congressional District Six and replaces Rebecca J. Hafner-Fogarty, M.D., M.B.A., on the Board.

Dr. Townley is an internal medicine physician and Medical Director at Axis Medical Center in Minneapolis. Dr. Townley completed his internal medicine training at the University of Chicago Hospitals and received his law and medicine degrees from the University of Minnesota. Dr. Townley represents Congressional District Five and replaces Charles F. Moldow, M.D., on the Board.

Agenda Item 3: Overview of Allied Health Professionals Presentation

Acupuncture Advisory Council Member (Gary) Steve Compton, L.AC, provided an overview of the acupuncture profession. A question and answer session followed. The Board gave a round of applause.

Naturopathic Doctor Advisory Council Chair Helen C. Healy Soley, N.D., provided an overview of the naturopathic doctor profession. A question and answer session followed. The Board gave a round of applause.

Michael Green, M.D., physician member and Chair of the Acupuncture Advisory Council and member of the Naturopathic Doctor Advisory Council, provided a summary of his background

and involvement in the Board's advisory councils. A question and answer session followed. Dr. Inampudi thanked Dr. Green for his service. The Board gave a round of applause.

Rebecca Ness, P.A., President of the Minnesota Academy of Physician Assistants provided an overview of the physician assistant profession. Leslie Milteer, P.A., immediate past President of the Minnesota Academy of Physician Assistants, and Gay Lentfer, P.A., Chair of the Physician Assistant Advisory Council were also in attendance and added to the discussion. A question and answer session followed. The Board gave a round of applause.

Agenda Item 4: Licensure and Registration

On recommendation of the Licensure Committee, physician applicants 1 – 352 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Licensure Committee, physician applicants 353 - 355 of the agenda were approved for Emeritus registration.

On recommendation of the Acupuncture Advisory Council, acupuncturist applicants 356 - 361 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Athletic Trainers Advisory Council, athletic trainer applicants 362 - 372 of the agenda were approved for registration subject to the receipt of verification documents.

On recommendation of the Physician Assistant Advisory Council, physician assistant applicants 373 - 394 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Respiratory Therapist Advisory Council, respiratory therapist applicants 395 – 398 of the agenda were approved for licensure subject to the receipt of verification documents.

Agenda Item 5: Licensure Committee Report

- Agenda Item 6a: Minutes of the June 16, 2016, Licensure Committee
Licensure Committee Chair Patricia Lindholm, M.D., FAAFP, presented the minutes of the June 16, 2016, Licensure Committee Meeting.

Dr. Lindholm summarized the Licensure Committee's actions and discussions.

Ms. Martinez acknowledged the efforts and resilience of Board staff in processing residency permit applications, license applications, and renewal applications for the allied professions renewing by June 30, during this peak application season. The volume of applications has been overwhelming, particularly with the significant staff turnover in licensure positions over the last two years, based on several retirements and a promotion of experienced staff. The entire office has pitched in to help. A special thanks to Licensure Unit Supervisor Molly Schwanz. The Board gave a round of applause.

Agenda Item 6: Health Professionals Services Program (HPSP) Program Committee Report

Allen G. Rasmussen, M.A., the Board's representative and Chair of the Health Professionals Services Program (HPSP) Program Committee presented his report summarizing the May 10, 2016, HPSP Program Committee meeting.

HPSP's authorizing statute requires that one health licensing Board be the administering Board for the HPSP Program. The previous administering Board was the Board of Dentistry and, most recently, the Board of Physical Therapy. Several smaller Boards were approached to

administer the HPSP Program but were not interested. HPSP Director Monica Feider inquired if the Board of Medical Practice would become the administering Board for the HPSP Program. Ms. Martinez stated that Board staff and she are willing to take on the duties of the administering Board for the HPSP Program.

After Board discussion, the motion to transfer administrative duties of the HPSP Program from the Board of Physical Therapy to the Board of Medical Practice passed unanimously.

Dr. Inampudi thanked Mr. Rasmussen for a great job.

Agenda Item 7: Executive Director's Report

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

- The Board continues to participate in the following external work groups:
 - State Opioid Oversight Project (SOOP)
 - National Governors' Association (NGA) Health Care Workforce Technical Assistance Program
 - Immigrant International Medical Graduate (IMG) Stakeholder Advisory Group & subgroups:
 - Licensure Study work group
 - Alternate Pathways work group
 - Drug Diversion Coalition through the MN Department of Health
 - The group has been reconvened to address current issues
 - - Dr. Berge and Ms. Martinez are, once again, involved with the group
 - One Health MN Antibiotic Stewardship
 - Community Dialogue on Diagnostic Error
 - MN Alliance for Patient Safety
 - Interstate Collaboration in Healthcare

Ms. Martinez will continue to report on the activities of external work groups.

- MN Tri-Regulatory Symposium
On June 1, 2016, the Minnesota Boards of Medical Practice, Nursing and Pharmacy hosted the inaugural MN Tri-Regulatory Symposium (Symposium) at The Commons Hotel in Minneapolis. The Symposium was a great success, with more than 60 attendees representing the national regulatory organizations and the Minnesota Boards of Medical Practice, Nursing and Pharmacy. Presentations by the national organizations' Chief Executive Officers and speakers Dr. Barbara Brandt and Dr. Doris Gundersen were well-received. A survey has been distributed to attendees and Ms. Martinez will provide the survey results at the September 10, 2016, Board meeting. Ms. Martinez invited comments from Board members who attended the Symposium.

Board members thought it was a wonderful, well organized event. They enjoyed being seated with Board members and staff from the other participating Boards. They also learned a lot about the other Boards from the presentations. Ms. Martinez will ask the executive directors of the Board of Nursing and Board of Pharmacy whether they are interested in hosting another Symposium and how frequently such an event should be held.

Ms. Martinez invited Board members to contact her with any suggestions for future Symposium topics.

Ms. Martinez thanked Medical Board Administrative Assistant Cheryl Johnston, Nursing Board Administrative Assistant Mary Luecke, and Pharmacy Board Office Manager Pat

Eggers for the great job they did organizing and facilitating the Symposium. The Board gave a round of applause.

- Interstate Medical Licensure Compact (IMLC) Commission Meeting
On June 24, 2016, the IMLC Commission held its fourth meeting in Salt Lake City, Utah. Since the last meeting in St. Paul on March 31 – April 1, five states have joined the IMLC, bringing the total number of member states to 17. New Commissioners were welcomed and the Executive Committee presented its report and a timeline for implementing issuance of licenses through the IMLC. IMLC committees reported on committee work since the last meeting and requested action on specific issues. The Commission passed a Conflict of Interest Policy and a resolution specifying that it does not have a conflict of interest with the Federation of State Medical Boards in the FSMB's facilitation of IMLC activities. The Commission passed a motion to set a target date of January 2017 to begin issuing licenses, and gave direction to committees for the significant work that will be required to meet the January 2017 target date. The Commission set dates for future meetings, on August 24, 2016 via conference call, and on October 3, 2016 in Kansas City, Kansas. Dr. Thomas serves on the Executive Committee and Technology Committee, and Ms. Martinez serves on the Bylaws and Rules Committee. Dr. Thomas and Ms. Martinez will keep the Board informed regarding IMLC progress.

- Other Activities

- Board staff was pleased to welcome Hanan Ahmad on June 7, 2016, as a Licensure Specialist.
- Board of Medical Practice, Attorney General, and MNiT staff provided orientation to new Board and advisory council appointees.
- The Board continues to seek applicants for an at large physician member seat and a public member seat. Ms. Martinez encouraged any Board member who knows of someone interested in either of the two vacancies on the Board to invite those individuals to contact the Secretary of State's Office. Ms. Martinez will e-mail the districts eligible for the vacancy of the public member seat.

- Legislation

The following health policy bills, passed during the 2016 legislative session, will become effective on August 1, 2016, unless otherwise noted:

- SF 454/HF 1036: Physician assistant housekeeping modifications; temporary suspension process alignment; and traditional midwifery statute modifications.

Modifies provisions of the physician assistant practice act to remove the cap on the number of PAs that a physician may supervise; eliminates the requirement for an alternate supervising physician; and requires practice location notification within 30 business days of starting practice.

The modification of the traditional midwifery statute includes a slight modification to scope of practice and allows the traditional midwifery professional association to recommend a physician to serve on the advisory council, rather than requiring the physician member to be recommended by the Minnesota Medical Association.

- SF 2341/HF 2445: Osteopathic physician housekeeping modifications. Updates references throughout the practice act; repeals obsolete language; modifies composition of the Board to allow more than one osteopathic physician to serve on the Board; aligns examination requirements between the COMLEX and the USMLE.

Ms. Martinez thanked Joe R. Willett, D.O., Nick Schilligo, M.S. Associate Vice President of the American Osteopathic Association, and Colleen Jensen Executive Director of the Minnesota Osteopathic Medical Society, all of whom worked with Board staff to draft language and prepare talking points to present to the legislature.

- SF 1440/HF 1652: Expands access to prescription monitoring program data for health licensing board designees during a complaint investigation; and mandates PMP registration by July 1, 2017 for prescribers.
The Board has already embedded a link to the registration site within the Board's on-line renewal process. There isn't a specified legislative penalty if prescribers do not register with the PMP by July 1, 2017; however, Ms. Martinez suggested implementation of a random audit process to ensure that physicians and physician assistants are compliant with the new law.

The Board will have access to PMP data when actively investigating a complaint alleging inappropriate prescribing or diversion of drugs for self-use. Board staff doesn't have direct access to retrieve data from the PMP; rather, the Board will process a request for data through the PMP. Board staff may delegate authority to the AGO as an agent of the Board to request information from the PMP during investigations on behalf of the Board.

Ms. Martinez noted that it is important to access PMP data responsibly and assure a sound basis for any data request. If anyone perceives that the access is being abused, there is potential for the legislature to remove access during investigations. Ms. Martinez will provide information as policies and procedures are implemented. Dr. Inampudi suggested that it would be worthwhile to get feedback from the Complaint Review Committees before policies are put into place.

- SF 37/HF 978: Authorizes licensing of genetic counselors by the Board of Medical Practice. The genetic counselors' professional association will work with the Board to establish an advisory council. Licensure of genetic counselors is mandatory by January 2018.
- SF 2475/HF 3142: HHS Omnibus Bill authorizes, in pertinent part, issuance of a medical faculty license to a qualifying individual by the Board of Medical Practice (language attached in the Board agenda).

Mayo Clinic brought forward the legislation very late in the 2016 session in an effort to hire a highly specialized physician who does not meet current licensing exam requirements. Practice is limited to the facility which hired the physician as medical faculty. This legislation will sunset in two years.

Upon learning of the legislative proposal, Ms. Martinez requested authority from Dr. Inampudi to work with the Mayo lobbyist to craft the language. Ms. Martinez thanked Complaint Review Supervisor Elizabeth Huntley and Licensure Unit Supervisor Molly Schwanz for their assistance with the language, which was significantly improved in its final form from the initial draft. A brief discussion followed.

Ms. Martinez suggested that the Board and the Minnesota Medical Association work together to gather opinions about the Medical Faculty License and consider whether and how to modify the language before it sunsets. Ms. Martinez requested that Board members communicate their thoughts and observations about the intended or unintended consequences of the medical faculty license.

National Defense Authorization Act for Fiscal Year 2017 (S. 2943), Sec. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care

The Board was notified of a federal bill, The National Defense Authorization Act for Fiscal Year 2017 (S. 2943), Sec. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care. Ms. Martinez stated that Sec. 705 of the legislation refers to the location of care as location of the practitioner, rather than where the patient is located (for the purpose of provider reimbursement.) Ms. Martinez asked Board members to review the legislation and contact Jonathan Jagoda at the Federation with comments. This item is on the agenda for the next Policy & Planning Committee meeting and will be fully discussed at that time.

Federal Register Notice

Ms. Martinez stated that Board staff forwarded a notice that was posted on July 8, 2016, in the Federal Register regarding opioid analgesic prescriber education and training with a request for comments by September 6, 2016. Ms. Martinez invited Board members to direct their comments either through her or directly through the notice. Ms. Martinez commented that the Board has never advocated for mandatory continuing education on any specific topic. Ms. Martinez is sensitive to the issue of opioid prescribing and a desire to educate practitioners, but noted that not every physician or physician assistant prescribes opioids.

September 10, 2016, Board Meeting

Ms. Martinez informed the Board that an invitation was extended to the Surgeon General to present at the Board's September 10, 2016, Board meeting. The Surgeon General graciously declined the invitation. Mayo also submitted a separate invitation to the Surgeon General which was also declined.

Ms. Martinez is working with a lobbyist in the Mayo's Government Relations Department to hold the September 10, 2016, Board meeting at Mayo Clinic. Mayo Clinic suggested that Dr. Tait D. Shanafelt be invited to present at the Board meeting on the topic of physician burn-out.

A motion was made and passed unanimously to hold the September 10, 2016 Board meeting at Mayo Clinic and to invite Dr. Shanafelt to present.

Mr. Kaplan will Chair the September 10, 2016, Board meeting, since Dr. Inampudi has a prior commitment.

Prison Tours

At the March 12, 2016, Board meeting, Health Services Director Nanette M. Larson offered prison tours to Board members and staff. Ms. Martinez is coordinating with Ms. Larson to schedule dates for prison tours of Stillwater and Oak Park Heights. Ms. Martinez will notify Board members when dates have been confirmed.

Board Committee Appointments

Dr. Inampudi asked Mr. Ella if he would remain Chair of the Policy & Planning Committee. Mr. Ella agreed. Dr. Inampudi appointed Gerald T. Kaplan, M.A., L.P., and Patrick R. Townley, M.D., J.D., to the Policy & Planning Committee.

Dr. Inampudi appointed Kimberly W. Spaulding, M.D., M.P.H. to the Licensure Committee.

Policy & Planning Committee Meetings

Dr. Inampudi proposed that the Policy & Planning Committee establish standing meetings every other month. If there aren't any items for the agenda, the meeting can be canceled.

Executive Director's Performance Evaluation

Ms. Martinez stated that the Executive Committee of the Board needs to conduct her performance evaluation. Traditionally the executive director's performance evaluation occurs on or around the September Board meeting.

Agenda Item 8: Corrective and Other Actions

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

Agenda Item 9: New Business

Dr. Thomas voiced concern about the possibility of Board members being sued by the Federal Trade Commission (FTC) for anti-competitive behavior following the Supreme Court ruling on the North Carolina Dentistry case. The Federation of State Medical Boards invited Dr. Thomas to meet with a FTC attorney on Senator Klobuchar's staff. A proposed recommendation to the FTC attorney was to include exemption from litigation for medical Boards in a current antitrust local government act. The FTC attorney felt that they would have to include all types of Boards, not just medical Boards. The Federation asked Dr. Thomas to meet with Senator Klobuchar's staff again in August. Both Senators Franken and Klobuchar are interested in resolving this issue.

Assistant Attorney General Brian Williams will ask whether the Attorney General is willing to take a position on this issue. Mr. Williams would like to be informed of conversations and communications regarding this issue because it involves not just the Board of Medical Practice, but also other licensing boards. Board members felt that the AGO should be proactive and not wait for a disaster to occur. Dr. Eggen asked that the AGO extend indemnification to include federal as well as state indemnification.

Dr. Thomas believes that the Board has good processes in place, including due process for licensees and individual case involvement. However, even if the Board is doing everything right, Board members can still be sued by the FTC and that could be financially devastating.

Dr. Inampudi thanked Dr. Thomas for his good work and for sharing information with the Board.

A motion was made to adjourn the public session of the Board.

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

TIMOTHY E.M. BEYER, D.O.

On recommendation of the Complaint Review Committee, the Board approved the Amended Stipulation and Order for stayed suspension and conditioned license signed by Dr. Beyer. Dr. Willett recused.

TIMOTHY LLOYD BURKE, M.D.

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

ALI EBRAHIMI, M.D.

On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license.

FREDRICK E. EKBERG, M.D.

On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license. Mr. Ella opposed.

HARVEY J. GREEN, M.D.

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

KEITH KRUEGER, M.D.

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

CHRISTOPHER P. MAIER, M.D.

On recommendation of the Complaint Review Committee, the Board approved the Order for unconditional license.

DOLINE OMIRERA KEBASSO, P.A.

On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for stayed suspension, conditioned license and reprimand signed by Ms. Omirera Kebasso.

ANTON ROHAN, M.B., B.S.

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

There being no further business, the meeting was adjourned.



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

September 2, 2016
Date

DATE: September 10, 2016

SUBJECT: Physician Burnout: Why
We Should Care and What
We Can Do About It

SUBMITTED BY: Subbarao Inampudi, M.B., B.S., FACR, President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For information only.

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

BACKGROUND:

Colin P. West, M.D., Ph.D, Professor of Medicine, Medical Education and Biostatistics at Mayo Clinic will provide a presentation on Physician Burnout: Why We Should Care and What We Can Do About it.

Bio of Dr. West:

Originally from Seattle, Dr. West received his M.D., and Ph.D., in Biostatistics from the University of Iowa in 1999. He completed residency and chief residency in internal medicine at Mayo Clinic, and joined the faculty in General Internal Medicine in 2004. He is currently Professor of Medicine, Medical Education and Biostatistics at Mayo. He directs the evidence-based medicine curriculum for the medical school, and is an Associate Program Director within the internal medicine residency program. He is also the Research Chair of General Internal Medicine. Dr. West's research has focused on medical education and physician well-being, and he is Co-Director of the Mayo Clinic Program on Physician Well-Being. Working closely with Tait Shanafelt, M.D., and Liselotte (Lotte) Dyrbye, M.D., MHPE, his work documenting the epidemiology and consequences of physician distress, as well as emerging research on solutions, has been widely published in prominent journals including Lancet, JAMA, Annals of Internal Medicine, and JAMA Internal Medicine.

DATE: 09/10/2016

SUBMITTED BY: Licensure Committee

SUBJECT: Physician Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following physician applicants for licensure be approved subject to receipt of all verification documents.

1 - 278 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 1 - 278 for each applicants credentials

COMB = COMBINATION of NBME,FLEX,USMLE
COMLEX = COMPREHENSIVE OSTEOPATHIC MLE
FLEX = FED. OF STATE MEDICAL BOARDS
LMCC = LICENTIATE MED CNCL OF CANADA
NBME = NATIONAL BRD OF MED. EXAMINERS
NBOME = NAT. BD OF OSTEOPATHIC EXAM.
STATE = LICENSED BY OTHER STATE
USMLE = UNITED STATES MED LIC EXAM

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
1		Passaic, NJ, USA 09/26/1986	ROSS U/U OF DOMINICA Portsmouth, Dominica M.D. 06/01/2012	University of Texas Houston, TX, USA 06/24/2013 to 06/30/2016 AMA FREIDA Online	07976640 04/08/2010 10/13/2011 04/22/2013 USMLE1 USMLE2 USMLE3 242 255 221 ECFMG 0-797-664-0
2		Al Mafrag, JORDAN 02/26/1985	U OF JORDAN Amman, JORDAN M.D. 06/15/2009	University of Texas Galveston, TX, USA 06/22/2011 to 06/30/2014 AMA FREIDA Online	07671464 01/26/2011 02/10/2010 03/15/2011 USMLE1 USMLE2 USMLE3 230 223 221 ECFMG 0-767-146-4
3		Burnsville, MN, USA 10/27/1986	MI STATE U/COL HUMAN MED Lansing, MI USA M.D. 05/02/2014	University of Minnesota Minneapolis, MN, USA 06/01/2014 to 06/30/2017 AMA FREIDA Online	52857562 06/19/2012 10/26/2013 08/11/2014 USMLE1 USMLE2 USMLE3 212 225 200
4		Ibadan, NIGERIA 03/23/1984	ROSS U/U OF DOMINICA Roseau, DOMINICA 03/31/2012	HCMC/Regions Hospital Minneapolis, MN, USA 06/17/2014 to 06/30/2018 AMA FREIDA Online	07775984 12/14/2009 12/16/2011 11/04/2015 USMLE1 USMLE2 USMLE3 188 207 205 ECFMG 07775984
5		Bryan, TX, USA 01/07/1980	ROSALIND FRANKLIN U OF MEDICINE & SCI North Chicago, IL USA M.D. 07/30/2010	Duke University Durham, NC, USA 07/01/2010 to 07/01/2016 DARP PG 360, 2010/11	51879013 07/20/2007 01/19/2010 05/10/2012 USMLE1 USMLE2 USMLE3 232 233 207

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
6		Santa Monica, CA, USA 03/15/1989	STANFORD U Stanford, CA USA M.D. 06/14/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53066395 05/24/2013 01/17/2015 01/28/2016 USMLE1 USMLE2 USMLE3 234 255 242
7		Mogadisho, SOMOLIA 06/07/1984	WINDSOR U SCHOOL OF MEDICINE Cayon, Saint Kitts M.D. 04/15/2014	University of Minnesota Minneapolis, MN, USA 07/09/2014 to 08/06/2017 AMA FREIDA Online	08513384 08/06/2012 08/29/2013 11/20/2014 USMLE1 USMLE2 USMLE3 219 222 203 ECFMG 0-851-338-4
8		Amman, JORDAN 05/26/1985	JORDAN U. of SCIENCE & TECHNOLOGY Irbid, Jordan M.B., B.S. 06/08/2010	Mayo Clinic Rochester, MN, USA 07/01/2014 to 06/30/2016 AMA FREIDA Online	0-804-885-2 06/19/2012 02/23/2011 03/10/2016 USMLE1 USMLE2 USMLE3 224 223 197 ECFMG 0-804-885-2
9		Maplewood, MN, USA 08/01/1988	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	United Family Medicine St. Paul, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	53036026 06/12/2013 12/10/2014 05/16/2016 USMLE1 USMLE2 USMLE3 213 237 239
10		Omsk, Russia 07/06/1974	TOMSK MED INSTITUTE Omsk, RUSSIA 06/20/1997	University of Kansas School of Med Kansas City, KS, USA 07/01/2006 to 06/30/2009 DARP PG 365, 2006/07	06603880 11/24/2004 06/28/2005 05/24/2006 USMLE1 USMLE2 USMLE3 213 242 199 ECFMG 06603880 ABMS IM Internal Medicine 08/24/2009-12/31/2019-MOC

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
11		Watertown, SD, USA 04/16/1979	NOVA SOUTHEASTERN U COLLEGE OF OSTEO MED Fort Lauderdale, FL USA D.O. 05/30/2010	South Pointe Hospital Warrensville Heights, OH, USA 07/01/2010 to 06/30/2015 AOA Website	877578 06/11/2008 07/16/2009 06/20/2011 COMLEX1 COMLEX2 COMLEX3 628 717 777
12		Los Angeles, CA, USA 10/30/1962	U OF CA/DAVIS SCHOOL OF MEDICINE Sacramento, CA USA M.D. 06/17/1988	University of California Sacramento, CA, USA 07/01/1988 to 06/30/1990 DARP PG 445, 1988/89	3-359-531-5 06/10/1986 04/12/1988 03/01/1989 NBME1 NBME2 NBME3 80 80 79 ABMS Anesthesiology- Anesthesiology 04/15/1994--Lifetime
13		Minneapolis, MN, USA 08/08/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 05/04/2013	University of Minnesota Minneapolis, MN, USA 07/01/2013 to 06/30/2017 AMA FREIDA Online	52636842 06/14/2011 12/10/2012 02/06/2014 USMLE1 USMLE2 USMLE3 221 221 208
14		Chicago, IL, USA 08/25/1987	OHIO STATE U Columbus, OH USA M.D. 05/10/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53064606 06/14/2013 11/29/2014 11/23/2015 USMLE1 USMLE2 USMLE3 259 255 246
15		Osceola, WI, USA 07/08/1983	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/23/2015	Mayo Clinic Mankato, MN, USA 06/01/2015 to 06/30/2016 AOA Website	107554 05/21/2013 07/19/2014 11/21/2015 COMLEX1 COMLEX2 COMLEX3 423 477 571

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
16		Lalitpur, NEPAL 03/25/1983	GUANGXI MEDICAL UNIVERSITY Nanning, China 06/30/2007	St. Joseph Hospital Chicago, IL, USA 07/12/2013 to 07/11/2016 AMA FREIDA Online	08056285 10/28/2010 04/06/2011 01/18/2012 USMLE1 USMLE2 USMLE3 239 228 213 ECFMG 0-805-628-5
17		Ankara, TURKEY 03/26/1981	AKDENIZ U Antalya, Turkey 06/20/2006	Georgetown University Washington, DC, USA 06/16/2009 to 06/30/2012 DARP PG 649, 2009/10	0-723-664-9 12/22/2007 08/20/2008 12/10/2011 USMLE1 USMLE2 USMLE3 217 199 190 ECFMG 0-723-664-9
18		St. Paul, MN, USA 03/26/1983	U OF MINNESOTA Minneapolis, MN USA M.D. 05/02/2009	University of Vermont Burlington, VT, USA 06/23/2009 to 06/30/2013 DARP PG 410, 2009/10	51954451 05/24/2007 11/18/2008 11/08/2010 USMLE1 USMLE2 USMLE3 233 247 234
19		Inglewood, CA, USA 11/19/1957	MED COL OF VIRGINIA Richmond, VA USA M.D. 05/14/1983	University of Texas Houston, TX, USA 07/01/1983 to 06/30/1986 DARP PG 131, 1982/83	21984364 12/04/1984 FLEX 81 ABMS IM Internal Medicine 01/01/1986-MOC
20		St. Cloud, MN, USA 07/29/1979	MI STATE U/COL HUMAN MED East Lansing, MI USA M.D. 05/06/2011	Strong Memorial Hospital Rochester, NY, USA 06/20/2011 to 06/23/2014 AMA FREIDA Online	52241148 06/23/2009 08/23/2010 01/15/2014 USMLE1 USMLE2 USMLE3 194 218 214

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
21		Calgary, AB, CANADA 02/26/1986	JAGIELLONIAN U MEDICAL COLLEGE Krakow, Poland M.D. 05/10/2013	Mayo Clinic Rochester, MN, USA 07/01/2014 to 06/30/2016 AMA FREIDA Online	0-821-947-9 08/17/2011 09/29/2012 02/17/2016 USMLE1 USMLE2 USMLE3 222 221 219 ECFMG 0-821-947-9
22		Milwaukee, WI, USA 08/23/1981	STATE U OF NY/SYRACUSE Syracuse, NY USA M.D. 05/17/2009	Orlando Health Orlando, FL, USA 07/01/2010 to 06/30/2013 DARP PG 98, 2010/11	51871416 06/14/2007 09/25/2008 01/22/2013 USMLE1 USMLE2 USMLE3 199 243 241
23		Virginia, MN, USA 08/22/1988	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	United Hospital St. Paul, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	53058103 06/15/2013 11/22/2014 05/16/2016 USMLE1 USMLE2 USMLE3 221 238 217
24		San Francisco, CA, USA 08/15/1958	U OF CA/SAN DIEGO La Jolla, CA USA M.D. 06/01/1986	Albert Einstein Montefiore Bronx, NY, USA 07/01/1986 to 06/30/1988 DARP PG 204, 1986/87	3-306-100-3 06/12/1984 09/29/1987 03/02/1988 NBME1 NBME2 NBME3 75 77 78.6 ABMS OB & GY- Obstetrics & Gynecology 12/09/1994-12/31/2016-MOC
25		St. Paul, MN, USA 03/19/1982	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2012	Johns Hopkins Baltimore, MD, USA 07/01/2012 to 06/30/2016 DARP PG 190, 2012/13	52182318 09/21/2010 09/22/2011 07/15/2014 USMLE1 USMLE2 USMLE3 204 230 232

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
26		York, NE, USA 08/04/1985	U OF MO/KANSAS CITY Kansas City, MO USA M.D. 05/29/2015	Truman Medical Center Kansas City, MO, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53093696 07/27/2013 06/25/2014 05/04/2016 USMLE1 USMLE2 USMLE3 221 248 225
27		Landstuhl, GERMANY 01/11/1986	MARSHALL U Huntington, WV USA M.D. 05/11/2013	Dwight David Eisenhower Fort Gordon, GA, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52508199 09/14/2010 06/02/2012 02/18/2014 USMLE1 USMLE2 USMLE3 202 218 224
28		Miles City, MT, USA 05/09/1985	U OF SOUTH DAKOTA Vermillion, SD USA M.D. 05/08/2015	Mayo Clinic Rochester, MN, USA 06/01/2015 to 06/30/2016 AMA FREIDA Online	52930054 06/17/2013 07/19/2014 02/29/2016 USMLE1 USMLE2 USMLE3 268 250 246
29		Albany, NY, USA 12/13/1985	LAKE ERIE COL OF OSTEO Erie, PA USA D.O. 05/31/2015	Albany Medical Center Albany, NY, USA 07/01/2015 to 06/30/2016 AOA Website	520009 05/25/2013 07/28/2014 02/09/2016 COMPLEX1 COMPLEX2 COMPLEX3 664 735 787
30		Minneapolis, MN, USA 04/22/1978	PIKEVILLE COL. OF OSTEO. MED. Pikeville, KY USA D.O. 05/09/2009	Gunderson Medical Foundation La Crosse, WI, USA 07/01/2009 to 06/30/2010 AOA Website	846631 07/10/2007 08/11/2008 02/06/2012 COMPLEX1 COMPLEX2 COMPLEX3 478 482 545

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
31		Yakima, WA, USA 11/24/1982	U OF WASHINGTON Seattle, WA USA M.D. 06/08/2012	University of Minnesota Minneapolis, MN, USA 06/10/2012 to 06/11/2016 AMA FREIDA Online	52319365 07/16/2009 01/31/2011 09/20/2013 USMLE1 USMLE2 USMLE3 198 215 205
32		Manama, BAHRAIN 01/23/1971	ARABIAN GULF UNIVERSITY Manama, Bahrain M.D. 12/26/1995	Providence Hospital Southfield, MI, USA 09/01/2001 to 06/30/2007 DARP PG 966, 2001/02	05057856 12/22/1999 08/27/1996 04/30/2003 USMLE1 USMLE2 USMLE3 217 178 184 ECFMG 0-505-785-6 ABMS Surgery- Surgery 10/30/2007-07/01/2018-Time Limited
33		Glenelg, CA, USA 06/15/1978	U OF MINNESOTA Minneapolis, MN USA M.D. 05/02/2009	Stanford Hospital Stanford, CA, USA 06/21/2009 to 06/30/2016 DARP PG 455, 2009/10	51198141 07/11/2003 02/23/2009 11/11/2009 USMLE1 USMLE2 USMLE3 248 235 219
34		Minneapolis, MN, USA 11/10/1980	COLUMBIA U New York, NY USA M.D. 05/16/2012	Harbor UCLA Medical Center Torrance, CA, USA 06/24/2012 to 06/30/2017 DARP PG 716, 2012/13	52479904 06/11/2010 11/07/2011 07/17/2013 USMLE1 USMLE2 USMLE3 213 240 225
35		Albany, NY, USA 12/31/1986	ST U OF NY/STONY BROOK Stony Brook, NY USA M.D. 05/22/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	53069811 06/13/2013 08/19/2014 04/25/2016 USMLE1 USMLE2 USMLE3 258 265 248

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
36		Sioux Falls, SD, USA 06/28/1984	U OF NEBRASKA/OMAHA Omaha, NE USA M.D. 05/08/2010	Maine Medical Center Portland, OR, USA 07/01/2010 to 06/30/2013 DARP PG 197, 2010/11	52162047 06/23/2008 10/16/2009 02/09/2012 USMLE1 USMLE2 USMLE3 192 244 227
37		Amherst, NY, USA 11/14/1978	ROSS U/U OF DOMINICA Roseau, Dominica 11/30/2008	Bergen Regional Medical Center Paramus, NJ, USA 07/01/2009 to 06/30/2013 DARP PG 654, 2009/10	07077274 07/31/2006 06/05/2008 04/26/2014 USMLE1 USMLE2 USMLE3 182 187 194 ECFMG 0-707-727-4
38		Austin, TX, USA 03/25/1977	U OF TEXAS/GALVESTON Galveston, TX USA M.D. 12/10/2004	William Beaumont Army El Paso, TX, USA 01/10/2005 to 01/13/2006 DARP PG 760, 2005/06	51098754 11/22/2002 03/23/2004 09/06/2006 USMLE1 USMLE2 USMLE3 202 214 214
39		Madrid, SPAIN 09/04/1986	U OF CA/IRVINE Irvine, CA USA M.D. 05/22/2015	Duluth Family Medicine Duluth, MN, USA 07/01/2015 to 07/30/2018 AMA FREIDA Online	52789971 04/30/2012 08/01/2013 12/07/2015 USMLE1 USMLE2 USMLE3 213 212 211
40		Chonburi, THAILAND 10/05/1980	U OF MO/KANSAS CITY Kansas City, MO USA M.D. 05/30/2012	University of Minnesota Minneapolis, MN, USA 07/01/2012 to 06/30/2016 DARP PG 54, 2012/13	52524238 07/06/2010 10/19/2011 05/29/2013 USMLE1 USMLE2 USMLE3 231 227 216

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
41		Kottayam, INDIA 10/08/1980	ARMED FORCES COL/PUNE U Maharastra, India M.B., B.S. 07/08/2004	University of Texas San Antonio, TX, USA 06/01/2011 to 07/01/2013 DARP PG 857, 2011/12	0-704-832-5 07/06/2010 12/22/2009 01/18/2011 USMLE1 USMLE2 USMLE3 206 226 218 ECFMG 0-704-832-5
42		Accra, GHANA 04/22/1982	KASTURBA MED COL/MYSORE Manipal, India M.B., B.S. 04/24/2007	University of Illinois Urbana, IL, USA 07/01/2010 to 06/30/2012 DARP PG 185, 2010/11	07172661 07/19/2007 12/23/2008 03/31/2010 USMLE1 USMLE2 USMLE3 230 245 215 ECFMG 0-717-266-1
43		Chang-Hua, TIAWAN 04/23/1987	U OF TEXAS/GALVESTON Galveston, TX USA M.D. 05/30/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53086039 06/19/2013 07/27/2014 12/21/2015 USMLE1 USMLE2 USMLE3 263 264 233
44		Jackson, MS, USA 10/26/1988	U OF ALABAMA Birmingham, AL USA M.D. 06/06/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	52915402 05/01/2013 08/23/2014 04/14/2016 USMLE1 USMLE2 USMLE3 255 258 249
45		Daejeon, KOREA 09/17/1974	KOREA U/WOO SOK/SOO DO Seoul, Korea 02/25/2005	John H. Stroger Hospital Chicago, IL, USA 09/29/2008 to 09/28/2011 DARP PG 605, 2008/09	06490692 09/01/2004 12/08/2005 09/05/2006 USMLE1 USMLE2 USMLE3 196 219 199 ECFMG 0-649-069-2 ABMS Pediatrics- Pediatrics 10/18/2012-02/15/2017-MOC

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
46		Salt Lake City, UT, USA 08/16/1989	U OF UTAH/SCH OF MED Salt Lake City, UT USA M.D. 05/23/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	53017653 06/13/2013 07/26/2014 04/28/2016 USMLE1 USMLE2 USMLE3 204 228 215
47		Smithtown, NY, USA 01/24/1990	ST U OF NY/STONY BROOK Stony Brook, NY USA M.D. 05/22/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	41172198 05/04/2013 11/20/2014 02/29/2016 USMLE1 USMLE2 USMLE3 262 277 254
48		Omaha, NE, USA 09/07/1977	CREIGHTON U Omaha, NE USA M.D. 05/15/2004	University of Wisconsin Madison, WI, USA 07/01/2004 to 06/30/2007 DARP PG# 111, 2004/05	51112126 06/05/2002 03/17/2004 09/29/2005 USMLE1 USMLE2 USMLE3 211 222 197 ABMS Anesthesiology- Anesthesiology 05/21/2015-12/31/2025-Time Limited
49		Cleveland, OH, USA 08/20/1950	MI STATE U/COL HUMAN MED East Lansing, MI USA M.D. 06/08/1979	Edward W. Sparrow Hospital Lansing, MI, USA 06/25/1979 to 06/30/1980 DARP PG 325, 1982/83	20933297 06/10/1980 FLEX 82 MI ABMS Orthopaedic Surgery- Orthopaedic Surgery 07/23/1987-12/31/2017-MOC

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
50		Fargo, ND, USA 06/13/1981	LOYOLA U/STRICTH MED SCH Maywood, IL USA M.D. 05/30/2008	Rhode Island Hospital Providence, RI, USA 06/19/2008 to 06/30/2010 DARP PG 399, 2008/09	02/29/2016 06/08/2006 02/16/2008 11/01/2010 USMLE1 USMLE2 USMLE3 256 271 250
51		Alma, MI, USA 05/05/1988	INDIANA U/SCH OF MED Indianapolis, IN USA M.D. 05/11/2014	University of Minnesota Minneapolis, MN, USA 06/08/2014 to 05/15/2020 AMA FREIDA Online	52867512 05/28/2012 06/28/2013 07/30/2015 USMLE1 USMLE2 USMLE3 222 248 214
52		Alamogordo, NM, USA 01/11/1987	MERCER U Macon, GA USA M.D. 05/04/2013	Palmetto Health - Univ of SC Columbia, SC, USA 07/01/2013 to 06/30/2014 AMA FREIDA Online	52607272 06/07/2011 08/02/2012 05/13/2014 USMLE1 USMLE2 USMLE3 230 244 213
53		Cedar Rapids, IA, USA 08/02/1983	CREIGHTON U Omaha, NE USA M.D. 05/16/2009	University of Massachusetts Worcester, MA, USA 07/01/2009 to 06/30/2012 DARP PG 617, 2009/10	51955144 08/22/2007 10/21/2008 06/23/2010 USMLE1 USMLE2 USMLE3 216 221 201
54		La Crosse, WI, USA 11/27/1986	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/15/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52811544 06/22/2012 12/29/2014 03/28/2016 USMLE1 USMLE2 USMLE3 231 253 238
55		Bismarck, ND, USA 08/08/1987	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/09/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53003703 06/19/2013 07/14/2014 11/19/2015 USMLE1 USMLE2 USMLE3 226 230 219

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
56		San Juan, PR, USA 03/13/1981	NEW JERSEY MED SCHOOL Newark, NJ USA M.D. 05/20/2009	Mount Sinai Medical Center Miami Beach, FL, USA 06/24/2009 to 06/30/2014 DARP PG 719, 2009/10	51834521 07/11/2007 10/17/2008 10/04/2010 USMLE1 USMLE2 USMLE3 209 194 206
57		Victoria, TX, USA 08/05/1984	U OF MO/KANSAS CITY Kansas City, MO USA M.D. 05/29/2009	St. Louis University Hospital St. Louis, MO, USA 07/01/2009 to 06/30/2013 DARP PG 198, 2009/10	51993194 06/20/2007 07/28/2008 04/14/2010 USMLE1 USMLE2 USMLE3 201 224 202
58		Johannesburg, SOUTH AFRICA 06/30/1978	TOURO U - NEVADA Henderson, NV USA D.O. 06/07/2010	St. John's Episcopal Hospital Far Rockaway, NY, USA 07/01/2010 to 06/30/2011 AOA Website	885704 07/14/2008 01/07/2010 12/21/2011 COMPLEX1 COMPLEX2 COMPLEX3 432 433 440
59		Huntington, WV, USA 07/08/1983	U OF MINNESOTA Minneapolis, MN USA M.D. 05/01/2010	University of Minnesota Minneapolis, MN, USA 06/16/2010 to 06/30/2013 DARP PG 190. 2010/11	52020997 06/05/2008 01/19/2010 03/20/2012 USMLE1 USMLE2 USMLE3 250 269 238
60		Jackson, MS, USA 08/24/1987	WILLIAM CAREY Hattiesburg, MS USA D.O. 05/23/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AOA Website	529200 07/22/2013 11/18/2014 04/11/2016 COMPLEX1 COMPLEX2 COMPLEX3 441 461 433

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
61		Atlanta, GA, USA 11/13/1987	WILLIAM CAREY Hattiesburg, MS USA D.O. 05/23/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AOA Website	529211 08/07/2013 01/20/2015 04/11/2016 COMLEX1 COMLEX2 COMLEX3 410 466 473
62		Fall River, MA, USA 09/27/1981	U OF MASSACHUSETTS Worcester, MA USA M.D. 06/01/2008	Beth Israel Deaconess Boston, MA, USA 06/23/2008 to 06/30/2011 DARP PG 387, 2008/09	51589711 06/16/2005 10/19/2006 11/19/2009 USMLE1 USMLE2 USMLE3 256 271 255
63		Evansville, IN, USA 07/26/1946	INDIANA U/SCH OF MED Indianapolis, IN USA M.D. 04/19/1975	Milwaukee Medical College Milwaukee, WI, USA 07/01/1975 to 06/30/1977 DARP PG#	20137840 06/10/1975 FLEX 82.20 ABMS Orthopaedic Surgery- Orthopaedic Surgery 09/10/1982--Lifetime
64		Fridley, MN, USA 07/29/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 05/10/2014	United Family Medicine St. Paul, MN, USA 07/01/2014 to 06/30/2017 AMA FREIDA Online	52637253 05/19/2011 09/20/2012 06/25/2015 USMLE1 USMLE2 USMLE3 224 224 226
65		Waterloo, IA, USA 07/09/1985	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/11/2012	University of Illinois Chicago, IL, USA 07/01/2012 to 06/30/2016 DARP PG 52, 2012/13	52505195 06/18/2010 09/21/2011 12/03/2013 USMLE1 USMLE2 USMLE3 219 239 212

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
66		Mounds View, MN, USA 10/27/1970	CASE WESTERN RESERVE U Cleveland, OH USA M.D. 05/17/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2020 AMA FREIDA Online	53079133 07/01/2013 11/19/2014 12/02/2015 USMLE1 USMLE2 USMLE3 226 248 238
67		Harlingen, TX, USA 04/26/1986	U OF TX SOUTHWESTERN MEDICAL SCHOOL Dallas, TX USA M.D. 05/27/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 07/14/2018 AMA FREIDA Online	53040465 06/19/2013 08/24/2014 06/28/2016 USMLE1 USMLE2 USMLE3 234 257 229
68		Alexandria, EGYPT 01/08/1984	U OF ALEXANDRIA Alexandria, Egypt M.B., B.Ch. 09/30/2007	Thomas Jefferson University Philadelphia, PA, USA 07/01/2012 to 06/30/2015 DARP PG 58, 2012/13	06672208 03/02/2010 09/08/2010 02/16/2011 USMLE1 USMLE2 USMLE3 253 244 210 ECFMG 0-667-220-8
69		New York, NY, USA 06/26/1961	U OF CA/SAN FRANCISCO San Francisco, CA USA M.D. 06/11/1989	NY Presbyterian Hospital New York, NY, USA 07/01/1989 to 06/30/1992 DARP PG 367, 1988/89	3-376-617-1 06/09/1987 09/28/1988 03/07/1990 NBME1 NBME2 NBME3 82 82 80 ABMS Pediatrics- Pediatrics 03/10/2000-MOC
70		Florence, SC, USA 05/16/1981	MED U OF SC Charleston, SC USA M.D. 05/16/2008	University of Iowa Iowa City, IA, USA 07/01/2008 to 06/30/2013 DARP PG 191, 2008/09	51555043 06/30/2006 08/18/2007 07/27/2009 USMLE1 USMLE2 USMLE3 210 216 198

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
71		Boston, MA, USA 08/18/1986	U OF MASSACHUSETTS Worcester, MA USA M.D. 06/02/2013	Dartmouth Hitchcock Lebanon, NH, USA 06/26/2013 to 06/30/2016 AMA FREIDA Online	52612348 06/28/2011 11/14/2012 08/11/2014 USMLE1 USMLE2 USMLE3 247 257 231
72		Nashville, TN, USA 09/28/1985	MEHARRY MED COL Nashville, TN USA M.D. 05/16/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2020 AMA FREIDA Online	52940939 06/27/2013 02/08/2015 04/13/2016 USMLE1 USMLE2 USMLE3 228 214 198
73		Point Fortin, TRINIDAD AND TOBAGO 02/01/1982	U OF MICHIGAN/ANN ARBOR Ann Arbor, MI USA M.D. 05/14/2010	University of Michigan Ann Arbor, MI, USA 06/27/2010 to 07/09/2014 DARP PG 189, 2010/11	52017142 04/30/2008 06/04/2009 12/02/2013 USMLE1 USMLE2 USMLE3 215 244 219
74		Minot, ND, USA 03/26/1984	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/13/2012	University of Missouri Kansas City, MO, USA 07/01/2012 to 06/30/2016 DARP PG 382, 2012/13	52464385 06/21/2010 07/26/2011 03/20/2013 USMLE1 USMLE2 USMLE3 210 237 219
75		Manhattan, KS, USA 08/11/1989	U OF KANSAS SCHL OF MED Kansas City, KS USA M.D. 05/17/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	53031597 06/13/2013 07/22/2014 02/13/2016 USMLE1 USMLE2 USMLE3 235 248 245

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
76		Two Rivers, WI, USA 04/26/1984	U OF WISCONSIN/MADISON Madison, WI USA M.D. 05/16/2010	University of Colorado Aurora, CO, USA 07/01/2011 to 06/30/2014 DARP PG 54, 2011/12	52066016 06/17/2008 07/28/2009 06/02/2011 USMLE1 USMLE2 USMLE3 220 249 234
77		Hudson, WI, USA 06/23/1983	GEORGETOWN U Washington, DC USA M.D. 05/17/2009	Childrens National Medical Center Washington, DC, USA 07/01/2009 to 06/30/2012 DARP PG 567, 2009/10	51944890 06/21/2007 07/25/2008 07/22/2010 USMLE1 USMLE2 USMLE3 209 215 210
78		Duluth, MN, USA 03/30/1979	U OF MINNESOTA Minneapolis, MN USA M.D. 05/06/2006	University of Pittsburgh Pittsburgh, PA, USA 06/22/2007 to 06/30/2011 DARP PG 388, 2007/08	51436202 06/07/2004 02/15/2006 03/25/2008 USMLE1 USMLE2 USMLE3 218 224 215
79		Breckenridge, MN, USA 08/01/1988	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/09/2015	Abbott Northwestern Hospital Minneapolis, MN, USA 06/24/2015 to 06/23/2016 AMA FREIDA Online	53003406 06/24/2013 07/17/2014 02/19/2016 USMLE1 USMLE2 USMLE3 250 257 239
80		Goodland, KS, USA 06/06/1983	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/28/2011	Firelands Regional Medical Center Sandusky, OH, USA 06/27/2011 to 06/22/2014 AOA Website	898005 07/13/2009 08/13/2010 09/19/2012 COMLEX1 COMLEX2 COMLEX3 474 491 491

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
81		Cochin, Kerala, INDIA 01/09/1984	GOVERNMENT MEDICAL COLLEGE Amritsar, INDIA M.B., B.S. 06/05/2007	Providence Hospital Washington, DC, USA 07/01/2011 to 06/30/2014 DARP PG 211, 2011/12	07426125 01/21/2008 06/18/2008 01/20/2010 USMLE1 USMLE2 USMLE3 246 230 214 ECFMG 07426125
82		Faridabad, INDIA 12/18/1988	U OF ARKANSAS Little Rock, AR USA M.D. 05/16/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2019 AMA FREIDA Online	52976008 06/28/2013 07/23/2014 06/30/2016 USMLE1 USMLE2 USMLE3 232 232 213
83		Winnipeg, MB, CANADA 05/12/1984	ST GEORGES U West Indies, Grenada M.D. 05/10/2013	Aultman Hospital Canton, OH, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	0-812-275-6 03/16/2011 07/21/2012 09/22/2014 USMLE1 USMLE2 USMLE3 211 217 200 ECFMG 0-812-275-6
84		Reading, UNITED KINGDOM 08/22/1988	U OF DUBLIN/TRINITY COLLEGE Dublin, IRELAND MB, BCh, BAO 05/15/2014	University of Minnesota Minneapolis, MN, USA 07/01/2014 to 06/30/2017 AMA FREIDA Online	08413304 08/21/2012 09/26/2013 09/20/2014 USMLE1 USMLE2 USMLE3 227 251 236 ECFMG 08413304
85		Scarborough, ON, CANADA 05/09/1981	AMERICA U OF THE CARIBBEAN, ST MAARTEN Cupecoy, ST. MAARTEN 04/05/2008	University of Missouri Columbia, MO, USA 07/01/2008 to 06/30/2010 DARP PG 642, 2008/09	06993356 06/23/2006 09/04/2007 06/02/2011 USMLE1 USMLE2 USMLE3 201 216 210 ECFMG 06993356

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
86		Zhenzhuo, CHINA 04/06/1987	U OF NEBRASKA/OMAHA Omaha, NE USA M.D. 05/09/2015	North Memorial Medical Center Minneapolis, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	53002267 06/15/2013 09/03/2014 01/25/2016 USMLE1 USMLE2 USMLE3 205 215 208
87		Bridgeport, CT, USA 03/17/1959	COLUMBIA U New York, NY USA M.D. 05/16/1984	University of Utah Salt Lake City, UT, USA 06/24/1984 to 06/30/1987 DARP PG 162, 1984/85	3-291-722-1 06/08/1982 09/27/1983 03/06/1985 NBME1 NBME2 NBME3 90 85 87.4 ABMS IM Internal Medicine 01/01/1987--Lifetime
88		Fargo, ND, USA 09/26/1981	U OF TOLEDO COLLEGE OF MEDICINE Toledo, OH USA M.D. 06/07/2013	University of Iowa Hospital and Clin Iowa City, IA, USA 06/24/2013 to 06/30/2016 AMA FREIDA Online	52663473 08/05/2011 11/09/2012 03/10/2015 USMLE1 USMLE2 USMLE3 247 264 242
89		Ft. Lauderdale, FL, USA 12/10/1985	U OF SOUTH FLORIDA Tampa, FL USA M.D. 04/17/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52931417 04/24/2013 06/06/2014 11/16/2015 USMLE1 USMLE2 USMLE3 246 248 235
90		Toledo, OH, USA 11/01/1971	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/25/2002	St. Vincent Hospital and Health Car Indianapolis, IN, USA 07/01/2002 to 08/15/2005 AOA Website	594215 06/06/2000 08/28/2001 12/10/2002 NBOME1 NBOME2 NBOME3 590 637 676 ABMS IM Internal Medicine 08/23/2005-MOC

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
91		New York City, NY, USA 10/03/1985	NEW JERSEY MED SCHOOL Newark, NJ USA M.D. 05/25/2011	Penn State Milton S Hershey Hershey, PA, USA 07/01/2011 to 06/30/2012 AMA FREIDA Online	52251170 05/19/2009 08/26/2010 09/22/2014 USMLE1 USMLE2 USMLE3 196 225 228
92		Marshall, MN, USA 11/25/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	North Memorial Medical Center Robbinsdale, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	52830395 06/12/2012 12/17/2013 04/05/2016 USMLE1 USMLE2 USMLE3 201 230 209
93		Long Prairie, MN, USA 09/09/1978	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2007	Mercy Medical Center Mason City, IA, USA 07/01/2007 to 06/30/2010 DARP PG# 287, 2007/08	51507101 05/27/2005 11/21/2006 02/28/2008 USMLE1 USMLE2 USMLE3 213 209 212
94		Hollowman AFB, NM, USA 04/28/1975	MEHARRY MED COL Nashville, TN USA M.D. 05/20/2006	Corpus Christi Family Practice Corpus Christi, TX, USA 07/01/2006 to 06/30/2009 DARP PG# 294, 2006/07	51330694 06/01/2004 08/11/2005 04/02/2007 USMLE1 USMLE2 USMLE3 252 252 254
95		Karachi, PAKISTAN 11/03/1968	WINDSOR U SCHOOL OF MEDICINE Basseterre, SAINT KITTS AND NEVIS 04/15/2006	Mountainside Hospital Montclair, NJ, USA 07/01/2007 to 06/30/2010 DARP PG# 381, 2007/08	06698492 12/30/2004 12/29/2005 08/29/2007 USMLE1 USMLE2 USMLE3 217 198 196 ECFMG 0-669-849-2

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
96		Meadowbrook, PA, USA 05/10/1961	HAHNEMANN MED COL/PHILI/DREXEL UNIV Philadelphia, PA USA M.D. 06/02/1988	Hahneman University Hospital Philadelphia, PA, USA 06/23/1988 to 06/22/1989 DARP PG# 698, 2006/07	3-349-518-5 06/11/1985 04/12/1988 03/06/1991 NBME1 NBME2 NBME3 77 81 80 ABMS Anesthesiology- Anesthesiology 10/29/1993--Lifetime
97		Cairo, EGYPT 05/20/1975	EIN SHAMS U Cairo, EGYPT M.B., Ch.B. 12/00/1999	Cincinnati Children's Hospital Cincinnati, OH, USA 09/18/2006 to 05/15/2008 DARP PG# 603, 2006/07 University of Arkansas for Medical S Little Rock, AR, USA 07/01/2008 to 06/30/2009 DARP PG# 705, 2008/09	06698070 03/22/2005 02/09/2006 02/20/2007 USMLE1 USMLE2 USMLE3 246 257 228 ECFMG 0-669-807-0 ABMS Urology- Urology 02/28/2015-02/28/2025-Time Limited
98		Treemonton, UT, USA 01/07/1966	MED COL OF VIRGINIA Richmond, VA USA M.D. 05/18/1996	Virginia Commonwealth University I Richmond, VA, USA 07/01/1996 to 06/30/1997 DARP PG# 550, 1996/97	40343485 06/08/1994 08/30/1995 03/25/2002 USMLE1 USMLE2 USMLE3 197 177 184 ABMS Radiology- Radiation Oncology 06/11/2002-MOC
99		Rice Lake, WI, USA 11/10/1979	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	Mayo School of GME Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	51978005 08/15/2007 02/11/2015 04/11/2016 USMLE1 USMLE2 USMLE3 200 226 217

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
100		Elmira, NY, USA 12/13/1984	STATE U OF NY/SYRACUSE Syracuse, NY USA M.D. 05/22/2010	Dartmouth Hitchcock Medical Center Lebanon, NH, USA 06/26/2011 to 06/25/2012 AMA FREIDA Online	52122579 06/20/2008 08/01/2009 10/27/2011 USMLE1 USMLE2 USMLE3 220 248 187
101		Junction City, KS, USA 11/21/1952	U OF TEXAS/GALVESTON Galveston, TX USA M.D. 05/25/1991	St Joseph's Hospital Phoenix, AZ, USA 06/23/1991 to 06/30/1996 DARP PG# 381, 1991/92	21284690 06/11/1991 06/11/1991 FLEX1 FLEX2 85 83 ABMS Pathology - Anatomic/Pathology - Clinical 10/04/1999--Lifetime
102		Yeosu, Junlanam-do, South Korea 04/27/1980	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/11/2008	University of Minnesota Minneapolis, MN, USA 07/01/2008 to 06/30/2011 DARP PG#	51727626 06/19/2006 11/07/2007 04/26/2010 USMLE1 USMLE2 USMLE3 184 196 207
103		Morgantown, WV, USA 05/12/1989	MAYO MED SCH Rochester, MN USA M.D. 05/16/2015	Eisenhower Medical Center Rancho Mirage, CA, USA 06/29/2015 to 06/26/2016 AMA FREIDA Online	52923802 05/21/2013 11/24/2014 12/02/2015 USMLE1 USMLE2 USMLE3 241 239 242
104		San Diego, CA, USA 09/02/1977	U OF TOLEDO COLLEGE OF MEDICINE Toledo, OH USA M.D. 06/02/2006	Johns Hopkins Bayview Medical Center Baltimore, MD, USA 07/01/2006 to 06/30/2010 DARP PG# 601, 2006/07	51333110 08/16/2004 03/23/2006 10/23/2009 USMLE1 USMLE2 USMLE3 184 185 192

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
105		Albany, NY, USA 01/18/1968	U OF ROCHESTER Rochester, NY USA M.D. 05/22/1994	Boston University Boston, MA, USA 06/24/1994 to 06/30/1998 DARP PG# 206, 1994/95	40114639 06/09/1992 03/30/1994 06/27/1995 USMLE1 USMLE2 USMLE3 217 220 222 ABMS IM Internal Medicine 05/05/2014-MOC
106		Charlotte, NC, USA 04/14/1985	EAST CAROLINA U Greenville, NC USA M.D. 05/08/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52989654 06/21/2013 07/17/2014 01/25/2016 USMLE1 USMLE2 USMLE3 235 244 238
107		Jacksonville, FL, USA 06/10/1986	MED COL OF GEORGIA Augusta, GA USA M.D. 05/31/2012	Palmetto Health Columbia, SC, USA 07/01/2012 to 06/30/2015 AMA FREIDA Online	52477148 06/24/2010 09/23/2011 03/04/2013 USMLE1 USMLE2 USMLE3 205 237 213
108		Busan, KOREA 10/30/1983	CREIGHTON U Omaha, NB USA M.D. 12/15/2012	Creighton University Omaha, NE, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52208766 01/17/2011 06/25/2012 05/20/2013 USMLE1 USMLE2 USMLE3 196 213 221
109		Vellore, INDIA 12/06/1990	U OF NEBRASKA/OMAHA Omaha, NE USA M.D. 05/09/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	53001673 06/15/2013 08/04/2014 02/26/2016 USMLE1 USMLE2 USMLE3 253 254 237

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
110		Munster, IN, USA 10/02/1983	NORTHWESTERN U Chicago, IL USA M.D. 05/14/2009	Akron General Medical Center Akron, OH, USA 07/01/2009 to 06/30/2010 DARP PG# 750, 2009/10	51894566 06/14/2007 03/03/2009 12/07/2009 USMLE1 USMLE2 USMLE3 230 253 241
111		Washington, DC, USA 12/30/1961	THOMAS JEFFERSON U Philadelphia, PA USA M.D. 06/10/1988	Bayfront Medical Center St. Petersburg, FL, USA 07/01/1988 to 06/30/1991 DARP PG# 447, 1988/89	3-351-890-3 06/10/1986 09/29/1987 03/01/1989 NBME1 NBME2 NBME3 82 83 84 ABMS Family Medicine- Family Medicine 07/12/1991-MOC
112		Davao City, PHILIPPINES 02/16/1979	U OF MINNESOTA Minneapolis, MN USA M.D. 05/06/2006	Rush University Medical Center Chicago, IL, USA 06/22/2006 to 06/21/2007 DARP PG# 663, 2006/07	51274470 05/28/2004 11/11/2005 03/07/2008 USMLE1 USMLE2 USMLE3 187 201 204
113		Grand Rapids, MI, USA 02/09/1961	MI STATE U/COL HUMAN MED East Lansing, MI USA M.D. 08/19/1993	Spectrum Health Grand Rapids, MI, USA 07/01/1993 to 06/30/1994 DARP PG# 323, 1993/94	3-431-214-0 06/11/1991 09/24/1992 03/02/1994 NBME1 USMLE2 NBME3 77 193 79 ABMS Physical Med. & Rehab.- Physical Medicine & Rehabil07/01/1998-12/31/2018- Time Limited

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
114		Longbranch, NJ, USA 09/13/1968	U OF MICHIGAN/ANN ARBOR Ann Arbor, MI USA M.D. 06/05/1998	Pennsylvania Hospital Philadelphia, PA, USA 06/18/1998 to 06/30/2004 DARP PG# 317, 1998/99	40534588 06/14/1995 03/04/1997 12/01/1998 USMLE1 USMLE2 USMLE3 207 230 222 ABMS Surgery- Surgery 12/14/2015-12/31/2025-Time Limited
115		Rugby, ND, USA 10/07/1988	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/09/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53003547 06/17/2013 07/15/2014 12/14/2015 USMLE1 USMLE2 USMLE3 207 233 212
116		Barton, NY, USA 02/04/1960	LOMA LINDA U Loma Linda, CA USA M.D. 06/30/1987	Loma Linda University Medical Loma Linda, CA, USA 07/01/1987 to 06/30/1988 DARP PG# 166, 1987/88	3-339-182-2 06/11/1985 04/07/1987 03/02/1988 NBME1 NBME2 NBME3 78 77 80.1 ABMS Anesthesiology- Anesthesiology 04/23/1993--Lifetime
117		Santa Barbara, CA, USA 01/30/1985	ST GEORGES U Grenada, WEST INDIES M.D. 04/12/2013	Louisiana State University Shreveport, LA, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	08234718 07/14/2011 08/11/2012 09/08/2014 USMLE1 USMLE2 USMLE3 244 250 250 ECFMG 0-823-471-8

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
118		Sopore, INDIA 06/14/1955	GOVT MED COL/KASHMIR U Srinagar, INDIA M.B., B.S. 06/30/1978	Sisters of Charity Hospital Buffalo, NY, USA 07/01/1994 to 06/30/1996 DARP PG# 441, 1994/95	04786984 09/21/1993 03/01/1995 12/05/1995 USMLE1 USMLE2 USMLE3 180 196 187 ECFMG 0-478-698-4 ABMS IM (Sub) - Cardiovascular Disease 11/04/2011-12/31/2021-Time Limited
119		Kinshasa, ZAIRE 11/11/1975	ST GEORGES U St. George's, GRENADA 05/16/2008	SUNY Syracuse, NY, USA 07/01/2008 to 06/30/2012 DARP PG# 715, 2008/09	07025752 08/04/2006 09/20/2007 06/08/2010 USMLE1 USMLE2 USMLE3 229 221 204 ECFMG 0-702-575-2
120		Patiala, INDIA 08/13/1983	DAYANAND MED COL/PUNJAB Ludhiani, INDIA M.B., B.S. 02/13/2008	Detroit Medical Center Detroit, MI, USA 07/01/2010 to 06/30/2013 DARP PG# 189, 2010/11	07581903 06/11/2008 06/01/2009 02/15/2010 USMLE1 USMLE2 USMLE3 202 230 202 ECFMG 0-758-190-3
121		Borujerd, IRAN 08/22/1977	TEHRAN U OF MED SCI & HLTH SERVICES Tehran, IRAN M.D. 04/19/2003	Presence St Francis Evanston, IL, USA 06/24/2013 to 06/23/2016 AMA FREIDA Online	06850960 05/02/2011 09/19/2005 01/23/2012 USMLE1 USMLE2 USMLE3 246 235 233 ECFMG 0-685-096-0

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
122		Tokyo, JAPAN 11/09/1982	CASE WESTERN RESERVE U Cleveland, OH USA M.D. 05/17/2009	University of Michigan Ann Arbor, MI, USA 06/24/2009 to 06/30/2013 DARP PG# 396, 2009/10	51941912 03/14/2007 08/21/2008 02/06/2012 USMLE1 USMLE2 USMLE3 234 225 212
123		West Allis, WI, USA 12/12/1985	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2012	Grand Rapids Medical Education P Grand Rapids, MI, USA 07/01/2012 to 06/30/2016 AMA FREIDA Online	52364064 06/21/2010 11/05/2011 04/24/2013 USMLE1 USMLE2 USMLE3 196 216 199
124		Pelican Rapids, MN, USA 11/07/1983	CREIGHTON U Omaha, NE USA M.D. 05/15/2010	University of North Dakota Fargo, ND, USA 07/01/2010 to 06/30/2011 DARP PG# 777, 2010/11	52084068 06/05/2008 11/25/2009 04/04/2011 USMLE1 USMLE2 USMLE3 245 225 216
125		Des Moines, IA, USA 02/01/1984	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/14/2010	University of Iowa Hospital and Clin Iowa City, IA, USA 07/01/2010 to 06/30/2015 AMA FREIDA Online	52057635 06/11/2008 10/30/2009 10/12/2010 USMLE1 USMLE2 USMLE3 234 262 230
126		Baton Rouge, LA, USA 10/26/1985	U OF ARIZONA Tucson, AZ USA M.D. 05/14/2011	Mayo Clinic Hospital Scottsdale, AZ, USA 07/02/2011 to 06/30/2015 AMA FREIDA Online	52204633 06/17/2009 08/04/2010 05/03/2012 USMLE1 USMLE2 USMLE3 227 257 238

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
127		Columbia, SC, USA 02/12/1974	TEXAS TECH U Lubbock, TX USA M.D. 05/22/1999	West Virginia University Morgantown, WV, USA 07/01/1999 to 06/30/2002 DARP PG# 472, 1999/00	50271337 06/10/1997 08/25/1998 04/11/2000 USMLE1 USMLE2 USMLE3 218 191 192 ABMS Emergency Medicine- Emergency Medicine 01/01/2014-12/31/2023-Time Limited
128		Chicgao, IL, USA 06/03/1982	U OF WISCONSIN/MADISON Madison, WI USA M.D. 05/15/2011	University of Wisconsin Hospital Madison, WI, USA 06/24/2011 to 06/23/2012 AMA FREIDA Online	52170776 06/19/2009 12/30/2010 11/08/2012 USMLE1 USMLE2 USMLE3 234 227 222
129		Madison, WI, USA 06/23/1989	MILWAUKEE MED COL Milwaukee, WI USA M.D. 05/15/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	53055497 06/13/2013 10/23/2014 11/19/2015 USMLE1 USMLE2 USMLE3 245 267 255
130		Marshfield, WI, USA 05/15/1989	U OF WISCONSIN/MADISON Madison, WI USA M.D. 05/15/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53021887 06/21/2013 12/22/2014 11/09/2015 USMLE1 USMLE2 USMLE3 248 250 237
131		Edinburgh, PA, USA 09/13/1985	U OF PITTSBURGH Pittsburgh, PA USA M.D. 06/18/2011	University of Pittsburgh Pittsburgh, PA, USA 06/24/2011 to 06/30/2014 AMA FREIDA Online	5-200-777-0 04/29/2009 08/21/2010 05/21/2012 USMLE1 USMLE2 USMLE3 228 241 229

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
132		Poltava, UKRAINE 06/12/1971	STOMATOLOGICAL ACADEMY Poltava, UKRAINE 06/26/1996	Cleveland Clinic Foundation Cleveland, OH, USA 10/03/2005 to 08/13/2010 DARP PG# 983, 2005/06	06562730 02/28/2004 05/24/2005 05/02/2006 USMLE1 USMLE2 USMLE3 187 216 185 ECFMG 0-656-273-0
133		Detroit, MI, USA 04/25/1941	KANSAS CITY U of MED & BIOSCIENCES Kansas City, MO USA D.O. 05/19/1971	Pontiac Osteopathic Hospital Pontiac, MI, USA 07/01/1971 to 06/30/2072 DARP PG# 292, 1971/72	031556 10/31/1969 10/18/1971 01/15/1972 COMLEX1 COMLEX2 COMLEX3 79 79 87 AOABPE Radiology (AOA) - Diagnostic Radiology 01/31/1979--Lifetime
134		Accra, GHANA 08/17/1981	U OF THE WEST INDIES Bridgetown, BARBADOS M.B., B.S. 07/01/2004	UIC College of Medicine Rockford, IL, USA 07/01/2009 to 06/30/2012 DARP PG# 302, 2009/10	06839369 07/24/2007 08/10/2006 12/05/2011 USMLE1 USMLE2 USMLE3 191 206 233 ECFMG 0-683-936-9
135		St. Louis Park, MN, USA 12/02/1987	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53035929 06/04/2013 06/24/2014 01/27/2016 USMLE1 USMLE2 USMLE3 240 252 232
136		Monroeville, PA, USA 02/02/1984	DREXEL U COLLEGE OF MEDICINE Philadelphia, PA USA M.D. 05/21/2010	University of Washington Seattle, WA, USA 06/25/2010 to 06/30/2011 AMA FREIDA Online	52147261 06/18/2008 07/28/2009 05/05/2011 USMLE1 USMLE2 USMLE3 228 234 194

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
137		Denver, CO, USA 09/30/1987	U OF COLORADO Denver, CO USA M.D. 05/22/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	53044111 04/09/2013 09/26/2014 02/26/2016 USMLE1 USMLE2 USMLE3 254 236 231
138		Kargat, RUSSIA 08/04/1966	TOMSK MED INSTITUTE Tomsk, RUSSIA 06/23/1990	Lincoln Medical and Mental Health Bronx, NY, USA 07/01/2007 to 06/30/2010 AMA FREIDA Online	06679443 09/23/2005 04/11/2006 02/01/2007 USMLE1 USMLE2 USMLE3 199 242 199 ECFMG 0-667-944-3
139		Southfield, MI, USA 03/16/1990	U OF ILLINOIS/CHICAGO Chicago, IL USA M.D. 05/08/2015	MacNeal Hospital Berwyn, IL, USA 06/15/2015 to 06/12/2016 AMA FREIDA Online	53033122 06/06/2013 07/29/2014 12/20/2015 USMLE1 USMLE2 USMLE3 251 263 245
140		Rensselaer, IN, USA 12/03/1988	U OF CINCINNATI Cincinnati, OH USA M.D. 06/05/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52947751 06/21/2013 09/23/2014 10/29/2015 USMLE1 USMLE2 USMLE3 232 245 230
141		Madison, WI, USA 05/10/1980	U OF WISCONSIN/MADISON Madison, WI USA M.D. 05/19/2013	Marshfield Clinic Marshfield, WI, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52438074 10/21/2010 07/30/2012 07/28/2014 USMLE1 USMLE2 USMLE3 207 229 221

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
142		Osage, IA, USA 07/15/1987	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	53057782 06/13/2013 05/30/2014 04/18/2016 USMLE1 USMLE2 USMLE3 256 255 226
143		Lincolnton, NC, USA 04/27/1985	U OF SOUTH CAROLINA Columbia, SC USA M.D. 05/06/2011	University of Tennessee Chattanooga, TN, USA 07/01/2011 to 06/30/2016 AMA FREIDA Online	52245503 06/08/2009 07/28/2010 09/26/2011 USMLE1 USMLE2 USMLE3 238 254 221
144		Blue Earth, MN, USA 08/12/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 05/04/2013	North Colorado Family Medicine Greeley, CO, USA 06/16/2013 to 06/30/2016 AMA FREIDA Online	52643491 06/20/2011 09/17/2012 01/30/2014 USMLE1 USMLE2 USMLE3 213 216 198
145		Roseau, MN, USA 04/03/1986	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/12/2013	Altru Health System Grand Forks, ND, USA 07/01/2013 to 08/05/2016 AMA FREIDA Online	52643269 06/28/2011 08/06/2012 08/25/2014 USMLE1 USMLE2 USMLE3 248 263 226
146		Davenport, IA, USA 07/26/1984	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/11/2012	The Ohio State University Columbus, OH, USA 07/01/2012 to 06/30/2015 AMA FREIDA Online	52504099 06/11/2010 07/21/2011 11/13/2013 USMLE1 USMLE2 USMLE3 224 249 251
147		San Juan, PR, UNITED STATES 01/04/1988	U OF PUERTO RICO San Juan, PR UNITED STATES M.D. 06/06/2014	San Juan City Hospital San Juan, PR, USA 07/01/2014 to 06/30/2015 AMA FREIDA Online	52744976 07/21/2012 08/14/2013 09/22/2014 USMLE1 USMLE2 USMLE3 223 256 221

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
148		Grand Rapids, MI, USA 02/13/1985	LOYOLA U/STRITCH MED SCH Maywood, IL USA M.D. 06/03/2012	West Suburban Medical Center Oak Park, IL, USA 07/01/2012 to 06/30/2015 AMA FREIDA Online	52413440 06/16/2010 07/22/2011 07/16/2013 USMLE1 USMLE2 USMLE3 204 231 214
149		Tokyo, JAPAN 02/20/1957	U OF COLORADO Auroro, CO USA M.D. 05/28/2010	St. Joseph Family Medicine Milwaukee, WI, USA 07/01/2010 to 06/30/2013 DARP PG# 144, 2010/11	51829679 06/17/2008 03/26/2010 11/23/2011 USMLE1 USMLE2 USMLE3 191 187 202
150		Cochabamba, BOLIVIA 05/15/1978	U MAYOR DE SAN ANDRES Cochabamba, BOLIVIA 03/02/2002	Temple University Hospital Philadelphia, PA, USA 06/20/2004 to 06/19/2007 DARP PG# 346, 2004/05	06503106 05/01/2003 08/29/2003 02/02/2004 USMLE1 USMLE2 USMLE3 226 246 220 ECFMG 0-650-310-6 ABMS IM Internal Medicine 08/29/2007-12/31/2017-Time Limited
151		Houston, TX, USA 06/10/1983	ROSS U/U OF DOMINICA Roseau, DOMINICA 03/31/2012	Rutgers New Jersey Medical Schoc Verona, NJ, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	07985427 03/18/2010 08/13/2011 08/11/2014 USMLE1 USMLE2 USMLE3 225 209 232 ECFMG 0-798-542-7
152		New York, NY, USA 10/06/1982	STATE U OF NY/SYRACUSE Syracuse, NY USA M.D. 05/18/2008	SUNY Stony Brook University Stony Brook, NY, USA 07/01/2008 to 06/30/2012 DARP PG 489, 2008/09	51745396 07/06/2006 02/16/2008 09/13/2010 USMLE1 USMLE2 USMLE3 226 234 219

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
153		Ames, IA, USA 05/03/1984	U OF MINNESOTA Minneapolis, MN USA M.D. 05/10/2014	Regions Hospital St. Paul, MN, USA 07/01/2014 to 06/30/2016 AMA FREIDA Online	52830239 06/09/2012 12/31/2013 06/08/2015 USMLE1 USMLE2 USMLE3 241 246 235
154		Lewiston, NY, USA 04/06/1986	STATE U OF NY/BUFFALO Buffalo, NY USA M.D. 06/01/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52985942 06/21/2013 08/14/2014 02/01/2016 USMLE1 USMLE2 USMLE3 260 259 255
155		Dunkirk, NY, USA 08/13/1989	STATE U OF NY/BUFFALO Buffalo, NY USA M.D. 06/01/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	52985363 06/15/2013 08/14/2014 02/01/2016 USMLE1 USMLE2 USMLE3 263 266 250
156		Jalandhar, INDIA 12/11/1976	GOVERNMENT MEDICAL COLLEGE Amritsar, INDIA M.B., B.S. 02/03/2000	Willaim Beaumont Hospital Royal Oak, MI, USA 07/01/2009 to 06/30/2013 AMA FREIDA Online	06718928 05/18/2005 12/01/2005 07/10/2006 USMLE1 USMLE2 USMLE3 233 247 193 ECFMG 0-671-892-8
157		Turku, FINLAND 09/06/1973	EMORY U Atlanta, GA USA M.D. 05/13/2002	Emory University School of Medicin Atlanta, GA, USA 07/01/2002 to 06/30/2005 DARP PG#	50798891 06/23/2000 12/11/2001 07/18/2003 USMLE1 USMLE2 USMLE3 225 235 227 ABMS Emergency Medicine- Emergency Medicine 06/14/2006-12/31/2016-Time Limited

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
158		Guatemala, GAUTAMELA 08/01/1983	U FRANCISCO MARROQUIN Guatemala City, GUATEMALA 07/31/2009	Bronx-Lebanon Hospital Center Bronx, NY, USA 07/01/2011 to 06/30/2015 AMA FREIDA Online	07687023 11/20/2008 09/14/2009 03/28/2013 USMLE1 USMLE2 USMLE3 207 218 205 ECFMG 0-768-702-3
159		Tamuning, GUAM 04/28/1980	U OF HAWAII/JOHN A BURNS Honolulu, HI USA M.D. 05/16/2009	University of Hawaii Honolulu, HI, USA 07/01/2009 to 06/30/2010 DARP PG#	51909158 06/04/2007 07/03/2008 12/03/2009 USMLE1 USMLE2 USMLE3 222 227 203
160		Morristown, NJ, USA 04/07/1980	KANSAS CITY U of MED & BIOSCIENCES Kansas City, MO USA D.O. 05/14/2011	Palms West Hospital Loxahatchee, FL, USA 07/01/2011 to 06/30/2012 AOA Website	898625 06/13/2009 07/14/2010 01/14/2012 COMLEX1 COMLEX2 COMLEX3 514 412 448
161		Bemidji, MN, USA 05/11/1985	U OF MINNESOTA Minneapolis, MN USA M.D. 05/04/2013	UPMC St Margaret Pittsburgh, PA, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52693124 10/12/2011 09/08/2012 06/26/2014 USMLE1 USMLE2 USMLE3 194 200 225
162		Milwaukee, WI, USA 02/13/1981	CREIGHTON U Omaha, NE USA M.D. 05/17/2014	U of MN Fairview Minneapolis, MN, USA 07/01/2014 to 06/30/2016 AMA FREIDA Online	52765724 06/04/2012 07/21/2013 08/15/2015 USMLE1 USMLE2 USMLE3 201 240 236

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
163		Des Moines, IA, USA 12/27/1987	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/23/2015	University of Minnesota Minneapolis, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	502393 07/16/2013 07/01/2014 08/25/2015 COMLEX1 COMLEX2 COMLEX3 544 625 675
164		San Dimas, CA, USA 02/03/1987	U OF CA/SAN DIEGO San Diego, CA USA M.D. 06/07/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	53092946 04/25/2013 06/03/2014 12/14/2015 USMLE1 USMLE2 USMLE3 260 275 252
165		Lima, PERU 11/06/1986	U OF CA/SAN DIEGO La Jolla, CA USA M.D. 06/07/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53093076 04/29/2013 06/04/2014 12/17/2015 USMLE1 USMLE2 USMLE3 234 259 245
166		Royal Oak, MI, USA 12/25/1987	U OF CENTRAL FL COL OF MEDICINE Orlando, FL USA M.D. 05/15/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FRIEDA Online	52913472 05/09/2013 05/29/2014 03/31/2016 USMLE1 USMLE2 USMLE3 254 265 245
167		Miami, FL, USA 06/01/1975	BAYLOR COL OF MED Houston, TX USA M.D. 05/23/2006	UT Southwestern Medical Center Dallas, TX, USA 07/01/2006 to 06/30/2009 DARP PG# 611, 2006/07	50654029 10/21/1999 04/26/2006 05/03/2007 USMLE1 USMLE2 USMLE3 216 199 194

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
168		Wheeling, WV, USA 01/11/1974	W VIRGINIA SCHL OF OSTEO Lewisburg, WV USA D.O. 05/27/2000	Sinai Hospital Baltimore, MD, USA 06/23/2000 to 06/22/2003 DARP PG# 189, 2000/01	451132 06/02/1998 08/17/1999 06/11/2002 COMLEX1 COMLEX2 COMLEX3 454 529 619 ABMS IM Internal Medicine 09/03/2013-12/31/2023-Time Limited
169		Minneapolis, MN, USA 10/02/1985	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2012	Strong Memorial Hospital Rochester, NY, USA 07/01/2012 to 06/30/2016 AMA FREIDA Online	52364445 06/08/2010 12/22/2011 11/14/2013 USMLE1 USMLE2 USMLE3 222 232 215
170		Mason City, IA, USA 04/16/1984	MAYO MED SCH Rochester, MN USA M.D. 05/16/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52232774 07/10/2009 02/20/2015 12/28/2015 USMLE1 USMLE2 USMLE3 250 255 245
171		Austin, MN, USA 01/11/1989	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	Abbott Northwestern Hospital Minneapolis, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53036612 06/04/2013 11/10/2014 02/19/2016 USMLE1 USMLE2 USMLE3 234 234 241
172		Addis Ababa, ETHIOPIA 10/09/1973	AMERICA U OF THE CARIBBEAN, ST MAARTEN St. Maarten, NETHERLAND ANTILLES 12/18/2004	Oakwood Hospital and Medical Cer Dearborn, MI, USA 07/01/2007 to 06/30/2010 DARP PG# 314, 2007/08	06413199 10/29/2003 11/01/2005 06/05/2009 USMLE1 USMLE2 USMLE3 185 203 198 ECFMG 0-641-319-9

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
173		Koothanallur, INDIA 01/06/1941	MADURAI U MED COL Madurai, INDIA M.B., B.S. 04/30/1964	Flushing Hospital Medical Center Flushing, NY, USA 07/01/1974 to 06/30/1979 DARP PG# 339, 1974/75	20603015 06/14/1977 FLEX 78.90 ECFMG 189-590-3 ABMS Surgery- (Sub) Surgical Critical Care 10/23/1987-12/31/2018-Time Limited
174		Phoenix, AZ, USA 11/28/1988	TX TECH U, PAUL L FOSTER SCH OF MEDICINE El Paso, TX USA M.D. 05/22/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	52942729 06/21/2013 09/20/2014 02/08/2016 USMLE1 USMLE2 USMLE3 253 254 224
175		New York, NY, USA 05/14/1958	STATE U OF NY/BROOKLYN Brooklyn, NY USA M.D. 05/26/1983	SUNY Health Service Brooklyn, NY, USA 07/01/1983 to 06/30/1987 DARP PG#	3-283-638-9 06/10/1981 09/28/1982 03/07/1984 NBME1 NBME2 NBME3 76 76 77 ABMS Surgery- Vascular Surgery 05/22/1995-12/31/2023-Time Limited
176		Lincoln, NE, USA 03/31/1978	U OF ILLINOIS/URBANA Urbana, IL USA M.D. 05/10/2015	University of Illinois Urbana, IL, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	51276855 06/26/2013 08/14/2014 03/17/2016 USMLE1 USMLE2 USMLE3 231 241 235

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
177		Randolf, CA, USA 12/17/1982	LOYOLA U/STRITCH MED SCH Maywood, IL USA M.D. 06/06/2010	University of California San Francisco, CA, USA 06/20/2010 to 06/30/2013 DARP PG# 613, 2010/11	52140639 06/11/2008 12/23/2009 02/09/2011 USMLE1 USMLE2 USMLE3 236 238 225
178		Minneapolis, MN, USA 10/12/1986	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/15/2015	United Hospital St. Paul, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	52810595 06/12/2012 07/10/2014 04/14/2016 USMLE1 USMLE2 USMLE3 219 227 207
179		Livingston, NJ, USA 08/04/1981	U OF MEDICINE AND DENTISTRY OF NJ Stratford, NJ USA D.O. 05/22/2007	UMDNJ School of Medicine Stratford, NJ, USA 06/18/2007 to 06/16/2008 AOA Website	772976 06/07/2005 11/09/2006 05/29/2008 COMLEX1 COMLEX2 COMLEX3 692 564 705
180		New York City, NY, USA 10/10/1990	U OF MO/KANSAS CITY Kansas City, MO USA M.D. 05/30/2014	Mayo School of Medicine Rochester, MN, USA 06/20/2015 to 06/30/2017 AMA FREIDA Online	52894862 09/28/2012 03/31/2014 11/16/2015 USMLE1 USMLE2 USMLE3 216 239 217
181		Minneapolis, MN, USA 11/14/1982	WAYNE STATE U Detroit, MI USA M.D. 06/08/2010	University of Cincinnati Cincinnati, OH, USA 07/01/2010 to 06/30/2014 AMA FREIDA Online	52117678 06/23/2008 08/20/2009 05/22/2012 USMLE1 USMLE2 USMLE3 202 207 206

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182		Charlotte, NC, USA 08/02/1988	BOSTON U Boston, MA USA M.D. 05/17/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52983665 05/20/2013 05/30/2014 03/14/2016 USMLE1 USMLE2 USMLE3 262 270 247
183		Urbana, IL, USA 06/28/1982	U OF MO/KANSAS CITY Kansas City, MO USA M.D. 05/31/2007	Rush Presbyterian Hospital Chicago, IL, USA 07/01/2007 to 06/30/2008 DARP PG# 686, 2007/08	51653608 10/11/2005 02/28/2007 12/14/2010 USMLE1 USMLE2 USMLE3 184 207 206
184		Cleveland, OH, USA 10/16/1974	NY COL OF OSTEO MED Old Westbury, NY USA D.O. 05/23/2004	Long Beach Medical Center New York, NY, USA 07/01/2004 to 06/30/2005 AOA Website	664774 06/04/2002 08/26/2003 12/14/2004 COMPLEX1 COMPLEX2 COMPLEX3 462 480 433 ABMS IM Internal Medicine 08/28/2008-12/31/2018-Time Limited
185		Robbinsdale, MN, USA 01/15/1986	MEDICAL COLLEGE OF WISCONSIN Milwaukee, WI USA M.D. 05/17/2013	Medical College of Wisconsin Milwaukee, WI, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52616760 06/08/2011 07/19/2012 05/19/2014 USMLE1 USMLE2 USMLE3 203 230 212
186		Park Ridge, IL, USA 09/11/1975	NY COL OF OSTEO MED Old Westbury, NY USA D.O. 05/20/2007	New York Hospital Medical Center Flushing, NY, USA 07/01/2007 to 06/30/2012 DARP PG# 716, 2007/08	770507 06/07/2005 03/22/2007 04/28/2008 COMPLEX1 COMPLEX2 COMPLEX3 508 558 615

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
187		Windsor, ENGLAND 08/01/1971	TUFTS U Boston, MA USA M.D. 05/01/1995	National Capital Consortium Bethesda, MD, USA 06/26/1995 to 06/30/1996 DARP PG# 342, 1995/96	40210999 06/08/1993 03/01/1995 05/14/1996 USMLE1 USMLE2 USMLE3 232 245 232 ABMS IM Internal Medicine 08/26/1998-12/31/2019-Time Limited
188		Jacksonville, FL, USA 09/18/1987	MAYO MED SCH Rochester, MN USA M.D. 05/16/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	52569225 06/04/2011 07/01/2014 02/29/2016 USMLE1 USMLE2 USMLE3 217 236 207
189		Des Moines, IA, USA 11/12/1988	U OF NEBRASKA/OMAHA Omaha, NE USA M.D. 05/09/2015	Creighton University Medical Center Omaha, NE, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53001574 06/13/2013 08/28/2014 12/07/2015 USMLE1 USMLE2 USMLE3 249 261 228
190		Scottsdale, AZ, USA 06/16/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 05/04/2012	Hennepin County Medical Center Minneapolis, MN, USA 07/01/2012 to 06/30/2015 AMA FREIDA Online	52363785 05/28/2010 09/21/2011 05/28/2013 USMLE1 USMLE2 USMLE3 221 242 226
191		Oxnard, CA, USA 01/20/1963	OREGON HEALTH SCIENCES U Portland, OR USA M.D. 06/08/2007	University of Wisconsin Madison, WI, USA 06/13/2007 to 06/30/2010 DARP PG# 293, 2007/08	51391100 06/18/2004 06/20/2005 09/09/2008 USMLE1 USMLE2 USMLE3 224 230 213

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
192		Mogadishu, SOMALIA 01/01/1980	WINDSOR U SCHOOL OF MEDICINE Basseterre, ST. KITTS M.D. 12/31/2013	HCMC Minneapolis, MN, USA 06/17/2014 to 06/30/2016 AMA FREIDA Online	08784894 10/24/2011 07/09/2013 11/22/2015 USMLE1 USMLE2 USMLE3 189 212 201 ECFMG 0-878-489-4
193		Istanbul, TURKEY 07/15/1974	NORTHWESTERN U Chicago, IL USA M.D. 05/23/2003	Presbyterian Hospital New York, NY, USA 06/14/2004 to 06/13/2005 DARP PG 962, 2004/05	50349182 06/26/2001 03/05/2003 11/12/2005 USMLE1 USMLE2 USMLE3 233 211 197 ABMS Radiology- Diagnostic Radiology 06/03/2009-12/31/2019-Time Limited ABMS Radiology- (Sub) Vascular & Interventional Radiology11/05/2012-MOC
194		Ogbomoso, NIGERIA 11/29/1981	MEHARRY MED COL Nashville, TN USA M.D. 10/31/2011	University of Tennessee Memphis, TN, USA 07/01/2012 to 06/30/2016 DARP PG 630, 2012/13	52271335 10/23/2009 06/28/2011 02/19/2014 USMLE1 USMLE2 USMLE3 203 216 225

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
195		Lagos, NIGERIA 01/01/1969	U OF IBADAN Ibadan, NIGERIA M.B., B.S. 06/28/1991	Howard University Washington, DC, USA 06/25/1995 to 06/24/1996 DARP PG 775, 1995/96 Howard University Washington, DC, USA 07/01/1996 to 06/30/1997 DARP PG 848, 1996/97	04477063 06/08/1994 03/05/1996 05/13/1997 USMLE1 USMLE2 USMLE3 200 193 190 ECFMG 04477063 ABMS Radiology- Diagnostic Radiology 06/13/2001--Lifetime ABMS Radiology- (Sub) Vascular & Interventional Radiology11/08/2004-MOC
196		Iowa City, IA, USA 12/09/1985	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	University of Minnesota Minneapolis, MN, USA 06/15/2015 to 06/30/2019 AMA FREIDA Online	53036943 06/06/2013 06/12/2014 04/08/2016 USMLE1 USMLE2 USMLE3 216 230 219
197		Rockford, IL, USA 07/30/1980	U OF ILLINOIS/ROCKFORD Rockford, IL USA M.D. 05/07/2006	University of Nebraska Omaha, NE, USA 07/01/2006 to 06/30/2008 DARP PG 667, 2006/07	51438174 06/14/2004 12/16/2005 05/05/2008 USMLE1 USMLE2 USMLE3 227 211 208
198		Fridley, MN, USA 09/28/1985	CHICAGO COL OF OSTEO MED Downers Grove, IL USA D.O. 05/23/2013	Advocate Christ Medical Center Oak Lawn, IL, USA 06/24/2013 to 08/18/2016 AOA Report	991249 05/27/2011 06/29/2012 06/19/2014 COMLEX1 COMLEX2 COMLEX3 606 724 999

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199		Urbana, IL, USA 08/22/1984	SOUTHERN ILLINOIS U Springfield, IL USA M.D. 05/21/2011	Children's Mercy Hospital Kansas City, MO, USA 07/01/2011 to 06/30/2014 DARP PG 608, 2011/12	52218476 06/20/2009 09/10/2010 06/04/2012 USMLE1 USMLE2 USMLE3 209 238 233
200		Bogota, COLUMBIA 04/29/1985	PONTIFICIA U/JAVERIANA Bogota, COLUMBIA 06/05/2008	North Memorial Medical Center Robbinsdale, MN, USA 07/01/2014 to 06/30/2017 AMA FREIDA Online	08551509 01/29/2013 08/01/2013 04/24/2015 USMLE1 USMLE2 USMLE3 218 241 219 ECFMG 08551509
201		Bangalore, INDIA 12/10/1977	BANGALORE MEDICAL COLLEGE Bangalore, INDIA M.B., B.S. 08/28/2003	O1 Visa Alien of Extraordinary Abilit No US/Canadian Medical Training F	08005951 05/20/2010 11/15/2010 06/21/2011 USMLE1 USMLE2 USMLE3 214 238 230 ECFMG 08005951
202		Little Falls, MN, USA 04/05/1983	U OF MINNESOTA Minneapolis, MN USA M.D. 05/02/2009	Indiana University Indianapolis, IN, USA 07/01/2009 to 06/30/2014 DARP PG 522, 2009/10	51953941 06/05/2007 12/30/2008 04/06/2010 USMLE1 USMLE2 USMLE3 240 245 240
203		Houston, TX, USA 02/10/1982	POZNAN U OF MEDICAL SCIENCES Poznan, POLAND M.D. 05/10/2012	Mayo Clinic Rochester, MN, USA 07/01/2014 to 06/30/2019 AMA FREIDA Online	08713471 04/29/2013 08/12/2013 06/01/2014 USMLE1 USMLE2 USMLE3 200 226 199 ECFMG 08713241

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204		New York, NY, USA 11/25/1963	DREXEL U COLLEGE OF MEDICINE Philadelphia, PA USA M.D. 05/29/1998	Medical College of Pennsylvania Philadelphia, PA, USA 06/23/1998 to 06/30/2001 DARP PG 588, 1998/99	50028323 06/11/1996 08/26/1997 12/01/1998 USMLE1 USMLE2 USMLE3 227 229 214 ABMS IM Internal Medicine 10/28/2011-12/31/2021-Time Limited ABMS IM (Sub) - Geriatric Medicine 11/07/2012-12/31/2022-Time Limited
205		New York, NY, USA 11/06/1956	MI STATE U/COL OF OSTEO East Lansing, MI USA D.O. 06/08/1990	Bay Regional Medical Center Bay City, MI, USA 07/01/1990 to 06/30/1991 AOA Report	240729 10/20/1988 03/15/1990 02/21/1991 COMPLEX1 COMPLEX2 COMPLEX3 561 680 519 ABMS Physical Med. & Rehab.- Physical Medicine & Rehabil07/01/2006-12/31/2016- Time Limited
206		Warangal, INDIA 06/19/1976	GANDHI MEDICAL COLLEGE, SECUNDERABAD Secunderabad, INDIA M.B., B.S. 09/13/2001	Creighton University Omaha, NE, USA 07/01/2005 to 06/30/2006 DARP PG 749, 2005/06 St. John's Episcopal Hospital Far Rockaway, NY, USA 06/24/2007 to 06/30/2010 DARP PG 382, 2007/08	06339931 03/27/2002 11/28/2002 01/17/2005 USMLE1 USMLE2 USMLE3 252 210 199 ECFMG 06339931 ABMS IM Internal Medicine 08/25/2010-12/31/2020-Time Limited

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
207		Dayton, OH, USA 08/17/1971	U OF KENTUCKY Lexington, KY USA M.D. 05/24/1997	University of Tennessee Memphis, TN, USA 06/23/1997 to 06/30/2001 DARP PG 591, 1198/99	40595696 06/14/1995 08/27/1996 05/12/1998 USMLE1 USMLE2 USMLE3 213 209 228 ABMS Pediatrics- Pediatrics 01/01/2016-MOC
208		Charleston, SC, USA 06/07/1968	U OF TEXAS/GALVESTON Galveston, TX USA M.D. 05/18/1996	University of Tennessee Memphis, TN, USA 06/23/1996 to 06/30/2000 DARP PG 548, 1996/97	40465866 06/08/1994 08/30/1995 12/02/1997 USMLE1 USMLE2 USMLE3 176 200 204 ABMS Pediatrics- Pediatrics 12/06/2009-MOC
209		Jinan, CHINA 11/27/1988	U OF ILLINOIS/CHICAGO Chicago, IL USA M.D. 05/10/2015	Mayo Clinic Rochester, MN, USA 06/01/2015 to 06/30/2018 AMA FREIDA Online	53033643 06/15/2013 07/19/2014 12/17/2015 USMLE1 USMLE2 USMLE3 237 246 234
210		Vancouver, BC, CANADA 02/19/1984	U OF ALBERTA Edmonton, AB CANADA M.D. 06/05/2009	British Columbia Children's Hospita Vancouver, BC, CANADA 07/01/2009 to 06/30/2012 ASTP Website	114467 05/01/2009 10/01/2010 LMCC1 LMCC2 635 536
211		Belgrade, YUGOSLAVIA 10/10/1974	U OF BELGRADE Belgrade, SERBIA M.D. 07/17/2000	Mayo Clinic Rochester, MN, USA 07/01/2014 to 06/30/2018 AMA FRIEDA Online	08369233 07/16/2012 11/18/2012 06/22/2016 USMLE1 USMLE2 USMLE3 230 220 208 ECFMG 08368233

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
212		Bangalore, INDIA 01/13/1980	KEMPEGOWDA INSTITUTE OF MEDICAL SCIENCES Bangalore, INDIA M.B., B.S. 03/24/2004	Beth Israel Medical Center New York, NY, USA 07/01/2008 to 06/30/2010 DARP PG 715, 2008/09	06869481 03/31/2006 09/13/2007 12/29/2007 USMLE1 USMLE2 USMLE3 206 247 230 ECFMG 06869481
213		Ismailia, EGYPT 07/06/1963	CAIRO U Cairo, Egypt M.B., B.Ch. 12/01/1987	Norwalk Hospital/Yale Univ Norwalk, CT, USA 07/01/1995 to 06/30/1996 DARP PG 469, 1995/96 Maine Medical Center Portland, ME, USA 07/01/1997 to 06/30/2001 DARP PG 824, 1996/97	05034855 12/07/1993 12/07/1993 FLEX1 FLEX2 78 78 ECFMG 0-503-485-5 ABMS Radiology- Diagnostic Radiology 11/04/2001--Lifetime
214		St. Paul, MN, USA 02/27/1975	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2007	Indiana University Indianapolis, IN, USA 06/24/2007 to 06/30/2011 DARP PG 374, 2007/08	51325918 07/07/2004 08/03/2005 10/26/2010 USMLE1 USMLE2 USMLE3 209 198 205
215		Padova, ITALY 02/25/1985	U OF CHICAGO Chicago, IL USA M.D. 06/13/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2022 AMA FREIDA Online	52346871 06/09/2009 09/17/2014 02/17/2016 USMLE1 USMLE2 USMLE3 260 256 228
216		Los Angeles, CA, USA 12/28/1980	DUKE U Durham, NC USA M.D. 05/10/2009	Montefiore Health System Bronx, NY, USA 07/02/2009 to 06/30/2013 DARP PG 496, 2009/10	51849875 05/28/2008 02/27/2009 12/21/2010 USMLE1 USMLE2 USMLE3 187 211 192

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
217		Port Townsend, WA, USA 12/06/1978	U OF CA/LOS ANGELES Los Angeles, CA USA M.D. 06/19/2015	Aurora St. Luke's Medical Center Milwaukee, WI, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	52968633 06/06/2013 02/10/2015 10/28/2015 USMLE1 USMLE2 USMLE3 247 254 238
218		Alexandria, LA, USA 03/25/1988	TEXAS A&M U Bryan, TX USA M.D. 05/09/2015	Mayo Clinic Rochester, MN, USA 04/01/2015 to 06/30/2019 AMA FREIDA Online	53026977 06/07/2013 07/03/2014 04/12/2016 USMLE1 USMLE2 USMLE3 243 255 218
219		Cleveland, MS, USA 07/20/1982	U OF SOUTHERN CALIFORNIA Los Angeles, CA USA M.D. 05/15/2015	Kaiser Permanente Oakland Oakland, CA, USA 06/24/2015 to 06/23/2016 AMA FREIDA Online	53007308 06/18/2013 12/17/2014 12/08/2015 USMLE1 USMLE2 USMLE3 243 232 227
220		Washington, DC, USA 06/20/1957	ROSALIND FRANKLIN U OF MEDICINE & SCI North Chicago, IL USA M.D. 06/09/1991	University of Chicago Hospitals Chicago, IL, USA 06/24/1991 to 06/30/1994 DARP PG 457, 1991/92	33908849 06/13/1989 04/02/1991 05/20/1992 NBME1 NBME2 NBME3 400 355 330 ABMS Psy. & Neur.- Psychiatry 09/09/2007-12/31/2017-Time Limited ABMS Psy. & Neur.- (Sub) Child & Adolescent Psychiatry 11/09/2012-MOC

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
221		Gulfport, MS, USA 05/16/1983	U OF SOUTH ALABAMA Mobile, AL USA M.D. 05/08/2010	University of Southern Alabama Mobile, AL, USA 07/01/2010 to 06/30/2014 DARP PG 630, 2010/11	52012721 07/11/2008 09/05/2009 11/14/2011 USMLE1 USMLE2 USMLE3 188 207 201
222		Delhi, INDIA 09/02/1981	GOVT MED COL/GUJARAT U Surat, INDIA M.B., B.S. 04/29/2005	St. Luke's Roosevelt New York, NY, USA 07/01/2009 to 06/30/2012 DARP PG 403, 2009/10	06931133 06/19/2006 02/20/2007 02/19/2008 USMLE1 USMLE2 USMLE3 219 227 190 ECFMG 06931133
223		Bandung, INDONESIA 06/20/1969	U OF CA/DAVIS SCHOOL OF MEDICINE Sacramento, CA USA M.D. 06/17/2004	University of California Davis Sacramento, CA, USA 06/25/2004 to 06/30/2006 DARP PG 953, 2004/05	51006260 06/18/2002 03/25/2004 04/14/2005 USMLE1 USMLE2 USMLE3 234 226 202 ABMS Anesthesiology- Anesthesiology 04/02/2015-12/31/2025-Time Limited
224		Rochester, NY, USA 01/01/1983	STANFORD U Stanford, CA USA M.D. 06/17/2012	UC San Francisco San Francisco, CA, USA 06/21/2012 to 09/27/2015 DARP PG 514, 2012/13	52336252 06/10/2009 11/17/2011 01/15/2013 USMLE1 USMLE2 USMLE3 241 234 206
225		Orange, CA, USA 12/31/1972	NATL U OF IRELAND/CORK Cork, IRELAND MB, BCh, BAO 05/29/2008	Robert Wood Johnson Piscataway, NJ, USA 07/01/2008 to 06/30/2012 DARP PG 643, 2008/09	06969737 08/07/2006 06/23/2007 05/18/2009 USMLE1 USMLE2 USMLE3 205 197 190 ECFMG 06969737

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
226		Baltimore, MD, USA 12/24/1984	TUFTS U Boston, MA USA M.D. 05/17/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	52751336 04/23/2012 08/29/2014 11/23/2015 USMLE1 USMLE2 USMLE3 253 263 241
227		Minneapolis, MN, USA 10/12/1984	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/23/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	109727 07/13/2012 06/27/2014 03/28/2016 COMPLEX1 COMPLEX2 COMPLEX3 451 554 621
228		Sisak, CROATIA 12/09/1966	U OF ZAGREB Zagreb, CROATIA 11/08/1991	Mayo Clinic Rochester, MN, USA 06/13/2000 to 07/31/2001 DARP PG 607, 2000/01 Mayo Clinic Rochester, MN, USA 06/28/2003 to 06/30/2006 DARP PG 509, 2003/04	04897195 06/10/1997 08/26/1997 02/14/2000 USMLE1 USMLE2 USMLE3 210 174 193 ECFMG 04897195 ABMS Dermatology- Dermatology 08/14/2006-12/31/2016-Time Limited
229		Tacoma, WA, USA 03/31/1986	U OF WASHINGTON Seattle, WA USA M.D. 06/12/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FREIDA Online	53042941 06/27/2013 07/10/2014 03/02/2016 USMLE1 USMLE2 USMLE3 245 260 246
230		Maywood, IL, USA 11/05/1983	ALBANY MED COL/UNION U Albany, NY USA M.D. 05/26/2011	Ohio State University Columbus, MN, USA 07/01/2011 to 06/30/2012 DARP PG 227, 2011/12	52302650 07/17/2009 08/23/2010 06/11/2012 USMLE1 USMLE2 USMLE3 219 238 207

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
231		Winfield, IL, USA 11/28/1986	U OF ILLINOIS/CHICAGO Chicago, IL USA M.D. 05/12/2013	University of Minnesota Minneapolis, MN, USA 06/24/2013 to 06/30/2016 AMA FREIDA Online	52682507 07/28/2011 08/22/2012 09/29/2014 USMLE1 USMLE2 USMLE3 214 218 214
232		Kaithlee Ghat, INDIA 01/28/1966	M GANDHI INST/WARDHA U Wardha, INDIA M.B., B.S. 03/15/1990	University of Toronto Toronto, ON, CANADA 07/01/2008 to 06/30/2011 ASTP Website	06804405 05/28/2013 12/16/2014 03/16/2015 USMLE1 USMLE2 USMLE3 188 214 197 ECFMG 06804405
233		Perm, RUSSIA 08/11/1983	I.M. SECHENOV MED ACAD. Moscow, RUSSIA 08/10/2006	Mercy Hospital Chicago, IL, USA 07/01/2009 to 06/30/2012 DARP PG 393, 2009/10	07338098 07/23/2007 11/15/2007 12/20/2010 USMLE1 USMLE2 USMLE3 199 199 226 ECFMG 07338098
234		Kathmandu, NEPAL 07/04/1980	MANIPAL COLLEGE Pokhara, NEPAL M.B., B.S. 09/17/2004	Danbury Hospital Danbury, CT, USA 07/01/2007 to 06/30/2010 DARP PG 370, 2007/08	07039597 06/14/2006 08/15/2006 12/27/2006 USMLE1 USMLE2 USMLE3 242 245 200 ECFMG 07039597

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
235		Thief River Falls, MN, USA 02/21/1956	U OF MINNESOTA Minneapolis, MN USA M.D. 06/13/1987	University of Minnesota Minneapolis, MN, USA 07/01/1987 to 06/30/1989 DARP PG 442, 1987/88	33403841 06/11/1985 09/23/1986 05/18/1988 NBME1 NBME2 NBME3 76 75 76.3 ABMS Anesthesiology- Anesthesiology 10/04/1996--Lifetime
236		Washington, DC, USA 07/19/1970	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/27/2006	OUCOM Doctor's Hospital Columbus, OH, USA 07/01/2006 to 06/30/2011 AOA Report	722708 06/08/2004 12/27/2005 04/05/2007 COMPLEX1 COMPLEX2 COMPLEX3 604 529 406
237		Florence, CO, USA 08/10/1983	ROSS U/U OF DOMINICA Roseau, DOMENICA M.D. 04/30/2012	Central Michigan University Saginaw, MN, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	08735755 05/10/2010 06/29/2011 09/04/2013 USMLE1 USMLE2 USMLE3 249 243 232 ECFMG 08735755
238		Westwood, NJ, USA 09/19/1986	DREXEL U COLLEGE OF MEDICINE Philadelphia, PA USA M.D. 05/15/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2020 AMA FREIDA Online	52605565 06/15/2011 04/30/2012 12/11/2015 USMLE1 USMLE2 USMLE3 251 265 234
239		Port-au-Prince, HAITI 03/21/1977	NY COL OF OSTEO MED Old Westbury, NY USA D.O. 05/20/2007	St. Barnabas Hospital Bronx, NY, USA 06/18/2007 to 06/30/2011 AOA Report	769974 06/07/2005 08/28/2006 04/21/2009 COMPLEX1 COMPLEX2 COMPLEX3 490 527 589

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
240		Lewistown, MT, USA 10/04/1986	U OF WISCONSIN/MADISON Madison, WI USA M.D. 05/18/2014	University of Minnesota Minneapolis, MN, USA 06/16/2014 to 06/30/2020 AMA FREIDA Online	52844040 06/22/2012 11/03/2013 11/19/2015 USMLE1 USMLE2 USMLE3 253 263 227
241		Madison, WI, USA 12/01/1985	MAYO MED SCH Rochester, MN USA M.D. 05/29/2015	Mayo Clinic Rochester, MN, USA 07/01/2012 to 06/30/2018 DARP PG 722, 2012/13	41192717 04/24/2014 05/29/2015 05/16/2016 USMLE1 USMLE2 USMLE3 197 229 226
242		Kansas City, MO, USA 02/01/1980	KIRKSVILLE COL OF OSTEO Kirksville, MO USA D.O. 08/01/2006	University of Wyoming Casper, WY, USA 08/03/2006 to 08/02/2009 AOA Report	715555 06/08/2004 08/23/2005 04/05/2007 COMPLEX1 COMPLEX2 COMPLEX3 427 441 421
243		Fushun, CHINA 08/12/1984	ROSS U/U OF DOMINICA Roseau, DOMINICA M.D. 04/30/2011	St. Louis University St. Louis, MO, USA 07/01/2011 to 06/30/2016 DARP PG 848, 2011/12	07789118 05/21/2009 08/02/2010 12/21/2015 USMLE1 USMLE2 USMLE3 258 248 225 ECFMG 07789118
244		Greensburg, KS, USA 12/21/1981	MED COL OF GEORGIA Augusta, GA USA M.D. 05/08/2009	University of Iowa Iowa City, IA, USA 06/24/2009 to 06/30/2013 DARP PG 492, 2009/10	51874683 06/27/2007 08/02/2008 05/02/2016 USMLE1 USMLE2 USMLE3 233 253 208

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NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
245		Robbinsdale, MN, USA 03/30/1985	U OF MINNESOTA Minneapolis, MN USA M.D. 05/07/2011	University of Minnesota Minneapolis, MN, USA 06/20/2011 to 06/24/2016 DARP PG 517, 2011/12	52181971 06/12/2009 01/23/2011 09/19/2011 USMLE1 USMLE2 USMLE3 244 242 234
246		Darby, PA, USA 10/30/1957	U OF TENNESSEE/MEMPHIS Memphis, TN USA M.D. 06/11/1983	Emory University Atlanta, GA, USA 07/01/1983 to 06/30/1986 DARP PG 76, 1982/83	32817348 06/10/1981 09/28/1982 03/07/1984 NBME1 NBME2 NBME3 675 620 500 ABMS Anesthesiology- Anesthesiology 10/30/1987--Lifetime
247		Maywood, IL, USA 07/11/1976	U OF SOUTHERN CALIFORNIA Los Angeles, CA USA M.D. 05/11/2007	Michigan State University Grand Rapids, MI, USA 07/01/2007 to 06/30/2008 DARP PG 689, 2007/08	51579589 06/29/2005 05/10/2007 10/16/2008 USMLE1 USMLE2 USMLE3 235 218 210
248		Minneapolis, MN, USA 09/04/1984	U OF MINNESOTA Minneapolis, MN USA M.D. 05/04/2013	Western Michigan University Kalamazoo, MI, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52637998 06/09/2011 12/29/2012 06/05/2015 USMLE1 USMLE2 USMLE3 237 245 238

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
249		Philadelphia, PA, USA 06/06/1973	PHILADELPHIA COL OSTEO Philadelphia, PA USA D.O. 05/24/2002	St. Joseph Medical Center Reading, PA, USA 07/01/2002 to 06/30/2005 AOA Report	564007 10/19/1999 08/27/2002 06/10/2003 COMLEX1 COMLEX2 COMLEX3 436 404 418 AOABPE FM (AOA) - Family Practice 01/01/2014-12/31/2021-Time Limited
250		Waconia, MN, USA 07/05/1981	U OF MINNESOTA Minneapolis, MN USA M.D. 05/02/2009	Indiana University Indianapolis, IN, USA 07/01/2009 to 06/30/2013 DARP PG 492, 2009/10	51848232 06/05/2007 01/15/2009 03/18/2010 USMLE1 USMLE2 USMLE3 214 222 216
251		Mitchell, SD, USA 02/27/1983	U OF MINNESOTA Minneapolis, MN USA M.D. 05/01/2010	University of Iowa Iowa City, IA, USA 06/24/2010 to 06/30/2013 DARP PG 525, 2010/11	51957587 06/07/2007 08/29/2009 01/30/2012 USMLE1 USMLE2 USMLE3 192 212 202
252		Fargo, ND, USA 02/08/1984	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/13/2012	Medical University of South Carolin: Charleston, MN, USA 07/01/2012 to 06/30/2016 DARP PG 388, 2012/13	52464484 06/24/2010 07/26/2011 05/28/2013 USMLE1 USMLE2 USMLE3 222 218 200

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
253		Whittier, CA, USA 03/11/1953	OREGON HEALTH SCIENCES U Portland, OR USA M.D. 06/08/1979	University of Iowa Iowa City, IA, USA 07/01/1979 to 07/01/1981 DARP PG 273, 1977/78	32132938 06/14/1977 04/10/1979 03/05/1980 NBME1 NBME2 NBME3 580 565 495 ABMS Neurological Surgery - Neurological Surgery 02/28/1986--Lifetime ABMS Psy. & Neur.- (Sub) Sleep Medicine 11/15/2007-12/31/2017-Time Limited
254		Katmandu, NEPAL 01/15/1981	GEORGETOWN U Washington, DC USA M.D. 05/19/2013	Danbury Hospital Danbury, CT, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	52439791 08/19/2010 01/20/2013 09/29/2014 USMLE1 USMLE2 USMLE3 201 233 206
255		Rochester, MN, USA 10/07/1987	MAYO MED SCH Rochester, MN USA M.D. 05/16/2016	Presence Resurrection Medical Cer Chicago, IL, USA 06/23/2015 to 06/22/2016 AMA FREIDA Online	52923331 05/13/2013 07/10/2014 10/01/2015 USMLE1 USMLE2 USMLE3 234 256 224
256		Sioux Falls, SD, USA 11/12/1984	U OF SOUTH DAKOTA Sioux Falls, SD USA M.D. 05/06/2011	Sanford School of Medicine Sioux Falls, SD, USA 06/20/2011 to 06/19/2012 DARP PG 898, 2011/12	52221611 06/16/2009 08/26/2010 06/18/2012 USMLE1 USMLE2 USMLE3 230 254 236

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
257		Edmonton, AB, CANADA 08/11/1984	U OF BRITISH COLUMBIA Vancouver, BC CANADA M.D. 05/13/2009	Vancouver General Hospital Vancouver, BC, CANADA 07/01/2009 to 06/30/2015 ASTP Website	41005554 12/13/2011 05/07/2009 09/23/2014 USMLE1 USMLE2 USMLE3 230 227 213
258		Salt Lake City, UT, USA 11/29/1981	U OF COLORADO Denver, CO USA M.D. 05/25/2012	St. Anthony North Hospital Westminster, CO, USA 06/23/2012 to 06/30/2015 DARP PG 121, 2012/13	52237880 04/13/2010 09/03/2011 07/19/2013 USMLE1 USMLE2 USMLE3 210 223 214
259		Sheboygan, WI, USA 08/10/1986	U OF MO/KANSAS CITY Kansas City, MO USA M.D. 05/29/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53093639 02/27/2013 06/27/2014 10/22/2015 USMLE1 USMLE2 USMLE3 249 252 221
260		Meridian, MS, USA 11/29/1980	U OF MISSISSIPPI Jackson, MS USA M.D. 05/25/2007	University of Mississippi Jackson, MS, USA 07/01/2007 to 06/30/2011 DARP PG 185, 2007/08	51639748 06/06/2005 07/24/2006 07/22/2008 USMLE1 USMLE2 USMLE3 217 207 187
261		Minneapolis, MN, USA 03/07/1954	U OF MINNESOTA Minneapolis, MN USA M.D. 06/13/1981	Abbott Northwestern Hospital Minneapolis, MN, USA 06/01/1981 to 05/31/1982 DARP PG 121, 1982/83	32516170 06/12/1979 04/07/1981 03/10/1982 NBME1 NBME2 NBME3 550 525 545 ABMS Anesthesiology- Anesthesiology 04/22/1988--Lifetime

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
262		Indianapolis, IN, USA 05/05/1981	MAYO MED SCH Rochester, MN USA M.D. 05/16/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2019 AMA FREIDA Online	52923588 05/13/2013 08/02/2014 02/04/2016 USMLE1 USMLE2 USMLE3 188 226 208
263		Detroit, MI, USA 10/03/1976	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/14/2004	MSU/KCMS Kalamazoo, MN, USA 07/01/2004 to 06/30/2008 DARP PG 871, 2004/05	51106417 06/13/2002 04/05/2004 04/15/2008 USMLE1 USMLE2 USMLE3 207 209 226
264		Fargo, ND, USA 04/02/1985	KANSAS CITY U of MED & BIOSCIENCES Kansas City, MO USA D.O. 05/14/2011	University of Kansas Kansas City, KS, USA 07/01/2011 to 06/30/2015 DARP PG 546, 2011/12	899561 05/21/2009 08/17/2010 09/29/2011 COMPLEX1 COMPLEX2 COMPLEX3 551 489 426
265		Mason City, IA, USA 08/18/1982	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/11/2012	University of Iowa Des Moines, IA, USA 07/01/2013 to 08/30/2016 AMA FREIDA Online	52068673 05/10/2010 03/08/2012 10/22/2015 USMLE1 USMLE2 USMLE3 207 219 205
266		Coon Rapids, MN, USA 08/01/1984	U OF MINNESOTA Minneapolis, MN USA M.D. 05/04/2013	HCMC Minneapolis, MN, USA 06/17/2013 to 06/30/2018 AMA FREIDA Online	52637170 05/19/2011 10/31/2012 12/16/2013 USMLE1 USMLE2 USMLE3 250 241 227

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
267		Rapid City, SD, USA 12/02/1984	U OF SOUTH DAKOTA Sioux Falls, SD USA M.D. 05/09/2014	University of Minnesota Minneapolis, MN, USA 06/09/2014 to 06/30/2017 AMA FREIDA Online	52221587 05/21/2009 08/26/2013 10/24/2015 USMLE1 USMLE2 USMLE3 216 243 236
268		Fargo, ND, USA 08/22/1984	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/15/2011	University of Minnesota Minneapolis, MN, USA 07/01/2011 to 06/01/2012 DARP PG University of North Dakota Fargo, ND, USA 07/01/2012 to 06/30/2016 DARP PG	52254166 06/29/2009 08/27/2010 10/01/2013 USMLE1 USMLE2 USMLE3 223 229 226
269		New Orleans, LA, USA 11/05/1986	MEDICAL COLLEGE OF WISCONSIN Milwaukee, WI USA M.D. 05/18/2012	Tulane University New Orleans, LA, USA 07/01/2012 to 06/30/2016 DARP PG 189, 2012/13	52452398 06/14/2010 09/24/2011 06/01/2013 USMLE1 USMLE2 USMLE3 220 228 215
270		Xi'an, CHINA 08/19/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2012	Albany Medical Center Albany, NY, USA 07/01/2012 to 06/30/2016 DARP PG 384, 2012/13	52364213 08/17/2010 08/30/2011 05/28/2013 USMLE1 USMLE2 USMLE3 191 220 214
271		San Luis Obispo, CA, USA 09/04/1984	ST GEORGES U St. George's, GRENADA M.D. 04/11/2014	University of Minnesota St. Cloud, MN, USA 07/01/2014 to 06/30/2017 AMA FREIDA Online	08393605 03/26/2012 07/22/2013 08/13/2015 USMLE1 USMLE2 USMLE3 201 211 195 ECFMG 08393605

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
272		Colorado Springs, CO, USA 08/08/1977	U OF TEXAS/HOUSTON Houston, TX USA M.D. 12/31/2004	University of Louisville Louisville, KY, USA 07/01/2005 to 06/30/2009 DARP PG 978, 2005/06	50932656 06/02/2005 12/28/2004 11/06/2006 USMLE1 USMLE2 USMLE3 207 182 188 ABMS Psy. & Neur.- Psychiatry 04/01/2011-12/31/2021-Time Limited
273		Woodland Hills, CA, USA 09/19/1988	CREIGHTON U Omaha, NE USA M.D. 05/16/2015	Mayo Clinic Rochester, MN, USA 07/01/2015 to 06/30/2018 AMA FRIEDA Online	52949195 06/04/2013 07/29/2014 12/07/2015 USMLE1 USMLE2 USMLE3 237 257 254
274		Stanford, CA, USA 03/03/1977	TEMPLE U Philadelphia, PA USA M.D. 05/22/2009	UC San Francisco San Francisco, CA, USA 06/21/2009 to 06/30/2012 DARP PG 390, 2009/10	51904902 05/15/2007 11/04/2008 09/16/2010 USMLE1 USMLE2 USMLE3 245 268 260
275		Seattle, WA, USA 02/09/1966	ROSS U/U OF DOMINICA Roseau, DOMENICA M.D. 04/01/2005	Flushing Hospital Flushing, NY, USA 07/01/2005 to 06/30/2006 DARP PG 753, 2005/06 Maimonides Medical Center Brooklyn, NY, USA 07/01/2006 to 06/30/2009 DARP PG 183, 2006/07	06448872 01/28/2003 08/20/2004 06/07/2006 USMLE1 USMLE2 USMLE3 205 201 188 ECFMG 06448872 ABMS Anesthesiology- Anesthesiology 04/11/2014-12/31/2024-Time Limited

09/10/2016

Physician Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
276		Albert Lea, MN, USA 10/06/1976	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2012	HCMC/Regions Minneapolis, MN, USA 06/22/2012 to 09/02/2016 DARP PG 624, 2012/13	52051562 02/02/2010 11/09/2011 07/19/2013 USMLE1 USMLE2 USMLE3 194 214 214
277		Kuwait City, KUWAIT 03/07/1980	JORDAN U. of SCIENCE & TECHNOLOGY Irbid, JORDAN M.B., B.S. 06/14/2004	North Central Texas Medical Found Wichita Falls, TX, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	06769111 07/27/2005 05/10/2006 09/15/2014 USMLE1 USMLE2 USMLE3 189 216 223 ECFMG 06769111
278		Tehran, IRAN 09/16/1967	SHAHID BEHESHTI U Tehran, Iran M.D. 01/20/1995	McGill University Hospital Montreal, QC, Canada 07/01/2012 to 02/09/2014 ASTP Website Mayo Clinic Rochester, MN, USA 07/31/2014 to 07/29/2017 AMA FREIDA Online	0-778-750-0 01/21/2010 08/11/2010 06/19/2012 USMLE1 USMLE2 USMLE3 226 229 195 ECFMG 0-778-750-0

DATE: 09/10/2016

SUBMITTED BY: Licensure Committee

SUBJECT: Physician Emeritus Registration

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following physician applicants be approved for Emeritus registration.

279 - 280 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 279 - 280 for each applicants credentials

09/10/2016

Physician Emeritus Registration

NO	NAME AND ADDRESS	LICENSE NUMBER	RETIREMENT DATE	RECOMMENDED BY
279		17503	January 1, 2001	Licensure Committee
280		24734	January 2, 2016	CRU

DATE: 09/10/2016

SUBMITTED BY: AP Advisory Council

SUBJECT: Acupuncture Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following acupuncture applicants for licensure be approved subject to receipt of all verification documents.

281 - 284 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 281 - 284 for each applicants credentials

GENAP = GENERAL REGISTRATION
RECIAP = RECIPROCITY REGISTRATION
RANAP = TRANSITIONAL REGISTRATION

09/10/2016

Acupuncture Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
281		Pittsburgh, PA, USA 04/11/1959	Intl Institute of Chinese Med Santa Fe, NM USA M.OM 12/12/2002	APRE	21068
282		Fridley, MN, USA 11/29/1986	NW Health Sciences U Bloomington, MN USA M.AC 08/15/2015	APGR	163927
283		St. Louis Park, MN, USA 12/13/1984	NW Health Sciences U Bloomington, MN USA M.AC 08/01/2011	APGR	151452
284		Xilan, CHINA 10/16/1982	Beijing U Beijing, China M.OM 07/01/2010	APGR	153057

DATE: 09/10/2016

SUBMITTED BY: AT Advisory Council

SUBJECT: Athletic Trainer Registration

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following athletic trainer applicants be approved subject to receipt of all verification documents.

285 - 314 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 285 - 314 for each applicants credentials

NATAEQ = EQUIVALENCY REGISTRATION
NATAGR = GENERAL REGISTRATION
NATARE = RECIPROCITY REGISTRATION
NATATR = TRANSITIONAL REGISTRATION
CATAEQ = CANADIAN EXAM

09/10/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
285		Marietta, GA, USA 06/19/1994	SOUTHEASTERN LOUISIANA Hammond, LA USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000023888
286		Marshfield, WI, USA 01/26/1991	Western Mi U Kalamazoo, MI USA NATA Approved NATA Approved 06/25/2016	NATARE	2000017250
287		Fargo, ND, USA 09/26/1991	U Of North Dakota Grand Forks, ND USA NATA Approved NATA Approved 05/10/2014	NATARE	2000014259
288		Fountain Valley, CA, USA 12/08/1985	Brigham Young U Provo, UT USA NATA Approved NATA Approved 06/01/2008	NATARE	2000002675
289		Appleton, WI, USA 12/29/1990	Coll of St. Scholastica Duluth, MN USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000024140
290		Minneapolis, MN, USA 12/14/1993	MN State U/Mankato Mankato, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000024249
291		Grand Rapids, MN, USA 04/22/1993	Coll of St. Scholastica Duluth, MN USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000024198
292		St. Cloud, MN, USA 07/20/1993	Winona State U Winona, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	BOC307713

09/10/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
293		Rapid City, SD, USA 09/25/1991	UNIVERSITY OF MARY Bismark, ND USA NATA Approved NATA Approved 05/04/2014	NATARE	2000018817
294		Ladysmith, WI, USA 07/21/1994	U Of Minnesota/Duluth Duluth, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000023676
295		Waconia, MN, USA 03/26/1994	Gustavus Adolphus St. Peter, MN USA NATA Approved NATA Approved 05/29/2016	NATAGR	2000024954
296		Faribault, MN, USA 03/18/1994	Gustavus Adolphus St. Peter, MN USA NATA Approved NATA Approved 05/29/2016	NATAGR	2000024953
297		Albuquerque, NM, USA 05/04/1988	Gustavus Adolphus St. Peter, MN USA NATA Approved NATA Approved 06/01/2013	NATAGR	2000007633
298		Minneapolis, MN, USA 12/30/1991	Bethel University St. Paul, MN USA NATA Approved NATA Approved 05/21/2016	NATAGR	2000024997
299		Sioux Falls, SD, USA 11/18/1993	Augustana College Sioux Falls, SD USA NATA Approved NATA Approved 05/19/2016	NATAGR	2000024060
300		Burnsville, MN, USA 02/03/1994	Gustavus Adolphus St.Peters, MN USA NATA Approved NATA Approved 05/29/2016	NATAGR	2000024952

09/10/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
301		St. Louis Park, MN, USA 07/14/1994	U Of Wisconsin/Eau Claire Eau Claire, WI USA NATA Approved NATA Approved 05/21/2016	NATAGR	2000024345
302		Duluth, MN, USA 03/15/1992	U Of North Dakota Grand Forks, ND USA NATA Approved NATA Approved 05/14/2014	NATARE	2000016783
303		Fridley, MN, USA 11/04/1993	Gustavus Adolphus St. Peter, MN USA NATA Approved NATA Approved 05/29/2016	NATAGR	2000024951
304		Owatonna, MN, USA 08/18/1994	Coe College Cedar Rapids, IA USA NATA Approved NATA Approved 05/08/2016	NATAGR	200023435
305		Fargo, ND, USA 01/05/1990	Moorhead State Moorhead, MN USA NATA Approved NATA Approved 05/17/2013	NATARE	2000014329
306		Fairmont, MN, USA 12/17/1993	U Of Northern Ia Cedar Falls, IA USA NATA Approved NATA Approved 05/07/2016	NATAGR	2000034127
307		Minneapolis, MN, USA 10/17/1990	St. Cloud State U St Cloud, MN USA NATA Approved NATA Approved 05/09/2015	NATAGR	2000221950
308		New Prague, MN, USA 09/02/1991	North Dakota State U Fargo, ND USA NATA Approved NATA Approved 06/04/2016	NATARE	2000017637

09/10/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
309		Marshfield, WI, USA 10/02/1991	UW-Stevens Point Stevens Point, WI USA NATA Approved NATA Approved 05/20/2016	NATAGR	2000024393
310		Minneapolis, MN, USA 07/26/1993	St. Louis, MO USA NATA Approved NATA Approved 05/14/2016	NATAGR	200024253
311		Pittsburg, PA, USA 09/26/1984	U Of North Carolina Chapel Hill, NC USA NATA Approved NATA Approved 06/10/2007	NATAGR	060702176
312		Robbinsdale, MN, USA 03/05/1991	U Of Wisconsin/La Crosse La Crosse, WI USA NATA Approved NATA Approved 05/19/2013	NATARE	2000014006
313		Burnsville, MN, USA 07/01/1992	U Of Wisconsin/Stevens Point Stevens Point, WI USA NATA Approved NATA Approved 05/21/2016	NATAGR	2000024386
314		Waconia, MN, USA 05/06/1994	IA State U Ames, IA USA NATA Approved NATA Approved 05/07/2016	NATAGR	2000024219

DATE: 09/10/2016

SUBMITTED BY: PA Advisory Council

SUBJECT: Physician Assistant Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following physician assistant applications for licensure be approved subject to receipt of all verification documents.

315 - 389 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 315 - 389 for each applicants credentials

NCCPA = NATL COMMISSION ON THE CERTIFICATION OF PA
OTHERPA = OTHER

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
315		St. Paul, MN, USA 05/15/1989	George Washington U Washington, DC USA MSPA 05/15/2016	NCCPA	1130582
316		Minneapolis, MN, USA 04/25/1991	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135093
317		Brainerd, MN, USA 06/06/1990	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134885
318		San Diego, CA, USA 03/23/1989	U Of Colorado Denver, CO USA MSPA 05/23/2014	NCCPA	1114793
319		Milwaukee, WI, USA 10/31/1988	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134888
320		Minneapolis, MN, USA 11/19/1989	U Of Wisconsin/Lacrosse LaCrosse, WI USA MSPA 05/14/2016	NCCPA	1133867
321		Waynesboro, PA, USA 06/17/1970	Rocky Mountain College Billings, MT USA B.S. 08/19/2004	NCCPA	1066024
322		Rochester, MN, USA 03/19/1991	U Of Wisconsin Madison, WI USA MSPA 05/14/2016	NCCPA	1133869
323		St. Louis Park, MN, USA 09/19/1988	Des Moines U Des Moines, IA USA MSPA 05/28/2016	NCCPA	1135368
324		Edina, MN, USA 01/02/1988	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134892

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Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
325		Washington, DC, USA 01/15/1967	U Of Iowa/Iowa City Iowa City, IA USA MSPA 06/20/2008	NCCPA	1082408
326		St. Louis Park, MN, USA 10/08/1988	Wake Forest U Winston Salem, NC USA MSPA 05/16/2016	NCCPA	1134557
327		Indiana, PA, USA 08/03/1990	UNIVERSITY OF THE SCIENCES Philadelphia, PA USA MSPA 05/25/2016	NCCPA	1134559
328		Downey, CA, USA 06/30/1966	Western U Of Hlth Sci Pomona, CA USA MSPA 07/31/2002	NCCPA	1057032
329		Crookston, MN, USA 01/16/1984	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135061
330		Forest Lake, MN, USA 03/24/1983	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135064
331		New Ulm, MN, USA 09/15/1988	Marquette U Milwaukee, WI USA MSPA 05/06/2016	NCCPA	1134902
332		Pittsburgh, PA, USA 10/07/1956	UNMC Omaha, NE USA MSPA 12/19/2008	NCCPA	1085818
333		Lafayette, LA, USA 04/20/1992	U Of Wisconsin/Lacrosse LaCrosse, WI USA MSPA 05/14/2016	NCCPA	1133879

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Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
334		Appleton, WI, USA 01/26/1981	Augsburg College Minneapolis, MN USA MSPA 04/08/2016	NCCPA	11332603
335		Homestead, FL, USA 08/29/1986	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135108
336		St. Cloud, MN, USA 06/30/1981	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135066
337		Madison, WI, USA 08/07/1983	U Of Wisconsin Madison, WI USA MSPA 05/01/2014	NCCPA	1115311
338		Worthington, MN, USA 05/16/1992	Union College Lincoln, NE USA MSPA 05/06/2016	NCCPA	1133684
339		Evanston, IL, USA 01/04/1988	U Of Wisconsin Madison, WI USA MSPA 05/15/2016	NCCPA	1133884
340		St. Cloud, MN, USA 04/11/1984	Duke U Durham, NC USA MSPA 09/01/2010	NCCPA	1094204
341		Saranac Lake, NY, USA 07/22/1982	George Washington U Washington, DC USA MSPA 08/31/2008	NCCPA	1084850
342		Duluth, MN, USA 08/20/1985	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135110
343		South St. Paul, MN, USA 08/15/1993	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134909

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Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
344		Sheboygan, WI, USA 08/15/1989	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134910
345		St. Paul, MN, USA 01/14/1991	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134911
346		Tacoma, WA, USA 03/01/1987	Pacific U Pacific University, WA usa MSPA 08/09/2014	NCCPA	1120744
347		Anchorage, AK, USA 07/30/1990	INDIANA STATE UNIVERSITY Terre Haute, IN USA MSPA 05/07/2016	NCCPA	1128770
348		Marshall, MN, USA 05/30/1992	Des Moines U Des Moines, IA USA MSPA 05/28/2016	NCCPA	1135377
349		Arden Hills, MN, USA 01/19/1991	Northwestern University Chicago, IL USA MSPA 05/14/2016	NCCPA	1133376
350		Breckenridge, MN, USA 10/31/1980	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135068
351		Hibbing, MN, USA 10/30/1985	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135071
352		Carrington, ND, USA 09/02/1988	Nova Southeastern U Ft. Lauderdale, FL USA MSPA 08/31/2015	NCCPA	1129989
353		Madison, WI, USA 01/21/1992	U Of Wisconsin Madison, WI USA MSPA 05/15/2016	NCCPA	1133893

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Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
354		Las Vegas, NV, USA 11/02/1990	Butler U Indianapolis, IN USA MSPA 05/07/2016	NCCPA	1133626
355		Litchfield, MN, USA 05/11/1990	MCPHS University, Boston, MA Boston, MA USA MSPA 05/07/2016	NCCPA	1134328
356		Edina, MN, USA 03/28/1992	U Of Wisconsin/Lacrosse LaCrosse, WI USA MSPA 05/14/2016	NCCPA	1133897
357		Rochester, NY, USA 01/23/1990	U of Rochester Rochester, NY USA B.S. 05/17/2013	NCCPA	1112879
358		Osmond, NE, USA 03/30/1990	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135129
359		Waukon, IA, USA 06/27/1990	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135133
360		Raleigh, NC, USA 04/23/1979	Des Moines U Des Moines, IA USA MSPA 05/23/2015	NCCPA	1127589
361		Chelan, WA, USA 05/07/1953	Kelting College Kettering, OH US MSPA 07/01/1984	NCCPA	1014793
362		Sunfish Lake, MN, USA 02/09/1987	Carroll U Waukesha, WI USA MSPA 05/08/2016	NCCPA	1126425

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Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
363		River Falls, WI, USA 07/01/1972	U Of Wisconsin/Lacrosse LaCrosse, WI USA B.S. 10/21/2001	NCCPA	1051761
364		Denver, CO, USA 04/22/1968	Wayne State U Detroit, MI USA MSPA 05/03/2016	NCCPA	1133820
365		Kisumu, NY, Kenya 04/23/1985	Rocky Mountain College Billings, MT USA MSPA 05/12/2016	NCCPA	1129586
366		El Paso, TX, USA 12/03/1978	Carroll U Waukesha, WI USA MSPA 05/08/2016	NCCPA	1126426
367		Fridley, MN, USA 04/19/1981	Seton Hill University Greensburg, PA USA MSPA 05/14/2016	NCCPA	1134728
368		Worthington, MN, USA 06/21/1987	Eastern VA Med Sch Norfolk, VA USA MSPA 05/21/2016	NCCPA	1135036
369		Springfield, IL, USA 05/08/1985	U Of Wisconsin/La Crosse La Crosse, WI USA MSPA 05/31/2016	NCCPA	1133916
370		Hibbing, MN, USA 07/12/1989	INDIANA STATE UNIVERSITY TerreHaute, ID USA MSPA 05/07/2016	NCCPA	1128789
371		Milwaukee, WI, USA 09/18/1989	U Of Wisconsin/Lacrosse LaCrosse, WI USA MSPA 05/14/2016	NCCPA	1133920
372		Indianapolis, IN, USA 09/17/1956	Des Moines U Des Moines, IA USA B.S. 05/24/2003	NCCPA	1058389

09/10/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
373		St. Cloud, MN, USA 05/19/1976	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135079
374		Mankato, MN, USA 09/07/1987	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134931
375		Minneapolis, MN, USA 02/16/1991	UNIVERSITY OF THE SCIENCES Philadelphia, PA USA MSPA 05/25/2016	NCCPA	1134647
376		St. Paul, MN, USA 11/27/1983	Marquette U Milwaukee, WI USA MSPA 05/22/2016	NCCPA	1134935
377		Denver, CO, USA 05/31/1978	New York Institute of Technology New York, NY USA MSPA 08/31/2008	NCCPA	1083520
378		Strongsville, OH, USA 05/15/1989	Idaho State U Pocatello, ID USA MSPA 08/07/2015	NCCPA	1128283
379		New Ulm, MN, USA 09/14/1988	Des Moines U Des Moines, IA USA MSPA 06/09/2016	NCCPA	1135402
380		Sioux City, IA, USA 08/25/1989	College of Hlth Sciences Roanoke, VA USA MSPA 12/13/2013	NCCPA	1116213
381		Salem, OR, USA 01/13/1989	U. of New England Portland, ME USA MSPA 05/21/2016	NCCPA	1134806
382		Great Lakes, IL, USA 02/10/1986	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135150

09/10/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
383		St. Cloud, MN, USA 10/15/1986	U Of Wisconsin Madison, WI USA MSPA 05/15/2016	NCCPA	1133936
384		Waseca, MN, USA 04/15/1984	St. Louis, MO USA MSPA 01/08/2010	NCCPA	1091909
385		Montgomery, AL, USA 08/17/1990	Des Moines U Des Moines, IA USA MSPA 05/28/2016	NCCPA	1135409
386		Staples, MN, USA 11/16/1981	U Of North Dakota Grand Forks, ND USA MSPA 05/14/2016	NCCPA	1135085
387		Madison, WI, USA 12/04/1988	U Of Wisconsin Madison, WI USA MSPA 05/15/2016	NCCPA	1133940
388		Oak Park, IL, USA 01/14/1980	Malcolm X College Chicago, IL USA MSPA 06/30/2008	NCCPA	1084345
389		Madison, WI, USA 06/22/1991	U Of Wisconsin/Lacrosse LaCrosse, WI USA MSPA 05/14/2016	NCCPA	1133944

DATE: 09/10/2016

SUBMITTED BY: RT Advisory Council

SUBJECT: Respiratory Therapist Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following respiratory therapist applicants for licensure be approved subject to receipt of all verification documents.

390 - 443 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 390 - 443 for each applicants credentials

NBRCGR = GENERAL REGISTRATION
NBRCRE = RECIPROCITY REGISTRATION

09/10/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
390		Harar, ETHIOPIA 05/10/1986	St. Catherine University St. Paul, MN USA BS 05/22/2016	NBRCGR	4593
391		Damascus, SYRIA 02/25/1991	St. Catherine University St. Paul, MN USA BS 05/22/2016	NBRCGR	0244
392		SOMALIA 01/01/1993	St. Catherine University Minneapolis, MN USA BS 06/22/2016	NBRCGR	6761
393		Las Vegas, NV, USA 07/26/1969	Carrington College Las Vegas, NV USA AS 12/03/2015	NBRCGR	156701
394		St. Louis, MO, USA 08/30/1991	SAINT LOUIS COLLEGE OF HEALTH CAREERS Fenton, MO USA AAS 12/13/2013	NBRCRE	157053
395		St. Cloud, MN, USA 04/19/1995	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	8326
396		Pipestone, MN, USA 11/24/1993	Dakota State U Madison, SD USA AS 05/09/2014	NBRCGR	146771
397		Chippewa Falls, WI, USA 01/12/1995	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	4318
398		Kofele, ETHIOPIA 12/20/1989	Dakota State U Madison, SD USA AS 05/06/2016	NBRCGR	1566

09/10/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
399		Fargo, ND, USA 08/17/1993	North Dakota State Univ/Sanford Health Fargo, ND USA Cert Res Care 12/18/2015	NBRCRE	153390
400		Princeton, MN, USA 06/01/1995	Lake Superior College Duluth, MN USA AS 05/16/2016	NBRCGR	9817
401		San Diego, CA, USA 08/21/1992	St. Catherines Minneapolis, MN USA BS 05/22/2016	NBRCGR	8387
402		Syracuse, NY, USA 12/10/1989	North Dakota State Univ/Sanford Health Fargo, ND USA Cert Res Care 10/26/2012	NBRCRE	135473
403		Mekelle, ETHIOPIA 01/31/1988	Seattle Central Comm College Seattle, WA USA AAS 06/19/2015	NBRCRE	151490
404		Linton, ND, USA 11/08/1960	PIMA Medical Inst Denver, CO USA AS 04/04/2012	NBRCRE	128935
405		Jamestown, ND, USA 01/01/1988	U of Mary St. Alexius Bismarck, ND USA BS 04/30/2010	NBRCRE	116806
406		Eau Claire, WI, USA 09/06/1978	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	155420
407		Rochester, MN, USA 12/31/1990	Kirkwood Comm Col Cedar Rapids, IA USA AS 05/14/2016	NBRCGR	155687

09/10/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
408		Eau Claire, WI, USA 10/10/1989	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	1893
409		Duluth, MN, USA 05/02/1992	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	3972
410		Spokane, WA, USA 09/18/1984	Rolla Tech Institute Rolla, MO AAS 05/01/2007	NBRCRE	xxxxx2625
411		Eau Claire, WI, USA 03/14/1993	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	9727081
412		Maplewood, MN, USA 08/03/1994	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	3599
413		Hibbing, MN, USA 03/17/1992	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	6271
414		Menomonee Falls, WI, USA 04/05/1990	Western WI Tech College La Crosse, WI USA AAS 04/29/2016	NBRCGR	9838
415		Bad Soden, GERMANY 08/18/1994	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	7562
416		Pomona, CA, USA 05/29/1992	Weber State U Ogden, UT USA BS 08/15/2014	NBRCGR	145926

09/10/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
417		Oceanside, CA, USA 11/05/1992	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	9833
418		Rochester, MN, USA 03/11/1996	Western WI Tech College La Crosse, WI USA AS 04/29/2016	NBRCGR	8028
419		Dubuque, IA, USA 10/12/1992	Western WI Tech College La Crosse, WI USA AAS 04/29/2016	NBRCGR	4315
420		Sharon, CT, USA 02/17/1956	WESTCHESTER COMMUNITY COLLEGE Valhalla, NY USA AAS 05/18/1980	NBRCRE	24726
421		Superior, WI, USA 04/16/1986	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	8226
422		New Richmond, WI, USA 06/20/1974	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	3467
423		Duluth, MN, USA 04/08/1987	Lake Superior College Duluth, MN AAS 05/16/2016	NBRCGR	7516
424		Chicago, IL, USA 03/14/1990	Western WI Tech College La Crosse, WI USA AS 04/29/2016	NBRCGR	2002
425		Robbinsdale, MN, USA 11/16/1984	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	9098

09/10/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
426		Granite Falls, MN, USA 06/23/1994	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	4809
427		Park Falls, WI, USA 09/19/1980	Western WI Tech College La Crosse, WI USA AAS 04/29/2016	NBRCGR	5599
428		Decorah, IA, USA 05/25/1995	Kirkwood Comm Col Cedar Rapids, IA USA AAS 05/13/2016	NBRCGR	156983
429		Queens, NY, USA 12/14/1971	Molloy College Rockville Center, NY USA AAS 07/28/1995	NBRCRE	2931
430		Norwich, CT, USA 09/13/1975	MORAIN PARK TECH COLLEGE Fond du lac, WI USA AAS 05/23/2016	NBRCGR	4047
431		Watertown, WI, USA 02/24/1982	Dakota State U Madison, SD USA AAS 05/06/2016	NBRCGR	155354
432		Rochester, MN, USA 07/07/1994	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	155919
433		Addis Ababa, ETHIOPIA 02/07/1987	St. Catherine University Minneapolis, MN USA BS 05/22/2016	NBRCGR	6787
434		Minneapolis, MN, USA 08/02/1994	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	0429

09/10/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
435		Ethiopia 01/01/1992	St. Catherines Minneapolis, MN BS 05/22/2016	NBRCGR	5732
436		SOMALIA 01/01/1990	St. Catherine University Minneapolis, MN BS 05/22/2016	NBRCGR	7183
437		Carthage, IL, USA 05/07/1993	Mayo-Rochester Com Col Rochester, MN USA BS 05/15/2016	NBRCGR	0113
438		Sagure, ETHIOPIA 06/26/1990	St. Catherine University St. Paul, MN USA BS 05/22/2016	NBRCGR	5094
439		Menomonie, WI, USA 03/07/1994	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	6807
440		Fargo, ND, USA 04/26/1994	U Of Mary Bismarck, ND USA BS 04/30/2016	NBRCGR	155478
441		Chippewa Falls, WI, USA 09/29/1982	Madison Area Tech Col Madison, WI USA AAS 05/16/2016	NBRCGR	9958
442		Eau Claire, WI, USA 03/03/1994	Chippewa Valley Technical College Eau Claire, WI USA AAS 05/06/2016	NBRCGR	XXXXX3892
443		Mogadishu, SOMALIA 04/25/1993	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	6595

DATE: 09/10/2016

SUBMITTED BY: ND Advisory Council

SUBJECT: Naturopathic Registration

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following naturopathic doctor applicants be approved subject to receipt of all verification documents.

444 - 445 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 444 - 445 for each applicants credentials

NPLEXGR = GENERAL REGISTRATION
NPLEXER = RECIPROCITY REGISTRATION
ST/PROV = STATE/PROVINCIAL REGISTRATION

09/10/2016

Naturopathic Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	EXAM SCORES
444		Everett, WA, USA 07/01/1967	National Coll of Natural Med Portland, OR USA ND 06/20/2009	NPLEXGR	NPLEX1; 07/06/2016; Passed; OR NPLEX2; 07/06/2016; Passed; OR
445		Decatur, IL, USA 12/21/1980	Bastyr University Kenmore, WA USA NMD 12/12/2015	NPLEXGR	NPLEX1; 02/01/2013; Passed; WA NPLEX2; 02/01/2016; Passed; WA

DATE: 09/10/2016

SUBMITTED BY: MW Advisory Council

SUBJECT: Midwifery Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following midwifery applicants be approved subject to receipt of all verification documents.

446 - 446 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 446 - 446 for each applicants credentials

09/10/2016

Midwifery Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
446		Albert Lea, MN, USA 02/07/1978		NARMGR	16040007

DATE: September 10, 2016

SUBJECT: Licensure Committee Meeting Minutes

SUBMITTED BY: Licensure Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Licensure Committee.

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

See attached August 18, 2016, Licensure Committee Meeting Minutes.

LICENSURE COMMITTEE MEETING
Minnesota Board of Medical Practice
University Park Plaza, 2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246

August 18, 2016

FINAL MINUTES

Of a meeting of the Licensure Committee (“Committee”) of the Board of Medical Practice held Thursday, August 18, 2016 at 5:30 p.m. in the fifth floor conference room.

Committee Members Present: Patricia J. Lindholm, M.D., FAAFP; Mark A. Eggen, M.D.; Allen G. Rasmussen, M.A.; and Kimberly W. Spaulding, M.D., M.P.H.

Others Present: Molly Schwanz; Paul Luecke; and Ruth Martinez, Board staff; and Greg Schaefer, Assistant Attorney General

ADMINISTRATIVE ISSUES:

- **Meeting Dates:** The Committee will meet on the following dates, in 2016, at 5:30 p.m.:
 - October 20, 2016
 - December 15, 2016
- **Physicians Requesting Resigned/Inactive Status:** The Committee approved the list of 35 requests for resignation/inactive status.
- **Respiratory Therapists Requesting Resigned/Inactive Status:** The Committee approved the list of 7 requests for resignation/inactive status.

ADVISORY COUNCIL APPOINTMENTS:

- **Acupuncture Advisory Council Appointment:** The Committee agreed to recommend the application of Patricia Casello-Maddox, D.C., LAc., Diplomate AC (NCCAOM), MBA, MOM to the Board in September, 2016.

DISCUSSION:

- **REDACTED:** The Committee authorized a request for REDACTED to appear before the Licensure Committee, in October, to discuss REDACTED disclosures on REDACTED application and REDACTED practice plans.

APPLICATION REVIEW:

- **REDACTED:** The Committee reviewed REDACTED application and authorized a referral to Health Professionals Services Program (HPSP), and issuance of an unrestricted license, upon procedural satisfaction of HPSP referral requirements.
- **REDACTED:** The Committee reviewed REDACTED application and agreed to deny a license under a Board Order.
- **REDACTED:** The Committee reviewed REDACTED application, agreed that REDACTED does not meet minimum requirements for licensure and offered the opportunity for REDACTED to withdraw REDACTED application, which will be destroyed after six months of inactivity.

OTHER BUSINESS: The Committee discussed the following subjects:

- **Preferred Time to Hold Meetings in 2017**
- **Issuance of Credentials – Roll Out**

DATE: September 10, 2016

SUBJECT: Acupuncture Advisory Council
Appointments

SUBMITTED BY: Licensure Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Appoint the following person to a three year term on the Acupuncture Advisory Council with term ending January, 2019:

Chiropractor/NCCAOM Certified Member

- Patricia Casello-Maddox, D.C., LAc., Diplomate AC (NCCAOM), MBA, MOM

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Acupuncture Advisory Council members are appointed to three year terms (Minn. Stat. §147B.05). The Board shall appoint a replacement to fill the vacancy created when the Council member's terms expire. The following Council member's term expired in January, 2016:

Council Member

Jay Greenberg, D.C.

Position

Chiropractor/NCCAOM Certified Member

One application has been received for the chiropractor/NCCAOM certified member. The application has been received from the following:

- Patricia Casello-Maddox, D.C., LAc., Diplomate AC (NCCAOM), MBA, MOM

The Licensure Committee is recommending Patricia Casello-Maddox for appointment to the Council.

See attached application.

*Current Council Member



STATE OF MINNESOTA
Office of the Minnesota Secretary of State
Steve Simon

TO: Minnesota Board of Medical Practice
Executive Director
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246

FROM: Nancy Breems
Open Appointments
651-556-0643

DATE: June 16, 2016

SUBJECT: APPLICATIONS RECEIVED FOR AGENCY VACANCIES

Enclosed are applications submitted to this office during the past week. For the convenience of the appointing authority, applications are transmitted each week but no appointments can be made until ten days after the application deadline. Applications received after the deadline will continue to be transmitted to you for possible consideration. At least five days before the appointment, a public announcement is required and a Notice of Intent to Appoint form must be submitted to this office. If the appointing authority intends to appoint a person other than persons for whom this office has transmitted applications, an application must be completed by or on behalf of the appointee and submitted with the Notice of Intent to Appoint form by the appointing authority. (Minnesota Statutes 15.0597, subd. 6)

Number of applications submitted this week for:

No.	Name of Agency
1	Acupuncture Advisory Council

Greene, Nancy (OSS)

From:
Sent: Monday, June 13, 2016 11:09 AM
To: Appointments, Open (OSS)
Subject: A New Application has been submitted!

We have received a new application for Commissions and Appointments.

Agency Name::
Acupuncture Advisory Council

Position Sought::
Memeber

First Name::
Patricia

Last Name::
Casello-Maddox

Street Address::

City::

State::

Zip::

Have you ever been convicted of a felony::
No

Phone::

Email::

County::
Hennepin

MN House of Representatives District::
50B

US House of Representatives District::
3

Did the Appointing Authority suggest that you submit an application?:
Yes

Cover Letter or other information helpful to the appointing authority::
Molly Schwanz
Supervisor, Licensure Unit
Minnesota Board of Medical Practice

Date: June 13, 2016
RE: Application to the Acupuncture Advisory Council

Dear Molly,
It was a pleasure to talk to you on the phone. Please find my CV attached as application for the open

BMP
6-15-16

DATE: September 10, 2016

SUBJECT: Licensure Update

SUBMITTED BY: Ruth 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:

- a) Medical Faculty License
- b) License Issued by Board Staff on August 1, 2016
- c) Licensure Processes

DATE: September 10, 2016

SUBJECT: Policy & Planning Committee Report
August 10, 2016

SUBMITTED BY: Policy & Planning Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Policy & Planning Committee.

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Attachments:

- a. August 10, 2016, Policy & Planning Committee Meeting Minutes
- b. Recommendation and Motion, Federal Legislation
- c. Recommendation and Motion to Endorse, Provide Orders for Life Sustaining Treatment (POLST)
- d. Meeting Agenda

**MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE MINUTES
August 10, 2016
(DRAFT)**

The Committee, chaired by V. John Ella, J.D., and attended by Patrick Townley, M.D., J.D., Keith Berge, M.D., Allen G. Rasmussen, M.A., and Gerald Kaplan, M.A., L.P., met at 4:30 p.m. at the Board offices in Medical Board's Conference Room. Also in attendance were Board members Subbarao Inampudi, M.B., B. S., FACR, and Jon Thomas, M.D., M.B.A., and members of the public. The Committee was assisted by Board staff, Ruth Martinez, Elizabeth Huntley and Molly Schwanz. The Committee considered the following items:

1. In the matter of the National Defense Authorization Act for 2017 (S 2943) federal legislation: The Committee considered whether to recommend that the Board take a formal position on this federal legislation. The Senate version includes in **Sec. 705, Enhancement of Use of Telehealth Services in Military Health System**, language that places care where the provider is located, rather than where the patient is located. Discussion included the long-standing position of Minnesota, other states and the Federation of State Medical Boards that care is where the patient is located. The Committee concluded that the language of the Senate bill nullifies a state's capacity to respond appropriately to patient complaints.

A motion was made and unanimously passed for the Policy & Planning Committee to recommend that the Board oppose the language of S 2943, Sec. 705 that places patient care where the provider is located. Further, the Committee authorized Board staff to draft and send a letter to Congressional conferees and Minnesota's Congressional representatives stating the Committee's recommendation, rationale, and intent to bring the recommendation to the full Board on September 10, 2016.

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

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

3. In the matter of Board Outreach: The Committee considered an invitation to exhibit at the Minnesota Medical Association Annual Meeting on September 23 – 24, 2016. Discussion included past outreach activities and anticipated costs, as well as plans for how the exhibit table would be staffed.

A motion was made and unanimously passed for the Policy & Planning Committee to recommend that the Board plan to exhibit at the MMA Annual Meeting and that Board members plan to participate with Board management in staffing the exhibit table on Friday, September 23,

2016. The Committee authorized Board staff to begin the process for securing space and preparing materials for distribution.

4. In the matter of 2017 State Legislation: The Policy & Planning Committee considered whether to pursue changes to the Medical Practice Act or other related statutes. Following review of statutory language and suggestions, the Committee recommended the following:

- a) Title Protection under Minn. Stat. § 147.081, Subd. 3(6), specific to use of the title of “physician”

A motion was made and unanimously passed to seek a housekeeping change that would strengthen language to protect the use of physician titles.

- b) Modification of grounds for disciplinary action, specifically Minn. Stat. § 147.091, Subd. 1(g), (k) and (l)

A motion was made and unanimously passed to modify the language of the referenced grounds for action to more accurately reflect the nature of cited misconduct under these grounds.

- c) Establishment of a public at large seat on the Board, either as an additional Board seat or as a conversion of an existing seat

A motion was made and unanimously passed to withhold pursuit of any changes to the composition of the Board at this time.

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

DATE: September 10, 2016

SUBJECT: S. 2943, T National Defense
Authorization Act for FY 2017,
Sec. 705 Enhancement of use of
Telehealth Services in Military
Health System, (d) Location of
Care

SUBMITTED BY: Policy & Planning Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Review the attached letter and discuss the Board's recommendation and make a motion on those recommendations.

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

BACKGROUND:

The Policy & Planning Committee sent letters to Congressional representatives stating that they will recommend that the Board oppose The National Defense Authorization Act for Fiscal Year 2017, specifically Sec. 705 Enhancement of use of Telehealth Services in Military Health System, (d) Location of Care (attached).

Request for motion to accept the Policy & Planning Committee's recommendation that the Board oppose Sec. 705 of the federal legislation.



MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

August 16, 2016

The Honorable Tom Emmer
U.S. House of Representatives
503 Cannon House Office Building
Washington, DC 20515

Dear Congressman Emmer:

On behalf of the Policy and Planning Committee of the Minnesota Board of Medical Practice, I am contacting you regarding *S. 2943, the National Defense Authorization Act for Fiscal Year 2017*, specifically *Sec. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care*. While we commend efforts to enhance the capability of telemedicine to expand access to care, especially in rural and underserved communities, we are recommending that the Minnesota Board of Medical Practice oppose *Sec. 705(d)* and urge for it to be stricken.

On August 11, 2016, at the direction of the Minnesota Board of Medical Practice, the Policy and Planning Committee vigorously discussed the legislation and unanimously passed a motion recommending that the Minnesota Board oppose *Sec. 705(d)* of the proposed legislation which would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine as occurring at the location of the provider, rather than the patient. The Policy and Planning Committee concluded that failure to remove *Sec. 705(d)* would compromise patient safety and significantly undermine a state board's ability to protect its own citizens and discipline physicians for unprofessional conduct. *Sec. 705(d)* would also inadvertently create an inefficient and impractical system in which each individual state board would be required to attempt to regulate medical practice across the nation, potentially impacting millions of patients.

In the interest of protecting the public, the Minnesota Board of Medical Practice has long believed that the practice of medicine occurs where the patient is located, rather than where the provider is located. This patient-centered model is both time-tested and practice-proven, and is the nationwide standard that ensures that state medical boards have the legal capacity and practical capability to regulate physicians treating patients within the borders of their states.

Sec. 705(d) would compromise patient safety by making it less likely that substandard care will be identified, properly reported to the state medical board of jurisdiction, and be subjected to an appropriate and thorough investigation. Moreover, this provision would create an ambiguous regulatory structure in which it is unclear if the provider must adhere to the Medical Practice Acts (laws and standards) of their state of licensure, or the state of the patient's location.

It is imperative that Congress implement strategies and mechanisms to expand and enhance health care in a safe manner that is not at the expense of quality and patient safety. By enacting *Sec. 705(d)*, Congress would be doing a disservice to the extraordinary sacrifice of millions of patients. While the stated goal of this provision is to improve access, the end result will be the loss of patient protections.

Thank you for considering the concerns of the Minnesota Board's Policy and Planning Committee.

Sincerely,

V. John Ella, J.D.
Chair, Policy and Planning Committee
Minnesota Board of Medical Practice

From: Johnston, Cheryl (HLB)
Sent: Thursday, July 07, 2016 11:15 AM
To: Allen Rasmussen, MA; 'Gerald Kaplan, MA, LP'; 'Gerald Kaplan, MA, LP'; Irshad H. Jafri, M.B., B.S., FACP; 'Jon Thomas, MD, MBA'; Joseph Willett, DO, FACOI; 'Keith Berge, MD'; 'Kelli Johnson, MBA'; 'Kelli Johnson, MBA'; Kimberly Spaulding, MD, MPH; M. B. B. S. FACR Subbarao Inampudi; 'Maria Statton, MD, Ph.D.'; Mark Eggen, MD; Patricia Lindholm, MD, FAAFP; Patricia Lindholm, MD, FAAFP; Patrick Townley, MD, JD; 'V. John Ella, JD'
Cc: Williams, Brian (AG);Schwanz, Molly (HLB); Elizabeth Huntley; Erickson, Mary K (HLB); Trinka, Tami (HLB); Ruth Martinez
Subject: Legislation of Concern
Importance: High

Ruth asked that I forward the below e-mail from Lisa Robin, Federation of State Medical Boards' Chief Advocacy Officer, regarding legislation of concern. This legislation will be discussed at the July 9, 2016, Board meeting.

Thanks! - Cheryl

Cheryl Johnston
Administrative Assistant
Minnesota Board of Medical Practice

From: Lisa A. Robin (FSMB)
Sent: Wednesday, July 06, 2016 1:34 PM
To: Lisa A. Robin (FSMB); Jonathan Jagoda
Subject: Legislation of concern

Dear Executive Directors,

Recently, the U.S. Senate passed the *National Defense Authorization Act for Fiscal Year 2017 (S. 2943)*, which includes *SEC. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care*. This section would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine as occurring at the location of the provider, rather than the patient. The provision further applies this expansion of state licensure exceptions to the TRICARE program, affecting 9.4 million TRICARE beneficiaries around the world. We are very concerned that this provision would significantly undermine patient safety and state boards' ability to regulate physicians providing patient care in their state.

The legislation will soon be considered in conference committee, though the House-passed version of the bill (*H.R. 4909*) does not include the language. Working with other stakeholders, **the FSMB is working to omit this language by ensuring that (d): Location of Care be stricken from Sec. 705 during conference.** Please consider raising these concerns with your federal legislators. If you or a member of your board are willing to contact your Congressional delegation, please contact Jonathan Jagoda, Director of Federal Government Relations, at jjagoda@fsmb.org. For your reference, I have included the legislation language, as follows:

SEC. 705. ENHANCEMENT OF USE OF TELEHEALTH SERVICES IN MILITARY HEALTH SYSTEM.

(a) INCORPORATION OF TELEHEALTH.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Defense shall incorporate, throughout the direct care and purchased care components of the military health system, the use of telehealth services, including mobile health applications—

(A) to improve access to primary care, urgent care, behavioral health care, and specialty care;

(B) to perform health assessments;

(C) to provide diagnoses, interventions, and supervision;

(D) to monitor individual health outcomes of covered beneficiaries with chronic diseases or conditions;

(E) to improve communication between health care providers and patients; and

(F) to reduce health care costs for covered beneficiaries and the Department of Defense.

(2) TYPES OF TELEHEALTH SERVICES.—The telehealth services required to be incorporated under paragraph (1) shall include those telehealth services that—

(A) provide real-time interactive communications and remote patient monitoring;

(B) allow covered beneficiaries to schedule appointments and communicate with health care providers; and

(C) allow health care providers, through video conference, telephone or tablet applications, or home health monitoring devices—

(i) to assess and evaluate disease signs and symptoms;

(ii) to diagnose diseases;

(iii) to supervise treatments; and

(iv) to monitor health outcomes.

(b) **COVERAGE OF ITEMS OR SERVICES.**—An item or service furnished to a covered beneficiary via a telecommunications system shall be covered under the TRICARE program to the same extent as the item or service would be covered if furnished in the location of the covered beneficiary.

(c) **REIMBURSEMENT RATES FOR TELEHEALTH SERVICES.**—The Secretary shall develop standardized payment methods to reimburse health care providers for telehealth services provided to covered beneficiaries in the purchased care component of the TRICARE program, including by using reimbursement rates that incentivize the provision of telehealth services.

(d) **LOCATION OF CARE.**—For purposes of reimbursement, licensure, professional liability, and other purposes relating to the provision of telehealth services under this section, providers of such services shall be considered to be furnishing such services at their location and not at the location of the patient.

(e) **REDUCTION OR ELIMINATION OF COPAYMENTS.**—The Secretary shall reduce or eliminate, as the Secretary considers appropriate, copayments or cost shares for covered beneficiaries in connection with the receipt of telehealth services under the purchased care component of the TRICARE program.

(f) **REPORTS.**—

(1) **INITIAL REPORT.**—

(A) **IN GENERAL.**—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report describing the full range of telehealth services to be available in the direct care and purchased care components of the military health system and the copayments and cost shares, if any, associated with those services.

(B) REIMBURSEMENT PLAN.—The report required under subparagraph (A) shall include a plan to develop standardized payment methods to reimburse health care providers for telehealth services provided to covered beneficiaries in the purchased care component of the TRICARE program, as required under subsection (c).

(2) FINAL REPORT.—

(A) IN GENERAL.—Not later than three years after the date on which the Secretary begins incorporating, throughout the direct care and purchased care components of the military health system, the use of telehealth services as required under subsection (a), the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report describing the impact made by the use of telehealth services, including mobile health applications, to carry out the actions specified in subparagraphs (A) through (F) of subsection (a)(1).

(B) ELEMENTS.—The report required under subparagraph (A) shall include an assessment of the following:

(i) The satisfaction of covered beneficiaries with telehealth services furnished by the Department of Defense.

(ii) The satisfaction of health care providers in providing telehealth services furnished by the Department.

(iii) The effect of telehealth services furnished by the Department on the following:

(I) The ability of covered beneficiaries to access health care services in the direct care and purchased care components of the military health system.

(II) The frequency of use of telehealth services by covered beneficiaries.

(III) The productivity of health care providers providing care furnished by the Department.

(IV) The reduction, if any, in the use by covered beneficiaries of health care services in military treatment facilities or medical facilities in the private sector.

(V) The number and types of appointments for the receipt of telehealth services furnished by the Department.

(VI) The savings, if any, realized by the Department by furnishing telehealth services to covered beneficiaries.

(g) DEFINITIONS.—In this section, the terms "covered beneficiary" and "TRICARE program" have the meaning given those terms in section 1072 of title 10, United States Code.

Thank you for your attention in this matter.

Sincerely,
Lisa

Lisa Robin
Chief Advocacy Officer

Federation of State Medical Boards

Federation of
STATE
MEDICAL
BOARDS

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DATE: September 10, 2016

SUBJECT: Provider Orders for Life Sustaining
Treatment (POLST)

SUBMITTED BY: Policy & Planning Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

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

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

BACKGROUND:

The Policy & Planning Committee met on August 10, 2016, and reviewed and discussed the POLST revised statement. The Committee recommends that the Board endorse the revised POLST statement. Request a motion to endorse the revised POLST statement.

POLST: Provider Orders for Life Sustaining Treatment POLST

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

Last Name

First/Middle Initial

Date of Birth

Primary Care Provider/Phone

A CARDIOPULMONARY RESUSCITATION (CPR):

Check One

Patient has no pulse and is not breathing.

CPR/ATTEMPT RESUSCITATION

DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

When not in cardiopulmonary arrest, follow orders in B and C.

B GOALS OF TREATMENT:

Check One Goal

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

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

Check all that apply:

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

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

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

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

Check one:

Do not intubate

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

PROVIDE LIFE SUSTAINING TREATMENT

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

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

C INTERVENTIONS AND TREATMENT

Check All That Apply

ANTIBIOTICS (check one):

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

Oral Antibiotics Only (No IV/IM)

Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION (check all that apply):

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

Tube feeding through mouth or nose

Tube feeding directly into GI tract

IV fluid administration

Other: _____

Additional Orders:

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

Provider Signature

Date

FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID.

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

POLST

D SUMMARY OF GOALS

Check All That Apply

DISCUSSED WITH:

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

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

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

Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
---	----------------	--------------	---------------

E SIGNATURE OF PATIENT OR HEALTH CARE AGENT / GUARDIAN / SURROGATE
THESE ORDERS REFLECT THE PATIENT'S TREATMENT WISHES

Name	Date
Relationship to Patient	Phone Number
Signature*	

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING POLST

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

USING POLST

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

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

REVIEWING POLST

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

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

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

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

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

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

CHECK ONE

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

When not in cardiopulmonary arrest, follow orders in B.

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

CHECK ONE
(NOTE REQUIREMENTS)

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

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

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

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (STRONGLY RECOMMENDED)	NAME (PRINT)
RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF")	PHONE (WITH AREA CODE)

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

D SIGNATURE OF PHYSICIAN / APRN / PA

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

NAME (PRINT) (REQUIRED)	LICENSE TYPE (REQUIRED)	PHONE (WITH AREA CODE)
SIGNATURE (REQUIRED)	DATE (REQUIRED)	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID

Policy & Planning Committee
August 10, 2016
4:30 p.m.
5th Floor Board of Medical Practice
Conference Room
Agenda

1. Federal Legislation – **National Defense Authorization Act for Fiscal Year 2017 (S. 2943)**
The US Senate passed the **National Defense Authorization Act for Fiscal Year 2017, which includes Sec. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care.**
 - Attached is an e-mail forwarded to Board members on July 7, 2016, from the Federation of State Medical Boards' Chief Advocacy Officer Lisa A. Robins containing **Sec. 705. Enhancement of use of Telehealth Services in Military Health System.** This legislation was also discussed at the July 9, 2016, Board meeting.
 - Determine if the Policy & Planning Committee recommends opposing this legislation. If so, determine if executive director Ruth Martinez should write a letter referencing a recommendation to oppose, since the Board would not take a formal position until September 2016. [Attached is a sample letter from the American Medical Association (AMA), American Osteopathic Association (AOA), and the Federation of State Medical Boards (FSMB) and an e-mail and sample letter from the FSMB Director of Federal Government Relations Jonathan Jagoda. Also attached is a listing of the Congressional Conferees who will negotiate the language between the Senate and House.]

2. POLST: Provider Orders for Life Sustaining Treatment
The Minnesota Medical Association has asked the Board to endorse the attached Provider Orders for Life Sustaining Treatment statement.
 - Determine whether to recommend that the Board take a position on the revised POLST statement. A previous POLST statement and a revised draft are enclosed.

3. Board Outreach to Licensees
The Minnesota Medical Association (MMA) has invited the Board to provide an exhibit at the MMA Annual Meeting on September 23 and 24, 2016, at the DoubleTree Park Place in St. Louis Park (agenda attached.)
 - Discuss financial implications:
Cost to exhibit (see attached):
 - E-mail from MMA's Sponsorship Manager Scott Wilson and Administrative Assistant Sandy Nentwig regarding costs for an exhibit booth.
 - MMA's 2016 Sponsorship Program with information regarding exhibit costs.
 - Members: \$149 (\$134 prior to August 15)
 - Non-members \$199 (179 prior to August 15)

4. State Legislation
 - a) Title Protection
 - Attached is an e-mail from Attorney General Brian Williams regarding sample statutory language for title protection of the term "physician."
 - Attached is New York Board language regarding title protection.
 - b) Grounds for Discipline
 - Attached is Minnesota Statute 147.091
 - c) Public at Large Seat
 - Determine if the Committee should recommend to the Board to create a public at large seat (Attached are Minnesota Statutes 147.01 and 214.09.)

From: Johnston, Cheryl (HLB)

Sent: Thursday, July 07, 2016 11:15 AM

To: Allen Rasmussen, MA; 'Gerald Kaplan, MA, LP'; 'Gerald Kaplan, MA, LP'; Irshad H. Jafri, M.B., B.S., FACP; 'Jon Thomas, MD, MBA'; Joseph Willett, DO, FACOI; 'Keith Berge, MD'; 'Kelli Johnson, MBA'; 'Kelli Johnson, MBA'; Kimberly Spaulding, MD, MPH; M. B. S. FACR Subbarao Inampudi; 'Maria Statton, MD, Ph.D.'; Mark Eggen, MD; Patricia Lindholm, MD, FAAFP; Patricia Lindholm, MD, FAAFP; Patrick Townley, MD, JD; 'V. John Ella, JD'

Cc: Williams, Brian (AG); Schwanz, Molly (HLB); Elizabeth Huntley; Erickson, Mary K (HLB); Trinkka, Tami (HLB); Ruth Martinez

Subject: Legislation of Concern

Importance: High

Ruth asked that I forward the below e-mail from Lisa Robin, Federation of State Medical Boards' Chief Advocacy Officer, regarding legislation of concern. This legislation will be discussed at the July 9, 2016, Board meeting.

Thanks! - Cheryl

Cheryl Johnston
Administrative Assistant
Minnesota Board of Medical Practice

From: Lisa A. Robin (FSMB)

Sent: Wednesday, July 06, 2016 1:34 PM

To: Lisa A. Robin (FSMB); Jonathan Jagoda

Subject: Legislation of concern

Dear Executive Directors,

Recently, the U.S. Senate passed the ***National Defense Authorization Act for Fiscal Year 2017 (S. 2943)***, which includes ***SEC. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care***. This section would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine as occurring at the location of the provider, rather than the patient. The provision further applies this expansion of state licensure exceptions to the TRICARE program, affecting 9.4 million TRICARE beneficiaries around the world. We are very concerned that this provision would significantly undermine patient safety and state boards' ability to regulate physicians providing patient care in their state.

The legislation will soon be considered in conference committee, though the House-passed version of the bill (*H.R. 4909*) does not include the language. Working with other stakeholders, **the FSMB is working to omit this language by ensuring that (d): Location of Care be stricken from Sec. 705 during conference.** Please consider raising these concerns with your federal legislators. If you or a member of your board are willing to contact your Congressional delegation, please contact Jonathan Jagoda, Director of Federal Government Relations, at jjagoda@fsmb.org. For your reference, I have included the legislation language, as follows:

SEC. 705. ENHANCEMENT OF USE OF TELEHEALTH SERVICES IN MILITARY HEALTH SYSTEM.

(a) INCORPORATION OF TELEHEALTH.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Defense shall incorporate, throughout the direct care and purchased care components of the military health system, the use of telehealth services, including mobile health applications—

(A) to improve access to primary care, urgent care, behavioral health care, and specialty care;

(B) to perform health assessments;

(C) to provide diagnoses, interventions, and supervision;

(D) to monitor individual health outcomes of covered beneficiaries with chronic diseases or conditions;

(E) to improve communication between health care providers and patients; and

(F) to reduce health care costs for covered beneficiaries and the Department of Defense.

(2) TYPES OF TELEHEALTH SERVICES.—The telehealth services required to be incorporated under paragraph (1) shall include those telehealth services that—

(A) provide real-time interactive communications and remote patient monitoring;

(B) allow covered beneficiaries to schedule appointments and communicate with health care providers; and

(C) allow health care providers, through video conference, telephone or tablet applications, or home health monitoring devices—

(i) to assess and evaluate disease signs and symptoms;

(ii) to diagnose diseases;

(iii) to supervise treatments; and

(iv) to monitor health outcomes.

(b) COVERAGE OF ITEMS OR SERVICES.—An item or service furnished to a covered beneficiary via a telecommunications system shall be covered under the TRICARE program to the same extent as the item or service would be covered if furnished in the location of the covered beneficiary.

(c) REIMBURSEMENT RATES FOR TELEHEALTH SERVICES.—The Secretary shall develop standardized payment methods to reimburse health care providers for telehealth services provided to covered beneficiaries in the purchased care component of the TRICARE program, including by using reimbursement rates that incentivize the provision of telehealth services.

(d) LOCATION OF CARE.—For purposes of reimbursement, licensure, professional liability, and other purposes relating to the provision of telehealth services under this section, providers of such services shall be considered to be furnishing such services at their location and not at the location of the patient.

(e) REDUCTION OR ELIMINATION OF COPAYMENTS.—The Secretary shall reduce or eliminate, as the Secretary considers appropriate, copayments or cost shares for covered beneficiaries in connection with the receipt of telehealth services under the purchased care component of the TRICARE program.

(f) REPORTS.—

(1) INITIAL REPORT.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report describing the full range of telehealth services to be available in the direct care and purchased care components of the military health system and the copayments and cost shares, if any, associated with those services.

(B) REIMBURSEMENT PLAN.—The report required under subparagraph (A) shall include a plan to develop standardized payment methods to reimburse health care providers for telehealth services provided to covered beneficiaries in the purchased care component of the TRICARE program, as required under subsection (c).

(2) FINAL REPORT.—

(A) IN GENERAL.—Not later than three years after the date on which the Secretary begins incorporating, throughout the direct care and purchased care components of the military health system, the use of telehealth services as required under subsection (a), the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report describing the impact made by the use of telehealth services, including mobile health applications, to carry out the actions specified in subparagraphs (A) through (F) of subsection (a)(1).

(B) ELEMENTS.—The report required under subparagraph (A) shall include an assessment of the following:

(i) The satisfaction of covered beneficiaries with telehealth services furnished by the Department of Defense.

(ii) The satisfaction of health care providers in providing telehealth services furnished by the Department.

(iii) The effect of telehealth services furnished by the Department on the following:

(I) The ability of covered beneficiaries to access health care services in the direct care and purchased care components of the military health system.

(II) The frequency of use of telehealth services by covered beneficiaries.

(III) The productivity of health care providers providing care furnished by the Department.

(IV) The reduction, if any, in the use by covered beneficiaries of health care services in military treatment facilities or medical facilities in the private sector.

(V) The number and types of appointments for the receipt of telehealth services furnished by the Department.

(VI) The savings, if any, realized by the Department by furnishing telehealth services to covered beneficiaries.

(g) DEFINITIONS.—In this section, the terms “covered beneficiary” and “TRICARE program” have the meaning given those terms in section 1072 of title 10, United States Code.

Thank you for your attention in this matter.

Sincerely,
Lisa

Lisa Robin
Chief Advocacy Officer

Federation of State Medical Boards



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July 11, 2016

The Honorable John McCain
Chairman
Senate Committee on Armed Services
228 Russell Senate Office Building
Washington, DC 20510

The Honorable Mac Thornberry
Chairman
House Committee on Armed Services
2216 Rayburn House Office Building
Washington, DC 20515

The Honorable Jack Reed
Ranking Member
Senate Committee on Armed Services
228 Russell Senate Office Building
Washington, DC 20510

The Honorable Adam Smith
Ranking Member
House Committee on Armed Services
2216 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen McCain and Thornberry, and Ranking Members Reed and Smith:

On behalf of the undersigned organizations, we appreciate your efforts to expand access to quality medical care, improve health outcomes, and promote patient safety as our organizations and membership have long been committed to these goals. It is in this spirit that we are writing to convey our strong opposition to *SEC. 705, Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care*, as incorporated into the Senate-passed version of the *National Defense Authorization Act for Fiscal Year 2017 (S. 2943)*, which would undermine and weaken essential patient safety measures that ensure patients receive quality care.

We commend the Armed Services Committees for recognizing the capability of telemedicine to expand access to care, especially in rural and underserved communities. Our organizations have dedicated significant efforts to removing barriers and accelerating access to telemedicine services over the past two years in order to drive health care transformations that improve patient health outcomes and safeguard patient safety. It is for the foregoing reasons that we strongly oppose *(d) Location of Care* that would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine as occurring at the location of the provider, rather than the patient.

On behalf of patients and public safety, we have regularly affirmed that the practice of medicine occurs where the patient is located, rather than where the provider is located. This patient-centered model is both time-tested and practice-proven, and is the nationwide standard that ensures that state medical boards have the legal capacity and practical capability to regulate physicians treating patients within the borders of their state, and to attest that those physicians meet the qualifications necessary to safely practice medicine.

Though well-intentioned, *(d) Location of Care* would significantly undermine state boards' ability to protect patients receiving medical care in their state and discipline physicians for unprofessional conduct. Each state establishes its own licensing and medical practice standards, regulations, and laws that meet the needs of the individuals receiving care within the state's borders. This provision

would compromise patient safety by making it exceedingly difficult and potentially impossible for patients and state medical boards where the care was rendered to address improper or unprofessional care. This provision will hinder the ability of patients to quickly and accurately identify and report adverse actions to the state medical board of jurisdiction, and actively support the medical board investigation. This provision would create an ambiguous medical regulatory structure, as it is unclear if the provider must adhere to the Medical Practice Acts (laws and standards) of their state of licensure, or the state of the patient's location. The latter would embroil patients, state medical boards, and health care providers in costly conflicts of law litigation ancillary to the issue of whether appropriate medical care was provided.

In the time-tested system of state-based medical licensure, patients and others may file a complaint with the state medical board where they received medical care in the event of an adverse action by a physician. Redefining the practice of medicine at the location of the provider, in the event of such an adverse action, would place the burden solely on the patient to navigate through the complaint filing and investigatory process (including identifying the state of licensure of the physician and applicable state medical practice laws) across one or more state lines.

This legislative provision would create an inefficient and unworkable system where each individual state board would be required to regulate medical practice across the nation, affecting 9.4 million TRICARE beneficiaries around the world. Generally, state boards' legal authority does not expand beyond their state borders – investigations and application of state medical practice laws stop at their border's edge.

The current fee structure of the state board licensing and renewal system allows state boards to use their limited resources to fund investigations and subsequent prosecutions of physicians suspected of unprofessional medical conduct in the state where the medical care was rendered. This proposal would create a significant and unsustainable financial burden on the state board where the physician is licensed, forcing the board to conduct its disciplinary proceedings and utilize their limited resources, at a much greater cost, to be able to conduct investigations in other states.

We are supportive of telemedicine, and have sought to develop and implement policies, rules and mechanisms that would expand access to care via telemedicine in a safe and accountable manner. Since 2015, as an example, seventeen states have enacted legislation to participate in the Interstate Medical Licensure Compact, a new pathway to expedite the licensing of qualified physicians seeking to practice medicine in multiple jurisdictions. Additional U.S. states and territories are expected to join the Compact in the years ahead.

The Compact provides for the key component of regulation at the point of care – a fundamental principle of medical regulation that must remain in place – while dramatically streamlining the licensing process. It accomplishes the major goals that telemedicine advocates promote: faster licensure, reduced barriers, and a system that can be applied nationwide, creating an enhanced environment for multi-state practice.

It is imperative that the U.S. Congress implement strategies and mechanisms to expand and enhance health care, but must do so in a safe manner that is not at the expense of quality. By not affording TRICARE beneficiaries with the same protections afforded to the public in terms of state licensure and regulatory oversight, we would be doing a disservice to their extraordinary sacrifice. While the stated goal of this provision is to improve access, the end result will be the loss of protections afforded to patients.

Recommendation

We commend the Senate and House Armed Services Committees for its leadership in expanding access to telehealth services, but respectfully request that only **(d), Location of Care, of Section 705, be stricken** from the Senate version of *National Defense Authorization Act for Fiscal Year 2017*, and thereby not be included in the conference legislation. We welcome the opportunity to meet with you and Committee staff during conference to further elaborate on the aforementioned concerns.

Sincerely,

American Medical Association (AMA)
American Osteopathic Association (AOA)
Federation of State Medical Boards (FSMB)

cc: U.S. Senate Committee on Armed Services
U.S. House of Representatives Committee on Armed Services

House Conferees for National Defense Authorization Act (NDAA), 2017

Republican Members

- Rep. Mac Thornberry (R-TX), Chairman of the House Armed Services Committee
- Rep. J. Randy Forbes (R-VA)
- Rep. Jeff Miller (R-FL)
- Rep. Joe Wilson (R-SC)
- Rep. Frank LoBiondo (R-NJ)
- Rep. Rob Bishop (R-UT)
- Rep. Mike Turner (R-OH)
- Rep. John Kline (R-MN)
- Rep. Mike Rogers (R-AL)
- Rep. Trent Franks (R-AZ)
- Rep. Bill Shuster (R-PA)
- Rep. Mike Conaway (R-TX)
- Rep. Doug Lamborn (R-CO)
- Rep. Rob Wittman (R-VA)
- Rep. Chris Gibson (R-NY)
- Rep. Vicky Hartzler (R-MO)
- Rep. Joe Heck (R-NV)
- Rep. Elise Stefanik (R-NY)

Democratic Members

- Rep. Adam Smith (D-WA), Ranking Member, House Armed Services Committee
- Rep. Loretta Sanchez (D-CA)
- Rep. Susan Davis (D-CA)
- Rep. James Langevin (D-RI)
- Rep. Rick Larsen (D-WA)
- Rep. Jim Cooper (D-TN)
- Rep. Madeleine Bordallo (D-GU)
- Rep. Joe Courtney (D-CT)
- Rep. Niki Tsongas (D-MA)
- Rep. John Garamendi (D-CA)
- Rep. Hank Johnson (D-GA)
- Rep. Jackie Speier (D-CA)
- Rep. Scott Peters (D-CA)

Senate Armed Services Members/NDAA Conferees

Republican Members:

McCain, John (AZ) , Chairman
Inhofe, James M. (OK)
Sessions, Jeff (AL)
Wicker, Roger F. (MS)
Ayotte, Kelly (NH)
Fischer, Deb (NE)
Cotton, Tom (AR)
Rounds, Mike (SD)
Ernst, Joni (IA)
Tillis, Thom (NC)
Sullivan, Dan (AK)
Lee, Mike (UT)
Graham, Lindsey (SC)
Cruz, Ted (TX)

Democratic Members:

Reed, Jack (RI), Ranking Member
Nelson, Bill (FL)
McCaskill, Claire (MO)
Manchin, Joe (WV)
Shaheen, Jeanne (NH)
Gillibrand, Kirsten E. (NY)
Blumenthal, Richard (CT)
Donnelly, Joe (IN)
Hirono, Mazie K. (HI)
Kaine, Tim (VA)
King, Angus S. (ME)
Heinrich, Martin (NM)

Martinez, Ruth (HLB)

From: Jonathan Jagoda [REDACTED]
Sent: Monday, July 11, 2016 1:03 PM
To: Jonathan Jagoda
Cc: Lisa A. Robin (FSMB); John Bremer
Subject: Model Letter - NDAA - Sec. 705(d)
Attachments: Model NDAA Letter.docx

Importance: High

Dear Colleagues,

Thank you for expressing interest in contacting your U.S. Representatives and Senators to oppose *Sec. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care* of the *National Defense Authorization Act for Fiscal Year 2017*. This section would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine as occurring at the location of the provider, rather than the patient. The provision further applies this expansion of state licensure exceptions to the TRI-CARE program, affecting 9.4 million TRICARE beneficiaries around the world.

I am providing you with a model letter that you may customize and send to your U.S. Representatives and Senators. I encourage you to personalize the letter, and expand upon how this provision would specifically affect your state board's ability to regulate medicine and protection patients in the state.

As a reminder, this provision was included in the Senate version of the bill, but not the House version of the bill. The bill is now in conference committee. The U.S. House of Representatives have named their conferees: <http://www.speaker.gov/press-release/house-moves-fund-military-increase-troop-pay>. The Senate has not yet named their conferees, but most likely will be comprised of Senators serving on the Senate Armed Services Committee: <http://www.armed-services.senate.gov/about/members>. As these individuals will be most influential during the conference process, I encourage you to focus your outreach efforts to those Members listed from your state.

When preparing your letters, you should mail a hard copy to the Washington, D.C. Office of the Representative/Senator, though it will take several weeks to process through security. Congressional websites with office locations are available at: <http://www.house.gov/representatives/> and <http://www.senate.gov/senators/contact/>. You should also email the letters to the Health and Military Legislative Assistants. If you need assistance with email addresses, please let me know.

The FSMB plans to send its letter of opposition in the next few days.

Please let me know if you have any questions. Thank you again for your support.

Sincerely,

Jonathan Jagoda
Director, Federal Government Relations

Federation of State Medical Boards

[REDACTED]

July 1, 2016

The Honorable [redacted]
U.S. House of Representatives/U.S. Senate
[redacted] House Office Building/Senate Office Building
Washington, DC 20515/20510

Dear Congress(wo)man/Senator [redacted]:

On behalf of the (State Medical Board), I am contacting you in regards to S. 2943, the National Defense Authorization Act for Fiscal Year 2017, specifically Sec. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care. While we commend the Senate for recognizing the capability of telemedicine to expand access to care, especially in rural and underserved communities, we strongly oppose Sec. 705(d) and urge for it to be stricken.

As passed by the Senate, Sec. 705(d) would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine as occurring at the location of the provider, rather than the patient. Though well-intentioned, it would significantly undermine state boards' ability to protect their own citizens and discipline physicians for unprofessional conduct. It would also inadvertently create an inefficient and unworkable system where each individual state board would be required to regulate medical practice across the nation, affecting 9.4 million TRICARE beneficiaries around the world.

To protect patients and the public, the (State Medical Board) believes that the practice of medicine occurs where the patient is located, rather than where the provider is located. This patient-centered model is both time-tested and practice-proven, and is the nationwide standard that ensures that state medical boards have the legal capacity and practical capability to regulate physicians treating patients within the borders of their state.

Each state determines its own licensing and medical practice standards that meet the individual needs of its citizens. This provision would compromise patient safety by making it less likely that improper or unprofessional care will be identified, properly reported to the state medical board of jurisdiction, and made subject of an investigation. Moreover, this provision would create an ambiguous medical regulatory structure, as it is unclear if the provider must adhere to the Medical Practice Acts (laws and standards) of their state of licensure, or the state of the patient's location.

It is imperative that Congress implement strategies and mechanisms to expand and enhance health care, but must do so in a safe manner that is not at the expense of quality. By not affording TRICARE beneficiaries with the same protections afforded to the public, Congress would be doing a disservice to their extraordinary sacrifice. While the stated goal of this provision is to improve access, the end result will be the loss of patient protections.

Again, thank you for the opportunity to express my concerns.

Sincerely,

POLST: Provider Orders for Life Sustaining Treatment **POLST**

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

Last Name _____

First/Middle Initial _____

Date of Birth _____

Primary Care Provider/Phone _____

A

CARDIOPULMONARY RESUSCITATION (CPR):

Patient has no pulse and is not breathing.

Check One

CPR/ATTEMPT RESUSCITATION

DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

B

GOALS OF TREATMENT:

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

Check One Goal

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

Check all that apply:

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

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

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

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

Check one:

Do not intubate

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

PROVIDE LIFE SUSTAINING TREATMENT

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

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

C

INTERVENTIONS AND TREATMENT

Check All That Apply

ANTIBIOTICS (*check one*):

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

Oral Antibiotics Only (No IV/IM)

Use IV/IM Antibiotic Treatment

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

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

Tube feeding through mouth or nose

Tube feeding directly into GI tract

IV fluid administration

Other: _____

Additional Orders:

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

Provider Signature _____

Date _____

FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID.

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

POLST

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

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

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____

PRIMARY MEDICAL CARE PROVIDER NAME _____ PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE) _____

A

CHECK ONE

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

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

When not in cardiopulmonary arrest, follow orders in B.

B

CHECK ONE
(NOTE REQUIREMENTS)

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

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

C

CHECK ALL THAT APPLY

DOCUMENTATION OF DISCUSSION

- Patient** (*Patient has capacity*) **Court-Appointed Guardian** **Other Surrogate**
- Parent of Minor** **Health Care Agent** **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (STRONGLY RECOMMENDED) _____ NAME (PRINT) _____

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

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

D

SIGNATURE OF PHYSICIAN / APRN / PA

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

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

SIGNATURE (REQUIRED) _____ DATE (REQUIRED) _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

INFORMATION FOR

PATIENT NAMED ON THIS FORM

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

E ADDITIONAL PATIENT PREFERENCES (OPTIONAL)

CHECK
ONE
FROM
EACH
SECTION

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

- Long-term artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- No artificial nutrition by tube.

ANTIBIOTICS

- Use IV/IM antibiotic treatment.
- Oral antibiotics only (no IV/IM).
- No antibiotics. Use other methods to relieve symptoms when possible.

ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

HEALTH CARE PROVIDER WHO PREPARED DOCUMENT

PREPARER NAME (REQUIRED)

PREPARER TITLE (REQUIRED)

PREPARER PHONE (WITH AREA CODE) (REQUIRED)

DATE PREPARED (REQUIRED)

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form

can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a Health Care Agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, Health Care Agent designated in a Health Care Directive, or a person whom the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a verbally designated surrogate, spouse, registered domestic partner, parent of a minor, or closest available relative.

Reviewing POLST

This POLST should be reviewed periodically, and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change, or
- The patient's Primary Medical Care Provider changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

Johnston, Cheryl (HLB)

From: Scott Wilson [REDACTED]
Sent: Wednesday, August 03, 2016 11:59 AM
To: Johnston, Cheryl (HLB)
Subject: FW: MMA Annual Conference Sponsor Opportunities

Hi Cheryl,

I wanted to reach out to let you know that we can offer you the state agency discount of \$75 off an exhibit booth (\$920 for a booth) or 10% off any larger sponsorship (Silver, Gold or Platinum level). Please let me know if you or anyone on the committee has any questions.

All the best,
Scott Wilson | Sponsorship Manager
Minnesota Medical Association

[REDACTED]

From: Sandy Nentwig
Sent: Wednesday, August 03, 2016 11:48 AM
To: Scott Wilson
Subject: FW: MMA Annual Conference Sponsor Opportunities

MN Board of Medical Practice is going to discuss sponsorship at their 8/13 meeting

From: Johnston, Cheryl (HLB) [<mailto:cheryl.johnston@state.mn.us>]
Sent: Wednesday, August 03, 2016 11:29 AM
To: Sandy Nentwig
Subject: RE: MMA Annual Conference Sponsor Opportunities

Thank you for the information. It will be discussed at the Board's Policy and Planning Committee meeting on August 13, 2016.

Sincerely,

Cheryl Johnston
Administrative Assistant
Minnesota Board of Medical Practice

[REDACTED]

From: Sandy Nentwig [[mailto:\[REDACTED\]](mailto:[REDACTED])]
Sent: Wednesday, August 03, 2016 11:24 AM
To: Johnston, Cheryl (HLB)
Subject: MMA Annual Conference Sponsor Opportunities

Here is the information you requested. We look forward to working with you!

Sandy Nentwig | Administrative Assistant for Health Policy and State and Federal Legislation Department
Minnesota Medical Association | mnmed.org

612-337-3755 office | sentwig@mnmed.org
1000 University Ave. | Minneapolis, MN 55415

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MMA ANNUAL CONFERENCE 2016



MINNESOTA
MEDICAL
ASSOCIATION

**2016
SPONSORSHIP
PROGRAM**
DOUBLETREE
PARK PLACE HOTEL
ST. LOUIS PARK, MN

**SEPT
23+24
2016**
**EXHIBIT
HALL
OPEN
9/23
ONLY**

REACH MINNESOTA PHYSICIANS – MULTIPLE TIMES

In addition to reaching Annual Conference participants, sponsors will be viewed by as many as 16,500 member and non-member physicians, more than a dozen times through September 2016, as MMA uses a multi-touch marketing and communications effort to promote the event. These touches include: monthly emails, weekly online newsletters, monthly magazine advertising and two targeted printed, direct mail invitations.

HUNDREDS OF ATTENDEES

MMA's Annual Conference will bring together up to 300 physicians and physicians-in-training from across Minnesota for a day-and-a-half of education, policy discussion, networking and celebrating medicine.

IT'S A CONFERENCE FOR ALL MINNESOTA PHYSICIANS!

DoubleTree Park Place Hotel
1500 Park Place Boulevard
St. Louis Park, MN 55416



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CONFERENCE
2016

SPONSORSHIP OPPORTUNITIES



Premier, Platinum, Gold and Silver packages include a booth location.

PREMIER | Inauguration | \$15,000

SOLD TO MMIC GROUP

Exclusive sponsorship of the Inauguration.

- Special personal recognition at dinner
- Four tickets to dinner
- Your logo appears on signage leading into your sponsored event
- Preferential booth location
- Your logo appears on all Annual Conference promotional material
- Your logo appears on signage at registration table and two other locations
- Four full page ads in *Minnesota Medicine* — use by September 2017
- Four MMA website ads — use by December 2016
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).



PLATINUM | MMA Keynote Speakers | \$5,000

ZDoggMD and Damon Tweedy, MD

(ONE AVAILABLE FOR ZDOGGMD AND ONE AVAILABLE FOR DAMON TWEEDY, MD)

Sponsorship of Friday's morning or evening keynote speakers (estimated attendance of 200+ at either event).

- Representative can introduce the keynote speaker (some restrictions apply)
- Two tickets to keynote presentations
- Premier booth location
- Your logo appears on signage leading into your sponsored event
- Your logo appears on all Annual Conference promotional material
- Your logo appears on signage at registration table and two other locations
- One full page ad in *Minnesota Medicine* — use by September 2017
- Three MMA website ads — use by December 2016
- Opportunity to sponsor one MMA "in-person" event during the year (October 2016 to September 2017) at 50 percent discount (excluding the MMA Annual Conference)
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).

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SPONSORSHIP OPPORTUNITIES



Premier, Platinum, Gold and Silver packages include a booth location.

MMA ANNUAL
CONFERENCE
2016

GOLD

Friday luncheon

\$2,750

(ONE AVAILABLE)

- Sponsor recognition from MMA speaker at luncheon
- Two tickets to Friday evening's keynote presentation featuring ZDoggMD
- Your logo appears on signage at luncheon
- Premier booth location
- Your logo appears on all Annual Conference promotional material
- Your logo appears on signage at registration table and two other locations
- One half-page ad in *Minnesota Medicine* — use by September 2017
- One MMA website ad — use by December 2017
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).



SATURDAY EDUCATION BREAKOUT SESSIONS

(each track offers two programs)

\$2,750

(THREE AVAILABLE)

Sponsorship of one of Saturday's education tracks (estimated attendance of 50 to 75+ in each program).

- Representative can introduce each program (some restrictions apply)
- Two tickets to Friday evening's keynote presentation featuring ZDoggMD
- Your logo appears on signage leading into your sponsored event
- Premier booth location
- Your logo appears on all Annual Conference promotional material
- Your logo appears on signage at registration table and two other locations
- One half-page ad in *Minnesota Medicine* — use by September 2017
- One MMA website ad — use by December 2016
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).

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CONFERENCE
2016

SPONSORSHIP OPPORTUNITIES

*

*Premier, Platinum,
Gold and Silver
packages include a
booth location.*

SILVER | Hippocrates Cafe | \$2,500

(THREE AVAILABLE)

Hippocrates Cafe is a theatrical production that explores complex health care topics using equal measures of humor and reflection. Join host Jon Hallberg, MD, as he and the cast of professional actors will read from a variety of sources, including selections from *Minnesota Medicine* while musicians perform instrumental interludes. This Thursday evening event will be an opportunity to network with as many as 100 physicians and physicians-in-training. The program will include hors d'oeuvres.

- Your logo appears on signage at the event
- Premier booth location at the conference plus a booth at the Hippocrates Cafe event on Thursday evening
- Your logo appears on all Annual Conference promotional materials
- Your logo appears on signage at registration table and two other locations
- Pre-event time to meet and greet attendees
- One MMA website ad — use by December 2016
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).
- Representative can introduce the program



SILVER | MMA's Got Talent | \$2,500 **(THREE AVAILABLE)**

Following the Friday evening Keynote featuring ZDoggMD will be an exciting first time MMA event in which physicians, residents, medical students, and health care teams will be invited to showcase their talents in a fun-spirited competitive talent show. A panel of judges, including ZDoggMD, will offer running commentary. A grand-prize winner will be chosen by the audience, and awarded with a stethoscope trophy and special prizes from sponsors of this fun event. This showcase will run on Friday evening, approximately 8:45pm - 10:30pm. Sponsorship will include:

- Your logo appears on signage at the Friday's MMA's Got Talent showcase (some restrictions apply)
- Premier booth location
- Your logo appears on all Annual Conference promotional materials
- Your logo appears on signage at registration table and two other locations
- Two tickets to Friday evening's keynote presentation featuring ZDoggMD
- One MMA website ad — use by December 2016
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).
- You can provide a prize (Minimum \$250 value) and a representative can present it to the winner of the MMA's Got Talent Showcase.

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SPONSORSHIP OPPORTUNITIES



Premier, Platinum, Gold and Silver packages include a booth location.

MMA ANNUAL
CONFERENCE
2016

EXHIBITOR BOOTH | \$995 (SPACE IS LIMITED)

You can add to the value of your booth by sponsoring one of the Annual Conference programs.

- Booth location
- Your logo appears on all Annual Conference promotional material
- Your logo appears on signage at registration table and two other locations
- Your logo appears in MMA print and email marketing materials sent to all Minnesota practicing and retired physicians, residents, fellows and medical students (as many as 16,500, twelve times).

SOCIAL RECEPTION\POSTER SESSION | \$1,000 (ONE AVAILABLE)

Sponsor the Friday evening social hour reception.

- Premier booth location (cost of exhibitor booth not included)
- Your logo appears on signage at the reception
- Your promotional materials displayed at the reception
- Sponsor will present the Poster Session winner with the \$500 prize at the inauguration.

BREAKFAST SPONSOR | Friday or Saturday | \$750 (TWO AVAILABLE)

Sponsor breakfast on Friday or Saturday morning (each breakfast will have an estimated audience of 150-200).

- Your logo appears on signage at breakfast table

BREAK SPONSORS | Saturday | \$500 (THREE AVAILABLE)

Sponsor food and beverage service at three breaks (each break will have an estimated audience of 150-200).

- Your logo appears on signage at break table
- Your promotional materials displayed at the break

CAN'T ATTEND? SUPPORT MMA WITH THESE SPONSORSHIPS!

Program Sponsorship

Logo recognition on all Annual Conference promotional materials — \$750

- Your logo appears on signage at registration table and two other locations
- Name recognition on all Annual Conference promotional materials — \$350
- Your name appears on signage at registration table and two other locations

Other customized sponsorships

If you are looking for a more customized sponsorship opportunity, consider these options or call Scott Wilson at 612-632-3748.

Item Sponsors

- Lanyards — \$1,500 (sponsor supplies 300 lanyards)
- Flash Drives with Conference Materials — \$3,000
- Pens — \$1,000 (sponsor supplies 300 pens)
- Centerpiece sponsorship for the Inauguration — \$1,500
- Name tags — \$1,000

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ANNUAL CONFERENCE SCHEDULE

(tentative)

**MMA ANNUAL
CONFERENCE
2016**

THURSDAY, SEPTEMBER 22

7 - 9 pm
Hippocrates Cafe
7 - 9 pm
Early exhibitor setup

FRIDAY, SEPTEMBER 23

6 am
Exhibit hall open for setup
7 am
Registration opens
7:30-8:30 am
Breakfast in exhibit hall
8:30 am
Opening Keynote
Damon Tweedy, MD
9 am
Exhibits must be set up
9:30 - 10 am
Break with exhibitors
10-11 am
Policy Session #1 and Education Session #1
11-11:30 am
Break with exhibitors
11:30 am
Luncheon
MMA update and awards
1-1:30 pm
Break with exhibitors
1:30-2:30 pm
Education Sessions #2

2:45-3:15 pm
Break with exhibitors
3:15-5pm
Open issues forum
4:30-6:30 pm
Exhibits open
5-6 pm
Poster session in exhibit area
5:30-6:30 pm
Inaugural reception in exhibit area
6:30-7:30 pm
Inauguration
7:30 - 8:45 pm
Keynote Speaker
ZDoggMD
8:45-10:30pm
MMA's Got Talent Showcase

SATURDAY, SEPTEMBER 24

Exhibit hall not open for Saturday events



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CONFERENCE
2016**



SPONSORSHIP REGISTRATION

SPONSORSHIP REGISTRATION

You have two options to complete the sponsorship registration:

- Online: visit [Annual Conference Exhibitor Application](#) and pay by credit card; *OR*
- Print out the attached registration, fill out and return it with payment to MMA.

Important dates to remember:

- July 20, 2016 — to have your logo/name included on the printed Annual Conference brochure that will be sent to as many as 16,500 Minnesota physicians
 - August 3, 2016 — to be recognized in the Annual Conference program
- Space will not be assigned without full payment. Visit mnmed.org/AC2016.



BOOTH SPECIFICATIONS

All exhibit tables will be eight feet long, skirted in white and be accompanied by two chairs. A company may opt to replace the table with their display provided it fits in the space. No space may be reserved except through the MMA exhibitor coordinator, Sandy Nentwig. Once reserved, no booth may be subleased except with the consent of the coordinator.

NETWORKING OPPORTUNITIES

In addition to meeting with Annual Conference participants in your booths, there are several other opportunities to meet and talk with physicians. These include:

- Exhibitors are welcome to attend the policy forums and the educational programs.
- Exhibitors may purchase tickets for the Inauguration, or Friday's keynote speakers. See the registration form for further details.
- The September 23 inaugural reception and poster symposium, 5-6:30 p.m., will be held in the exhibit area. This is an excellent time to visit with attendees. Please be available.
- Break service for Annual Conference attendees also will be in the exhibit area.

ASSIGNMENT OF BOOTHS

Exhibit spaces will be located in high traffic areas, with preferential sponsors receiving the best locations. No assignments will be made until a completed application and full payment are received. Booth numbers will be assigned and communicated 10 days prior to the Annual Conference. Organizations requesting placement next to, or away from, other organizations will be accommodated to our best ability. MMA reserves the right to assign all space in the best interest of the conference. MMA reserves the right to reassign booths when necessary. Booths must be completed and ready to show at 7:30am on Friday and must remain intact until 6:30pm on Friday.

RELOCATION

The MMA exhibitor coordinator retains the right to change exhibit locations for reasons beyond the control of MMA or if it becomes advisable in the best judgment of the exhibitor coordinator. All such changes will be discussed with the exhibitor in advance, if possible.

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CONFERENCE
2016**

SPONSORSHIP REGISTRATION

ELECTRICITY AND INTERNET ACCESS

Electrical forms will be sent upon request. There is internet access throughout the property. Contact Sandy Nentwig at 612-362-3755 for assistance.

SPACE CANCELLATION

Cancellations must be sent in writing to snentwig@mnmed.org. Cancellations received by August 1 will receive a full refund, minus a \$100 per booth administrative fee. Cancellations received after August 1 will receive a full refund, minus a \$100 per booth administrative fee, if it can be resold. If the booth cannot be resold, the MMA will retain 100 percent of the exhibitor's payment.

SHIPPING

Shipments should be sent, no earlier than September 22, to:

DoubleTree Park Place

1500 Park Place Blvd

Minneapolis, MN 55416

Hold for: <Your Company Name>

Minnesota Medical Association Conference 9/23-24, 2016

Please note: If pallets of boxes are delivered, there is a \$150 hotel charge to move each pallet.

SECURITY

MMA will take all reasonable precautions against damage or loss by fire, theft, strikes or other accidents. MMA cannot, however, guarantee exhibitors against loss or damage. Small and valuable materials should be removed or packed away each night.

REGISTRATION

Online: Visit [Annual Conference Exhibitor Application](#) and pay by credit card.

Mail: Send the completed exhibit application and fee to:

MMA Annual Conference

Attn: Scott Wilson

1300 Godward St. NE, Suite 2500

Minneapolis, MN 55413

For questions concerning exhibit applications or additional information, contact Scott Wilson at 612-362-3748 or swilson@mnmed.org.

EXHIBIT REGULATIONS

- All exhibits must be set up by 9 am on September 23. Exhibits must be removed by 1 pm, September 26.
- Orders may be taken, but no sales (money exchanged) during the meeting.
- MMA reserves the right to deny booth space to any organization whose products do not contribute directly to the meeting registrants' medical practices.
- Gifts distributed from the exhibitors must be of minimal value, practice-related and provide a benefit to patients. Textbooks and other gifts are appropriate if they serve a genuine educational function. The law stipulates that physicians are not allowed to accept gifts worth more than \$50 per year from manufacturers, wholesale drug distributors and their agents. We expect that exhibitors will follow these requirements.
- Raffles, lotteries or games of chance of any kind are expressly prohibited. Drawings will be allowed.
- Exhibitors will receive an attendee list during the conference. This list is for a one-time use. In any communications, MMA only can be named as presenting the Annual Conference and cannot be presented as endorsing a product or service.

MINNESOTA MEDICAL ASSOCIATION EXHIBITOR APPLICATION

2016 ANNUAL CONFERENCE

September 23 • DoubleTree Park Place Hotel

Organization name (as it will appear in our program)

Parent Organization (if applicable)

Contact name (receives all correspondence)

Other conference attendee, first and last name

Other conference attendee, first and last name

Street address

City, state, zip

Phone Fax

E-mail

Electricity: Please contact Sandy Nentwig at 612-362-3755.
Internet service is available throughout the property.

If applicable, list organizations that you wish to be located near, or not near, your booth.

Near

Not Near

 PLEASE EMAIL A COMPANY LOGO TO
SNENTWIG@MINNED.ORG

MMA STAFF USE ONLY

Date received:

Date paid:

Booth # assigned

Logo attached

Sponsorship level (check one):

- Platinum **\$5,000**
- Gold **\$3,000**
- Silver (Hippocrates Cafe) **\$2,500**
- Silver (MMA's Got Talent) **\$2,500**
- Exhibit **\$995**

Meal/networking tickets

	# tickets	Total Cost
Friday keynote with Damon Tweedy, MD (\$30 each)		
Friday evening keynote with ZDoggMD (\$50 each)		
Total		

Payment

Full payment, or request for payment arrangements, must be received by September 1, 2016, for booths to be assigned. Booths will be assigned 10 days prior to event.

Online Registration

Visit [Annual Conference Exhibitor Application](#) and pay by credit card.

Pay by credit card

Name on Card: _____

- M/C Visa Discover American Express

Card Number: _____

Exp.: _____ Security code: _____

Mail-in registration/Pay by check

Print and mail this form with payment to:

MMA Annual Conference
Attn: Sandy Nentwig
1300 Godward St. NE
Suite 2500
Minneapolis, MN 55413

Rules

The exhibitor agrees to abide by all rules, regulations and restrictions outlined in this document.

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**DoubleTree by Hilton Hotel
Minneapolis - Park Place**
St. Louis Park, Minnesota

MMA ANNUAL CONFERENCE 2016



MINNESOTA
MEDICAL
ASSOCIATION

WWW.MNMED.ORG/AC2016
#MNMED16

**FRIDAY
AND
SATURDAY**

**SEPT
23+24
2016**



Note from the MMA's President

I hope you can join us for the MMA 2016 Annual Conference! It will be an excellent opportunity to meet your colleagues from around the state, learn about the latest innovations in health care, and hear how the work you do is changing lives. Come prepared to share best practices, ask questions, and interact with the people involved in developing the resources and services to help you succeed. Tell us what we can do to support you in your work, so that together, we can make Minnesota the best state to practice medicine.

A handwritten signature in black ink, appearing to read "David C. Thorson, MD".

David C. Thorson, MD
MMA President

AGENDA OVERVIEW

Conference attendees will have the opportunity to meet and share ideas with colleagues from throughout the state. They also will be able to interact with product and service providers essential to the industry.

The MMA Annual Conference includes:

- National and local speakers who will discuss the future of health care, emerging technology, health disparities, opioid prescribing, and much more!
- A preconference Hippocrates Cafe performance with MPR's Jon Hallberg, MD
- Educational sessions
- Policy forums
- Networking opportunities

Who Should Attend

Physicians and physicians-in-training from all specialties and all parts of Minnesota are encouraged to attend.

Contact Us

Have questions? Contact Sandy Nentwig at am@mnmed.org or call (612) 362-3755.

CONFERENCE SCHEDULE

PRECONFERENCE SESSION:

Thursday, Sept. 22

7-9pm Hippocrates Cafe

Friday, Sept. 23

- 7am-8pm Registration
- 7am-8:30am Exhibitors Open
- 7:30-8:30 Breakfast
- 7:30-8:30 **Breakfast with**
Damon Tweedy,
MD (ticketed
event)
- 8:30-9:30 **GENERAL SESSION:** "Is there a
Black Doctor in the House?" *Damon
Tweedy, MD*
- 9:30-10 Break time with Exhibitors
- 10-11:20 CONCURRENT SESSIONS
 - Future Trends-Mayo Center for
Innovation
 - Physician Aid-in-Dying
 - Turning the Tide on Physician
Burnout
- 11-11:30 Break time with Exhibitors
- 11:30-1pm **Welcome/Awards Lunch**
- 1-1:30 Break time with Exhibitors
- 1:30-2:30 CONCURRENT SESSIONS
 - Diagnostic Errors
 - Implicit Bias
 - The Changing Landscape of
Opioid Prescribing
- 2:30-3 Break time with Exhibitors
- 3-4:30 **Open Issues Forum**
- 4:30-5:30 **MEDPAC Reception**
- 4:30-6:30 **Exhibits Open**
- 5-6 **Poster Symposium**
- 5:30-6:30 **Inaugural Reception**
- 6:30-7:30 **President's Inauguration**
- 7:30-9 **GENERAL SESSION:** *Health Care,
Remixed Zubin Damania, MD
(a.k.a. ZDoggMD)*
- 9-10:30 **MMA's Got Talent**

Saturday, Sept. 24

- 7am-1pm Registration
- 7-7:45 SECTION MEETINGS
 - Medical Students
 - Residents/Fellows
 - Young Physicians
- 7:45-9:15 Breakfast
- 7:45-9:15 **House of Delegates**
- 9:30-10:50 CONCURRENT SESSIONS
 - Health Disparities Panel Discussion
 - Quality Measurement
 - Resiliency: Your Guide to Stress-Free Living
- 11-12 **GENERAL SESSION:** "Make Medicine Great Again!" *The
Stevie Ray's Comedy Troupe*
- 12pm Adjourn

DO YOU HAVE AN ISSUE TO DISCUSS?

Here's your opportunity

The MMA Policy Council is seeking physician input for its Open Issues Policy Forum.

Sharing your idea is easy.

Visit www.mnmed.org/issues

and complete the form by **Aug. 1.**

Submissions received after that date may not be considered at the conference.

GENERAL SESSIONS



“IS THERE A BLACK DOCTOR IN THE HOUSE?”

Damon Tweedy, MD

Dr. Tweedy, author of the *New York Times* best seller, *Black Man in a White Coat*, will look at why such a small percentage of physicians in the United States are black and the implications for doctors and patients.



HEALTH CARE, REMIXED

Zubin Damania, MD (a.k.a. ZDoggMD)

Dr. Damania is a Las Vegas physician who mixes medicine and music to entertain and educate. Best known for his ZDoggMD videos, he'll discuss two topics he's passionate about—health care reform and preventing physician burnout—and give a live performance.



MAKE MEDICINE GREAT AGAIN!

The Stevie Ray's Comedy Troupe

One candidate proposes we build a wall around Zika (and make Brazil pay for it) and another uses an unsecure server to talk about Zika. Who will win your vote? Join professional comedians for a hilarious session on the current state of medicine. Sense of humor required.

CONCURRENT SESSIONS

Diagnostic Errors

Laurie Drill-Mellum, MD, MPH

Diagnostic errors are the leading cause of medical malpractice claims in the United States. Because these errors can be hard to detect and measure, they have escaped the level of scrutiny received by more visible errors. Dr. Drill-Mellum will address factors that contribute to diagnostic errors and present strategies to minimize their impact.

Future Trends – Mayo Center for Innovation

Doug Wood, MD

What does the future hold for health care? Join Dr. Wood for a stimulating discussion on topics such as participatory health care, wearables, and more.

Health Disparities Panel Discussion

Brooke Cunningham, MD, PhD, Christopher Reif, MD, and Stephen C. Nelson, MD

Minnesota consistently scores high in state health rankings, but those numbers don't tell the whole story. Certain racial and ethnic groups in the state fare much worse than the general population on a variety of health indicators. Panel members will discuss why these disparities exist and what physicians can do to close the gap.

Implicit Bias

Stephen C. Nelson, MD

Research suggests that implicit or unconscious bias may influence a clinician's behavior resulting in differences in care provided to members of certain racial and ethnic groups as compared with the general population. Join Dr. Nelson to learn about implicit bias, review factors that affect health outcomes among Minnesotans and discover tools to help us move towards health equity.

Open Issues Forum

What are the concerns in your practice that keep you awake at night? How can the MMA address these issues? Join your colleagues for a discussion on a variety of timely and relevant topics. Submissions must be received by Aug. 1.



Physician Aid-in-Dying

This controversial topic continues to generate debate across the country. Although the MMA has long opposed physician aid-in-dying, it recognizes that physicians' opinions on the matter may be changing. Help inform the MMA's position on this important issue.

Quality Measurement

Measurement drives quality improvement. But how much is too much? Are the various measurement efforts by payers and the state and federal government accomplishing their goals? Is there a better approach? Share your thoughts and opinions.

Resiliency: Your Guide to Stress-Free Living

Amit Sood, MD

Would you like to be more resilient, decrease your level of stress and anxiety, and enhance your well-being? Then this is the session for you! Dr. Sood has developed an innovative approach to mind-body medicine by incorporating concepts within neurosciences, psychology, philosophy and spirituality. Participants will leave refreshed and with strategies they can use in everyday life.

The Changing Landscape of Opioid Prescribing

Charles Reznikoff, MD

Prince's death from an opioid overdose made headlines around the world. It also brought home the problem of opioid abuse and addiction. Opioids can be useful medications when used properly, but how is a physician to know where to draw the line? This session will explore the history of opioids, the prevalence of addiction, and how physicians can help curb the epidemic.

Turning the Tide on Physician Burnout

Martin Stillman, MD, JD, and Sandra Shallcross, PhD, LP

Join this engaging duo from HCMC's Office of Professional Work/Life to learn about the signs and symptoms of burnout, best practices for responding to it, and interventions you and your organization can take to promote resiliency.



CONTINUING MEDICAL EDUCATION

Learning Objectives

The MMA 2016 Annual Conference attendees will:

- Discuss current issues, innovations and trends in the field of medicine
- Discover operational and clinical approaches to optimize patient care
- Participate in an environment of peer networking and collaboration

Online Conference Evaluations and Verification of Attendance

Attendees will complete the evaluation and verify attendance for continuing medical education (CME) credits online after the conference.

CME Requirements

CME credits are available for participants who attend the sessions and then complete and submit the online evaluation. Attendees will receive an email following the meeting to verify attendance and complete evaluations for all sessions attended. Upon completion of the online evaluation, attendees will receive a Certificate of Attendance via email stating the number of education credits earned. Please retain this email for your records.

Deadline

CME credits will only be awarded to those who submit the required evaluation by Oct.15, 2016. Credits will not be issued after this date.

Accreditation and Credit Statements

The Minnesota Medical Association (MMA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Minnesota Medical Association designates this live activity for a maximum of 6.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



REGISTRATION

Registration at the MMA Annual Conference includes attendance at all general, educational and policy sessions (unless otherwise noted), as well as meals during scheduled conference activities.

Registration Fees

- **Members \$149** (\$134 before Aug. 15)
- **Non-members \$199** (\$179 before Aug. 15)
- **Retired \$99** (\$89 before Aug. 15)
- **Students and Residents \$25**
- **Sponsor a student or resident \$99**

Daily registration rates are also available. Visit www.mnmed.org/AC2016 for more information.



Important Dates

- **Aug. 15** *Early Registration Discount Ends*
- **Sept. 1** *Last Day for DoubleTree Hotel Rate*
- **Sept. 1** *Online Registration Closes*

Register Online

To complete the quick and easy registration, visit www.mnmed.org/AC2016 and click Register Now. You will receive an email confirmation of your registration and a summary of your selected itinerary once you complete registration.

Attendees must provide a credit card (VISA or MasterCard) or mail a check to the address below for meeting registration fees:

Minnesota Medical Association
Attn: Annual Conference
1300 Godward St. N.E. Suite 2500
Minneapolis, MN 55413

Cancellations

The Minnesota Medical Association requires written notification in order to process a cancellation. Registration fees will be refunded in full for cancellations received by the MMA on or before Sept 1, 2016. After this date, no registration refunds will be provided for cancellations. Send cancellation requests to: am@mnmed.org. Please note, guests are responsible for cancelling their own hotel and any travel reservations.

Badge and Registration Materials

MMA Annual Conference registration materials, including attendee badges and optional event tickets, will only be available for pick up on site at the DoubleTree Park Place meeting venue.

SPECIAL EVENTS

Breakfast with Damon Tweedy, MD (\$89, Separate Ticketed Event)

Limited to 20 participants, this intimate gathering will give each participant a chance to speak to Dr. Tweedy about racial health disparities and his thoughts about the future.

Hippocrates Cafe

Developed by Jon Hallberg, MD, Hippocrates Cafe uses professional actors and musicians to explore health topics through song and story. The performers will present selected readings from *Minnesota Medicine*.

Poster Symposium

A poster symposium will feature the work of our medical student, resident and fellow members. Take this opportunity to view the posters, talk with the participants and vote for a "People's Choice" award winner. **Submit your abstract at www.mnmed.org/AC2016.**

President's Inauguration

Join us as President David Thorson, MD, passes the Presidential Medallion to David Agerter, MD, as the 150th president of the MMA. We will also announce the MMA's highest honor, the Distinguished Service Award.

MMA Foundation Awards

The awards lunch on Friday will recognize our colleagues as the MMA Foundation presents the President's Award and Community Service Award.

MMA's Got Talent

MMA members are talented! Whether you sing, play piano, tell jokes, juggle or do imitations, we want you to perform. Prizes will be awarded to first, second and third place. **Submit an audition video at www.mnmed.org/AC2016.**



GENERAL CONFERENCE INFORMATION

ADA Accessibility/Accommodations

The Minnesota Medical Association is committed to ensuring that the Annual Conference is fully accessible to all persons. If you have a specific dietary need or accessibility requirement please indicate this when you register and every effort will be made to accommodate your request. If you require auxiliary aids or services identified in the Americans with Disabilities Act, please submit a request for this when you register.

Conference Presentation Materials

Presentation materials will be available for downloading at the MMA website after the conference.

Family Fun

You'll find shopping, dining, arts, parks, zoos, museums and college and professional sports just minutes away. Downtown Minneapolis is 10 minutes to the east, The Mall of America is 25 minutes to the southeast and The Shops at West End are across the street from the conference hotel. There are activities for kids and adults (in-room babysitting is available).

Lodging

Lodging is available at the DoubleTree Park Place at the discounted rate of \$112/night for single or double occupancy standard rooms (including tax and service fees). Contact the DoubleTree at 952-542-8600, click on the link below, or visit the Annual Conference Website (www.mnmed.org/AC2016) to reserve your room. Make sure to mention that you are with the Minnesota Medical Association. You must book your room by Sept. 1 to receive the MMA rate.

DoubleTree online reservations

Name Badges

Attendee name badges must be displayed for admittance to all conference sessions and social events. Name badges will be available for pick up at the MMA registration desk at the DoubleTree Park Place.

Photography Release

As part of your registration for the MMA 2016 Annual Conference, the MMA reserves the right to use photographs taken during the conference for future MMA marketing purposes.

Sponsor Exhibits

Representatives from sponsoring organizations will be available to discuss their products and services.

Schedule: Friday, Sept. 23 7am-8pm



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BRONZE



Martinez, Ruth (HLB)

From: Williams, Brian [REDACTED]
Sent: Wednesday, June 22, 2016 6:29 PM
To: Martinez, Ruth (HLB)
Subject: The Term "Physician" - Statutory Language used by MN Board of Chiropractic Examiners

Ruth,

Following up on a possible legislative fix re: use of the term "physician", I thought the approach of the Minnesota Board of Chiropractic Examiners was one to consider as well.

148.105 VIOLATION.

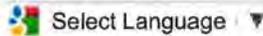
Subdivision 1. **Generally.**

Any person who practices, or attempts to practice, chiropractic or who uses any of the terms or letters "Doctors of Chiropractic," "Chiropractor," "DC," or any other title or letters under any circumstances as to lead the public to believe that the person who so uses the terms is engaged in the practice of chiropractic, without having complied with the provisions of sections 148.01 to 148.104, is guilty of a gross misdemeanor; and, upon conviction, fined not less than \$1,000 nor more than \$10,000 or be imprisoned in the county jail for not less than 30 days nor more than six months or punished by both fine and imprisonment, in the discretion of the court. It is the duty of the county attorney of the county in which the person practices to prosecute. Nothing in sections 148.01 to 148.105 shall be considered as interfering with any person:

- (1) licensed by a health-related licensing board, as defined in section 214.01, subdivision 2, including psychological practitioners with respect to the use of hypnosis;
- (2) registered or licensed by the commissioner of health under section 214.13; or
- (3) engaged in other methods of healing regulated by law in the state of Minnesota; provided that the person confines activities within the scope of the license or other regulation and does not practice or attempt to practice chiropractic.

Brian

Brian L. Williams
Manager, Health Occupations Division
Assistant Attorney General
Bremer Tower, Suite 1400
445 Minnesota Street
St. Paul, MN 55101-2131
Tel: (651) 757-1478
Fax: (651) 297-2576
brian.williams@ag.state.mn.us



Google Translate Disclaimer



Education Law

Article 131, Medicine

Effective June 18, 2010

[§6520. Introduction.](#) | [§6521. Definition of practice of medicine.](#) | [§6522. Practice of medicine and use of title "physician".](#) | [§6523. State board for medicine.](#) | [§6524. Requirements for a professional license.](#) | [§6525. Limited permits.](#) | [§6526. Exempt persons.](#) | [§6527. Special provisions.](#) | [§ 6528. Qualification of certain applicants for licensure.](#) | [§6529. Power of board of regents regarding certain physicians.](#)

§6520. Introduction.

This article applies to the profession of medicine. The general provisions for all professions contained in article one hundred thirty of this title apply to this article.

§6521. Definition of practice of medicine.

The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.

§6522. Practice of medicine and use of title "physician".

Only a person licensed or otherwise authorized under this article shall practice medicine or use the title "physician".

§6523. State board for medicine.

A state board for medicine shall be appointed by the board of regents on recommendation of the commissioner for the purpose of assisting the board of regents and the department on matters of professional licensing in accordance with section sixty-five hundred eight of this title. The board shall be composed of not less than twenty physicians licensed in this state for at least five years, two of whom shall be doctors of osteopathy. The board shall also consist of not less than two physician's assistants licensed to practice in this state. The participation of physician's assistant members shall be limited to matters relating to article one hundred thirty-one-B of this chapter. An executive secretary to the board shall be appointed by the board of regents on recommendation of the commissioner and shall be either a physician licensed in this state or a non-physician, deemed qualified by the commissioner and board of regents.

§6524. Requirements for a professional license.

To qualify for a license as a physician, an applicant shall fulfill the following requirements:

1. Application: file an application with the department;
2. Education: have received an education, including a degree of doctor of medicine, "M.D.", or doctor of osteopathy, "D.O.", or equivalent degree in accordance with the commissioner's regulations;
3. Experience: have experience satisfactory to the board and in accordance with the commissioner's regulations;
4. Examination: pass an examination satisfactory to the board and in accordance with the commissioner's regulations;
5. Age: be at least twenty-one years of age; however, the commissioner may waive the age requirement for applicants who have attained the age of eighteen and will be in a residency program until the age of twenty-one;
6. Citizenship or immigration status: be a United States citizen or an alien lawfully admitted for permanent residence in the United States; provided, however that the board of regents may grant a three year waiver for an alien physician to practice in an area which has been designated by the department as medically underserved, except that the board of regents may grant an additional extension not to exceed six years to an alien physician to enable him or her to secure citizenship or permanent resident status, provided such status is being actively pursued; and provided further that

(10) A person who practices ritual circumcision pursuant to the requirements or tenets of any established religion.

(11) A Christian Scientist or other person who endeavors to prevent or cure disease or suffering exclusively by mental or spiritual means or by prayer.

(12) A physician licensed to practice medicine in another state who is in this state for the sole purpose of providing medical services at a competitive athletic event. The physician may practice medicine only on participants in the athletic event. A physician shall first register with the board on a form developed by the board for that purpose. The board shall not be required to adopt the contents of the form by rule. The physician shall provide evidence satisfactory to the board of a current unrestricted license in another state. The board shall charge a fee of \$50 for the registration.

(13) A psychologist licensed under section 148.907 or a social worker licensed under chapter 148D who uses or supervises the use of a penile or vaginal plethysmograph in assessing and treating individuals suspected of engaging in aberrant sexual behavior and sex offenders.

(14) Any person issued a training course certificate or credentialed by the Emergency Medical Services Regulatory Board established in chapter 144E, provided the person confines activities within the scope of training at the certified or credentialed level.

(15) An unlicensed complementary and alternative health care practitioner practicing according to chapter 146A.

History: (5716) *RL s 2299; 1971 c 485 s 4; 1980 c 567 s 1; 1981 c 23 s 4; 1985 c 247 s 12; 1986 c 444; 1987 c 384 art 1 s 17; 1990 c 542 s 5; 1990 c 576 s 4; 1991 c 255 s 19; 1993 c 21 s 8; 1993 c 326 art 8 s 2; 1Sp1995 c 3 art 16 s 13; 1996 c 324 s 3; 1996 c 424 s 1; 1999 c 54 s 1; 2000 c 260 s 24; 2000 c 460 s 21; 2003 c 130 s 12; 2005 c 147 art 1 s 5; 2009 c 159 s 13*

147.091 GROUNDS FOR DISCIPLINARY ACTION.

Subdivision 1. **Grounds listed.** The board may refuse to grant a license, may refuse to grant registration to perform interstate telemedicine services, or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

(a) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements.

(b) Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to: (1) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (2) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (3) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine or osteopathy. Conviction as used in this subdivision shall include a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.

(e) Advertising which is false or misleading, which violates any rule of the board, or which claims without substantiation the positive cure of any disease, or professional superiority to or greater skill than that possessed by another physician.

(f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 604.201, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

(g) Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(h) Failure to supervise a physician assistant or failure to supervise a physician under any agreement with the board.

(i) Aiding or abetting an unlicensed person in the practice of medicine, except that it is not a violation of this paragraph for a physician to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority.

(j) Adjudication as mentally incompetent, mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise.

(k) Engaging in unprofessional conduct. Unprofessional conduct shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice in which proceeding actual injury to a patient need not be established.

(l) Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.

(m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(n) Failure by a doctor of osteopathy to identify the school of healing in the professional use of the doctor's name by one of the following terms: osteopathic physician and surgeon, doctor of osteopathy, or D.O.

(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298 or to furnish a medical record or report required by law.

(p) Fee splitting, including without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;

(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;

(3) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the referring physician has a "financial or economic interest," as defined in section 144.6521, subdivision 3, unless the physician has disclosed the physician's financial or economic interest in accordance with section 144.6521; and

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest.

The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(r) Becoming addicted or habituated to a drug or intoxicant.

(s) Prescribing a drug or device for other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency or referring a patient to any health care provider as defined in sections 144.291 to 144.298 for services or tests not medically indicated at the time of referral.

(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

(u) Failure to make reports as required by section 147.111 or to cooperate with an investigation of the board as required by section 147.131.

(v) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(w) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(1) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(2) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(3) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(4) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

(x) Practice of a board-regulated profession under lapsed or nonrenewed credentials.

(y) Failure to repay a state or federally secured student loan in accordance with the provisions of the loan.

(z) Providing interstate telemedicine services other than according to section 147.032.

Subd. 1a. Conviction of a felony-level criminal sexual conduct offense. (a) The board may not grant a license to practice medicine to any person who has been convicted of a felony-level criminal sexual conduct offense.

(b) A license to practice medicine is automatically revoked if the licensee is convicted of a felony-level criminal sexual conduct offense.

(c) A license that has been denied or revoked pursuant to this subdivision is not subject to chapter 364.

(d) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, and "criminal sexual conduct offense" means a violation of sections 609.342 to 609.345 or a similar statute in another jurisdiction.

Subd. 1b. Utilization review. The board may investigate allegations and impose disciplinary action as described in section 147.141 against a physician performing utilization review for a pattern of failure to exercise that degree of care that a physician reviewer of ordinary prudence making utilization review determinations for a utilization review organization would use under the same or similar circumstances. As part of its investigative process, the board shall receive consultation or recommendation from physicians who are currently engaged in utilization review activities. The internal and external review processes under sections 62M.06 and 62Q.73 must be exhausted prior to an allegation being brought under this subdivision. Nothing in this subdivision creates, modifies, or changes existing law related to tort liability for medical negligence. Nothing in this subdivision preempts state peer review law protection in accordance with sections 145.61 to 145.67, federal peer review law, or current law pertaining to complaints or appeals.

Subd. 2. Automatic suspension. (a) A license to practice medicine is automatically suspended if (1) a guardian of a licensee is appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other than the minority of the licensee; or (2) the licensee is committed by order of a court pursuant to chapter 253B. The license remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee, the suspension is terminated by the board after a hearing.

(b) Upon notice to the board of a judgment of, or a plea of guilty to, a felony reasonably related to the practice of patient care, the credentials of the regulated person shall be automatically suspended by the board. The credentials shall remain suspended until, upon petition by the regulated person and after a hearing, the suspension is terminated by the board. The board shall indefinitely suspend or revoke the credentials of the regulated person if, after a hearing, the board finds that the felonious conduct would cause a serious risk of harm to the public.

(c) For credentials that have been suspended or revoked pursuant to paragraphs (a) and (b), the regulated person may be reinstated to practice, either with or without restrictions, by demonstrating clear and convincing evidence of rehabilitation, as provided in section 364.03. If the regulated person's conviction is subsequently overturned by court decision, the board shall conduct a hearing to review the suspension within 30 days after receipt of the court decision. The regulated person is not required to prove rehabilitation if the subsequent court decision overturns previous court findings of public risk.

(d) The board may, upon majority vote of a quorum of its members, suspend the credentials of a regulated person without a hearing if the regulated person fails to maintain a current name and address with the board, as described in paragraph (e), while the regulated person is: (1) under board investigation, and a notice of conference has been issued by the board; (2) party to a contested case with the board; (3) party to an agreement for corrective action with the board; or (4) under a board order for disciplinary action. The suspension shall remain in effect until lifted by the board pursuant to the board's receipt of a petition from the regulated person, along with the regulated person's current name and address.

(e) A person regulated by the board shall maintain a current name and address with the board and shall notify the board in writing within 30 days of any change in name or address. If a name change only is requested, the regulated person must request revised credentials and return the current credentials to the board. The board may require the regulated person to substantiate the name change by submitting official documentation from a court of law or agency authorized under law to receive and officially record a name change. If an address change only is requested, no request for revised credentials is required. If the regulated person's current credentials have been lost, stolen, or destroyed, the person shall provide a written explanation to the board.

Subd. 2a. **Effective dates.** A suspension, revocation, condition, limitation, qualification, or restriction of a license or registration shall be in effect pending determination of an appeal unless the court, upon petition and for good cause shown, shall otherwise order. A revocation of a license pursuant to subdivision 1a is not appealable and shall remain in effect indefinitely.

Subd. 3. **Conditions on reissued license.** In its discretion, the board may restore and reissue a license to practice medicine, but as a condition thereof may impose any disciplinary or corrective measure which it might originally have imposed.

Subd. 4. **Temporary suspension of license.** In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a physician if the board finds that the physician has violated a statute or rule which the board is empowered to enforce and continued practice by the physician would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the physician, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The physician shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

Subd. 5. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, paragraph (c) or (d), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency which entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of the contents thereof.

Subd. 6. **Mental examination; access to medical data.** (a) If the board has probable cause to believe that a regulated person comes under subdivision 1, paragraph (1), it may direct the person to submit to a

mental or physical examination. For the purpose of this subdivision every regulated person is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that the same constitute a privileged communication. Failure of a regulated person to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstance beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A regulated person affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of the regulated profession with reasonable skill and safety to the public.

In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a regulated person in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a regulated person or applicant without the person's or applicant's consent if the board has probable cause to believe that a regulated person comes under subdivision 1, paragraph (1). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

Subd. 7. Tax clearance certificate. (a) In addition to the provisions of subdivision 1, the board may not issue or renew a license if the commissioner of revenue notifies the board and the licensee or applicant for a license that the licensee or applicant owes the state delinquent taxes in the amount of \$500 or more. The board may issue or renew the license only if (1) the commissioner of revenue issues a tax clearance certificate and (2) the commissioner of revenue or the licensee or applicant forwards a copy of the clearance to the board. The commissioner of revenue may issue a clearance certificate only if the licensee or applicant does not owe the state any uncontested delinquent taxes.

(b) For purposes of this subdivision, the following terms have the meanings given.

(1) "Taxes" are all taxes payable to the commissioner of revenue, including penalties and interest due on those taxes.

(2) "Delinquent taxes" do not include a tax liability if (i) an administrative or court action that contests the amount or validity of the liability has been filed or served, (ii) the appeal period to contest the tax liability has not expired, or (iii) the licensee or applicant has entered into a payment agreement to pay the liability and is current with the payments.

(c) In lieu of the notice and hearing requirements of subdivision 1, when a licensee or applicant is required to obtain a clearance certificate under this subdivision, a contested case hearing must be held if the licensee or applicant requests a hearing in writing to the commissioner of revenue within 30 days of the date of the notice provided in paragraph (a). The hearing must be held within 45 days of the date the commissioner of revenue refers the case to the Office of Administrative Hearings. Notwithstanding any law to the contrary, the licensee or applicant must be served with 20 days' notice in writing specifying the time

and place of the hearing and the allegations against the licensee or applicant. The notice may be served personally or by mail.

(d) The board shall require all licensees or applicants to provide their Social Security number and Minnesota business identification number on all license applications. Upon request of the commissioner of revenue, the board must provide to the commissioner of revenue a list of all licensees and applicants, including the name and address, Social Security number, and business identification number. The commissioner of revenue may request a list of the licensees and applicants no more than once each calendar year.

Subd. 8. **Limitation.** No board proceeding against a regulated person shall be instituted unless commenced within seven years from the date of the commission of some portion of the offense or misconduct complained of except for alleged violations of subdivision 1, paragraph (t).

History: 1971 c 485 s 3; 1974 c 31 s 1; 1975 c 213 s 1; 1976 c 222 s 34; 1981 c 83 s 1; 1982 c 581 s 24; 1985 c 21 s 1; 1985 c 247 s 7,25; 1986 c 444; 1Sp1986 c 1 art 7 s 7; 1Sp1986 c 3 art 1 s 82; 1987 c 384 art 2 s 1; 1988 c 557 s 2; 1989 c 184 art 2 s 3; 1992 c 559 art 1 s 3; 1992 c 577 s 1; 1Sp1994 c 1 art 2 s 3,4; 1995 c 18 s 4-8; 1996 c 334 s 4; 1997 c 103 s 1; 1999 c 227 s 22; 2001 c 137 s 7; 2002 c 361 s 3; 2004 c 146 art 3 s 6; 2004 c 198 s 16; 2005 c 56 s 1; 2007 c 147 art 10 s 15; 2014 c 291 art 4 s 58

147.0911 DIVERSIONARY PROGRAM.

A person licensed under this chapter who is unable to practice with reasonable skill and safety by reason of illness; use of alcohol, drugs, chemicals, or any other materials; or as a result of a mental, physical, or psychological condition may participate in the health professional services program under sections 214.31 to 214.36 if the person meets the eligibility requirements.

History: 2013 c 44 s 4

147.092 PROBABLE CAUSE HEARING; SEXUAL MISCONDUCT.

(a) In any contested case in which a violation of section 147.091, subdivision 1, paragraph (t), is charged all parties shall be afforded an opportunity for a probable cause hearing before an administrative law judge. The motion for a hearing must be made to the Office of Administrative Hearings within 20 days of the filing date of the contested case and served upon the board upon filing. Any hearing shall be held within 30 days of the motion. The administrative law judge shall issue a decision within 20 days of completion of the probable cause hearing. If there is no request for a hearing, the portion of the notice of and order for hearing relating to allegations of sexual misconduct automatically becomes public.

(b) The scope of the probable cause hearing is confined to a review of the facts upon which the complaint review committee of the board based its determination that there was a reasonable belief that section 147.091, subdivision 1, paragraph (t), was violated. The administrative law judge shall determine whether there is a sufficient showing of probable cause to believe the licensee committed the violations listed in the notice of and order for hearing, and shall receive evidence offered in support or opposition. Each party may cross-examine any witnesses produced by the other. A finding of probable cause shall be based upon the entire record including reliable hearsay in whole or in part and requires only a preponderance of the evidence. The burden of proof rests with the board.

(c) Upon a showing of probable cause, that portion of the notice of and order for hearing filed by the board that pertains to the allegations of sexual misconduct, including the factual allegations that support the charge, become public data. In addition, the notice of and order for hearing may be amended. A finding of

147.01 BOARD OF MEDICAL PRACTICE.

Subdivision 1. **Creation; terms.** The Board of Medical Practice consists of 16 residents of the state of Minnesota appointed by the governor. Ten board members must hold a degree of doctor of medicine and be licensed to practice medicine under this chapter. Not less than one board member must hold a degree of doctor of osteopathy and either be licensed to practice osteopathy under Minnesota Statutes 1961, sections 148.11 to 148.16; prior to May 1, 1963, or be licensed to practice medicine under this chapter. Five board members must be public members as defined by section 214.02. The governor shall make appointments to the board which reflect the geography of the state. In making these appointments, the governor shall ensure that no more than one public member resides in each United States congressional district, and that at least one member who is not a public member resides in each United States congressional district. The board members holding the degree of doctor of medicine must, as a whole, reflect the broad mix of expertise of physicians practicing in Minnesota. A member may be reappointed but shall not serve more than eight years consecutively. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements are as provided in sections 214.07 to 214.09. The provision of staff, administrative services and office space; the review and processing of complaints; the setting of board fees; and other provisions relating to board operations are as provided in chapter 214.

Subd. 2. **Recommendations for appointment.** Prior to the end of the term of a doctor of medicine or public member on the board, or within 60 days after a doctor of medicine or public member position on the board becomes vacant, the State Medical Association, the Mental Health Association of Minnesota, and other interested persons and organizations may recommend to the governor doctors of medicine and public members qualified to serve on the board. Prior to the end of the term of a doctor of osteopathy, or within 60 days after a doctor of osteopathy membership becomes vacant, the Minnesota Osteopathic Medical Society may recommend to the governor three doctors of osteopathy qualified to serve on the board. The governor may appoint members to the board from the list of persons recommended or from among other qualified candidates.

Subd. 3. **Board administration.** The board shall elect from among its number a president, a vice-president, and a secretary-treasurer, who shall each serve for one year, or until a successor is elected and qualifies. The board shall have authority to adopt rules as may be found necessary to carry out the purposes of this chapter. The members of the board shall have authority to administer oaths and the board, in session, to take testimony as to matters pertaining to the duties of the board. Nine members of the board shall constitute a quorum for the transaction of business. The board shall have a common seal, which shall be kept by the executive director, whose duty it shall be to keep a record of all proceedings of the board, including a register of all applicants for license under this chapter, giving their names, addresses, ages, educational qualifications, and the result of their examination. These books and registers shall be prima facie evidence of all the matters therein recorded.

Subd. 4. **Disclosure.** Subject to the exceptions listed in this subdivision, all communications or information received by or disclosed to the board relating to any person or matter subject to its regulatory jurisdiction are confidential and privileged and any disciplinary hearing shall be closed to the public.

(a) Upon application of a party in a proceeding before the board under section 147.091, the board shall produce and permit the inspection and copying, by or on behalf of the moving party, of any designated documents or papers relevant to the proceedings, in accordance with the provisions of rule 34, Minnesota Rules of Civil Procedure.

(b) If the board takes corrective action or imposes disciplinary measures of any kind, whether by contested case or by settlement agreement, the name and business address of the licensee, the nature of the misconduct, and the action taken by the board are public data. If disciplinary action is taken by settlement agreement, the entire agreement is public data. The board shall decide disciplinary matters, whether by settlement or by contested case, by roll call vote. The votes are public data.

(c) The board shall exchange information with other licensing boards, agencies, or departments within the state, as required under section 214.10, subdivision 8, paragraph (c), and may release information in the reports required under section 147.02, subdivision 6.

(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 (t), 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 (t), 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

214.02 PUBLIC MEMBER, DEFINED.

"Public member" means a person who is not, or never was, a member of the profession or occupation being licensed or regulated or the spouse of any such person, or a person who does not have or has never had, a material financial interest in either the providing of the professional service being licensed or regulated or an activity directly related to the profession or occupation being licensed or regulated.

History: *1973 c 638 s 61*

214.09 MEMBERSHIP; COMPENSATION; REMOVAL; VACANCIES.

Subdivision 1. **General.** The following standard provisions shall apply to the health-related and non-health-related licensing boards and to agencies created after July 1, 1975 in the executive branch, other than departments, whose primary functions include licensing, registration or certification of persons in specified professions or occupations.

Subd. 2. **Membership terms.** An appointment to a board must be made in the manner provided in section 15.0597. The terms of the members shall be four years with the terms ending on the first Monday in January. The appointing authority shall appoint as nearly as possible one-fourth of the members to terms expiring each year. If the number of members is not evenly divisible by four, the greater number of members, as necessary, shall be appointed to terms expiring in the year of commencement of the governor's term and the year or years immediately thereafter. If the number of terms which can be served by a member of a board is limited by law, a partial term must be counted for this purpose if the time served by a member is greater than one-half of the duration of the regular term. If the membership is composed of categories of members from occupations, industries, political subdivisions, the public or other groupings of persons, and if the categories have two or more members each, the appointing authority shall appoint as nearly as possible one-fourth of the members in each category at each appointment date. Members may serve until their successors are appointed and qualify. If the appointing authority fails to appoint a successor by July 1 of the year in which the term expires, the term of the member for whom a successor has not been appointed shall extend until the first Monday in January four years after the scheduled end of the original term.

Subd. 3. **Compensation.** (a) Members of health-related licensing boards may be compensated at the rate of \$75 a day spent on board activities and members of non-health-related licensing boards may be compensated at the rate of \$55 a day spent on board activities when authorized by the board, plus expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred, may be reimbursed for those expenses upon board authorization.

(b) Members who are state employees or employees of the political subdivisions of the state must not receive the daily payment for activities that occur during working hours for which they are also compensated by the state or political subdivision. However, a state or political subdivision employee may receive the daily payment if the employee uses vacation time or compensatory time accumulated in accordance with a collective bargaining agreement or compensation plan for board activity. Members who are state employees or employees of the political subdivisions of the state may receive the expenses provided for in this subdivision unless the expenses are reimbursed by another source. Members who are state employees or employees of political subdivisions of the state may be reimbursed for child care expenses only for time spent on board activities that are outside their working hours.

(c) Each board must adopt internal standards prescribing what constitutes a day spent on board activities for purposes of making daily payments under this subdivision.

Subd. 4. **Removal; vacancies.** A member may be removed by the appointing authority at any time (1) for cause after notice and hearing, (2) if the board fails to prepare and submit the report required by section 214.07, or (3) after missing three consecutive meetings. The chair of the board shall inform the appointing authority of a member missing the three consecutive meetings. After the second consecutive missed meeting and before the next meeting, the secretary of the board shall notify the member in writing that the member may be removed for missing the next meeting. In the case of a vacancy on the board, the appointing authority shall appoint a person to fill the vacancy for the remainder of the unexpired term.

Subd. 5. **Health-related boards.** No current member of a health-related licensing board may seek a paid employment position with that board.

History: 1975 c 136 s 51; 1976 c 222 s 205; 1984 c 571 s 3; 1986 c 444; 1987 c 354 s 5; 1990 c 506 art 2 s 20; 1993 c 80 s 6; 2001 c 61 s 3; 1Sp2001 c 10 art 2 s 70; 2012 c 278 art 4 s 1; 2014 c 291 art 4 s 47

DATE: September 10, 2016

SUBJECT: Updated Opiate Antagonist Protocol

SUBMITTED BY: Ruth Martinez, M.A., Executive Director

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Motion to provide feedback and what the feedback should be.

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Attached is a draft Opiate Antagonist Protocol prepared by the Board of Pharmacy pursuant to 2016 legislation. The Board of Medical Practice is specifically authorized by the legislation to consult and provide feedback on the protocol. The enclosed draft reflects feedback from other entities, to date. The protocol will be finalized in late September. It includes comments that explain which organization or agency suggested each change.

The Board members should determine what, if any, feedback it wishes to offer.

Opiate Antagonist Protocol

Background

This protocol has been prepared as required by Minnesota Session Laws, 2016 Regular Session, [Chapter 124](#). This protocol was developed for the use of the Commissioner of Health to distribute to the medical consultants of community health boards or to be used by Minnesota Department of Health practitioners designated by the Commissioner. Pharmacists may also use this protocol when working in collaboration with other practitioners. Pharmacists are **not** required to use this protocol in order to be involved in the prescribing of opiate antagonists. Instead, they can work with a physician, advanced practice registered nurse (APRN) or physician assistant (PA) to develop a different protocol as allowed by Minn. Stats. §151.01, subd. 27(6).

Protocol

1. General considerations

- a. Pharmacists who enter into this protocol with a physician, APRN or PA are authorized to issue prescriptions for, and to dispense naloxone in accordance with, the provisions of this protocol. The physician, APRN or PA is considered to be the prescriber of record.
- b. Pharmacists who enter into this protocol must keep a written copy of it at each location from which they issue prescriptions or dispense naloxone. They must make a copy of the protocol available upon the request of a representative of the Board of Pharmacy. This protocol must list the name and contact information for the responsible practitioner and each pharmacist working under the protocol. To the extent that a practitioner agrees to allow all pharmacists that work for a pharmacy, a chain of pharmacies or a health care system to participate in the protocol, the individual pharmacists do not need to be named.

Comment [CW1]: Listed each type of practitioner, as suggested by board of nursing

Comment [CW2]: Listed each type of practitioner, as suggested by board of nursing

Comment [CW3]: Inserted at suggestion of MN Pharmacists Association – this is consistent with sections of Chapter 151 related to other types of protocols.

- c. While not required by law, the responsible practitioner and pharmacists should strongly consider completing appropriate training related to opioid overdoses and the use of naloxone, unless they have already done so. Examples of such training are:

Comment [CW4]: Included at suggestion of MDH.

- i. Pharmacist Letter:
<https://pharmacistsletter.therapeuticresearch.com/logon.aspx?bu=/ce/course.aspx?pc=16-242> (requires account)
- ii. Boston College and SAMHSA Program:
http://www.opioidprescribing.com/naloxone_module_1-landing
- iii. College of Psychiatric & Neurologic Pharmacists:
<https://cpnp.org/guideline/naloxone> (requires account)
- iv. California Society of Addiction Medicine:
<http://www.csam-asam.org/naloxone-resources>
- v. Prescribe to Prevent Videos for Pharmacists, Prescribers and Patients:
<http://prescribetoprevent.org/video/>
- vi. Substance Abuse and Mental Health Service Administration SAMSHA:
<http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742>
- vii. Emergency Medical Service Training
<http://steверummlerhopefoundation.org/emergency-medical-service-training/>

Comment [CW5]: Included at suggestion of MDH.

2. Procedure

- a. When an individual requests naloxone, or when a pharmacist in his or her professional judgement decides to advise an individual of the availability of naloxone, the pharmacist shall complete the following steps:

- 1) Screen for the following, in the primary spoken language of the recipient, upon request and when possible:
 - a) Does the potential recipient currently use or have a history of using illicit or prescription opioids;
 - b) Is the potential recipient in contact with anyone who uses or has a history of using illicit or prescription opioids;

Comment [CW6]: Modified version of a suggestion made by MDH. I added "when possible" because, unfortunately, many pharmacies would not have the ability to screen individuals in languages other than English. Requiring such screening would most likely mean that pharmacists would not utilize this protocol at all.

- c) Does the person to whom the naloxone would be administered have a known hypersensitivity to naloxone (if yes, do not furnish).
- b. Provide training in opioid overdose prevention and recognition, the administration of naloxone, and in the appropriate response to an opioid overdose, including the need to pursue immediate, follow-up treatment (e.g. calling 911).
- c. When naloxone is dispensed:
- 1) The pharmacist shall provide the individual to whom naloxone is dispensed ("recipient") with appropriate written information and with counseling on the product dispensed, including information concerning administration, effectiveness, adverse effects, storage conditions, shelf-life, safety, and any other information deemed necessary in the professional judgment of the pharmacist. A pharmacist dispensing naloxone pursuant to this protocol shall not permit the recipient to waive the provision of the written information and the counseling required by this protocol. Whenever possible, the pharmacist should provide information, whether written or oral, to the recipient in the primary language of the recipient.
 - 2) The pharmacist shall provide the recipient with information about and/or referrals to substance abuse treatment resources if the recipient indicates interest in substance abuse treatment, recovery services.
 - 3) The pharmacist shall provide the recipient with information about proper disposal of medications and needles/syringes and appropriate resources.
 - 4) The pharmacist shall answer all questions the recipient may have regarding naloxone.

Comment [CW7]: In this sub-paragraph, I modified a suggestion made by MDH. I used "when possible" because, unfortunately, many pharmacies would not have the ability to provide individuals with written information in languages other than English. That requirement would most likely mean that pharmacists would not utilize this protocol at all. The most appropriate written information may be instructions for use in the FDA-approved labeling (which includes package inserts). The Board of Pharmacy does not have the resources to develop written information.

Comment [CW8]: MDH suggested adding language about labeling here, but that is not necessary. Paragraph 4 (records) includes this sentence – "The prescription must be processed in the same manner that any other prescription is processed, pursuant to the applicable statutes and rules for the dispensing of prescription drugs" – which would include correct labeling.

3. Authorized drugs.

- a. The issuance of prescriptions and the dispensing done pursuant to this protocol is limited to naloxone (or other appropriate opiate antagonist that may be developed). A pharmacist may supply naloxone hydrochloride as an intramuscular injection, intranasal spray, autoinjector or any other FDA- approved product. A pharmacist may not dispense a compounded version of naloxone. A pharmacist may also recommend optional items when appropriate, such as alcohol pads, rescue breathing masks, and protective gloves.
- b. In selecting a product to be prescribed and dispensed, the pharmacist shall obtain sufficient information from the recipient to make a decision that is based on: products available; how well the product can be administered by the individuals likely to be involved in administering the product; and any other pertinent factor.

Comment [CW9]: Added at suggestion of MDH

4. Records. The pharmacist must generate a written or electronic prescription for any naloxone dispensed. If a written prescription is prepared, it shall be signed in the following format: *[signature of pharmacist], R.Ph. per naloxone protocol with [name of practitioner], [credential – i.e. MD, APRN, PA]*. The prescription must be processed in the same manner that any other prescription is processed, pursuant to the applicable statutes and rules for the dispensing of prescription drugs. The prescription shall be kept on file and maintained for a minimum of two years, as required by the rules of the Minnesota Board of Pharmacy. Pharmacists are reminded that prescriptions paid for by Medicare and Medicaid must be kept on file for even longer periods of time.
5. Notification. If the recipient is the potential individual to whom the naloxone will be administered, the recipient is considered to be the patient. In that case, with patient consent, the pharmacist shall notify the patient's primary care provider of any drug or device dispensed. If the patient does not have a primary care provider, or does not consent to have the primary care provider notified, then

the pharmacist shall provide a written record of the drug or device dispensed and advise the patient to consult an appropriate health care provider of the patient's choice.

Names and Contact Information of Responsible Practitioner and Pharmacists (enter below)

(Note: to the extent that a practitioner agrees to allow all pharmacists that work for a pharmacy, a chain of pharmacies or a health care system to participate in the protocol, the individual pharmacists do not need to be named. However, a statement indicating that all pharmacists may participate should be included.)

Comment [CW10]: Added at suggestion of MPhA

151.01 DEFINITIONS.

[...]

Subd. 27. Practice of pharmacy.

[...]

(6) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

CHAPTER 124—S.F.No. 1425

An act relating to health; adding provisions to the definition of the "practice of pharmacy"; making changes concerning the collection and disposal of legend drugs as pharmaceutical waste; requiring an opiate antagonist protocol; amending Minnesota Statutes 2014, sections 151.01, by adding a subdivision; 151.37, subdivisions 6, 7, by adding subdivisions; Minnesota Statutes 2015 Supplement, sections 151.01, subdivision 27; 151.37, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 152.

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

Section 1. Minnesota Statutes 2015 Supplement, section 151.01, subdivision 27, is amended to read:

Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

- (1) interpretation and evaluation of prescription drug orders;
- (2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);
- (3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;
- (4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;
- (5) participation in administration of influenza vaccines to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:
 - (i) the protocol includes, at a minimum:
 - (A) the name, dose, and route of each vaccine that may be given;
 - (B) the patient population for whom the vaccine may be given;
 - (C) contraindications and precautions to the vaccine;
 - (D) the procedure for handling an adverse reaction;
 - (E) the name, signature, and address of the physician, physician assistant, or advanced practice registered nurse;
 - (F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse can be contacted; and

(G) the date and time period for which the protocol is valid;

(ii) the pharmacist has successfully completed a program approved by the Accreditation Council for Pharmacy Education specifically for the administration of immunizations or a program approved by the board;

(iii) the pharmacist utilizes the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(iv) the pharmacist reports the administration of the immunization to the Minnesota Immunization Information Connection; and

(v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

(6) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(7) participation in the storage of drugs and the maintenance of records;

(8) patient counseling on therapeutic values, content, hazards, and uses of drugs and devices;
~~and~~

(9) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy; and

(10) participation in the initiation, management, modification, and discontinuation of therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

(i) a written protocol as allowed under clause (6); or

(ii) a written protocol with a community health board medical consultant or a practitioner designated by the commissioner of health, as allowed under section 151.37, subdivision 13.

Sec. 2. Minnesota Statutes 2014, section 151.01, is amended by adding a subdivision to read:

Subd. 39. **Ultimate user.** "Ultimate user" means a natural person who possesses a legend drug that was lawfully obtained for personal use or for the use of a household member or for the use of an animal owned by the natural person or by a household member.

Sec. 3. Minnesota Statutes 2015 Supplement, section 151.37, subdivision 2, is amended to read:

Subd. 2. Prescribing and filing. (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician assistant; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of section 147A.18.

(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the conditions triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(d) A prescription drug order for the following drugs is not valid, unless it can be established that the prescription drug order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

- (1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;
 - (2) drugs defined by the Board of Pharmacy as controlled substances under section 152.02, subdivisions 7, 8, and 12;
 - (3) muscle relaxants;
 - (4) centrally acting analgesics with opioid activity;
 - (5) drugs containing butalbital; or
 - (6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.
- (e) For the purposes of paragraph (d), the requirement for an examination shall be met if an in-person examination has been completed in any of the following circumstances:
- (1) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;
 - (2) the prescribing practitioner has performed a prior examination of the patient;
 - (3) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;
 - (4) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or
 - (5) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine.
- (f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a drug through the use of a guideline or protocol pursuant to paragraph (a).
- (g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription or dispensing a legend drug in accordance with the Expedited Partner Therapy in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control.
- (h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of legend drugs through a public health clinic or other distribution mechanism approved by the commissioner of health or a community health board in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.
- (i) No pharmacist employed by, under contract to, or working for a pharmacy located within the state and licensed under section 151.19, subdivision 1, may dispense a legend drug based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).
- (j) No pharmacist employed by, under contract to, or working for a pharmacy located outside the state and licensed under section 151.19, subdivision 2, 1, may dispense a legend drug to a resident of this state based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner, or, if not a licensed practitioner, a designee of the commissioner who is a licensed practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of a communicable disease according to the Centers For Disease Control and Prevention Partner Services Guidelines.

Sec. 4. Minnesota Statutes 2014, section 151.37, subdivision 6, is amended to read:

Subd. 6. **Exclusion for course of employment.** (a) Nothing in this chapter shall prohibit the possession of a legend drug by an employee, agent, or sales representative of a registered drug manufacturer, or an employee or agent of a registered drug wholesaler, or registered pharmacy, while acting in the course of employment.

(b) Nothing in this chapter shall prohibit an employee of the following entities, while acting in the course of employment, from possessing a legend drug for the purpose of disposing of the legend drug as pharmaceutical waste, provided that controlled substances listed in section 152.02, subdivisions 3 to 6, may only be collected and disposed of as allowed under section 152.105:

(1) a law enforcement ~~officer~~ agency;

(2) a hazardous waste transporter ~~licensed by the Department of Transportation~~ that has notified the Pollution Control Agency of its activity;

(3) a facility permitted by the Pollution Control Agency to treat, store, or dispose of hazardous waste, including household hazardous waste;

(4) a facility licensed by the Pollution Control Agency or a metropolitan county, as defined in section 473.121, as a very small quantity generator collection program or a minimal generator or household hazardous waste collection program; or

(5) ~~a county that collects, stores, transports, or disposes of a legend drug pursuant to a program in compliance with applicable federal law or a person authorized by the county to conduct one or more of these activities; or~~

(6) a sanitary district organized under chapter 115, or a special law.

Sec. 5. Minnesota Statutes 2014, section 151.37, is amended by adding a subdivision to read:

Subd. 6a. **Collection of legend drugs by pharmacies.** A pharmacy licensed under section 151.19 may collect a legend drug from an ultimate user, or from a long-term care facility on behalf of an ultimate user who resides or resided at the long-term care facility, for the purpose of disposing of the legend drug as pharmaceutical waste, provided that:

(1) a pharmacy may collect and dispose of controlled substances listed in section 152.02, subdivision 3 to 6, only as allowed under section 152.105; and

(2) a pharmacy that has established a controlled substance disposal program pursuant to section 152.105 may also collect and dispose of noncontrolled substance legend and nonlegend drugs, but only in the same manner in which it collects and disposes of controlled substances.

Sec. 6. Minnesota Statutes 2014, section 151.37, subdivision 7, is amended to read:

Subd. 7. **Exclusion for prescriptions.** (a) Nothing in this chapter shall prohibit the possession of a legend drug by a person for that person's use when it has been dispensed to the person in accordance with a valid prescription issued by a practitioner.

(b) Nothing in this chapter shall prohibit a person, for whom a legend drug has been dispensed in accordance with a written or oral prescription by a practitioner, from designating a family member, caregiver, or other individual to handle the legend drug for the purpose of assisting the person in obtaining or administering the drug or sending the drug for destruction.

(c) Nothing in this chapter shall prohibit a person for whom a ~~prescription~~ legend drug has been dispensed in accordance with a valid prescription issued by a practitioner from transferring the legend drug to ~~a county that collects, stores, transports, or disposes of a legend drug pursuant to a program in compliance with applicable federal law or to a person authorized by the county to conduct one or more of these activities.~~ an entity identified in subdivision 6. Controlled substances listed in section 152.02, subdivision 3 to 6, may only be collected, stored, transported, and disposed of as allowed under section 152.105.

Sec. 7. Minnesota Statutes 2014, section 151.37, is amended by adding a subdivision to read:

Subd. 13. **Opiate antagonists protocol.** (a) The board shall develop an opiate antagonist protocol. When developing the protocol, the board shall consult with the Board of Medical Practice, the Board of Nursing, the commissioner of health, and professional associations of pharmacists, physicians, physician assistants, and advanced practice registered nurses.

(b) The commissioner of health shall provide the following items to medical consultants appointed under section 145A.04, subdivision 2a:

(1) educational materials concerning the need for, and opportunities to provide, greater access to opiate antagonists;

(2) the opiate antagonist protocol developed by the board under paragraph (a); and

(3) a notice of the liability protections under section 604A.04, subdivision 3, that are extended to cover the use of the opiate antagonist protocol developed under this subdivision.

(c) The commissioner of health may designate a practitioner who is authorized to prescribe opiate antagonists to enter into the written protocol developed under paragraph (a) with pharmacists practicing within one or more community health service areas, upon the request of the applicable community health board. A community health board making a request to the commissioner under this section must do so by October 1 for the subsequent calendar year.

(d) The immunity in section 604A.04, subdivision 3, is extended to both the commissioner of health and to the designated practitioner when prescribing according to the protocol under this subdivision. The commissioner of health and the designated practitioner are both deemed to be acting within the scope of employment for purposes of section 3.736, subdivision 9, when prescribing according to the protocol under this subdivision.

Sec. 8. **[152.105] DISPOSAL.**

Controlled substances listed in section 152.02, subdivisions 3 to 6, may be collected and disposed of only pursuant to the provisions of Code of Federal Regulations, Title 21, parts 1300, 1301, 1304, 1305, 1307, and 1317, that are applicable to the disposal of controlled substances. Disposal of controlled substances and legend and nonlegend drugs must also comply with the requirements of section 116.07 governing the disposal of hazardous waste, and the rules promulgated thereunder.

Sec. 9. **EFFECTIVE DATE.**

Sections 1 to 8 are effective the day following final enactment.

Presented to the governor May 17, 2016

Signed by the governor May 19, 2016, 10:57 a.m.

DATE: September 10, 2016

SUBJECT: Health Professionals Services Program
(HPSP) Program Committee Report

SUBMITTED BY: Allen G. Rasmussen, M.A.

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 9, 2016, HPSP Program Committee meeting.

HPSP Report

The Health Professional Services Program (HPSP) Program Committee met on August 9, 2016, at 10:00 a.m. Fourteen Minnesota Health Regulatory Boards were represented.

Allen Rasmussen (Medical Practice) and Kathy Polhamus (Physical Therapy) were unanimously reelected as Chair and Vice Chair.

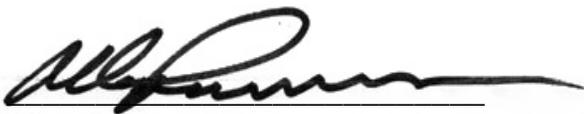
The Board of Medical Practice and its Executive Director Ruth Martinez agreed to become the HPSP Administering Board. The Program Committee voted to approve.

Monica Feider, HPSP Director, presented the Fiscal Year 2016 Report which included participation statistics, budget numbers, strategic planning updates, and Program Committee goals (attachment 1).

HPSP is asking the Executive Directors of the Health Licensing Boards to support HPSP's request for additional funding from the legislature to address technological improvements (attachment 2).

Ms. Feider presented the fourth update to the ongoing Strategic Planning Process (attachment 3).

Allen Rasmussen and the other members in attendance, Board of Nursing Representative Shirley Brekken, Board of Medical Practice Representative Ruth Martinez, Board of Marriage and Family Therapy representative Jennifer Mohlenhoff, Board of Physical Therapy Representatives Marshall Shragg and Kathy Polhamus, Board of Dietetics and Nutrition Practice and Board of Podiatric Medicine Representative Margaret Schreiner, presented the final recommendation from the Strategic Planning Governance Working Group which had met prior to the Program Committee meeting. They recommended keeping the present governance structure the same for the time being and have a subgroup of the Program Committee review the Committee's oversight responsibilities and functions and make future recommendations about potential governance, duties, structure, and statutory changes. Volunteers were requested and approved by the Committee. Work Group members will be Catherine Floyd (Health Department), Yvonne Hundshamer (Board of Behavioral Health & Therapy), Kathy Polhamus (Board of Physical Therapy), Margaret Schreiner (Board of Dietetics and Nutrition Practice and Board of Podiatric Medicine), Allen Rasmussen (Board of Medical Practice), and Steve Gulbrandsen or another HPSP Advisory Committee Member. Shirley Brekken (Board of Nursing) agreed to serve in an advisory role. The meeting of the Work Group will be noticed to all program Committee members and interested members are encouraged to attend.



Allen Rasmussen
HPSP Program Committee Chair

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 monitoring plans that oversee the participants' illness management and professional practice, both of which are tied to patient safety. A monitoring plan 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 monitoring contracts:

- 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

- *The whole program/process kept me very accountable.*
- *I would not have been as successful without urine tox screens early in recovery.*
- *Overall I can't say enough how thankful I am for what HPSP has done for me and my life. I have never been so confident in my sobriety.*
- *The entire program has clearly been a great benefit for me.*
- *HPSP gave me confidence and "protection." It gave me a way to display and prove or proof of competency and safety*

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 and Monitoring Plan are 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 when they are at various points in their 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 also subject to immunity if they are 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.
- **Action (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 Board 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, we 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 third party, the first referral source for their second admission to the program would be a *third party* referral.

Referrals by First Referral Source and Board

In fiscal year 2016 (July 1, 2015 to June 30, 2016), 452 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.

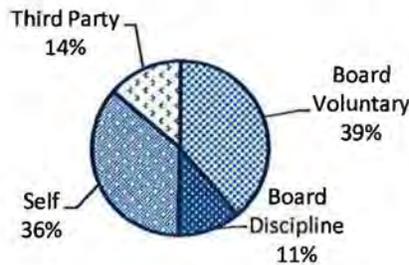
Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Board Voluntary	0	1	0	0	12	8	11	13	15	16	19	13	46	65	77	54	1	2	4	3	1	0	0	0
Board Discipline	0	0	0	0	2	3	1	1	2	2	0	0	5	5	0	2	1	0	1	2	0	0	0	0
Self	1	1	0	0	6	2	8	8	3	5	3	0	3	0	8	1	1	1	1	2	0	1	0	3
Third Party	0	0	0	0	5	5	3	6	0	0	0	1	1	7	6	2	0	1	0	0	1	0	0	0
SUM	1	2	0	0	25	18	23	28	20	23	22	14	55	77	91	59	3	4	6	7	2	1	0	3

Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Board Voluntary	14	9	5	8	2	2	1	3	11	12	12	9	37	43	30	51	0	1	0	0	0	3	9	2
Board Discipline	1	1	3	1	0	0	0	0	5	2	5	1	73	65	54	41	0	0	0	0	3	1	2	0
Self	5	7	8	3	1	4	1	2	47	30	21	33	122	93	97	97	0	0	0	0	7	10	4	3
Third Party	0	0	0	0	0	0	1	0	9	10	12	10	46	47	49	38	0	0	0	0	4	2	0	3
SUM	20	17	16	12	3	6	3	5	72	54	50	53	278	248	230	227	0	1	0	0	14	16	15	8

Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Board Voluntary	4	1	13	9	0	0	0	0	1	1	0	0	2	10	6	8	3	7	2	2	149	181	189	175
Board Discipline	2	1	0	0	0	0	0	1	0	1	1	1	0	0	3	0	1	0	1	2	95	81	71	52
Self	1	3	3	1	0	0	1	0	3	1	2	0	6	4	5	9	1	0	1	1	207	162	163	163
Third Party	1	0	0	1	0	0	0	0	2	2	4	0	2	1	3	1	0	2	1	0	71	77	79	62
SUM	8	5	16	11	0	0	1	1	6	5	7	1	10	15	17	18	5	9	5	5	522	501	502	452

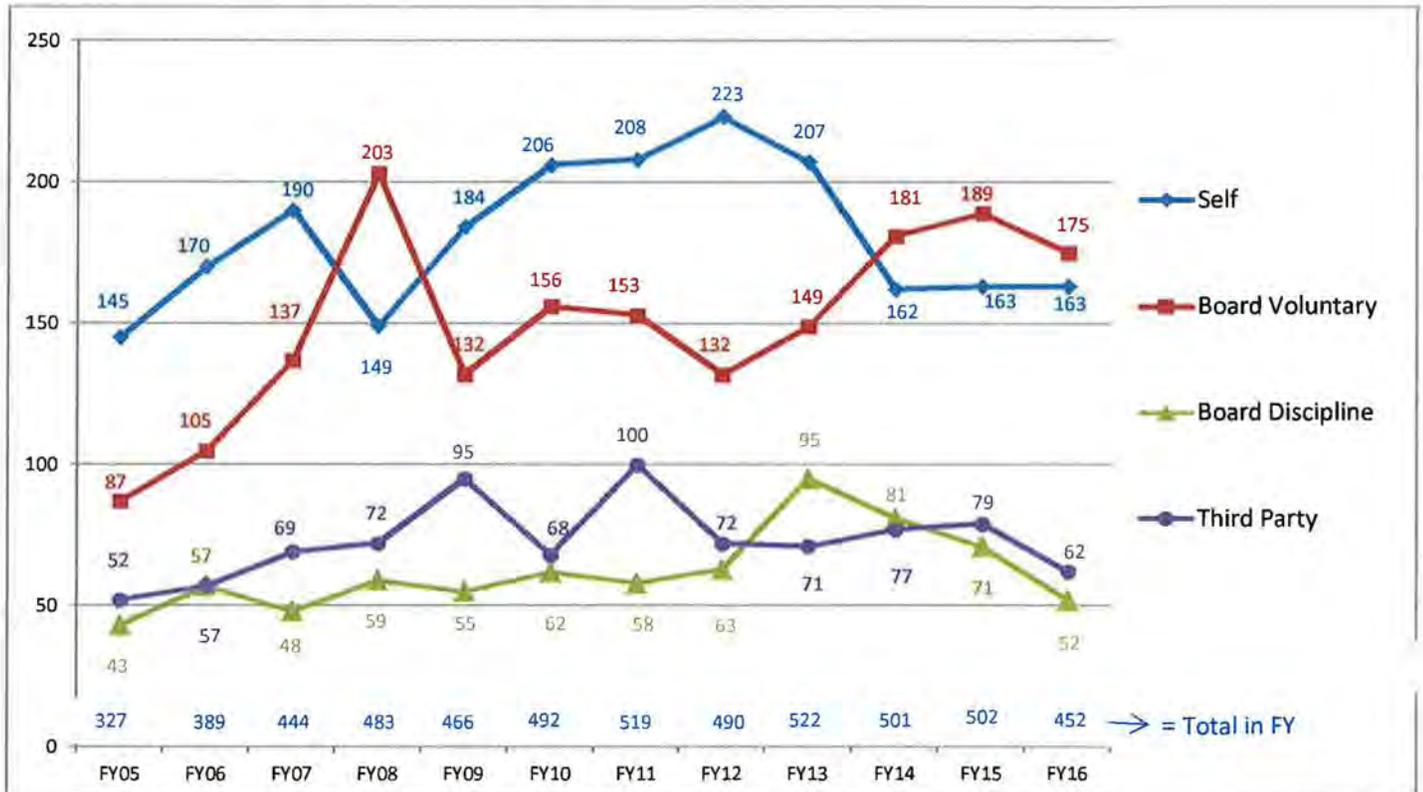
Referrals by First Referral Source

The chart below shows the percentage of referrals to HPSP by first referral source from July 1, 2015 to June 30, 2016:



Referral Trends

The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2005 through fiscal year 2016. Board disciplinary referrals shot up in 2013 by 51% and have steadily decreased since then. Self-referrals remain lower than expected based on the trajectory from 2008 to 2012. Third party referrals also declined, resulting in the fewest number of referrals since 2007. This is the third consecutive year since 2008 that board voluntary referrals exceeded self-referrals.



Self-Referrals – How Did They Learn About HPSP?

Practitioners learn about HPSP from multiple sources. The following data shows how the 163 practitioners who self-referred to HPSP in fiscal year 2016 learned about the program:

- 43% Treatment providers/programs
- 17% Employee health services
- 12% Supervisors
- 9% Previously referred
- 6% Board
- 4% Colleagues
- 9% Other (includes union, HPSP website or brochure, attorney, sponsor and other sources)

As the program ages, we anticipate seeing more people self-report who had previously been enrolled in the program. The large number of persons who learned about HPSP by their treatment providers/programs is congruent with what we see with continuing care planning. Treatment programs encourage patients to contact HPSP to improve their compliance with recovery activities and improves their likelihood for long-term recovery which in turn, helps protect the public.

Third Party Referrals

When HPSP receives a third party report about a licensee, we typically send the licensee a letter and direct them to contact us within two weeks to follow-up on the report. In cases where immediate public safety is at risk, we call the licensee upon receipt of the report. If the licensee fails to contact HPSP in response to the report, they are discharged as *no contact*. If the licensee fails to cooperate with the intake process, they are discharged as *non-cooperative*. 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.

In fiscal year 2016, HPSP third party reports came from the following:

- 42% Treatment Providers
- 19% Supervisors
- 15% Colleagues
- 11% Employee Health
- 8% Family or Friends
- 5% Other

Fiscal Year 2016 Additional Referral Sources

The previous data showed how health practitioners were referred to HPSP in fiscal year 2016 by first referral source. The following data shows subsequent referral sources:

First Referral Source	Second Referral Source	Third Referral Source
Self (#163)	8 Third Party	2 Board Disciplinary
Third Party (#62)	1 Board Disciplinary	
Board Voluntary (#174)	7 Board Disciplinary	

Note: Second and third referral sources are for a single admission into the program. (See page 2 for definitions)

Re-Referrals

Of the 452 persons referred to HPSP between July 1, 2015 and June 30, 2016, 117 (26%) had previously participated in the program. Seventy percent of persons re-referred to HPSP were referred by their licensing boards. Their referral sources for entry to the program are described below:

- Board Voluntary: 48 or 11% of referrals
- Board Discipline: 34 or 8% of referrals
- Self-referrals: 25 or 6% of referrals
- Third Party Referrals: 10 or 2% of referrals

Self-Re-Referrals

Self-re-referrals to HPSP are permitted only under the following circumstances: (1) the participant previously successfully completed HPSP; (2) if discharged to the board, the case was dismissed by the board; or (3) HPSP determined there was no jurisdiction (no illness) in the previous admission.

In fiscal year 2016, the average length between prior discharge and self-re-referral was six years. The shortest time-frame was 11 months and the longest was just short of 18 years. The table below shows the timeframe from prior discharge and self-re-referral to HPSP:

Time between prior discharge and self-re-referral	Number of Participants
<1 to 3 years	6
>3 to 6 years	9
>6 to 9 years	4
>9 to 12 years	3
>12 to 18 years	3

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 and Monitoring Plan.

2. **Non-Compliance***

Participant violates the conditions of their Participation Agreement/Monitoring Plan; 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 and Monitoring Plan; the case manager closes 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. Subcategories 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
- 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.

Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Completion	0	0	0	1	2	6	5	2	2	3	5	3	6	7	6	6	1	0	0	0	0	0	0	0
Voluntary Withdraw	0	0	0	0	0	0	2	1	0	1	1	0	2	0	3	0	1	0	1	0	0	0	0	0
Non-Compliance	0	0	0	0	7	6	5	6	3	2	0	2	7	6	10	6	0	1	0	0	0	0	0	0
Deceased	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ineligible Monitored	0	0	0	0	1	0	0	1	0	3	1	0	0	2	0	1	0	1	0	1	0	0	0	0
Ineligible Not Monitored	0	0	0	0	1	1	0	1	0	0	0	0	1	1	2	1	0	0	0	0	0	0	0	0
No Contact	0	0	0	0	3	1	5	0	1	0	0	0	0	2	5	3	0	1	2	0	1	0	0	0
Non Cooperation	0	0	0	0	5	5	4	4	3	1	1	1	5	7	8	3	0	1	0	1	0	0	0	0
Non-Jurisdictional	0	2	0	0	4	1	3	3	10	14	16	10	34	55	58	39	0	1	1	2	0	0	0	1
SUM	0	2	0	1	23	20	25	18	19	24	24	16	55	80	92	59	2	5	4	4	1	0	0	1

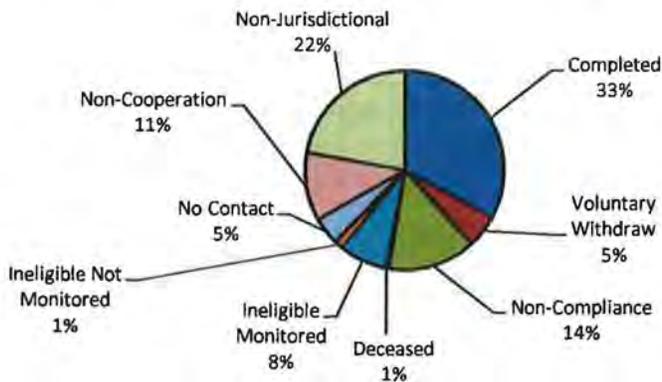
Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Completion	2	2	3	4	1	1	2	0	34	34	41	27	100	91	102	85	0	0	0	0	6	3	10	1
Voluntary Withdraw	1	1	2	2	0	0	0	0	1	5	1	2	28	18	15	15	0	0	0	0	1	0	1	0
Non-Compliance	3	3	1	3	1	0	0	0	0	1	0	0	68	74	50	39	0	0	0	0	3	4	2	3
Deceased	0	0	0	1	0	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	1	0
Ineligible Monitored	1	0	1	1	0	1	0	0	11	11	6	6	17	14	15	20	0	0	1	0	0	0	0	0
Ineligible Not Monitored	0	1	0	0	0	1	0	0	1	4	0	1	20	12	17	1	0	0	0	0	0	0	0	1
No Contact	1	1	1	1	0	0	0	0	1	1	3	2	7	11	12	11	0	0	0	0	1	3	4	1
Non Cooperation	4	2	4	3	0	1	1	3	6	2	4	1	24	22	26	24	0	0	0	0	3	2	1	2
Non-Jurisdictional	3	5	4	3	2	3	1	2	14	11	11	9	30	19	23	20	0	0	0	0	2	0	2	0
SUM	15	15	16	18	4	7	4	5	68	70	66	49	295	261	260	215	0	0	1	0	16	12	21	8

Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Completion	3	1	6	3	0	0	0	0	2	1	3	2	3	6	2	4	0	0	3	1	162	155	188	139
Voluntary Withdraw	0	0	1	0	0	0	0	0	0	0	0	1	0	2	0	2	0	0	0	0	34	27	27	23
Non-Compliance	1	2	2	0	0	0	0	0	0	2	2	0	0	2	1	2	1	1	1	0	94	104	74	61
Deceased	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2	2	2
Ineligible Monitored	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2	0	1	0	1	33	33	24	33
Ineligible Not Monitored	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	1	0	2	0	0	24	23	21	6
No Contact	0	0	1	1	0	0	0	0	0	0	1	0	0	1	1	0	1	0	0	0	16	21	35	19
Non Cooperation	0	0	1	1	0	0	1	0	0	0	0	0	3	1	2	4	1	2	1	0	54	46	54	47
Non-Jurisdictional	4	2	7	4	0	0	0	0	1	0	1	0	0	1	6	0	0	3	1	1	104	117	134	94
SUM	10	5	18	9	0	0	1	0	3	3	7	3	8	15	14	15	3	9	6	3	522	528	559	424

Note: Discharge categories highlighted in blue represent categories of persons who did not engage in monitoring.

Discharges by Category

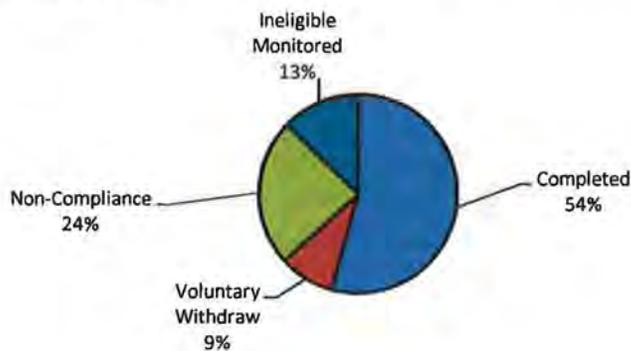
The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2016.



Of persons discharged in fiscal year 2016, 39% 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%.

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 2016.



The completion rate of 54% reflects only persons that engaged in monitoring.

Discharges Due to Ineligibility for Monitoring

Thirty-nine (39) health professionals were discharged in fiscal year 2016 because they were not eligible for program services; 33 were monitored and 6 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (33)

- 26 were discharged because their licenses were suspended, revoked, or changed to inactive status;
- 5 were discharged because their illnesses were too severe to warrant continued monitoring; and
- 2 were discharged because they violated their practice act.

Not-monitored and discharged as ineligible (6)

- ~~3 were discharged because their license was suspended, revoked or inactive;~~
- 2 were discharged because their illnesses were too severe to warrant monitoring; and
- 1 was discharged due to practice act violations.

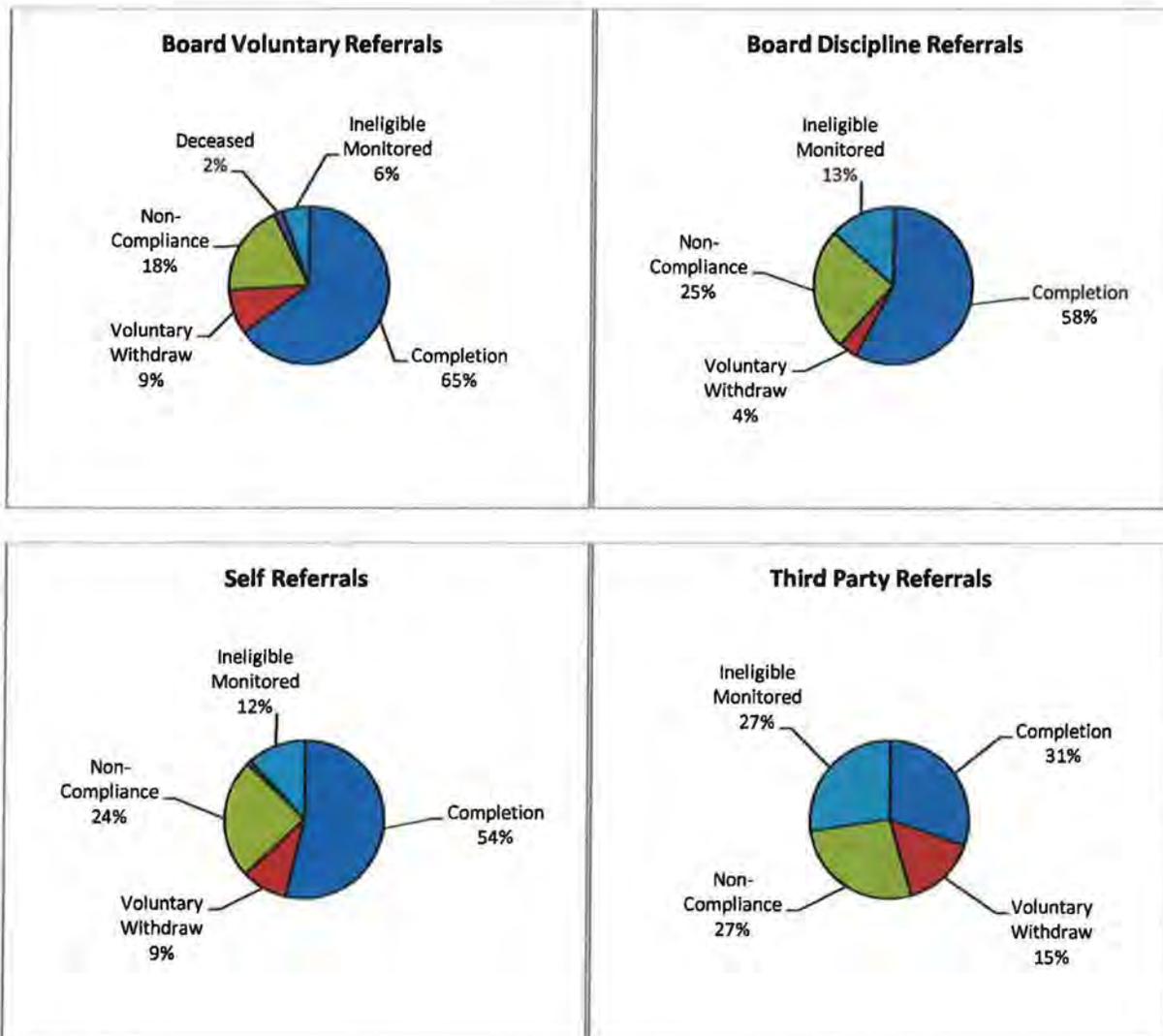
Discharges for Non-Compliance (61)

The sub-categories of the 61 persons discharged for non-compliance in fiscal year 2016 are as follows:

- 23 were discharged for non-compliance with Monitoring Plan (i.e. relapse and refusing evaluations);
- 19 were discharged for problem toxicology screen results (i.e. not providing as requested or dilute);
- 16 were discharged for positive screens; and
- 3 were discharged for non-compliance with treatment.

Discharges by Referral Source for Those Monitored

The charts below show the percentages of licensees monitored by first referral source and discharge category in fiscal year 2016. The *completion* rate is highest among board referred licensees and lowest among those referred by third parties. Third party referents had a significantly higher rate of *ineligible* discharges than other referral sources.



Length of Monitoring

Successful Completion: In fiscal year 2016, the average length of monitoring of practitioners who successfully completed monitoring was two years and eight months. The shortest length was shy of nine months and the longest was six years and ten months.

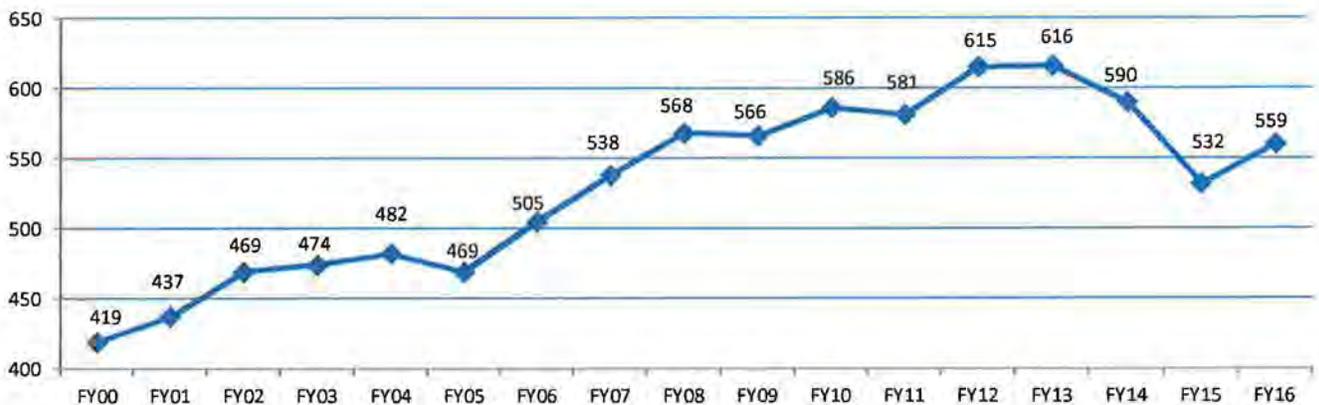
HPSP satisfactorily discharges persons based on the following protocols: (1) The individual is in sustained remission after a period of monitoring (usually the case for substance use disorders); (2) there is new information indicating the diagnosis has changed, or (3) the participant is deemed to be appropriately managing the illness after a period of monitoring (usually the case in chronic health or mental health illnesses).

Unsatisfactory Completion: In fiscal year 2016, the average length of monitoring for persons who were monitored but did not complete monitoring was just over twelve months (367 days). The shortest length was 27 days, and the longest was five years and nine months. The majority, 65%, were discharged in the first year of monitoring, followed by 22% in the second year, 8% in the third year, and 5% 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 17 fiscal years. While HPSP's caseload decreased in fiscal years 2014-2015, it started rebounding in fiscal year 2016.



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, 2016, 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.

Board	Number Licensed or Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Licensed or Regulated
Board of Behavioral Health & Therapy	4,619	23	4.98
Board of Podiatric Medicine***	256	1	3.91
Board of Medical Practice	29,919	90	3.01
Board of Chiropractic Examiners	3,044	8	2.63
Board of Nursing	124,732	306	2.45
Board of Dietetics and Nutrition Practice***	1,735	4	2.31
Board of Physical Therapy	6,849	13	1.90
Board of Veterinary Medicine	3,822	7	1.83
Board of Psychology	3,850	7	1.82
Board of Dentistry	17,313	29	1.68
Board of Social Work	14,429	20	1.39
Board of Pharmacy*	16,718	23	1.38
Department of Health**	7,167	7	0.98
Board of Marriage and Family Therapy	2,417	2	0.83
Emergency Medical Services Regulatory Board	29,405	12	0.41
Board of Optometry	1,084	0	0
Board of Exam. of Nursing Home Admin.	837	0	0
Total	268,196	552	2.06

The data for the Number Licensed or Regulated were gathered from Board websites or office managers from June to July 2016 unless otherwise noted.

*Pharmacy licensee number is based on number of pharmacists and pharmacy techs that live in Minnesota.

** Does not include unlicensed complementary and alternative health care practitioners (CAP). CAPs are subject to investigation and discipline but because they are not licensed, they are not required to register. The Dept. of Health estimates over 3,000 CAPs.

***Based on number licensed per last year's report.

Active Caseload by Board and Profession

The chart below shows the number of licensees active with HPSP on July 12, 2016 by Board and Profession. It includes persons in the enrollment phase as well as those with signed Participation Agreements.

Board	Number of Participants
Board of Behavioral Health & Therapy	23
LPC	2
LADC	21
Board of Chiropractic Examiners	8
Board of Dentistry	29
Dental Assistants	11
Dental Hygienists	8
Dentists	10
Department of Health	7
Occupational Therapists	6
Hearing Instrument Dispensers	1
Board of Dietetics and Nutrition Practice	4
Board of Exam. of Nursing Home Admin.	0
Emergency Medical Services Regulatory Board	12
EMR	0
EMT1	4
EMTN	2
EMTP	6
Board of Marriage and Family Therapy	2
Board of Medical Practice	90
Physician Assistant	6
Physician	78
Respiratory Care Practitioner	5
Resident	1
Board of Nursing	306
RN	252
LPN	54
Board of Optometry	0
Board of Pharmacy	23
Intern	1
Pharmacist	18
Technician	4
Board of Physical Therapy	13
Physical Therapist	9
Physical Therapist Assistant	4
Board of Podiatric Medicine	1
Board of Psychology	7
Board of Social Work	20
LGSW	8
LICSW	4
LISW	2
LSW	6
Board of Veterinary Medicine	7
Total	552

Of the 552 active cases on July 12, 2016, 503 had signed Participation Agreements and 49 were in the enrollment process.

Registered Nurses make up the greatest number of HPSP participants (46%), which is consistent with the fact that there are more Registered Nurses licensed than any other profession eligible for HPSP services.

ILLNESSES MONITORED

General Illness Data:

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 19, 2016, there were 496 health professionals enrolled in HPSP with signed Participation Agreements. Many were monitored for more than one illness. The following data identify the illnesses for which they are being monitored.

Illness Category	Number of participants	Percent of 496 participants
Substance Use Disorders	404	81%
Psychiatric Disorders	346	70%
Medical Disorders	68	14%

We have seen a steady increase in the number of participants monitored for psychiatric disorders. In fiscal year 2007, 51% of participants were monitored for psychiatric disorders compared to 70% this fiscal year.

Comorbid Disorders	Number of participants	Percent of 496 participants
Substance and Psychiatric	226	46%
Substance and Medical	8	2%
Psychiatric and Medical	14	3%
Substance, Psychiatric & Medical	38	8%

Substance Use Disorders (SUD)	Number of participants with SUD: 404	Percent of 496 participants	Percent of 404 with a SUD
Alcohol	317	64%	78%
Prescription	123	25%	31%
Amphetamine	10	2%	3%
Barbiturate	5	1%	1%
Benzodiazepine	35	7%	9%
Opiate	98	20%	24%
Sedative/Hypnotic	14	3%	4%
Illicit	46	9%	12%
Cannabis	25	5%	6%
Cocaine	8	2%	2%
Heroin	4	1%	1%
Methamphetamine	15	3%	4%
Other (OTC)	3	<1%	1%

Many participants used more than one substance.

Psychiatric Disorders	Number of participants with a psychiatric: 346	Percent of 496 participants	Percent of 346 with a psychiatric
Anxiety and/or Depression	292	59%	84%
Attention Deficit	18	4%	5%
Bipolar	35	7%	10%
PTSD	35	7%	10%
Eating Disorder	16	3%	5%
Other	23	5%	7%

It is not uncommon for participants to be monitored for more than one psychiatric disorder.

Medical Disorders	Number of participants with medical disorders: 68
The majority of persons (>82%) 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, chronic fatigue, and seizure disorders. Some are monitored for more than one medical illness.	

Gastric Bypass

Gastric bypass surgery can have unintended consequences that patients are not consistently educated about. Several studies have shown an increase in alcohol use disorders among persons who have had bariatric surgery.

Adults who had a common bariatric surgery to lose weight had a significantly higher risk of alcohol use disorders (AUD) two years after surgery, according to a study by a National Institutes of Health research consortium.

<https://www.nih.gov/news-events/news-releases/weight-loss-surgery-increases-alcohol-use-disorders-over-time>

On July 12, 2016, 7% (37) of participants with signed Participation Agreements had a history of having gastric bypass surgery.

- 84% (31) had an alcohol use disorder (9 with co-occurring prescription medication use disorder)
- 73% (27) had depression and/or anxiety
- 35% (13) had a prescription medication use disorder (4 without a co-occurring alcohol use disorder)
- 14% (5) had other psychiatric disorders (3 of which were co-occurring with anxiety and/or depression)
- 11% (4) had medical disorders

One might expect health care practitioners to have greater information about gastric bypass surgery, which may lead to higher utilization of the surgery than that of the general population. The professions of those who had the surgery include:

- 28 Nurses (20 RNs and 8 LPNs)
- 2 Alcohol and Drug Counselors
- 2 Psychologists
- 2 Social Workers
- 1 Dental Assistant
- 1 Physician
- 1 Reparatory Care Practitioner

DIVERSION OF CONTROLLED SUBSTANCES

HPSP Definition of Diversion

The HPSP working definition of diversion is *the inappropriate acquisition of controlled or other potentially abusive substances*. Note the term “diversion” is umbrella terminology in which stealing drugs from the work place is included. Methods of diversion vary greatly, as does the impact and potential impact on patients.

Monitoring Conditions

Our 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 19, 2016, a total of 496 health professionals had signed participation agreements. Of the 496 health professionals with signed agreements, 123 (25%) were addicted to prescription medication. Of the 123 addicted to prescription medications, 86 (70%) engaged in diversion.

Diversion by Board

The table below shows the number of participants with signed Participation Agreements on July 19, 2016, 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).

Board	Number of persons who diverted by board	Diversion took place at work	Diversion did not take place at work	Percent being monitored by board
Nursing	50	33	30	50/275 =18%
Pharmacy	12	11	3	12/20=60%
Medical Practice	11	9	6	11/85=13%
Other boards	13*	6**	7***	13/47=28%*
Totals	86	59	46	-

*Represents persons regulated by the Boards of Dentistry (3), Behavioral Health and Therapy (2), Emergency Medical Services (2), Physical Therapy (3), Podiatric Medicine(1), and Veterinary Medicine (2).

**Represents persons regulated by the Boards of Dentistry (2), Emergency Services (1), Podiatric Medicine (1), and Veterinary Medicine (2)

***Represents persons regulated by the Boards of Behavioral Health and Therapy (2), Dentistry (1), Emergency Medical Services (1), and Physical Therapy (3)

Methods of Diversion

The tables below shows more specific data about how 86 health professionals engaged in diversion.

Diversion took place at work (69%)	59 total participants	Diversion did not take place at work (53%)	46 total participants
Took from inventory	23	Took from family or friends	42
Took from waste	23	Ordering off the internet	4
Withdrew more than patient needed and kept extra for self	6	Wrote prescription for self	3
Wrote prescription for patient and filled for self	7	Wrote prescription for fake patient	1
Other	10	Other	2

Note: HPSP does not currently track participants who buy medications from illegitimate sources.

Other forms of diversion included substituting medications, taking medications that patients brought to the hospital, writing a prescription for a patient and splitting it with them, ordering medications for the clinic and taking them for personal use and other methods. Persons who engaged in substitution of medications and falsifying prescriptions were referred to HPSP by their Boards as part of disciplinary actions.

Referral Sources of Persons who Diverted by First Referral Source:

The referral sources of HPSP participants who diverted medications include are described below:

- 54% self-referred
- 37% were board referred with discipline
- 6% were third party referred
- 3% were board referred without discipline (voluntary)

Trends

Diversion at Work

As seen in previous years, health care practitioners with the greatest access to controlled substances are more likely to divert substances than those in professions with limited or no access. In this fiscal year all diversion that occurred in the work setting was done by persons with access to controlled substances in the work setting. Pharmacists represent less than 3% of HPSP participants but 14% of diversion cases compared to nurses who represent 55% of HPSP participants and 58% of diversion cases.

Diversion from Other Sources

The most common form of non-work-related diversion is taking (or receiving) medications from family members or friends. We are seeing this increase 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 participants they have in the program at the end of each month. No additional fees are collected by HPSP for program participation from licensees.

EXPENSES

HPSP's operating budget in fiscal year 2016 was \$850,000. Spending was within projected levels. Ninety percent of HPSP's budget was directed to staffing (salaries/benefits). The next greatest cost was rent, which made up just shy of 5% of expenses. The remaining 5% was directed toward all other operating costs, including but not limited to information technology (IT) services (MN.IT), consulting services (IT and a psychiatrists/addictionologist, and supplies. HPSP stayed well within its spending authority and anticipates carrying over roughly \$21,000 to fiscal year 2017.

HPSP's fiscal year 2017 budget is \$864,000. As noted above, HPSP will carry over roughly \$21,000 to fiscal year 2017, which will increase the budget to \$885,000. This will help address increases in staffing costs of approximately \$31,000.

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. The lease agreement is in effect for two and one half years at the following rates:

Lease Period	Annual Payment
7/1/15 to 6/30/16	\$35,837.40
7/1/16 to 6/30/17	\$36,283.20
7/1/17 to 1/31/18	\$21,150.75*

*Represents 6 months of rent, so HPSP's lease timeframe will be consistent with the Health Licensing Boards.

HIGHLIGHTS

STRATEGIC PLANNING

In fiscal year 2016, HPSP remained focused on the strategic goals established in fiscal year 2014 and 2015. The goals were developed through a strategic planning process facilitated by the Minnesota Department of Administration's Management, Analysis and Development (MAD) department that included stakeholders from the health licensing boards. Some goals have been completed while others remain a work in progress. HPSP staff will review the progress made with each goal and work on identifying new goals. An update of HPSP's strategic planning progress is in separate document.

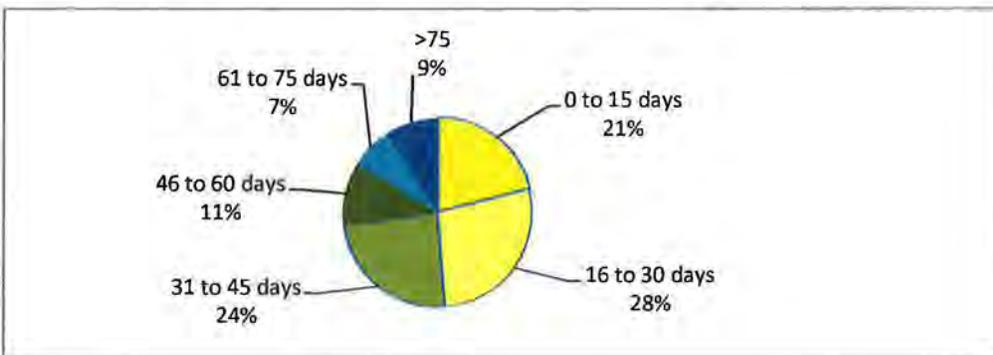
PARTICIPATION AGREEMENTS

HPSP strives to have Participation Agreements signed within 60 days of participant contact with the program. However, when participants are in the intake process prior to a signed Participation Agreement, an intervention has been initiated that protects the public when warranted.

In fiscal year 2016, 203 participation agreements were signed. Of these, 93% were signed within 60 days following the individual's contact with the program. The average timeframe was 33 days. Factors contributing to signed agreements exceeding 60 days were commonly related to the need for specialized assessments (i.e. pain management, neuropsychological), as well as delays in obtaining medical records. Participant cooperation with the intake process was a less frequently cited reason for the delay in the signing of Participation Agreements.

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 50% of referrals in 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 an exacerbation 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 is a complex interaction when providing any type of service. Beyond our 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 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 and 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 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 very effective 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. 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.

HPSP will be seeking additional funding in the upcoming biennium to address technological needs, which will improve quarterly reporting efficiencies.

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.

SUMMARY

HPSP is committed to protecting the Minnesota public by providing monitoring services that include the monitoring of professional performance and illness management. HPSP does this by seeking feedback from participants' work site monitors, treatment providers and other sources. HPSP is also committed to providing services in an effective and efficient manner. This is done 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 has the benefit of collaborating with regulators in an ongoing assessment of the effectiveness of program communications and monitoring processes to assure public protection. HPSP and the Boards interact closely to carry out the shared goal of public protection.

COMMITTEE MEMBERS AND STAFF LIST

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.

Board	Member Name	Term Expires
Behavioral Health and Therapy	Yvonne Hundshamer	1/1/2017
Chiropractic Examiners	Nestor Riano	1/1/2017
Dentistry	Bridgett Anderson	1/1/2017
Department of Health	Catherine Lloyd	1/1/2017
Dietetics and Nutritionists	Margaret Schreiner	1/1/2017
Emergency Medical Services	Matthew Simpson	1/1/2017
Marriage and Family Therapy	Kathryn Graves	1/1/2017
Medical Practice	Allen Rasmussen	1/1/2017
Nursing	Christine Norton	1/1/2017
Nursing Home Administrators	Randy Snyder	1/1/2017
Optometry	Michelle Falk	1/1/2017
Pharmacy	Joseph Stanek	1/1/2017
Physical Therapy	Kathy Polhamus, Vice Chair	1/1/2017
Podiatric Medicine	Margaret Schreiner	1/1/2017
Psychology	Angelina Barnes	1/1/2017
Social Work	Rosemary Kassekert	1/1/2017
Veterinary Medicine	Julia Wilson	1/1/2017

ADMINISTERING BOARD

HPSP is not an independent State agency. By statute, one of the health licensing boards must be designated by the Program Committee to administer the program. Marshall Shragg, throughout his tenure at the Board of Dentistry and later at the Board of Physical Therapy, served as the Executive Director of HPSP's Administering Board.

The HPSP staff would like to thank Marshall for acting as the Executive Director of HPSP's Administering Board since June 2008. Throughout that time, Mr. Shragg provided HPSP with sound, positive, thoughtful and pragmatic leadership. He was an exceptional advocate for the program and its mission. Mr. Shragg will be leaving the health licensing boards in the fall of 2016, at which time the Program Committee will direct a Board to administer the program.

ADVISORY COMMITTEE MEMBERS

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

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

Professional Association	Member	Term Expires
Public Member	Sadiq Abdirahman	1/1/2017
MN Pharmacists Assoc.	Jim Alexander	1/1/2017
MN Health Systems Pharmacists	S. Bruce Benson	1/1/2017
MN Assoc. of Social Workers	Pam Berkwitz	1/1/2017
MN Veterinary Assoc.	Marcia Brower	1/1/2017
MN Psychological Assoc.	Lois Cochrane-Schlutter	1/1/2017
MN Dental Assoc.	Stephen Gulbrandsen, Chair	1/1/2017
MN Nurses Assoc.	Jody Hagg	1/1/2017
MN Assoc. of Marriage & Fam. Therapy	Eric Hansen	1/1/2017
MN Ambulance Assoc.	Megan Hartigan (Debbie Gillquist alt)	1/1/2017
MN Chiropractic Assoc.	Rick Heuffmeier	1/1/2017
Public Member	Abdiaziz Hirsi	1/1/2017
MN Academy of Physician Assist.	Tracy Keizer	1/1/2017
MN Medical Assoc.	Teresa Knoedler	1/1/2017
MN Academy of Nutrition and Dietetics	Sheryl Lundquist	1/1/2017
MN Nurse Peer Support Group	Marie Manthey	1/1/2017
Physicians Serving Physicians	Jeff Morgan	1/1/2017
Ad Hoc Member	Rose Nelson	1/1/2017
MN Occupational Therapy Assoc.	Karen Sames	1/1/2017
MN Organization of Registered Nurses	Joseph Twitchell	1/1/2017
MN LPNA/AFSCME	Lisa Weed	1/1/2017

HPSP STAFF

Staff Person	Position
Monica Feider, MSW, LICSW	Program Manager
Tracy Erfourth, BA	Case Manager
Marilyn Miller, MS, LICSW	Case Manager
Mary Olympia, BS, LSW	Case Manager
Kurt Roberts, EdD, LADC	Case Manager
Kimberly Zillmer, BA, LADC	Case Manager
Daisy Chavez	Case Manager Assistant
Sheryl Jones	Office Manager

Health Professionals Services Program

The Health Professionals Services Program (HPSP) is asking the Executive Directors of the Health Licensing Boards to support HPSP's request for additional funding to address technological improvements. More specifically, we are asking for the following:

In FY 2018:

- \$25,000 to enhance our case management database – Why? We would like to improve the quality and data entry efficiency of our intake form.
- We also want to examine ways to ensure all data fields are completed in real time (sometimes they are missed only identified after doing queries to double check that all data was entered).
- \$25,000 to automate the receipt of screen results from HCMC into our database – Why? Currently all screen results are faxed to HPSP – thousands each year. They are then manually entered into our database and manually filed. These processes use a lot of paper and staff resources. HCMC is ready to work with us on this.

In FY 2019:

- \$50,000 to enable the submission of web based reports - Why? It is time. Each quarter we receive roughly four reports for each participant. With an average of 500 participants with signed Participation Agreements, we receive at least 2,000 reports each quarter. They are faxed and mailed to us (some people fax and mail them). All reports are manually entered into the database and then given to case managers for review and then filed. We would like to eliminate the handling of paper as much as possible. We have received requests from participants, work site monitors and treatment providers to make the submission of reports easier - electronic. Another advantage would be that participants could see what reports were/were not submitted without calling their case manager.
- This may also enable the electronic submission of files to the Boards.

Thank you for your consideration.

Health Professionals Services Program

Strategic Planning Update

August 2016

Background of Strategic Planning Process

In preparation for strategic planning in 2014, the Health Professionals Services Program (HPSP) asked Management Analysis & Development (MAD) to gather stakeholders' views on strengths, weaknesses, opportunities and challenges facing the program. In November 2013 MAD conducted focus group interviews with the HPSP Program Committee, Advisory Committee, staff, and interviewed the HPSP program manager and in December surveyed health licensing board executive directors. Five of 16 executive directors responded to the survey. The following is a summary of HPSP's strategic planning process:

Step 1: Situational Analyses

- Program Committee
- Advisory Committee
- Executive Directors
- Program Staff
- Program Manager

Step 2: Create a Strategic Planning Team

- HPSP staff
- Administering Board ED
- Executive Director volunteers from small, medium and large sized boards: Ruth Grendahl (Board of Podiatric Medicine), Angelina Barnes (Board of Psychology), and Shirley Brekken (Board of Nursing)

Step 3: Review Situational Analyses

The strategic planning team met to review the situational analyses.

Step 4: Develop Strategic Goals Based on Situational Analyses

Based on the review of the situational analyses, the strategic planning group created the following strategies:

- Measure program effectiveness
- Best practices drive the program
- Develop/create governance that supports the mission
- Strengthen board and staff relationship and understanding of roles
- Develop, strengthen and maintain efficient processes
- Support staff well-being and professional growth

Step 5: Create Work Groups to Address Each Strategic Goal

Steps one through five were facilitated by MAD. HPSP staff volunteered to lead each strategic goal. Initial meetings to address each strategic goal were also facilitated by MAD. Work group members were chosen based on their knowledge of the program and specific areas of expertise needed to address the strategic goal. HPSP staff are in the process of addressing the strategic goals and their progress is outlined on the following pages. Since the strategic planning process started, HPSP provided updates to the Program Committee on the strategic planning process in Mid-Year and Annual reports, as well as in more thorough written updates in May and August 2015 and again in February 2016. This is the fourth report on HPSP's strategic planning progress.

Strategic Goal 1: Measure Program Effectiveness

Leader: Mary Olympia, HPSP Case Manager

Team/Work Group: Barbara Damchik-Dykes, Board of Nursing and HPSP staff. Barbara Deming (MAD) facilitated initial meetings.

1A. Early Intervention

HPSP is informed immediately about problem behaviors by worksite monitors and illness exacerbations/relapses from treatment providers.

Background: Some worksite monitors feel they have to consult with human resources prior to calling HPSP to report concerns about participant behavior. This delays intervention by HPSP. Some treatment providers do not think to contact HPSP about illness exacerbations of their clients. Additionally, both may be reluctant to contact HPSP because they may consider the response of HPSP as punitive. Worksite monitors and treatment providers could benefit from additional education about HPSP services and how we respond to symptom exacerbations.

Baseline: We identified how HPSP learned about substance use disorder relapses between July 1, 2014 through July 30, 2015. We used a database query that identified positive screens and/or relapses within a specified time period. We excluded the following positive screens from the query: Those that were positive due to a prescription; EtG (metabolite of ethyl alcohol) screens that were positive with bacteria; EtG positive but below 500, or EtS (metabolite of ethyl alcohol) that were positive but below 250. We included the following positive screen types: EtG screens that were greater than 500, or positive EtS screens that were greater than 250. All positives for illicit substances were considered relapses, except in the case of morphine where a medical review officer opinion attributed the positive to poppy seeds. If there was a second positive/relapse within seven days of each other, it was considered one relapse.

The results were as follows:

- We learned about relapses from positive screens in 57 cases
- We learned about relapses from the participants in 16 cases
- We learned about relapses from the treatment providers in two (2) cases
- We learned about relapses from the worksite monitor in one (1) case

Analysis: We do not have data as to how many treatment providers and worksite monitors were aware of the relapses in the 57 cases of positive screens. The data do show, however, that the most frequent way of learning about relapses is via toxicology screening. Nonetheless, it would be more productive from an illness management/public safety standpoint to learn about relapses from the participant and the treatment provider. It can be assumed that if the worksite monitor knows about the relapse, it is more likely related to work behavior which would indicate the illness has progressed. Even so, these would be the most important relapses to learn about from a public safety point of view.

Implementing change: Recommend treatment providers and work site monitors view HPSP's *Overview* video, which will help them better understand the program. Case managers contact every work site monitor to review how they and HPSP can work together.

1. The letter to the worksite monitor was revised in February 2016 to encourage reporting of concerns and to encourage viewing of the newly-developed program overview video on the HPSP website.
2. The letter to the treatment provider has not yet been revised. Once revised, the letter will encourage reporting and viewing of the newly-developed program overview video.

Measure effectiveness: The data will be gathered again in 2017 and analyzed for any improvement as a result of these recommendations in the letters.

1B. Participants understand their monitoring conditions

Background: Some participants report that their non-compliance with monitoring conditions or toxicology screening is because they did not understand HPSP instructions.

Baseline: We developed a survey of 10 multiple-choice questions about some of the baseline monitoring conditions to determine if participants understand those conditions in their monitoring plans. We excluded current participants who do not have toxicology screening as a condition in their monitoring plans. We interviewed participants who signed their Participation Agreements between January 1, 2015 and June 30, 2015. The number of eligible participants was seventy-nine (79). Fifty-eight (58) chose to engage in the survey. The survey was conducted via telephone between February 9, 2016 and April 12, 2016. The survey questions and results are as follows:

- Question 1. At what time does the toxicology phone-line stop announcing the colors of the day? (The choices were: 4 PM, 5 PM, 6 PM, or 7 PM. The correct answer is 4 PM.)
Correct: 47 - 81% Incorrect: 11 - 19%
- Question 2. By what time do urine samples need to be collected? (The choices were 4 PM, 5 PM, 6 PM, or 7 PM. The correct answer is 6 PM.)
Correct: 52 - 90% Incorrect: 6 - 10%
- Question 3. If you forget to call the toxicology phone-line by 4 PM, what should you do? (The choices were: Nothing, Give a specimen the next day, Notify HPSP, or both give a specimen that day and notify HPSP. The correct answer is giving a specimen that day and notify HPSP.)
Correct: 56 - 97% Incorrect: 2 - 3%
- Question 4. Which of the following are not acceptable as a urine screen collector? (The choices were: Coworker, Your clinic, A family member who is a health professional. The correct answers were coworker and family member.)
Correct: 38 - 66% Incorrect: 20 - 34%
- Question 5. If you are planning a trip, how many days in advance at a minimum you need to ask HPSP to be excused from screening? (The choices were: One day, Three days, or Five days. The answer was three days.)
Correct: 26 - 45% Incorrect: 32 - 55%
- Question 6. If you are prescribed a new controlled substance, how soon you have to inform HPSP of your prescription? (The choices were: One day, Three days, Five days, or It can wait until your quarterly report. The answer is one day.)
Correct: 47 - 81% Incorrect: 11 - 19%
- Question 7. If you are prescribed a new controlled substance, how soon does HPSP need a copy of your prescription? (The choices were: One day, Three days, Five days, or It can wait until your quarterly report. The correct answer is within three business days.)
Correct: 31 - 53% Incorrect: 27 - 46%
- Question 8. If you have a new job or change your position, how soon do you need to tell HPSP? (The choices were: Before you start, The day you start, or Within two weeks after the start. The correct answer is before you start.)
Correct: 53 - 91% Incorrect: 5 - 9%
- Question 9. If you have an emergency room visit or are hospitalized, how soon do you need to tell HPSP? (The choices were Within one day of admission, Within three days of admission, or Within five days after discharge. The correct answer is within three days of admission.)
Correct: 41 - 71% Incorrect: 17 - 29%
- Question 10. If you ingest alcohol or other drug of abuse for any reason or circumstance, how soon are you required to tell HPSP? (The choices were: Within one day, Within three days, Within five days, or You can wait until after you see your counselor. The correct answer is within one day.)
Correct: 56 - 97% Incorrect: 2 - 3%

Summary, Analysis:

- a) At 97% correct, Participants were most correct on what is arguably the most important question in the survey -- how soon they are required to inform HPSP after using alcohol or drugs.
- b) Participants were also equally correct (97%) about what to do if they forgot to call the toxicology line.
- c) Participants were least correct (55%) about knowing how many days' advance notice to request toxicology screening clearance.
- d) Nearly one-half of the participants (46%) did not know the deadline for submitting a copy of the controlled substance prescription.

- e) Nearly one-third (29%) did not know the deadline for informing the case manager of an emergency room visit or hospitalization.
- f) One-third (34%) were incorrect as to naming acceptable urine screen collectors.
- g) Nearly one-fifth (19%) were incorrect as to the time the toxicology phone line stops announcing and the question as to how soon HPSP must be informed of the new controlled substance prescription.
- h) One-tenth (10% and 9% respectively) were incorrect regarding the deadline for collecting urine specimens and the question about when to inform HPSP about starting a new position.

Implement change:

Items a) and b) above will not be addressed for improvement due to the high rate of correct answers.

Items c), f), g), and h) are addressed in the Toxicology Video on the HPSP web site. Information about the Toxicology Video was recently added to the letter sent to participants about screening and a smart code was put on the toxicology instructions that links participants to the video. In addition, these identified informational deficiencies can be addressed via a brief announcement on the call-in toxicology phone line. In 2017, we will measure if there is improved understanding in these areas.

Items (d) and (e) are in regard to timeframes for submitting copies of controlled prescriptions and notifying HPSP about receiving medical attention in the ER or Urgent Care. Strategies for improving these time frames will be identified. Strategies that will be discussed include editing the monitoring plan for better understanding, using a table or a grid as an addendum to the monitoring plan, and one on one educational focus by case managers on these areas with new participants.

1C. More health professionals with potentially impairing illnesses who are eligible for HPSP services are reporting to the program or being reported to the program.

Background: Some professions are under-represented in HPSP (i.e. Boards of Pharmacy, Social Work, Marriage and Family Therapy, Emergency Medical Services, and Optometry).

Create baseline: The rate of utilization of HPSP by board ranges from zero to 4.98 per thousand licensees (FY 2016 data). In both fiscal years 2015 and 2016, seven boards had utilization rates below 1.50 participants per thousand licensees.

Implement change: HPSP will focus outreach efforts to the professional associations related to the health licensing boards noted above. Efforts may include providing presentations, submitting HPSP information to professional newsletters, and other forms of outreach. HPSP will engage the Advisory Committee in these efforts.

Measure effectiveness: Measure the rate of participation by board in fiscal year 2016 and identify if any gains have been made in the under-represented professions.

A comparison of the number of participants utilizing HPSP per one thousand licensed has not been effective, as the numbers participating per board are generally quite small. After talking

Strategic Goal 2: Best Practices Drive the Program

Leader: Monica Feider, HPSP Program Manager

Team/Work Group: Mary Olympia, Tracy Erfourth and Jeff Morgan, MD (Addiction Medicine Physician)

The work group focused on identifying best practices with regard to monitoring conditions for persons with substance use disorders, who represent 80% of HPSP participants.

The National Council of State Boards of Nursing's (NCSBN) book titled *Substance Use Disorders in Nursing* and the Federation of State Physician Health Programs' (FSPHP) *Monitoring Guidelines* outline monitoring protocols for health practitioners with substance use disorders. These documents were reviewed and compared by the work group. For the purposes of this report, the NCSBN book will be identified as *NCSBN* and the FSPHP guidelines will be referred to as *FSPHP*.

The NCSBN provides a much more detailed description of monitoring requirements than those outlined by the FSPSP. Even so, the NCSBN and the FSPHP monitoring requirements are fairly consistent with one another as well as HPSP practices. The following are uniformly required monitoring conditions for persons monitored for substance use disorders:

- Abstinence
- Immediately report any use of alcohol or mood altering substances to the monitoring program
- Meet with treatment providers and follow treatment recommendations
- Maintain authorizations between the program and participant providers, treatment programs and work site monitors
- Immediately notify the monitoring program of changes in employment, treatment providers, address, or phone number

Monitoring conditions for persons with substance use disorders differ slightly between the NCSBN, the FSPHP, and HPSP as described below:

Length of Monitoring	
NCSBN	Three to five years for persons with substance use disorders
FSPHP	Five years for persons with a diagnosis of substance dependence and one to two years for persons with a diagnosis of substance abuse
HPSP	Average length is three years for persons with substance dependence and two years for persons with substance abuse. The length may be increased based on a variety of factors (i.e. diversion, risk to patients by profession).
Random Toxicology Screening	
NCSBN	Requires a minimum of two to three per month for first year of monitoring and practice - frequency may be reduced after first year
FSPHP	Requires but does not specify frequency
HPSP	Requires nine screens per quarter (average is three per month) for the first two years – frequency may be reduced to six per quarter in third year of monitoring. Screen frequency may be reduced based on participant's ability to pay and work status. Screen frequency may be increased based on return to access of controlled substances, monitoring compliance and risk to patients.
Attend mutual support groups and provide documentation of attendance	
NCSBN	Requires three per week – documentation is required monthly
FSPHP	Requires but does not specify frequency – frequency of documentation is not indicated
HPSP	Requires a minimum of two per week unless otherwise specified by treatment provider – documentation is required quarterly
Work site monitor that oversees professional performance	
NCSBN	Requires monthly check-ins with supervisor and other conditions
FSPHP	Requires
HPSP	Requires – additional requirements for persons who diverted or who are in high risk professions
Not prescribe for self or family members	
NCSBN	No identified
FSPHP	Requires
HPSP	Requires

Where Monitoring Programs Differ

The greatest difference among monitoring programs appears to be: 1) how they are administered, 2) their relationships with health licensing boards, and 3) their reporting requirements. The administration of monitoring programs varies considerably. Some programs are administered by licensing boards while others are administered by professional associations, private companies, or other entities. Most programs not administered by boards have written agreements with boards detailing the services they provide and their reporting requirements. HPSP is a program of the Minnesota Health Licensing Boards, which is bound by Minn. Stat. 214.31-214.35. Many reporting requirements are outlined in HPSP's governing legislation. In addition, over the past twenty years, HPSP has developed monitoring plans and monitoring guidelines in concert with board staff. HPSP staff and board staff have quarterly meetings to review monitoring protocols and address questions or concerns.

Summary

The review of monitoring program best practices was based on a review of recommendations by the NCSBN and the FSPHP. We found that the HPSP's practices are relatively consistent with both organizations. We also found that reporting requirements are more program-specific than universal, which is likely due to program administration and governing legislation.

As we move forward, HPSP will keep abreast of new research and national norms related to monitoring health professionals and ensuring our practices are consistent with best practices.

Strategic Goal 3: Develop Governance that Supports the Program

Leader: Monica Feider, HPSP Program Manager

Work Group: Barbara Deming (MAD), Allen Rasmussen, (Chair of Program Committee); Stephen Gulbrandsen, Chair of Advisory Committee; Shirley Brekken, Executive Director Board of Nursing; Ruth Martinez, Executive Director, Board of Medical Practice; Jennifer Mohlenhoff, Executive Director, Board of Marriage and Family Therapy; Marshall Shragg, previously Board of Dentistry Executive Director and currently Board of Physical Therapy Executive Director (HPSP Administering Board, and Monica Feider, HPSP Program Manager

Barbara Deming from MAD facilitated four meetings with the work group to review the strengths and vulnerabilities of HPSP's current governance structure and to consider other possible governance structures. The work group identified the pros and cons of the current governance structure as well as those of several other possible governance structures. The work group created a proposed governance structure and reviewed it at the Executive Director's Forum in June 2015. Recommendations for improving the proposal were made. The work group met again and incorporated feedback from the Executive Director's Forum. The work group presented the revised proposal at the Executive Director's Forum in October 2015. The proposal was unanimously approved with the recommendation that it go to the Program Committee for consideration. [It should be noted that there was low attendance at the Executive Director's Forum in October. However, the Executive Directors had the proposal to review prior to the meeting and had the opportunity to voice concerns prior to the meeting.]

The work group brought the proposal to the Program Committee in November 2015. The Committee provided feedback, which was reviewed with the work group. A survey of Program Committee members was also developed and administered to provide greater feedback to the Program Manager and governance work group about the Program Committee and program governance. This was reviewed at the February 20146 Program Committee meeting.

The Program Committee recommended broadening the membership of the Governance Work Group to include two additional Program Committee members. Margaret Schreiner and Kathy Polhamus volunteered to participate. The first meeting with the expanded group was on June 9, 2016 and a second is scheduled for ~~July 27, 2016~~. Recommendations from the meetings will be reviewed with the Program Committee.

Aug 5 - 16

Strategic Goal 4: Strengthen Board and HPSP Staff Relationships and Understanding of Roles

Leader: Tracy Erfourth, Case Manager

Work Group: Mary Olympia, HPSP case manager; Monica Felder, HPSP program manager; Barbara Damchik-Dykes, Board of Nursing; and Elizabeth Huntley, Board of Medical Practice. Barbara Deming (MAD) facilitated initial meeting.

The February and May 2015 HPSP and Board staff meetings focused on HPSP and Board staff communications and processes. Also discussed were ways to ensure all boards know and understand the HPSP process. In cases of dual monitoring, HPSP staff will work with the health licensing boards to develop quarterly report forms that are mutually agreed upon to ensure each board is getting the information they need.

The August 2015 HPSP and Board staff meeting focused on reviewing HPSP's monitoring protocols. Monica Feider and Kimberly Zillmer met with staff from the Boards of Medical Practice and Nursing to review HPSP's monitoring protocols in more detail. The protocols appeared well understood and mutually agreeable. Tracy Erfourth facilitated another meeting with staff from the Boards of Nursing and Medical Practice to brainstorm additional ways to enhance communication. HPSP had an open house in February 2016 for Board staff.

Strategic Goal 5: Develop, Strengthen, and Maintain Efficient Processes

Leader: Marilyn Miller, HPSP Case Manager

Work Group: HPSP staff. Barbara Deming (MAD) facilitated initial meetings.

5A. Work flow enhancement through error reduction and efficient information management

HPSP staff has identified issues that contribute to internal work flow problems. Most of these issues are closely related to the need for error reduction. Based on the recent error tracking from the staff, we have discovered most of the obstacles to smooth work flow are related to data entry errors and omissions. A specific list of target errors was identified for both the case managers and the support staff. Management conducts audits on an ongoing basis and provides feedback to staff for continued improvement.

Due to budget limitations, we were unable to purchase LEAN services to formally analyze the efficiency of our inner agency work flow and efficiency. We did, however, consult with Board staff that accessed the LEAN services and learned of some basic changes to consider based on their experience. An HPSP work group is in the process of conducting an informal internal analysis of work flow and efficiency. The changes may affect the roles and responsibilities of our support staff.

We have also been maintaining an open dialogue with Board staff regarding improvements in work flow between our programs and have made an effort to incorporate new ideas. We maintain this as a consistent agenda item in our quarterly meetings with Board staff.

5B. Database enhancement

Database Fixes

The HPSP team has been contributing to a list of data base fixes over the last year. To date, a total of 32 items for improvement have been identified most of which have been reviewed with the database programmer. We are hopeful that these fixes will be completed by October 2016. We continue to maintain a "Database Item Fix List" that staff contributes to on an ongoing basis.

Electronic Intake

We reviewed intake information collected by other state programs. A work group created a draft of a new electronic intake form. After consulting with the data base developer and examining our budget, we are unable to move forward on this goal during this funding cycle. Because we cannot realize our goal of providing a new efficient and comprehensive electronic intake form that connects well with our existing database, the software developer will focus on making minor changes to our existing electronic intake form allowing critical information to connect to the database which is needed for reports.

Monitoring Documents Update

Minor data base fixes have been accomplished with current letters which has saved time and improved work flow efficiency. We have formed a work group that are systematically refreshing letters, forms, Participation Agreements/Monitoring Plans and other important documents to eliminate multiple corrections/customizations by case managers. These updates will result in greater efficiencies.

5C. Optimization of technology

Videos

We successfully launched a Program Overview video and a Toxicology Overview video on our website in July, 2015. We have received very positive feedback from the licensing Boards, participants, treatment providers, worksite monitors and other stakeholders. We continue to incorporate the Program Overview video in our annual presentations to the Boards and in the Community.

Though both of these videos are basic overviews, we hope to build more specific video tutorials for the many aspects of monitoring over time, as our budget allows.

Voice recognition and keyboard short cuts

We purchased and received the dictation software which has been used by two case managers over the last few months. These case managers report that it is easier to provide more detail in case notes, write customized letters and reduces spelling errors. Our office manager is in the process of researching software to program F keys on our computer keyboards which will save considerable time when typing standard repetitive sentences, comments and paragraphs.

Clarifying Roles and Responsibilities:

This objective ties into work flow enhancement and error reduction objective. As we move forward, we will take into consideration individual's strengths and skills when looking at the most efficient way to process information within our agency. Through our error reduction efforts and open dialogue, we have gained awareness and sensitivity to each other's duties and how they are interdependent and necessary for program effectiveness and success.

When coordinating with other state programs we continue to take opportunities to ask about their structure and staff roles and responsibilities to learn how they best utilize staff and will apply ideas that may help us identify possible improvements for our agency.

Strategic Goal 6: Promote Staff Well-being and Professional Growth

Leader: Kurt Roberts, HPSP Case Manager

Team/Work Group: HPSP staff Bruce Benson and Elizabeth Huntley participated in this. Barb Demming facilitated initial meeting.

A 12 question employee engagement survey was conducted through the Gallup website in April 2015 with all seven HPSP staff members participating. The results were presented and discussed during a series of staff meetings in May and June facilitated by Barbara Deming (MAD). Due to staff LOA's and vacations, follow-up meetings were postponed through the remainder of the year. A final meeting took place in January 2016 that identified priorities and the following actions were agreed on:

- Weekly staff meetings will start by reading aloud one of the statements from “Commitment to Co-Workers”
- Changes in program policies and monitoring guidelines will be posted and reviewed by HPSP staff for at least three months
- Bi-monthly staff training sessions on clinical issues will be conducted by Dr. Sheila Specker, medical consultant.
- A staff potluck lunch will be held at least quarterly
- Spontaneous personal comments of gratitude and recognition will be encouraged among HPSP staff

These activities will be evaluated in January 2017 to see if they should be continued, adjusted or eliminated, and if any new ideas should be considered.

Strategic Goal 7: Enhance Program Outreach

Leader: Kimberly Zillmer, HPSP Case Manager

Team/Work Group: Monica Feider, Mary Olympia, Marilyn Miller with input from Advisory Committee and Board Staff. Barbara Deming facilitated initial meeting.

An outreach tracking document was developed that enables the program to track the number of outreach activities performed, who we are meeting with, and how many people are reached in each presentation. This will create a baseline to prompt additional goals.

Outreach

- Minnesota Hospital Association (MHA)
 - Met with the MHA in an effort to create more awareness of HPSP services and assistance in establishing additional outreach/educational opportunities within the healthcare community
 - Staff presented at the MHA Workforce Development Committee
 - Currently working on developing articles to be included in the MHA weekly newsletter, “Newline.”
- Additional community presentations provided to:
 - Association of Operating Room Nurses
 - Hazelden Health Professionals Treatment Program staff and Fellowship Club staff
 - Minneapolis School of Anesthesiology
 - Minnesota Home Care Association
 - Minnesota Association of Nutrition and Dietetics
 - Fairview Mental Health
 - HealthEast Human Resources and Employee Health Services
 - National Association of Social Workers – Minnesota Chapter
 - University of Minnesota, Schools of Dentistry and Pharmacy
 - University of St. Thomas, School of Social Work
- Next steps include:
 - Continue to develop additional outreach/educational opportunities
 - Request Advisory Committee members share information about HPSP with their associations
 - Seek opportunities to present at or have materials provided at association state conferences

Moving Forward

The HPSP staff will be meeting in August to review the status of the strategic goals described above. Decisions will be made about how and whether to proceed on specific goals. We will also identify new goals that will improve program services.

DATE: September 10, 2016

SUBJECT: Executive Director's Report

SUBMITTED BY: Ruth M. Martinez, M.A., Executive Director

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For information only.

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

BACKGROUND:

Attached is the Executive Director's Report of activities since the last board meeting.

EXECUTIVE DIRECTOR'S REPORT

September 10, 2016

External Stakeholder Groups/Outreach

The Board continues to participate in the following external work groups:

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

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

Plans are underway to exhibit at the MN Medical Association Annual Meeting on September 22-23, 2016.

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

Implementation of 2016 Legislation

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

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

MN Department of Health X-ray Unit Listening Session

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

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

Interstate Medical Licensure Compact (IMLC) Commission Meeting

On August 24, 2016, the IMLC Commission held its fifth meeting, by conference call. IMLC committees continue work toward a target date of January 2017 for issuance of licenses. The Bylaws and Rules Committee has drafted a proposed Licensing Rule, which has undergone a comment period and which will be presented for Commission approval at its next meeting on October 3, 2016 in Kansas City, Kansas. Minnesota continues to work with the Council of State Governments, MN Criminal Background Checks Program, National Crime Prevention and Privacy Compact Council, and the IMLC Executive Committee to address an FBI determination (in three states, including Minnesota) that the IMLC statutory language for criminal background checks does not comply with federal requirements for receipt of FBI data.

National Governors' Association (NGA) Health Care Workforce Technical Assistance Program

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

Prison Tours

On August 3 and 24, 2016, the MN Department of Corrections (DOC) conducted tours of the Stillwater and Oak Park Heights prisons for Board members, medical coordinators, and staff. 14 people participated in the tours. Attendees were very impressed with the DOC healthcare system.

Other Activities

- Administrators in Medicine (AIM) will hold its Executive Directors Workshop and Certified Member Board Executive training in Minneapolis in October 2016. Board staff facilitated the planning committee in securing presenters, including Chief Administrative Law Judge Tammy Pust, former Board member Sarah Evenson, and MN Alliance for Patient Safety Executive Director Marie Dotseth.
- Budget planning for the next biennium is underway, as is preparation of the current Biennial Report, which will be presented at the November Board meeting.
- The Board continues to seek applicants for an at large physician member seat and a public member seat.
- The Policy & Planning Committee established a set schedule for meetings for the remainder of the calendar year. Meetings will begin at 4:30 p.m. in the Board conference room on the following dates:
 - August 10, 2016
 - October 12, 2016
 - December 7, 2016



100 Influential Minnesota Health Care Leaders

In preparing this feature, we asked each of the nominated health care leaders to answer two questions:

- 1 **What are the biggest changes your organization has made in the past four years?**
- 2 **What are the biggest challenges these changes will face in the next four years?**

We invite you to read their responses.



Hamid R. Abbasi
MD, PhD, FACS, FAANS
Partner/Surgeon
Tristate Brain and Spine Institute

Changes: Over the last four years, we established ourselves as a world leader in minimally invasive spine surgery. We fine-tuned and made Oblique Lateral Lumbar Interbody Fusion (OLLIF) a routine procedure. Spine surgery that once took four hours to complete is now done in only 40 minutes with tremendous success and benefits to our patients.

Challenges: Our biggest challenges are related to bringing the OLLIF procedure and related technology to more patients. Currently, additional surgeons are needed to perform this cutting-edge procedure. We've had national and international surgeons come to our facilities so we can train them. We have also published in peer-reviewed journals to highlight the superiority of OLLIF.



Sue Abderholden
MPH
Executive Director
NAMI Minnesota

Changes: We have been working hard to increase the mental health literacy of families; people who work in health care or with youth and older adults; employers; and first responders. We have also greatly increased our work on suicide prevention and safe messaging.

Challenges: Our mental health system isn't broken—it has never been built. Increased awareness has led to more people seeking treatment and the realization that we are not meeting their needs. How we build on what we know works in the community, while at the same time ensuring access to acute care, is our biggest challenge.



Craig Acomb
Interim President and CEO
Institute for Clinical
Systems Improvement

Changes: We have continued to pursue our collaborative focus on the Triple Aim goals of better care, smarter spending, and healthier people. Our accomplishments include leadership on integrating behavioral health into primary care, award-winning work to reduce avoidable hospital readmissions, and pioneering efforts to help medical groups forge partnerships with their communities to accelerate improvements in health.

Challenges: We know that health care will continue to evolve rapidly, and the need for a coordinated community approach to robust measurement, clinical care innovation, aligned payment models, and consumer engagement will be critical to achieving our collective goal of better value for our investments in health.



Brian Amdahl
MD, MMM
VP and Executive Medical Director
Post-Acute Care, Medical Specialties
HealthEast

Changes: We have transitioned from siloed care delivery areas to a systematized care continuum approach, integrating acute hospitals, clinics, post-acute care programs, and community services into a single care delivery business unit. Unified operational and medical director oversight, as well as shared clinical care pathways and personnel, has improved patient safety and overall experience during care transitions. Streamlined electronic medical records support seamless delivery of critical medical data. These changes align with customers' expectations for fully integrated care.

Challenges: We need to be aware of our customers' continually evolving expectations, and be nimble enough to quickly change processes to deliver care when, where, and how it is desired.



Tom Arneson
MD, MPH
Research Manager
Office of Medical Cannabis
Minnesota Department of Health

Changes: The 2014 law that established the Minnesota Medical Cannabis Program tasked the MDH with running it and set a tight timeframe to make it operational. Having key aspects of the program differ from most other states' medical cannabis programs added to the challenge—and opportunity (laboratory-tested extraction products with specified cannabinoid content; participant experience).

Challenges: Cost has emerged as a major issue, because the medical cannabis products available through the program are quite expensive and not covered by insurance. A rapid, feasible solution to this issue is not in sight. There is widespread lack of awareness among clinicians on what is known about the endocannabinoid system and research into therapeutic potential of plant-based cannabinoids and synthetic modulators of the ECS.



Ruby Azurdia-Lee
President
CLUES

Changes: We promote integrative approaches to access health care and stimulate community well-being. Latinos in Minnesota continue to experience increased barriers and a lack of culturally and linguistically appropriate treatment. We focus on a model of service that advances two generations forward and out of poverty. Our services work with families in a holistic way, and we emphasize prevention and behavioral change.

Challenges: The explosive growth of Latinos in Minnesota will necessitate our innovation and cultural and bilingual responsiveness in the provision of health and wellness services. Most Latino families today have mixed immigration status, and some face barriers to accessing health care. The stresses of acculturation can impact health outcomes and the healthy functioning of the family, which we want to strengthen.



Susan A. Berry
MD
Immediate Past President
Minnesota Chapter of the
American Academy of Pediatrics

Changes: We worked to increase the number of active member advocates and enhance engagement with other primary providers who care for children. In collaboration with others, we were successful in changing newborn screening in Minnesota. This restored the ability of the Minnesota Department of Health to maintain records of the life-saving early screening assessment, which is an essential public health measure.

Challenges: As advocates for children, our group needs to remain vigilant, focused, and committed. Positive change happens with attention and preparation.



Joseph Bianco
MD, FAAFP
Chief of Primary Care
Essentia Health

Changes: Our movement from volume-based to value-based reimbursement has led us to completely transform our practice. By continuing to strive to meet the goals of the Triple Aim, the changes to all aspects of our care delivery are profound.

Challenges: Working to promote the health and well-being of not only our patients, but our workforce will be a great challenge in the midst of rising prevalence of chronic disease. We will need to partner with our communities to address health behaviors and the social determinants that lead to disease. The challenge will be to create the partnerships that will lead to positive outcomes.



Hanna E. Bloomfield
MD, MPH
Associate Chief of Staff for Research
Minneapolis VA Medical Center

Changes: The biggest changes we have made are to prioritize the growth of clinical and health services research, strengthen research infrastructure (e.g., personnel, equipment, data management systems), and remodel space to better meet the needs of clinical and basic science researchers.

Challenges: The biggest challenge for the Minneapolis VA Research enterprise is to recruit a new generation of well-trained investigators who are passionate about conducting well-designed research projects that address the major health care problems affecting veterans, including post-traumatic stress disorder, obesity, cardiovascular and metabolic disorders, and diseases of the aging brain.



Bob Bonar
MA, MS, DrHA
CEO
Children's Minnesota

Changes: We've developed laser focus on producing top outcomes for the children and families that we serve, across our hospitals, specialty clinics, primary and virtual care settings. There's an art and science to pediatrics and I'm very proud of what our team has accomplished.

Challenges: What Children's offers this community is unique. We know that kids do best in a health environment that's dedicated solely to kids. As the industry continues to transform, we must be courageous, innovative, and selfless in partnering with others to protect this asset and to ensure better health for our kids.



Mary Brainerd
President and CEO
HealthPartners

Changes: We've expanded care options, in person and virtually, where we've provided over 200,000 treatments, and over 20 worksite clinics, including virtuwell.com, our online medical clinic. We've created more affordable options using measurement tools like Total Cost of Care. We're serving more people: twice as many patients and 38 percent more members than five years ago.

Challenges: Care will come to patients—at work, at home, or on their phones—and fundamentally change how we relate to them. Our efforts to tackle mental health stigma, health care disparities, early childhood development, opioid addiction, obesity, and chronic disease will create healthier communities. We'll remain focused on affordability, measuring cost, and quality to improve results!



Matt Brandt
CEO
PrimaCare Direct

Changes: PrimaCare Direct has expanded to include 13 practices with 20 clinic sites. By expanding the network of clinics, we are now able to offer employers primary care services for a low monthly membership fee to all their employees across the Twin-Cities.

Challenges: The current economics of health care make it tough to change. Premiums continue to rise placing a burden on employers, governments, and patients, however the flip side is that more money is flowing into the health care system. Innovative models that try to disrupt these burdens meet a lot of resistance from the current health care players. I see this battle daily.



Shirley A. Brekken
MS, RN
Executive Director
Minnesota Board of Nursing

Changes: We've focused more on changes in the environment rather than on internal organization. Technology, economics, the ACA, millennials entering the field, and greater utilization of nurses in primary care are causing a historic transformation of health care. Increased scrutiny of the effectiveness and efficiency of regulatory models demands increased transparency and accountability.

Challenges: We must implement regulatory solutions with increased relevance and responsiveness to the changes in health care, the transformation of education, and emergent trends in workforce and population health. Greater mobility, response to emergencies, and communication with patients across state borders call for a new licensure model that supports interstate practice. Regulation must be innovative and pragmatic.



Sally T. Buck
MS
CEO
National Rural Health Resource Center

Changes: The Center has been collaborating and innovating to improve rural health for over 20 years. Our services have expanded beyond rural clinics and hospitals to health networks and communities. We continue to develop and disseminate knowledge of the new models for rural providers and identify strategies to bridge the gap between the current structure and the emerging environment.

Challenges: The Center has witnessed a growing number of challenges facing rural providers. They are striving to maintain local health care resources including workforce, technology, and capital, while preventing the out-migration of patients and adapting to value-based purchasing from being reliant on quality, population health, and patient satisfaction.



Christopher Cassirer
ScD, MPH
President and CEO
Northwestern Health Sciences University

Changes: We are committed to optimizing patient, family, and community health through nutrition, early diagnosis, and treatment. We work in partnership with conventional health and medical providers to start with conservative, natural approaches to care before considering more aggressive treatments like drugs and surgery.

Challenges: Our challenge is to prepare our graduates for a rapidly evolving health care system and educate communities that the best approach to health is to prevent disease. The best primary care option isn't to take a pill, but to first try natural care solutions like chiropractic, acupuncture, therapeutic massage, getting more rest, or improving nutrition. We want to be culturally aware that the communities we serve are diverse and may have different health traditions.



Steven Connelly
MD
President
Park Nicollet Health Services and HealthPartners Institute

Changes: The combination of HealthPartners and Park Nicollet in 2013 is certainly the biggest change. The cultures of the two organizations were extremely similar before the combination, as they both centered on the Triple Aim. This allowed us to concentrate on and accelerate our efforts around health outcomes and affordability.

Challenges: Addressing patients' needs in an ever-changing environment is a growing challenge. We must offer options—from traditional office visits to telemedicine, to virtual and online care. Also, we need to continually improve the current EMR functionality to contribute to a more efficient and fulfilling clinical practice. We must address this to succeed in providing access.

WANTED: DOCTORS

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Kathryn Correia
MHA
President and CEO
HealthEast

Changes: Implementing lean and aligning leadership to reach our strategic objectives were some of the biggest changes we've undergone over the past four years. We made those changes while rolling out our new electronic health record—so, these were courageous decisions to be sure. With a clear focus on best serving our patients, physicians, employees, and community, these were the right decisions.

Challenges: Our biggest challenge will be to continue to reduce the burden of medical care as we work in partnership with our patients and our communities to improve health and well-being.



Kent Crossley
MD, MHA
Chief of Staff
Minneapolis VA Healthcare System

Changes: The Minneapolis VA has expanded available specialty services, increased its number of community clinics, grown its education and research activities, and worked to be more patient-centric. We offer same-day access in primary care and mental health, have developed a comprehensive integrative health program, and offer online services and provider access. Our tele-health and tele-ICU programs are state of the art.

Challenges: The VA is the largest provider of health care in the U.S. and part of a complex system. Decision-making may be a challenging process. Our leadership may change with the presidential election and this could lead to modification of our current priorities.



J. Kevin Croston
MD
CEO
North Memorial Health Care

Changes: We transitioned from being a hospital that owns clinics to that of a value-based health care delivery system. We improved health care access and services in the ambulatory setting and introduced online care and retail clinics. We also placed our customers squarely in the center of our decision-making so our work is entirely mission-driven.

Challenges: Value-based reimbursement requires collaboration between customers, providers, and payers, but the insurance industry is reluctant to compensate smaller systems equitably. While our small size lets us make necessary changes faster, we aren't currently rewarded for these efforts by payers. Larger systems are paid more because of market share dynamics that reward patient access over outcomes. To offset this inequity, we need to empower our customers to achieve their best health.



John Dahm
President and CEO
Accra

Changes: Our biggest changes were driven by rapid growth while experiencing unprecedented change in our industry. We created efficiencies within our systems and added staff to ensure that we meet and exceed the needs of our participants and our mission. Our focus also included participating in stakeholder groups, and working with other organizations and thought leaders to influence change.

Challenges: The greatest challenge will be the changing demographics that will result in the demand for more people needing services and a reduced workforce to meet their needs. Our focus will be to manage this continued growth and the rapidly changing regulatory environment, while continuing to help families and older adults find what services are available to meet their needs.

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Bobbi Daniels
MD
CEO
University of Minnesota Physicians

Changes: We established an enhanced collaboration with Fairview called University of Minnesota Health, which paved the way for our Clinics and Surgery Center, enhanced financial support for the medical school, and greater integration of UMP and UMMC. We developed a new ambulatory care model coupled with a different architectural design and expanded hours to enhance the patient experience and our ability to do clinical research and education.

Challenges: We will need to continue to innovate in all parts of our commitment to academic medicine and work with partners who share that goal. Patient care needs to become even more patient focused, evidence based, and efficient and that goal takes on additional importance as we educate the next generation of health care professionals.



Mark Dayton
Governor of Minnesota

Changes: Minnesota has been a national leader in health care reform. Our uninsured rate has been cut in half, and is now the second lowest in the nation. We have implemented reforms to improve health and lower costs in our public health care programs, including a competitive bidding process for managed care contracts. Integrated Health Partnerships in Minnesota's Medicaid program have saved \$150 million, while providing better care to low-income Minnesotans.

Challenges: Big challenges remain, such as an aging population, persistent health inequities among Minnesotans, and better access to mental health and dental care, especially in Greater Minnesota. It will take all of us working together to meet these challenges, while keeping health care affordable for Minnesotans who need it.



Rhonda Degelau
JD
Executive Director
Minnesota Association
of Community Health Centers

Changes: We've focused heavily on preparing member clinics to participate in accountable care models, such as the Medicaid Integrated Health Partnerships, and to prepare for a value-based payment world. We've also stepped up our advocacy work on emerging payment reforms at the national and state levels, to ensure that new payment models work for safety net clinics.

Challenges: Current marketplace and legal barriers to Health Information Exchange will limit successful participation in accountable care models. Our member clinics also face financial resource barriers to securing the data analytics capacity needed to succeed under new models. We must ensure that payment reform works for the safety net by recognizing the impact of social determinants of health on health outcomes.



Edward Ehlinger
MD, MSPH
Commissioner
Minnesota Department of Health

Changes: To address health equity, we created the Triple Aim of Health Equity, which provides the framework for the transformation of public health practice. These aims include using a health in all policies approach, with health equity as the goal; expanding our understanding of what creates health; and strengthening communities to create their own healthy futures.

Challenges: The dominant public narrative is that health is created by access to high quality health care and good personal choices. The biggest challenge is for people to understand that health is mostly due to the physical, social, and economic environments in which they live, and that to improve health in a socially responsible way, we need to invest in community-wide public health efforts.

WANTED: DOCTORS

WHO VALUE ACCOUNTABILITY TO PATIENTS' HEALTH, and all it

takes to achieve it, over fitting into uniform algorithms designed more to ensure profitability to others for whom the priority isn't always patient health. We're a healthy, independent physician owned practice offering patient centered, physician directed primary and specialty care in three modern clinics. And we're always looking for independent minded, energetic talent to join us. To arrange an interview at your convenience, please call **Matt Brandt: 763-785-7710.**

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James W. Eppel
President and CEO
UCare

Changes: This has been a period of great change in health care and at UCare. We have entered the individual commercial market on MNsure, introduced value-based relationships and "private-labeled" products with our delivery system partners, and experienced significant growth, followed by significant contraction.

Challenges: The exchange market remains immature and volatile; we all have to work together to find solutions. Despite the high level of collaboration today, we have significant work to do to reduce health care costs. The entire health care system will need to focus on viewing our world through the patient's eyes, recreating the system accordingly.



Al Franken
U.S. Senate

Changes: Because of the ACA, we've seen the rate of uninsured Americans fall below 10 percent nationally, and under 5 percent in Minnesota. Because of the provision 1 wrote in the ACA, known as the Medical Loss Ratio, insurance companies are now required to spend more on health care and less on administrative costs, saving consumers billions of dollars.

Challenges: We need to focus on delivery system reform. I think Minnesota is a great model for the rest of the country. For example, in the ACA, I helped establish the National Diabetes Prevention Program, based in part on work done in Minnesota. So far, the results have been clear: not only does this program make people healthier, it also saves taxpayers a significant amount of money.



Kevin Garrett
MD, FCCP, FAASM, CPE
Senior VP, Chief Medical Officer
HealthEast

Changes: A redesign of our care delivery system included the creation of dynamic, dyadic relationships between operations leaders and our physician leaders. This has allowed us to keep everyone moving in the same direction, led by the same strategy. We have also continued our efforts to deepen our culture of continuous improvement.

Challenges: Staying aligned with the right work to better respond to evolving community needs; providing capacity for physicians to find a pathway to personal and professional success; and continuing to move in a strategic, unified direction.



Julie Gerndt
MD
Chief Medical Officer
Mankato Clinic, Ltd.

Changes: We have focused on relationships with our community and with one another. Full engagement of providers in leading change and cascading goals and incentives down to front line staff has been key in producing the best health care outcomes for our patients. We are fully transparent about outcomes and the use of care-related data to improve our work.

Challenges: Our ongoing success will hinge on keeping pace with changes in payment and providing access for patients in the face of a physician shortage. We will address provider burnout by further developing our care teams, expanding our use of technology, and developing purposeful leadership.

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President
Minnesota Oncology

Changes: We continue to grow with many new physicians and expanded utilization of advanced practice providers to integrate a broader range of patient services including palliative care, genetic assessment, survivorship care, and end-of-life counseling in addition to our core services. Outcomes measurement and reporting have driven improved internal efficiency, enhanced value delivery, and high patient satisfaction.

Challenges: The cost of breakthrough therapies for our cancer patients has reached unsustainable levels. Preauthorization and payment approvals have frequently resulted in delays of potentially life-saving treatment. The complexities of precision medicine, expanded diagnostic testing, and complicated new therapies requires greater time and attention by providers in an environment in which many of these cognitive services are unreimbursed or under-reimbursed.



H. Theodore (Ted) Grindal
JD
Partner
Lockridge Grindal Nauen, PLLP

Changes: The biggest changes for my clients have been complying with the ACA and reacting to the continued consolidation in the health care delivery system in Minnesota. Also, there seems to be no reason to believe that continued integration in the health care provider market will not continue to leave us with even fewer large delivery systems.

Challenges: Managing costs and quality will only continue to be more challenging. Purchasers are demanding both and all the large health care delivery systems are embracing these priorities. The pressure on providing lower costs and higher quality will be supported by more and more data analytics. The ability to access and manage this data will continue to impact every level of the delivery systems.



Julia U. Halberg
MD, MS, MPH
Chief Wellness Officer,
VP Global Health
General Mills

Changes: Transitioning from a company-owned, prevention-based, onsite clinic with specialties (dental screens, cardiology, optometry, PT) to a Wellness Center. While our onsite clinic was outsourced, we've added integrative services (acupuncture, nutrition, aromatherapy) and also designed Zenergy rooms where employees can re-energize in zero-gravity chairs, use brain-fitness technologies such as MUSE, or nap.

Challenges: Evolving an ongoing innovative, holistic (mind, body, community) approach to the well-being of our employees; identifying technologies and programing that engage our employees to be active, make healthy nutrition choices that incorporate our Brands (Cheerios, Annie's, Yoplait, Nature Valley); and connect with the community by volunteering—making their time at work the healthiest and safest time of their day.



Peter J. Henry
MD
Chief Medical Officer
Essentia Health—Brainerd

Changes: To ensure access for patients in rural communities, we've expanded our clinical team to include advanced practice clinicians. As our teams have grown, standardizing our workflow in primary and specialty care has improved the quality of care all patients receive. We are becoming a truly integrated health system, where the community and patients are seen as "ours" to care for.

Challenges: Although the quality of life and teamwork are strong differentiators, it's a challenge to attract candidates who want to care for patients in rural communities. Continuing to evolve and improve patient care makes all health systems better and benefits our communities. As health care moves to a value payment model, aligning compensation to this change will pose new challenges.

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John R. Hering
MD
Chief Medical Officer
CentraCare Health—Monticello

Changes: In 2013, our Critical Access Hospital transitioned from an independent organization run by a hospital district to a regional affiliate of CentraCare Health. Our patients and community have benefited tremendously from the additional resources and support that come from being a member of a large health system.

Challenges: The biggest challenge we face is our intensely competitive market; multiple health systems converge in our area. It is vital for us to work collaboratively with our local physician partners, most of who are in independent practices, to ensure that we deliver the quality and value of care our community deserves.



David C. Herman
MD
CEO
Essentia Health

Changes: We have made the commitment and built new systems to support the move from volume to value. The design of our Primary Care team model, along with the great support our care teams provide our patients, have dramatically improved our ambulatory care quality measures. We are working to sustain the resilience of our staff as well.

Challenges: Health care in a community accounts for just 10 percent of residents' health status, while socioeconomic factors, behaviors, and the environment contribute to 80 percent of overall health. Our challenge is building strong partnerships within the communities we serve to address those factors to keep our communities healthy, while continuing to build the systems of care needed when people become ill.



Patrick Herson
MD
President
Fairview Medical Group

Changes: As a multispecialty group that is only seven years old, we have embraced being integrated and interdependent. This has meant having challenging conversations about where to invest in new programs and areas of growth, and how to have one set of clinical and financial standards across an almost 600 provider group. We have also begun to do the necessary work to succeed in a value-based model.

Challenges: We want to perform well across a balanced scorecard of measures including clinical quality, patient experience, provider and staff engagement, and financial excellence. It is relatively easy to perform well on one or two—it is much more challenging to perform across all of them in a balanced fashion.



Ken Holmen
MD
President and CEO
CentraCare Health

Changes: We recognize that our employees and physicians ultimately make the difference in how well we serve our patients and the community. Based on a culture change transformation, we migrated our organizational structure so executives and physicians share responsibility for leading all clinical service areas. Then we realigned our governance structure to ensure optimal oversight of our strategic initiatives.

Challenges: Whenever organizations attempt deep and systemic change, they risk having insufficient employee engagement to sustain the work. Understanding this, we have processes that regularly re-energize and support our team. We plan to develop change management tools that employees will need to ensure success under the new structure. This is essential to recruit and retain excellent people in a competitive labor market.

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Dan Holub
JD

Executive Director
Minnesota Association
of Professional Employees

Changes: Our newer members are looking for a greater sense of connection to their workplace and union. As a result, we are more relational in the way we approach our work. We led efforts to establish better parental leave for state employees, because a newer group of members took up the issue, organized around it, and created positive change.

Challenges: Our biggest challenge is organizing professional employees in a way that results in positive change and builds relationships. Like everyone else, we are trying to control rising health insurance costs without sacrificing quality. We will also continue to prioritize healthy work climates that are free from bullying and other conditions that impact mental and physical health.



Mary Hondl
MBA

CEO
Regional Diagnostic Radiology

Changes: HealthCare Reform has affected every aspect of operations for providers and health care facilities, and we have focused on understanding those regulations. We developed additional practices and policies to meet and exceed compliance standards, while providing the best possible care to our patients and serving our referring clinicians.

Challenges: Continuous regulatory changes are a big challenge. Advanced technology is essential for producing metrics and meeting the reporting requirements, but comes at a high price. Educating physicians and staff on new ways to practice and on new reporting processes is necessary, yet takes time. We are working with our hospitals and referring clinicians to meet these challenges and with this team approach, we are confident that our community will be well served.



Maria Huntley
CAE, MAM

Executive Vice President
Minnesota Academy
of Family Physicians

Changes: In 2015, our Legacy Staff Leader of 30 years retired. I arrived with a whole new set of experiences and expectations to help drive change. We are evolving as an organization to ensure that we meet the needs of all of our members and keep up with industry trends.

Challenges: I am excited about the opportunities these changes are going to bring to family physicians. We are actively working to cultivate diverse future leaders in family medicine. We will do this by offering our members not only top notch CME, but enhanced networking and advocacy support.



Brooks Jackson
MD, MBA

*VP for Health Sciences and
Dean of the Medical School*
University of Minnesota

Changes: I have increased scholarship and developed new interprofessional practice models across all our health sciences schools, increased diversity in our student body, promoted groundbreaking research, and brought the best possible clinical care to people across the state. We also launched an initiative in partnership with the state to create Medical Discovery Teams focused on pressing health issues facing Minnesota.

Challenges: Health care is changing rapidly with an increasing focus on bundled payments and team care, while higher education is struggling with declining state support. High quality facilities and faculty is critical to providing leading edge education, research, and care. Building partnerships to ensure necessary resources will continue to be a priority.

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William Katsiyannis
MD

*President and Chairman of Cardiology
Minneapolis Heart Institute; Abbott
Northwestern Hospital/Allina Health*

Changes: While there is a rich history of innovation in cardiovascular medicine, from surgery to stents to pacemakers, we are now innovating in the *delivery* of cardiovascular care. This means evolving from practicing in silos to practicing in coordinated teams. We're also recognizing and reducing unnecessary variation in care. These innovations have improved quality and reduced costs.

Challenges: The next four years will challenge us to balance the tension between novel and innovative care delivery and the antiquated reward systems that currently exist. Many of the needed changes in care delivery currently carry negative financial incentives for providers and health systems.



Nissim Khabie
MD

*President
ENT Specialtycare*

Changes: Although the EMR is ubiquitous in physician's offices and hospitals, we are just beginning to scratch the surface in terms of optimal utilization of technology to improve effective and efficient patient care. Although we have already aligned our practices with care systems and independent groups, with the advent of ACOs and changes in payer models, we are seeing an acceleration in developing these relationships.

Challenges: Our increased utilization of technology will improve data collection and best practice elements, and will expand our reach to patients via improved portal access and telemedicine. We need to leverage our experience in delivering top-notch otolaryngology care with the advantages inherent in having a patient-centered medical home and integrating best practices into these systems.



Amy Klobuchar
U.S. Senate

Changes: I have focused on bringing down the high prices of prescription drugs. That's why I've introduced the Medicare Prescription Drug Price Negotiation Act to empower Medicare to negotiate for the best possible price of prescription medication for seniors; the Safe and Affordable Drugs from Canada Act to help Americans access safe, affordable prescription drugs from Canada; and the Preserve Access to Affordable Generics Act to expand consumers' access to cost-saving generic drugs.

Challenges: The increasing prices of prescription drugs are a huge burden on families across the country. One in five Americans skip medication doses or decline to fill a prescription because of cost concerns. I'll continue working with my colleagues from both sides of the aisle to pass these bills into law.



Rahul Koranne
MD, MBA, FACP
*Chief Medical Officer
Minnesota Hospital Association*

Changes: In order to continue to deliver the best health care in the nation, Minnesota's health systems are re-engineering the value chain of outpatient offerings, hospital care, and home and community-based services. Financing innovations in Medicare and Medicaid are increasingly supporting these new delivery models.

Challenges: Ensuring true patient, family, and community engagement with health care stakeholders; reducing burnout while increasing clinician satisfaction; and transforming the overall financing of health care in order to reduce the burden being placed on society remain mission critical work in progress. Information technology vendors and pharmaceutical companies will be key in supporting the goal of improving population health.



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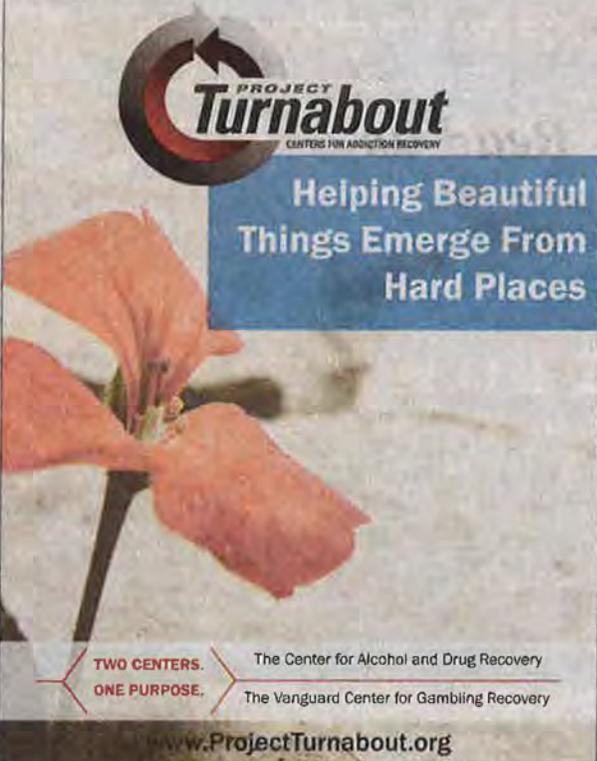
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Kelby K. Krabbenhoft
MBA
President and CEO
Sanford Health

Changes: After significant growth from 2007 through 2013, we fully aligned our 1,500 physician clinics, care institutions, and health plan. All necessary competencies are established to support alternative payment models and maximize value for patients. Sanford also refocused its research efforts in areas with the greatest potential for patient care (genetics, genomics, immunotherapy, and cellular therapies).

Challenges: Driving the shift from volume to value requires aligning interests external to Sanford, including consumers, employers, independent providers, government, and private insurers. Application of medical discovery is constrained by bureaucracy. An efficient process to assess new treatments is as critical as ensuring their safety and efficacy.



Gayle M. Kvenvold
MSW
President and CEO
LeadingAge Minnesota

Changes: Expanding our membership for a growing array of senior care services, particularly new configurations of housing, including services for both post- and pre-acute care and home and community based services—for example, we just merged with Minnesota Adult Day Services Association. Finding solutions to our growing workforce challenges is a priority, alongside performance and quality improvement.

Challenges: We'll strive to find the common causes that ignite passion and fuel action among diverse constituents, while meeting the specialized needs of an individual member segment. Keeping pace with the unprecedented amount of experimentation in new service delivery and payment models, gathering and analyzing relevant data, and creating tools providers and consumers will need to work across siloes of care.



Richard F. Kyle
MD
Chairman Emeritus,
Department of Orthopaedics
Hennepin County Medical Center

Changes: We moved to computer documentation of all records for patient care from physicians, physician assistants, and nurses. Overall, the records are certainly more accessible and organized with computer navigation. Patients who are computer savvy have access to their information, which is good.

Challenges: We must make time for adequate patient contact including examination, counseling, and personal interaction during clinic and hospital visits despite time spent documenting on the computer. Communicating with patients on a personal level is incredibly important. I am concerned about the accuracy of entering data when providers want to save time and get back to patient care. Data that is not accurate when initially entered may lead to errors in patient care.

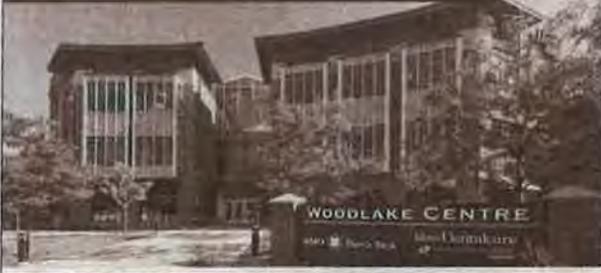


Leota Lind
CEO
South Country Health Alliance

Changes: Building on our existing partnerships and care model, we met the increased demand for data to support value-based care and local health care reform initiatives. We are working toward implementing an HIE that will provide interoperability between disparate electronic medical records, and that allows us to work collaboratively with our providers and counties, coordinate services, and reduce costs.

Challenges: As we face an aging population and workforce shortages in our rural communities, technology that provides data and analytics becomes crucial to improving health outcomes, operational efficiency, and reducing costs as regulation increases and reimbursement continues to trend downward. We must continue to look for opportunities to collaborate with our communities to ensure access to quality and cost-effective local health care.

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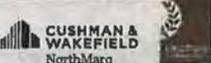


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Jeff Lindoo

RPh

*VP of Governmental and Regulatory Affairs
Thrifty White Pharmacies*

Changes: We expanded the use of technology for product fulfillment and product offerings to include specialty medications. We also engaged our pharmacists in clinical services to transition the community pharmacist from a provider of product to a provider of patient care services to help control the total health care spend.

Challenges: We want continued access to our patients through pharmacy network contracts and maintaining sustainable reimbursement for product and clinical services. We are working with state and federal legislators and regulators to ensure an environment that allows patients to receive the full benefit of a pharmacist's clinical training and expertise from the pharmacy of their choice.



Richard L. Lindstrom

MD

*Founder and Attending Surgeon
Minnesota Eye Consultants*

Changes: We are growing 8-10 percent per year and will be opening a new facility in Woodbury next year. We continue to add new providers to help us meet expanding needs of an aging population and growing community. Our advances include: presbyopia correction surgery, minimally invasive glaucoma, advanced corneal transplantation, aesthetic and functional ophthalmic plastic surgery, and new therapies in dry eye and ocular surface disease.

Challenges: The biggest challenge is managing decreased reimbursement while, continuing to provide high quality care, new technology, and an extraordinary patient experience. It is critical, and we are deeply committed, to enhance the value we bring to each individual patient; the third party payers; and the Minnesota and Midwestern community we serve.



Jennifer P. Lundblad

PhD, MBA

*President and CEO
Stratis Health*

Changes: Improving quality and safety continue to be our focus and we translate research into practice to improve care. The widespread recognition that the majority of health happens outside formal care settings has led us to test new models of care. Some of our most groundbreaking work has the community as the unit of improvement, reflecting the need to address population health and social determinants.

Challenges: It is an exciting time in health care, and we are thriving in the midst of change. Our new work requires creative and strategic thinking; disciplined approaches in engaging patients; focusing on the health of populations; developing meaningful collaborations; integrating care delivery across settings and into the community; and using robust data analytics.



Susan M. Markstrom

MD

*Chief of Staff
St. Cloud VA Health Care System*

Changes: We have a strong commitment to providing highly accessible care. To meet that need, we developed and expanded our telemedicine program. Through multiple modalities, we are connecting veterans with physicians not only within our system, but throughout the nation. Additionally, the Choice Act was signed to further enhance access. Considerable effort and resources have been focused to stand up this program and develop strong networks with community hospitals and medical services.

Challenges: Recruitment of health care professionals is an ongoing challenge in today's market. Connecting with our community non-VA partners requires strong care coordination and communication to assure seamless care. This can be challenged by an EMR that is separate and distinct from the private system's records. Sharing medical information with our Choice Act community partners is often challenging.

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Ruth M. Martinez
MA
Executive Director
 Minnesota Board of Medical Practice

Changes: Minnesota enacted the Interstate Medical Licensure Compact (IMLC) and we are working to issue expedited licenses in 2017. We are implementing legislative changes to statutes, including the addition of two new license types (genetic counselors and medical faculty); making modifications to the medical, physician assistant, and traditional midwifery practice acts, chapter 214 relating to temporary suspension of health provider licenses, and chapter 152 relating to mandatory prescriber registration; and expanding access to the prescription monitoring program.

Challenges: We need to establish and orient a new advisory council for genetic counselors, develop applications and database requirements to manage and track new application and license information, train staff on new procedures, and engage in rule-writing and other implementation processes for the IMLC.



Lawrence J. Massa
MS, FACHE
President and CEO
 Minnesota Hospital Association

Changes: We, along with our hospital and health system members have led significant work to improve health care quality and safety for patients and families across Minnesota. We are among a select group chosen to participate in the Centers for Medicare and Medicaid Services' Partnership for Patients, to reduce preventable hospital-acquired conditions by 40 percent and readmissions by 20 percent.

Challenges: Minnesota's hospitals and health systems will strive to deliver the highest-quality health care; ensuring meaningful access and holding down the rate of health care cost growth. They will adopt and leverage new technologies and transform the way caregivers work together as a cohesive and coordinated team to improve the health of individuals over their lifetime and entire communities over generations.



David McKee
MD
CMO, Integrity Health Network
 Northland Neurology and Myology, P.A.

Changes: The most significant changes at IHN relate to moving from a successful utilization of the shared savings model to the more demanding requirements of TCOC especially as it relates to our MSSP ACO. We established one of the first ACOs in the state and have continued collaboration between primary and specialty care physicians to establish optimal care protocols.

Challenges: Penalties exist for groups that were high quality/low cost before establishing the ACO. Since success is defined by reductions in cost and improved quality metrics, IHN, is punished for its past success. We also face a CMS-invoked disadvantage in reimbursement relative to hospital-owned clinics. We will continue to do more with less, while integrating data from numerous clinics over different EHR platforms.



Robert K. Meiches
MD, MBA
CEO
 Minnesota Medical Association

Changes: We have worked to be more responsive to our members and the rapid changes in health care. We are helping Minnesota physicians to improve patient health, make Minnesota the best place to practice medicine, and strengthen the profession. We have improved member needs through research, listening sessions, and policy conversations. We have also sought guidance from a wider range of physicians with diverse backgrounds.

Challenges: It is important to be inclusive and listen to all voices. We will continue to be challenged by physician dissatisfaction and burnout and shrinking resources. Staying true to our vision and mission, and having a laser-like focus on the most important initiatives where physicians can make a difference will be crucial for success.

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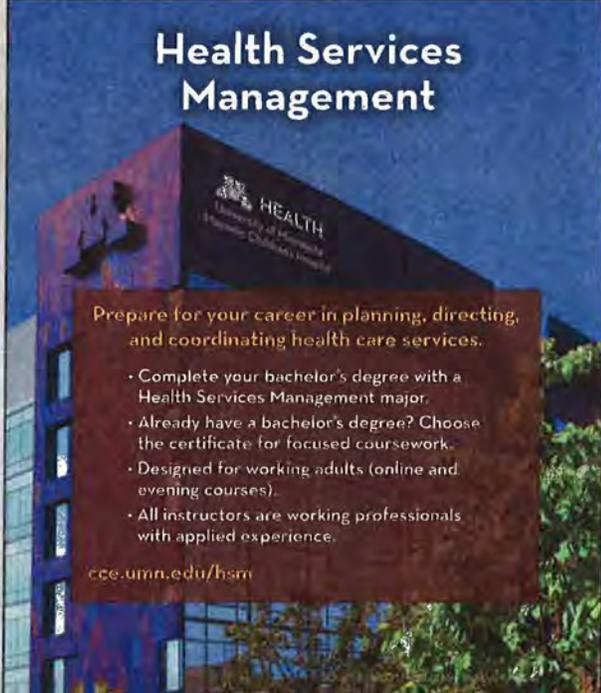
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Aaron J. Milbank
MD
President
Metro Urology

Changes: We are continuously adapting to the rapidly evolving medical landscape, including the changing payment model that is beginning to favor quality over quantity. It has been an exciting challenge to adapt, while continuing to provide the same high level of care to our patients. This has required a focus on value (quality divided by cost) while continuing to enhance our patients' experience.

Challenges: The downward pressure on fee-for-service reimbursement and upward pressure on expenses will continue to require us to find ingenious efficiencies to provide a high level of care. As a large, independent subspecialized practice, we are well positioned to thrive in this changing environment.



Steven Mulder
MD
President and CEO
Hutchinson Health

Changes: First, we completed our integration with Hutchinson Medical Center, our local 30-provider multispecialty physician group and adopted a common electronic health record. Our primary care clinics have become certified health care homes and we invested financial and staff resources to develop a truly team-based care model (including our formal collaboration with McLeod County Public Health).

Challenges: Solving the financial riddle of moving from volume to value compensation models will be essential. As an independent community health system, we must determine the best corporate model to ensure that we can achieve our mission of "Advancing Health with our Community" into the future.



Jon S. Nielsen
MD, FACOG
President and CEO
Oakdale ObGyn, a division of Premier ObGyn of Minnesota

Changes: We advanced our affiliation with Premier ObGyn of Minnesota, an independent divisional merger and have improved quality, access, and satisfaction for our patients. We have advanced gynecological surgical expertise and services for an ever-aging population of women, with a focus on minimally invasive surgical procedures and urogynecology. We're offering more appointment times and an online patient portal.

Challenges: One of our greatest challenges is maintaining our independent obgyn practice model, while continuing to work with most of the large health care systems. Expanding our data analytics capabilities will require a forward-thinking approach that anticipates our patients' changing needs and use of health care services. It will be a challenge to continue to provide patient-centered and individualized health care in our increasingly "commoditized" environment.



Allison O'Toole
JD
CEO
MNSure

Changes: Four years ago MNSure didn't even exist. We've come quite a long way in our short history and are now considered the place for Minnesotans to shop and compare health insurance options, whether that's for a private plan or one of Minnesota's public program options.

Challenges: We have done a lot in our short time, including helping to lower Minnesota's uninsured rate to the lowest level in state history. Over the next four years, we will continue to increase health insurance awareness and work to make sure that all Minnesotans have access to quality, affordable coverage.

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Thursday, September 15 ~ 8:15am to 5:00pm
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Joel V. Oberstar
MD
CEO
PrairieCare

Changes: PrairieCare and PrairieCare Medical Group together have grown exponentially and now comprise one of the largest psychiatric group practices in Minnesota. Our efforts to provide each individual patient the psychiatric care they truly need have positively impacted patients from all parts of Minnesota and beyond.

Challenges: Deployment of innovative strategies to reduce morbidity and mortality, while achieving reductions in total cost of care will result in expanded access to mental health care across Minnesota. Partnering with primary care and specialty clinics, schools, and the use of televideo technologies are critical pathways to achieving these goals and more.



Vicki Oster
MD
Pediatrician and President
Southdale Pediatric Associates, Ltd.

Changes: The biggest change our organization made was moving to an electronic medical record system just over two years ago. This was a major change for us, and even though we were well prepared it has taken a long time for us to get back to a comfortable level of functioning.

Challenges: We will continue to be challenged moving forward with our EMR, especially as we try to communicate electronically with other EMR systems. The Health Information Exchange is something that needs to be addressed by payers, hospitals, and the government so that a solution can be found!



Mark S. Paller
MD, MS
Senior Associate Dean
and Professor of Medicine
University of Minnesota Medical School

Changes: The Medical School adopted a strategic plan that re-emphasizes research, education, and clinical excellence. We partnered with the state to develop Medical Discovery Teams focused on solving key health issues. We opened the Clinics and Surgery Center focused on new models of care.

Challenges: Our faculty must work to balance scholarly work and clinical service when research and academic funding is tight. Only by finding that proper balance can we effectively bring the benefits of an academic health system to all Minnesotans. We also need to develop an integrated academic health system to better serve the state and must continue to work with Fairview and others to accomplish this.



Erik Paulsen
U.S. House of Representatives

Changes: I became the newest member of the Ways and Means Health Subcommittee last December. This position gave me the opportunity to successfully turn off the harmful medical device tax for two years, which means more Minnesota jobs and more investment in life-saving innovation. I will continue to push for reforms to Medicare, so that it works better for both doctors and our seniors.

Challenges: Partisanship from both sides of the aisle continues to be a hindrance to enacting better policy. Thankfully, I am second in the House for the number of members supporting my legislation and first in the Minnesota House delegation for writing bipartisan bills. By working together, we can overcome this partisanship and get things done.

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Minnesota
Department of Health
DIABETES PROGRAM



Emily Piper
JD
Commissioner
Minnesota Department
of Human Services

Changes: We serve more than 1 million Minnesotans a year, through programs such as child care assistance to services that help people stay in their homes as they age. Medical Assistance enrollment has more than doubled in the past decade, while we controlled costs through statewide competitive bidding and payment reform. We have begun to improve the child protection system and continue to do so.

Challenges: Improving the mental health system remains a top challenge as we expand community services and address issues in state-run facilities. Long term, our goal is to provide a full continuum of mental health services.



Rita M. Plourde
CEO
Sawtooth Mountain Clinic, Inc.

Changes: We continue to grow our services in family medicine, with the integration of behavioral health and care coordination services. This growth provides us with the opportunity to focus on developing patient-centered services, involving patients and their communities in their health care experience, and growing access to care for all, regardless of their ability to pay.

Challenges: Our challenges today and tomorrow are to be present, and expect and provide the highest standards of care with adequate insurance and financial reimbursement for all services. We also want to welcome all patients, listen to their questions, and assist them in their healing journey while supporting and promoting a healthy community to live in. The challenge remains the goal: Continue to provide access to quality health care to all!



Jon L. Pryor
MD, MBA
CEO
Hennepin County Medical Center

Changes: The two changes that have improved our ability to advance care are the integration of the Hennepin Faculty Associates physician practice into HCMC and the continued expansion and adoption of Lean methodologies. These efforts promote engagement of staff and allow us to align strategies across the organization improving patient care and business operations.

Challenges: With our high percentage of uninsured or under-insured patients, finances will always be a challenge. Moving to a value-based care model, will pose challenges within the reimbursement methodology. We are investing in the infrastructure to align with a population health model, but payment models and financial incentives will need to be developed to support this transition and reward organizations that advance the health of our community.



Brian Rank
MD
Co-Executive Medical Director
Park Nicollet HealthPartners
Care Group

Changes: Combining HealthPartners and Park Nicollet in 2013 enhanced our ability to support patients, families, and our community by finding new ways to offer high-quality care, reduce costs, and improve health. Together, we've focused on improving all we do, particularly around mental health outcomes, health care disparities, children's health, and chronic illness.

Challenges: Aligning all we do to support our clinicians to provide high-quality, effective care that meets our patients' needs, whether in person, online, or on the phone. In addition, continuing to build stronger connections across our care group to seamlessly provide the best care and best experience for those we serve.



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Megan Remark
MHA, MBA
President and CEO
Regions Hospital

Changes: Neurological illnesses such as stroke and Alzheimer's are among the leading causes of death in the U.S. and we've made significant investments in this area. In 2014, Regions Hospital became the first Joint Commission-certified comprehensive stroke center in Minnesota. Next year, HealthPartners will open a neuroscience center dedicated to care, rehabilitation, and research. It will be the largest free-standing neuroscience center in the upper Midwest.

Challenges: By 2025, one in five Americans will be over the age of 65 and we must be prepared to meet the needs of our aging population. Our focus on providing state-of-the-art, patient-centered specialty care in areas of oncology, orthopaedics, and neurosciences will provide a needed community resource to address this challenge.



Scott Riddle
MBA
CEO and President
Walker Methodist

Changes: We developed the mission, vision, and values for our organization, which puts the customer first, followed closely by our employees. We want to provide the best place to live for our customers and the best place to work for our employees. Everything we do centers on this objective. We now not only focus on delivering excellent care but also providing superior service.

Challenges: It is a challenge to find quality employees to meet the increasing number of older adults who are seeking senior housing and care. The increase in demand is outpacing growth of the labor pool. We are going to have to be creative when recruiting and utilize technology to improve how we care for people.



Rose Roach
Executive Director
Minnesota Nurses Association

Changes: For decades, we have promoted effective RN staffing and safe working conditions for both patients and registered nurses in direct patient care, policy, and political arenas. In 2015, we partnered with police officers to create a law that established violence committees, preparedness plans, and de-escalation training. We also worked on system reforms to recognize health care as a human right.

Challenges: We want a Safe Patient Standard based on a nurse's professional judgment of acuity, census, and daily needs. We need procedures to keep health care workers and patients safe from violent assaults in hospitals. We want to focus legislative, educational, and organizing efforts by advocating for the creation of a universal publicly financed, privately delivered health care system.



Patrick M. Rock
MD
CEO
Indian Health Board
of Minneapolis, Inc.

Changes: Our organization has made significant changes related to the ACA. We are working on a demonstration project with the state of Minnesota to form the only safety-net network Accountable Care Organization in the state. We are the only participating Indian Health Service funded in the United States to form an ACO. We remodeled our clinic facilities to reflect the ACO model and improve workflows and care coordination.

Challenges: The biggest challenge we face is related to funding from the Indian Health Service for the work that we do under the ACA. We also have to comply with ACA technology requirements that will require us to change IT platforms or modify them.



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Catherine M. Rydell
CAE
Executive Director and CEO
American Academy of Neurology

Changes: We've expanded our leadership training programs and developed a clinical data registry currently in pilot phase. We're working to identify the causes of physician burnout and find well-being tools to combat it. We continue to advocate for resources and assistance to our members for MOC and changes due to Medicare and Medicaid reimbursement.

Challenges: We want to expand and monetize our data registry to assure goals are met and patient care is improved. We want to continue to evolve our annual meeting to best meet the needs of all member segments and to build capacity to segment services to our members. We will strive to communicate MACRA implementation to our members in impactful ways.



Sue Schettle
CEO
Twin Cities Medical Society

Changes: We have deliberately moved away from the traditional role of a county medical society. It became apparent that we had to serve as convener, coordinator, and catalyst to advance public health initiatives such as tobacco policy, environmental health issues, and end-of-life care planning. That switch in focus has successfully increased revenue and more importantly, made a significant impact on the health and well-being of the patients that our members serve.

Challenges: I would say that competition is probably one of our biggest challenges. Once you create a successful model there are others that work to replicate it. There are also significant challenges that physicians are facing and joining their medical association is sometimes not top priority.



Jeff Schiff
MD, MBA
Medical Director
Minnesota Department
of Human Services

Changes: We have moved to address quality and efficacy more significantly in our health care strategies. Our foci, on both specific issues (e.g., the ongoing opioid crisis) and more overarching efforts (e.g., accountable care models), align to create real mechanisms to provide greater value to those we serve and the Minnesota community.

Challenges: We need to make progress on real sustainable integration of services in health care and between health care and social services. We need to rethink quality measurement and improvement so that the efforts are meaningful to our communities and to our providers. This work must align to decrease disparities in health outcomes.



William F. Schnell
MD
Vice President
Orthopaedic Associates of Duluth

Changes: We recently incorporated occupational and physical therapy services into our practice and expanded the range of surgical procedures to include outpatient hip and knee replacement. Additional changes involved technology, such as installing onsite digital X-ray and magnetic imaging equipment. We also implemented a new electronic medical record system.

Challenges: Keeping up with the latest EMR technology is an ongoing challenge, and often the benefits are questionable. In our practice, the time and effort it takes to implement the EMR or the computerized physician order entry (CPOE) systems takes away from patient care. It's very important to us to spend as much time with patients as possible.



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HEALTH^{GM}



Jim Schowalter
MPP
President
Minnesota Council of Health Plans

Changes: Council members made a huge commitment to make reform work in Minnesota. We are working more closely than ever before with hospitals, doctors, and the broader community to make sure people get the care they need in new and hopefully more convenient ways.

Challenges: We need to figure out a better way to deal with increasing medical expenses. Health insurance is so expensive because care is so expensive. Unless we come together and do something to slow down galloping prescription drugs and other medical expenses, none of us will be able to afford the care that we need.



David M. Schultz
MD
Medical Director
MAPS Medical Pain Clinics

Changes: In 2014, we merged with a larger pain clinic to become part of a bigger, regional medical practice. This integration allowed us to reduce costs and gain financial stability in a rapidly changing and sometimes unpredictable health care marketplace. The merge created significant changes in our workflows, electronic infrastructure, and corporate culture.

Challenges: Declining reimbursement and restrictions in patient access to interventional pain procedures have reduced revenue at the same time that costs have increased. Computerized automation of systems increases efficiency, but maintaining a compassionate connection to our patients while using computers is challenging. Our challenge is to reduce the abuse and diversion of prescription opioids, while safely providing opioid medications to chronic pain patients who truly need them.



Kathleen Sheran
RN, MS, APRN
Minnesota Senate

Changes: Over the past four years, we have advanced numerous reforms in the area of health care. The largest change has been the implementation of the Affordable Care Act at the state level. We also passed a bill removing barriers for advanced practice registered nurses, giving more Minnesotans access to advanced health care.

Challenges: As with all changes, the challenges ahead will be to keep them in place and continue to improve upon them. While we are pleased with the implementation of the ACA, there are certainly changes we can make to improve delivery and cost of care.



Janice M. Sinclair
MD
Former President
Minnesota Academy
of Ophthalmology

Changes: The Minnesota Academy of Ophthalmology has had to become a stronger voice to advocate for and protect our patients' access to high quality eye care.

Challenges: It will continue to be a challenge to ensure the delivery of the best eye care as we strive to improve outcomes, reduce cost, and pursue technological innovation all at the same time.

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Cindy Firkins Smith
MD
President and CEO
ACMC Health

Changes: The most visible change is the transformation of our leadership team. Leaders who had served our organization for 10 to 15 years either retired or transitioned to new positions. In the last year we've welcomed a new chief administrative officer, CMO, medical director of quality and innovation, and I stepped into my role in January 2016.

Challenges: We have ambitious goals to transform health care delivery in rural Minnesota, while keeping patients first. We must transition to a system where we are reimbursed for the value we deliver. We will be challenged by geographic, age, economic, social, and racial diversity when we design systems for our communities. Our biggest challenge will be to recruit talented and committed providers and support staff.



Deborah L. Smith-Wright
MD
Director of Pediatrics
Shriners Hospitals for Children
-Twin Cities

Changes: Until five years ago, all care was provided free of charge. When we began to bill insurance, our mission changed to assisting families with out-of-pocket expenses that caused them financial hardship. The billing change necessitated multiple changes in resources, manpower, and clinical services. We continue to provide specialty pediatric orthopaedic care regardless of ability to pay.

Challenges: As an independent hospital system, we anticipate facing an increasingly competitive environment where hospitals and clinics are merging and forever-changing the medical landscape. We anticipate in order to compete as a standalone specialty center, we will need to embrace the use of technology such as telemedicine and other programs to provide our care in an affordable, efficient, and accessible manner.



John Solheim
MA, FACHE
CEO
Cuyuna Regional Medical Center

Changes: The biggest change has been the explosive growth since we integrated with our medical staff. We have recruited more physicians and built a \$16 million renovation that includes a new OR suite, PACU, and outpatient area. Our new EMR and financial reporting systems gave us one platform between the hospital and clinic, which has been beneficial to our patients.

Challenges: The biggest challenge in the future is to remain an independent medical center as health care consolidation continues. We are converting to a 501-(c)3, which will give us more flexibility in a competitive environment. We need to recruit a quality workforce to meet the growing demand of medical services and manage the infrastructure needed to ensure quality outcomes while moving toward population health management.



Tony Spector
MA, JD
Executive Director
Emergency Medical Services
Regulatory Board

Changes: This agency has become more transparent, collaborative, and mission-focused. The Board has been more engaged in establishing policies that address emerging issues that impact the public's health and safety generally and the EMS system specifically. Staff have operationalized and executed these policies with integrity, with responsibility, and with professionalism that includes timely responses to our clients, our stakeholders, and our partners.

Challenges: As new and emergent diseases and hazards pose greater threats to the public, this agency must be proactive in establishing standards that serve the public and protect the EMS professional. In addition, we must be at the forefront of creating guidelines and benchmarks for those EMS provider categories created to address gaps in the health care system.



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Keith Stewart
MB, ChB, MBA

Carlson and Nelson Endowed Director
Mayo Clinic Center for
Individualized Medicine

Changes: For every patient to benefit from precision medicine the Mayo Clinic Center for Individualized Medicine continues to make significant advances to employ genomic sequencing to reach the correct diagnosis faster, provider safer drug prescribing, and identify novel treatments for cancer. Transforming how we deliver care to our patients, results in better-informed care and outcomes, reduced side effects, earlier interventions, and increased prevention and prediction of disease.

Challenges: To revolutionize how we improve and treat disease through precision medicine, we need to rapidly modernize the treatments and diagnostics. We also need to improve and maintain efficiency, productivity, and quality to provide high quality, affordable outcomes at a low cost. This requires intentional efforts to innovate to determine if new methods produce better results.



L. Read Sulik
MD, FAAP, DFAACAP

Chief Integration Officer, PrairieCare
Executive Director, PrairieCare Institute

Changes: We opened a new 50-bed state-of-the-art child and adolescent psychiatric hospital in Brooklyn Park and the PrairieCare Institute, our center for innovation, training, and research. The Institute houses the "hub" for our Integrated Health and Wellness Clinics (IHCs), "a clinic in a clinic" that are now in six different primary care clinic sites.

Challenges: The biggest challenges will likely be keeping up with the growing demands for our newest area of innovation, the Integrated Health and Wellness Clinics. We also want to bring these Clinics into companies that are self-insured. The recruitment, training, and ongoing development of the right people committed to this exciting innovative work is already a challenge we are attempting to solve proactively.



Allison Suttle
MD, MBA

Senior VP and Chief Medical Officer
Sanford Health

Changes: We have worked to prepare our organization for value-based health care. The delivery model for primary care needed redesigning to better meet the needs of patients. For example, we've implemented options for virtual care and created a team-based medical home. Additionally, our integrated structure has allowed Sanford to standardize care delivery to remove unnecessary variation and improve quality.

Challenges: The new model of health care demands adaptability. Sanford will need to maintain a workforce and have mechanisms in place to incentivize value-based health care. Technology is an extraordinary tool, but it's important to keep medicine a personal and connected experience. It's critical that we leverage the valuable data collected to impact outcomes.



Lori Swanson
JD

Minnesota Attorney General

Changes: This is a period of significant change in our health care system. As insurance costs rise, more patients are shifted to high deductible health plans. The problem is that many families can't afford these high deductibles. We have also seen patients impacted by increases in prescription drug costs.

Challenges: Our state faces many challenges: Competition is the best regulator of rates and services, and I'm concerned about consolidation. Rising health insurance costs continue to squeeze employers and individuals. The system must ensure that financial incentives in ACOs don't result in undisclosed rationing. The system also lacks capacity and resources to properly serve the mentally ill.



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Paula M. Termuhlen
MD
Regional Campus Dean
University of Minnesota Medical
School-Duluth Campus

Changes: The biggest change for our campus has been the recruitment of new leadership with fresh ideas to reinvigorate our campus mission to serve rural and Native American communities through research and medical education. Education and health care are becoming increasingly interprofessional. We have embraced this goal with enthusiasm.

Challenges: While Minnesota is one of the healthiest states, it also has some of the largest health disparities, particularly in its Native American and rural communities. We hope to promote health equity through research and practice. Funding for research of all types is challenging and yet essential to ensure better understanding of disease.



Paul Thissen
JD
Minnesota House of Representatives

Changes: The biggest change we've seen is the proliferation of new models of care delivery and risk assignment. Minnesota is a creative, exciting place to be as someone who thinks hard about how to fit new ideas into outdated regulatory boxes.

Challenges: The biggest challenges we face as a state government and in the private/non-profit sector of health care is moving away from a discussion of health insurance reform (which is where the conversation has been) and into true health care reform. How do we deliver high-quality health care services to everyone as inexpensively as possible and how do we make the tremendous amount of health care data work for us while balancing privacy concerns?



Jon Thomas
MD, MBA
Minnesota Commissioner
Interstate Medical Licensure
Compact Commission

Changes: As chair of the Federation of State Medical Boards in 2013-2014, I shepherded development of the Interstate Medical Licensure Compact Commission legislation. This set forth the idea of a compact, which is an agreement between states that would facilitate and expedite medical licensure. The goal is that once a qualified physician has a license in one of the compact states, he or she would be able to become licensed in any or all of the other compact states within days to weeks. This will facilitate licensure, mobility of a qualified physician workforce, and telemedicine.

Challenges: The biggest challenges are political barriers and the erroneous belief that this is somehow related to MOC.



David Tilford
President and CEO
Medica

Changes: The ACA has impacted nearly every segment of our business. Changes to the individual market have resulted in new opportunities, but great challenges. Our Medicaid business has grown significantly due to how the state awards that business. We have begun to make changes in our Medicare business as we prepare for the sunset of the Medicare Advantage program.

Challenges: Affordable health care is our biggest challenge. Advancements in medical technology and treatment are exciting. At the same time, we need to use health care dollars wisely and efficiently. The individual market continues to be a challenge. Insurer losses on ACA plans nationwide are expected to run into the billions. It will take time for pricing and medical expenses to get in line.

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Christopher Tillotson
MD

*President and Musculoskeletal Radiologist
Consulting Radiologists, Ltd.*

Changes: Our biggest change has been converting to a completely physician-led practice. In the past, we had utilized a non-physician CEO. Our reasoning is that only through physician leadership could the group fully realize its potential and be in a position to respond to the rapidly changing health care environment in the upper Midwest. Also, the high degree of physician involvement promotes cohesion and more fully leverages our intrinsic talents.

Challenges: We are a large independent physician group and wish to remain so. There is a fair amount of uncertainty as to how to maintain a successful practice as we move further into the ACO era. For example, what is the best approach, configuration and size to navigate in this rapidly changing environment?



Ensor E. Transfeldt
MD

*Spine Surgeon, Twin Cities Spine Center
Medical Director, Allina Spine Program*

Changes: We have moved from a boutique spine surgery practice toward an integrated, comprehensive spine practice with other providers and health systems. The partnership with Allina has allowed us to focus on patient-centric care. Measurement of outcomes and costs makes it possible to eliminate waste and encourage continuous quality improvement, while reducing costs.

Challenges: The biggest challenges these changes face are: Providers across the continuum must embrace the changes needed. An integrated network must be created and maintained throughout a vast population and geographic area. Consensus needs to be achieved among providers regarding care pathways.



Misty Tu
MD

*Senior Medical Director for Psychiatry and Behavioral Health
Blue Cross and Blue Shield of Minnesota*

Changes: We are deeply committed to advancing health equity. We are proud to have made a healthy difference over the past few years by increasing access to healthy food and improving conditions where Minnesotans live, work, and play. Finally, behavioral health is a growing area where we need to continue asking the right questions in order to make progress.

Challenges: The biggest challenge is to pay for services, without sacrificing quality. We don't have enough mental health care inpatient beds or a robust enough outpatient and safety network. Funding is available, but that won't help if we aren't offering the right services at the right time. These are some of our most vulnerable members, and they need us to do the best job we can.



Jeffrey L. Tucker
EFPM

*President and CEO
Integrity Health Network*

Changes: We launched a Medicare Shared Savings Program ACO and a state of Minnesota Medicaid ACO through the Integrated Partnership Program. We received grant dollars from the State of Minnesota State Improvement Model to help us develop and implement a health information exchange. Additional funding allowed us to develop a regional accountable community for health (ACH).

Challenges: A rapidly evolving health care market taxes our clinics' ability to respond and apply limited resources. We need to find ways to make each initiative sustainable and keep partners at the table (counties, hospitals and clinics). Increasing government regulation and decreasing reimbursement and resources has accelerated consolidation in the Minnesota marketplace and caused the loss of independent clinics in large numbers.



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Paul E. Van Gorp
MD
Family Physician
CentraCare Health-Long Prairie

Changes: From my perspective as a small-town rural family physician, there have been two major changes for us in the past few years: our team-based care pilot project to improve the care of those with chronic disease, and our drive to build a new medical campus to serve our community.

Challenges: We need to put a succession plan in place to ensure continuity of quality care. We currently cover the bases with a relatively young group of advanced practice providers, but our physician leaders are nearing retirement and must be replaced and expanded to allow comprehensive care to continue. Furthermore, growth will be necessary to cover the cost of the new facility.



Tim Weir
MA, MBA
CEO
Olmsted Medical Center

Changes: Many of our recent changes relate to our continued patient engagement initiatives, care redesign efforts, and market share growth strategies. Employee and provider recruitment and retention continue to be critical for our ongoing success.

Challenges: Ongoing declining reimbursement, coupled with required capital and IT obligations, will continue to challenge our organization. Additionally, change management skill sets that are required to be successful in a rapidly changing health care delivery system, will be critical. We will see challenges related to employee satisfaction and retention as our patients expect their care to be available in a variety of delivery models.



Penny Wheeler
MD
President and CEO
Allina Health

Changes: We increased our focus on supporting health in addition to responding to illness. We also invested in community collaborations (even with competitors!), which improved the community's health, while improving affordability and decreasing unnecessary duplication of services in our community. We worked with HealthPartners on the ACO-like NW Alliance; Mother-Baby partnered with Children's; we merged with Courage to create Courage-Kenny; and worked with the state on Integrated Health Partnerships.

Challenges: Declining revenue will have us reduce costs, while we invest in new models of care (not yet paid for) that support the health of our community (such as mental health resources, care management, data/information systems to improve care, etc.) We'll also shift our thinking to value-based services for volume-based successes.



Cody Wiberg
PharmD, MS, RPh
Executive Director
Minnesota Board of Pharmacy

Changes: The Board has worked on legislation to tighten the regulation of compounding pharmacies, allow pharmacists to administer vaccines to children 13 years of age or older, improve our Prescription Monitoring Program (PMP), and allow pharmacies to collect unwanted drugs for disposal.

Challenges: We continue to have problems with compounding pharmacies that are not fully complying with the laws. It has been difficult to get PMP legislation passed, due to concerns about data privacy. Prescription drug abuse has become an epidemic, making it a challenging issue to respond to, but the Board is working with many other state agencies to address it.

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- Physician (Cardiology)
- Physician (Maplewood)
- Physician (Northwest Metro Clinic)
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- General Internal Medicine (Rice Lake/Hayward, WI Outpatient Clinic)
- General Internal Medicine (Rochester, MN Outpatient Clinic)

Physician applicants should be BC/BE. Possible recruitment bonus.

Interested applicants should email

Ann L. Chilson, Human Resource Specialist/Physician Recruiter

Minneapolis Veterans Health Care System (MVAHCS), 4M-120, One Veterans Drive, Minneapolis, MN 55417

Phone: 612-467-4304 • Fax: 612-467-2287 • Email: ann.chilson@va.gov

EEO Employer

DATE: September 10, 2016

SUBJECT: Tri-Regulatory Symposium Survey
Results

SUBMITTED BY: Ruth Martinez, M.A., Executive Director

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Discuss the survey results and determine if the Board wants to continue with the Tri-Regulatory Symposium (Symposium). If yes, Board members are requested to make a motion to continue the Symposium and indicate how often the Symposium should be held.

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

BACKGROUND:

The Tri-Regulatory Symposium survey results are attached for review. The Board should also discuss whether or not to host a future Symposium and, if so, Board members are requested to make a motion to continue the Symposium and indicate how often the Symposium should be held.

Tri-Regulatory Symposium Evaluation – survey responses

Q1

Show Benchmark

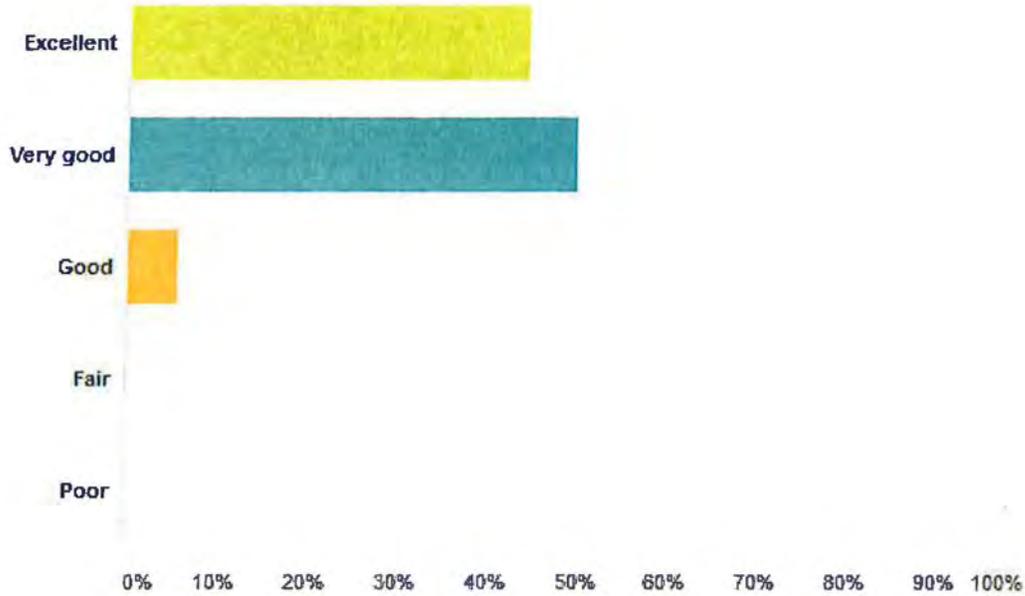
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Export



Overall, how would you rate the Tri-Regulatory Symposium?

Answered: 18 Skipped: 0



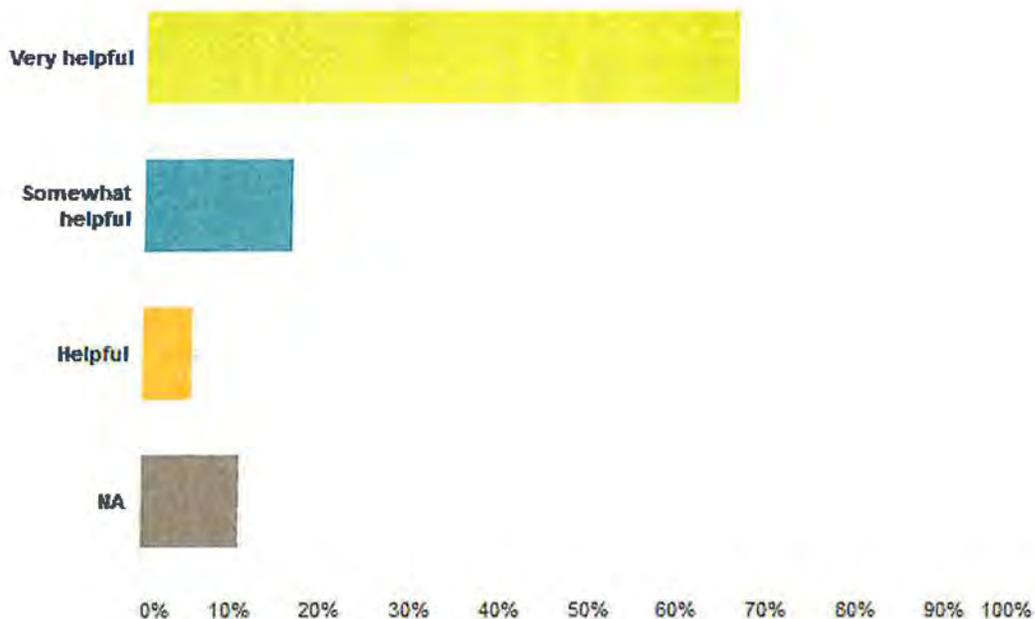
Answer Choices	Responses	
Excellent	44.44%	8
Very good	50.00%	9
Good	5.56%	1
Fair	0.00%	0
Poor	0.00%	0
Total		18

Q2

Customize Export

How helpful to your role as a regulator was the content presented by Dr. Humayun Chaudhry, President and CEO of FSMB?

Answered: 18 Skipped: 0



Answer Choices	Responses	
Very helpful	68.67%	12
Somewhat helpful	16.67%	3
Helpful	5.56%	1
NA	11.11%	2
Total		18

Comments (1)

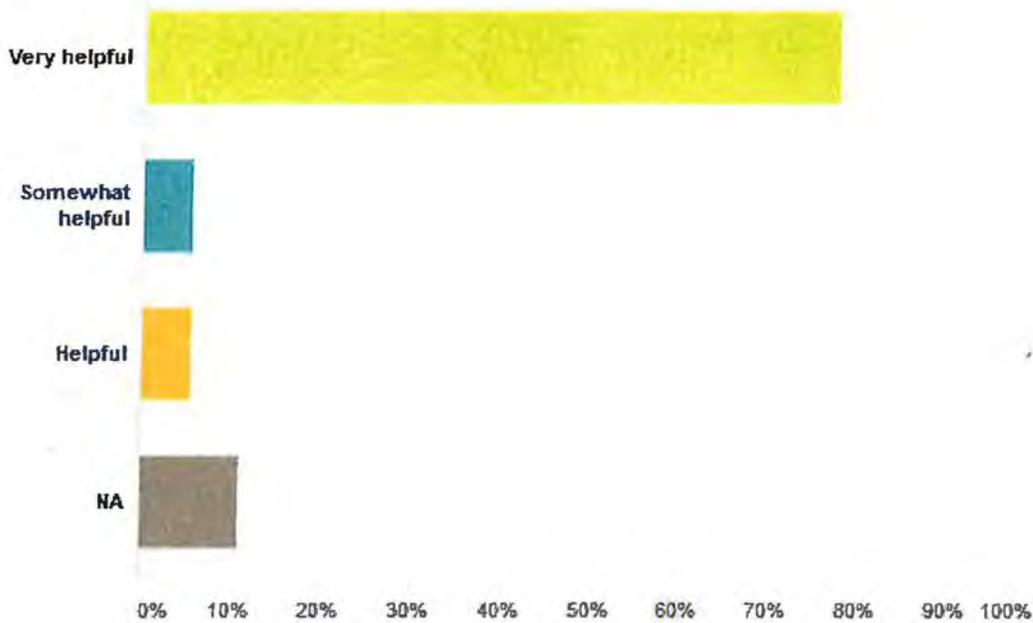
Comment: Good overview of the tri-regulator efforts thus far - set the foundation - important point to be sure to have contingency in Washington D.C. to be politically effective

Q3

Customize Export

How helpful to your role as a regulator was the content delivered by Dr. Carmen Catizone, Executive Director, NABP

Answered: 18 Skipped: 0



Answer Choices	Responses	Count
Very helpful	77.78%	14
Somewhat helpful	5.56%	1
Helpful	5.56%	1
NA	11.11%	2
Total		18

Comments (1)

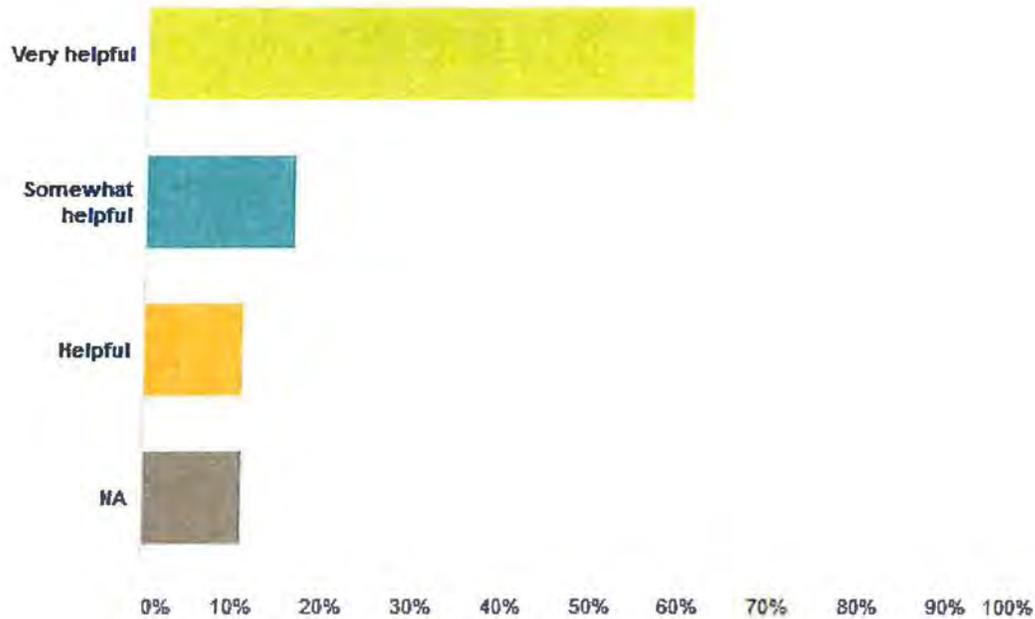
Comment: Good information about how pharmacy regulation has authority to regulate pharmacies, online vendors, and individuals. Uses surveyors, on site inspection, has .pharmacy domain to regulate online vendors. May be room for cross-over application to other regulatory bodies

Q4

Customize Export

How helpful to your role as a regulator was the content delivered by Dr. David Benton, Executive Director, NCSBN

Answered: 18 Skipped: 0



Answer Choices	Responses
Very helpful	61.11% 11
Somewhat helpful	16.67% 3
Helpful	11.11% 2
NA	11.11% 2
Total	18

Comments (2)

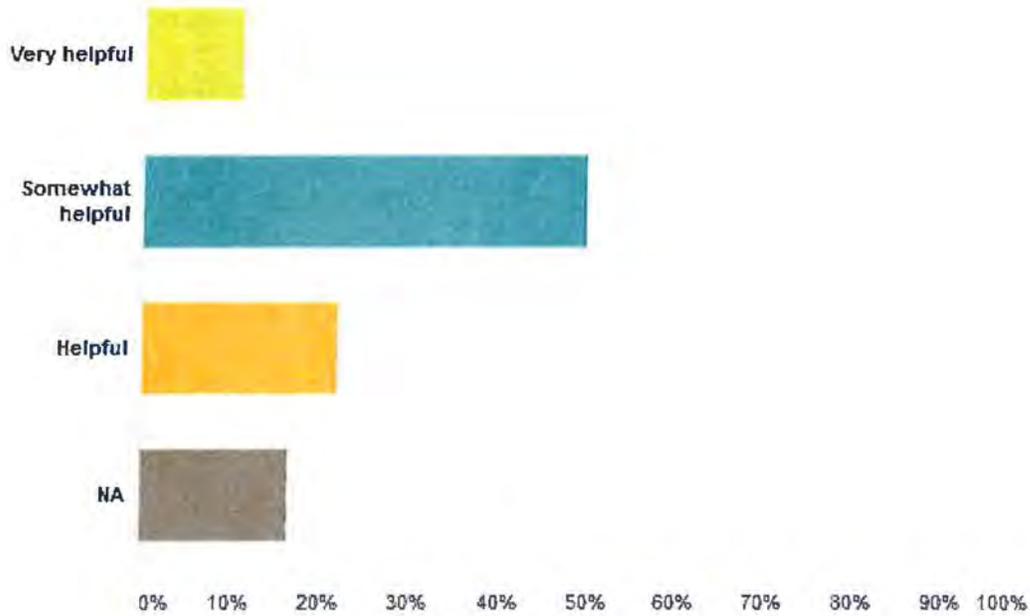
Comments: (1) Great international knowledge of regulation and push to focus on healthcare delivery and regulatory needs for the future - also incorporate other providers in the discussion (2) I appreciate the global perspective and broad thinking that Dr. David Benton brings forward.

Q5

Customize Export

How helpful to your role as a regulator was the content delivered by Dr. Barbara Brandt, Director, University of Minnesota Center for Interprofessional Practice and Education

Answered: 18 Skipped: 0



Answer Choices	Responses	
Very helpful	11.11%	2
Somewhat helpful	50.00%	9
Helpful	22.22%	4
NA	16.67%	3
Total		18

Comments (3)

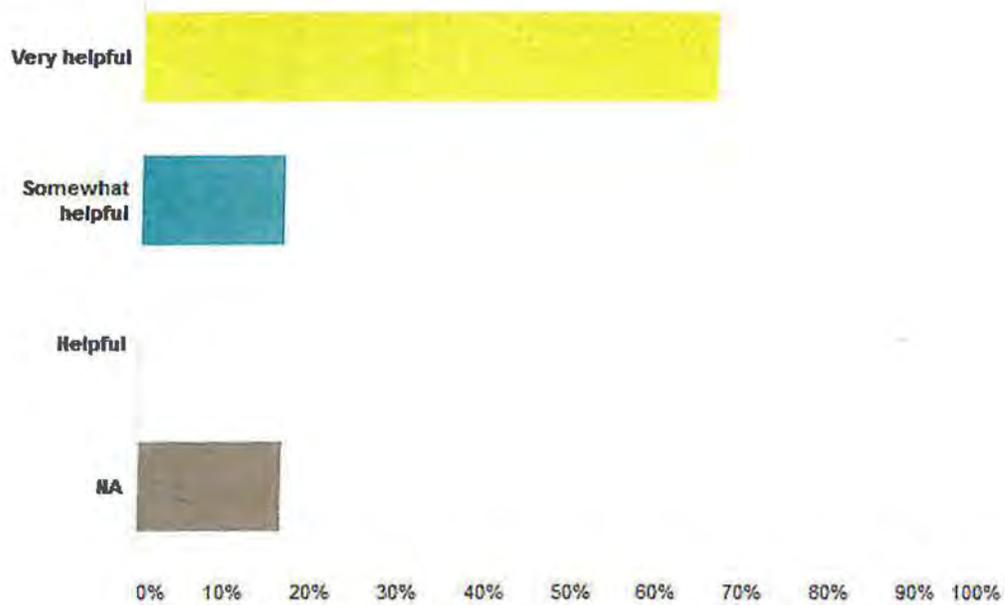
Comments: (1) Felt like she provided piecemeal presentation due to time constraints - obviously education will be critical to reach future goals - the research she discussed about collaboration needs to be done soon - the panel of regulators did not have an effective role for enhancing this presentation (2) It was more like a sales pitch for the U of MN.... (3) A bit rambling and too long.

Q6

Customize Export

How helpful to your role as a regulator was the content delivered by Dr. Doris Gunderson, Medical Director, Colorado Physician Health Program

Answered: 18 Skipped: 0



Answer Choices	Responses	Count
Very helpful	66.67%	12
Somewhat helpful	16.67%	3
Helpful	0.00%	0
NA	16.67%	3
Total		18

Comments (2)

Comments: (1) Very interesting - good scenario to use for recognition of the need for collaboration in regulation - the panel could have been more effective if they would have had the opportunity to hear some of her information prior to the presentation and think about the impact of the decision made in Colorado (2) Her presentation was difficult to follow.

Q7

Show Benchmark ▾

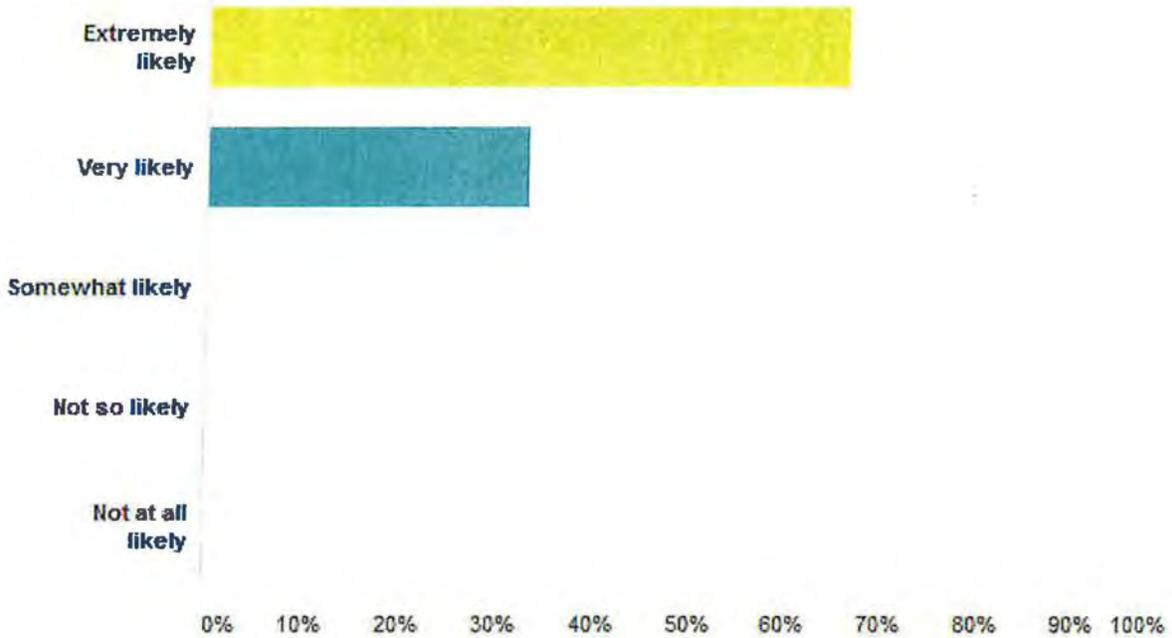
Customize

Export ▾



How likely are you to attend a Tri-Regulatory Symposium again in the future?

Answered: 18 Skipped: 0



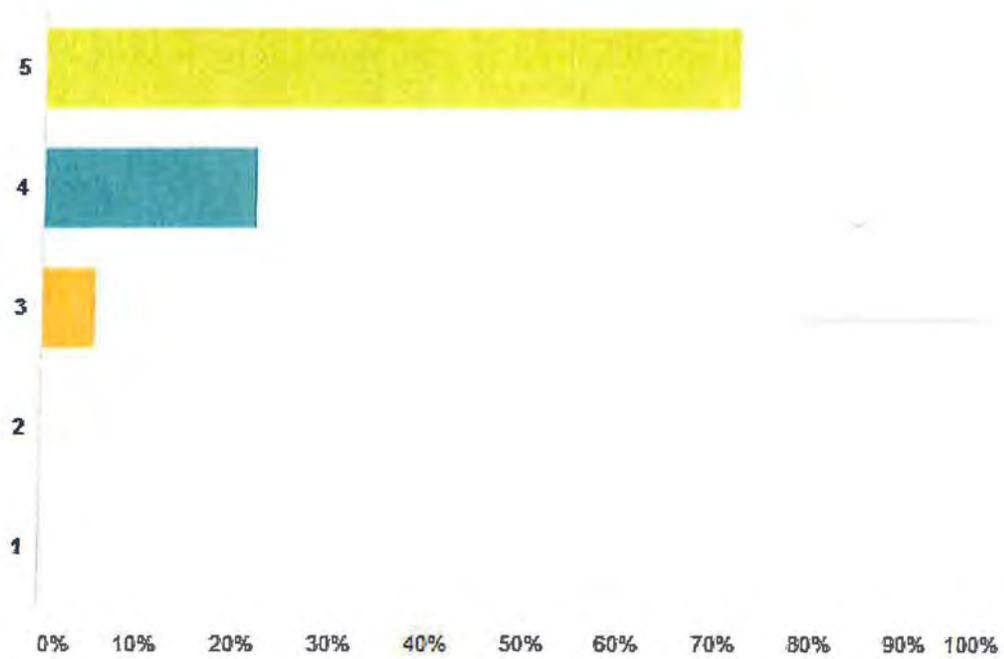
Answer Choices	Responses	
Extremely likely	66.67%	12
Very likely	33.33%	6
Somewhat likely	0.00%	0
Not so likely	0.00%	0
Not at all likely	0.00%	0
Total		18

Q8

Customize Export ▾

Please rate how conducive the environment was to your learning, with 5 as a highest rating and 1 the lowest rating.

Answered: 18 Skipped: 0



Answer Choices	Responses	
5	72.22%	13
4	22.22%	4
3	5.56%	1
2	0.00%	0
1	0.00%	0
Total		18

Tri-Regulatory Symposium Evaluation – survey responses

Any other comments, questions, or concerns?

- (1) Needed a wrap up to get the group thinking about next steps in building relationships between the three regulatory bodies and strategies/ideas/projects we should be considering
- (2) Somewhat cold/chilly in the room
- (3) I was grateful for the opportunity to participate in this event. The presenters and discussions were thoughtful and thought-provoking. It was a great opportunity to connect and collaborate with others tasked with public protection through the role of regulation.
- (4) It was off schedule almost immediately, which, for those who work the next day, made for a very late evening. The Commons itself, seems like a good place for this type of event.
- (5) Well done. Look forward to the next Tri-Regulatory Symposium. Am very proud of Minnesota.
- (6) although I am not a regulator, the information was extremely helpful and educational to better understand what is going on in regulation of health professionals
- (7) In a true effort of collaboration, inviting all of the Executive Directors from the all of the HRLBs would be optimal.
- (8) Doris Gunderson's presentation was terrific
- (9) Having both Dr. Brandt and Gunderson was too much. Would have liked more of Dr. Gunderson.

What topics would you like to see presented for a future Tri-Regulatory Symposium?

- (1) Developing guidelines and scenarios to begin applying tri-regulation to healthcare issues and future planning
- (2) Substance Use Disorder, diversion
- (3) Examples of collaboration on investigations by multiple agencies
- (4) Collaborative practices
- (5) data driven examples of team care better than prior. What is the return on investment team vs. current? Convince me that it fulfills the triple aim, of cheaper, safer and higher access.
- (6) chemical dependency monitoring mental health monitoring
- (7) More opportunity for the members of the boards to interact.
- (8) How to assess ongoing competency to practice. Approaches to disciplinary cases. Use of HPSP. Borderless practice.
- (9) The role, impact, perception of the Public Member on HLBs. Continued attention paid to states that have legalized MJ - and up-to-date stats on how, if at all, it has/is affecting the surrounding states that do NOT have legal MJ.
- (10) Possible joint guidelines on certain topics: opioid dependency; medical cannabis; substance use disorders
- (11) Team Based Care. Employment structures.
- (12) Minnesota legislation reform as it relates to health professionals
- (13) Addressing aging health care practitioners: 1) impact of fewer health care practitioners, 2) cognitive decline among aging health care practitioners, and 3) the the promotion of careers in health care.
- (14) scope of practice
- (15) Team based care
- (16) Pharmacy compounding, scope of practice, cosmetic spas, clinics with out of state ownership that are money mills
- (17) Scope of practice conflicts (i.e. turf wars)
- (18) Medical cannabis and implications for regulatory - perhaps a joint approach from the 3 boards. Implications for MN HLB following the NC Dental board case. Collaboration on other issues such as PMP utilization, etc.

DATE: September 10, 2016

SUBJECT: Appointment of a Nominating Committee

SUBMITTED BY: Subbarao Inampudi, M.B., B.S., FACR

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following Board Members are suggested for appointment to the Board's Nominating Committee.

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

The Board is asked to approve their appointment to the Committee.

MOTION BY:

SECOND:

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

The election of Board Officers for the Year 2017 will take place at the regularly scheduled meeting of the Board on November 12, 2016.

It is the custom of the Board that the current Board President suggests appointments to the Nominating Committee for approval by the full Board.

The criteria for the make-up of the Nominating Committee has, historically, been that it consists of two physicians and one public member, that one member be at the end of Board service, one member be a newer Board member and one member be the out-going Board President.

DATE: September 10, 2016

SUBJECT: Proposed 2017 Meeting Dates

SUBMITTED BY: Ruth M. Martinez, M.A., Executive Director

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Check your calendars for the 2017 Board meetings.

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

The following dates are anticipated for Board meetings during calendar year 2017.

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 14
March 11
May 13
July 8
September 10
November 11 (Veterans Day – discuss)

CONTESTED CASE DATES

February 11
April 8
June 10
August 12
October 14
December 9

The Federation of State Medical Boards' Annual Meeting will be April 20-22, 2017, at the Omni Fort Worth Hotel in Fort Worth, Texas.

DATE: September 10, 2016

SUBJECT: New Business

SUBMITTED BY: Subbarao Inampudi, M.D., B.S., FACR, Board President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

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

BACKGROUND:

On August 31, 2016, the Executive Committee conducted a performance evaluation of executive director, Ruth Martinez. Results of the performance evaluation were communicated to Ms. Martinez by Dr. Inampudi.

Any other new business to be discussed?

DATE: September 10, 2016

SUBJECT: Corrective or Other Actions

SUBMITTED BY: Complaint Review Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Licensure Committee.

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

For your information only, attached are copies of Corrective or other Actions that were implemented between May 1 and September 2, 2016.

**TRUE AND EXACT
COPY OF ORIGINAL**

**BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE**

In the Matter of the
Physician Assistant License of
David S. Pecora, P.A.
Year of Birth: 1963
License Number: 10,593

**COMMITTEE ORDER
AMENDING THE BOARD'S
STIPULATION AND ORDER**

FACTS

1. During all times herein, David S. Pecora, P.A. ("Respondent"), has been and now is subject to the jurisdiction of the Minnesota Board of Medical Practice ("Board") from which he holds a license to practice as a physician assistant in the State of Minnesota.

2. By Stipulation and Order dated January 10, 2015, Respondent's license to practice as a physician assistant in the State of Minnesota was indefinitely suspended by the Board based upon his relapse to chemical use.

3. By Stipulation and Order dated November 14, 2015 ("2015 Order"), Respondent's license to practice as a physician assistant was reinstated by the Board. Under the provisions of the 2015 Order, Respondent's license was also suspended, but the suspension was stayed contingent upon Respondent's compliance with terms and conditions that required, in part, that Respondent participate in the Health Professionals Services Program (HPSP) and fully comply with all terms and conditions of his HPSP monitoring plan; practice in a pre-approved group setting; restrict his access to controlled substances at work, with a provision for Respondent to submit a petition to the Complaint Review Committee to modify or remove this restriction at the Committee's discretion and by its own order; obtain a work-site monitor to

submit periodic reports regarding Respondent's overall work performance; and meet with a designated Board member on a quarterly basis.

4. On June 13, 2016, the Board received Respondent's written petition for modification of the terms of his 2015 Order to eliminate the requirement that prohibited his access to controlled substances at work.

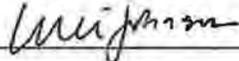
5. The Complaint Review Committee, having convened on July 18, 2016, to review and consider the above-referenced matter, issues the following:

ORDER

6. IT IS HEREBY ORDERED that the requirement that prohibited Respondent's access to controlled substances at work shall be eliminated. The remainder of the terms and conditions of the Stipulation and Order of November 14, 2015, shall remain in full force and effect.

7. IT IS FURTHER ORDERED that this Committee Order, amending the Board's Stipulation and Order of November 14, 2015, is hereby adopted and implemented on this 21st day of July, 2016.

MINNESOTA BOARD OF
MEDICAL PRACTICE
COMPLAINT REVIEW COMMITTEE

By: 



MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246

Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us

MN Relay Service for Hearing Impaired (800) 627-3529

PUBLIC DOCUMENT

**TRUE AND EXACT
COPY OF ORIGINAL**

August 11, 2016

David Richard Moyer, M.D.
Virginia Clinic
1101 Ninth Street North
Virginia, MN 55792

RE: Agreement for Corrective Action, Dated February 19, 2015

Dear Dr. Moyer:

The Complaint Review Committee of the Minnesota Board of Medical Practice has reviewed your Agreement for Corrective Action and documentation in support of satisfaction of the terms contained therein. The Committee concluded that the Agreement has been satisfied.

Thank you for your cooperation.

Sincerely,

A handwritten signature in black ink, appearing to read "Ruth M. Martinez", written over a horizontal line.

Ruth M. Martinez
Executive Director

TRUE AND EXACT COPY OF ORIGINAL

BEFORE THE MINNESOTA BOARD OF MEDICAL PRACTICE COMPLAINT REVIEW COMMITTEE

In the Matter of the
Medical License of
David F. Labadie, M.D.
Year of Birth: 1968
License Number: 39,500

AGREEMENT FOR CORRECTIVE ACTION

This Agreement is entered into by and between David F. Labadie, M.D. ("Respondent"), and the Complaint Review Committee ("Committee") of the Minnesota Board of Medical Practice ("Board") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (2014). 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 Mark R. Whitmore, Bassford Remele, 33 South Sixth Street, Suite 3800, Minneapolis, Minnesota 55402, telephone (612) 333-3000. The Board was represented by Brian L. Williams, Assistant Attorney General, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101, (651) 296-7575. Respondent and the Committee hereby agree as follows:

FACTS

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 January 11, 1997. Respondent is board-certified in orthopedic surgery.
 - b. In April 2015, the Board received a medical malpractice payment report alleging that Respondent failed to provide appropriate surgical care for a patient, who had sustained an injury to the elbow as a result of a fall.

c. The Board initiated an investigation into Respondent's practice, which revealed concerns regarding Respondent's post-operative patient care, particularly for elbow fractures; and concerns regarding Respondent's formal supervision of a physician assistant, who had rendered follow-up care to Respondent's patients.

2. On April 21, 2016, 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. § 147.091, subd. 1(h) (failure to supervise a physician assistant) and (k) (failure to conform to the minimal standard of acceptable medical practice) (2014), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action under this statute.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraph 1 by taking the following corrective action:

a. Respondent shall successfully complete the following coursework, approved in advance by the Committee or its designee, within six months of the date of this Agreement:

(1) One-on-one educational program offered by the Physician Assessment and Clinical Education (PACE) program, or its equivalent, on the best practices for supervision of a physician assistant.

(2) Management of elbow fractures.

Successful completion shall be determined by the Board or its designee.

b. Following successful completion of the above-referenced coursework and within one year of the date of this Agreement, Respondent shall write and submit a paper, for

review and approval by the Committee or its designee, discussing what he has learned from the required coursework and how he has implemented the knowledge into his practice.

4. This Agreement shall become effective upon execution by the Committee and shall remain in effect until Respondent successfully completes the terms of the Agreement. Successful completion shall be determined by the Committee.

5. Upon Respondent's satisfactory completion of the Agreement for Corrective Action, the Committee agrees to issue a letter of satisfaction to Respondent and dismiss the complaint(s) referred to in paragraph 1. Respondent agrees that the Committee shall determine satisfactory completion. Respondent understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to the information in paragraph 1, the Committee may reopen the dismissed complaint(s).

6. If Respondent fails to complete the corrective action satisfactorily or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the Committee may, in its discretion, reopen the investigation and proceed according to Minn. Stat. chs. 147, 214, and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minnesota Statutes section 147.131. In any subsequent proceeding, the Committee may use as proof of the allegations of paragraphs 1 and 2 Respondent's agreements herein.

7. Respondent understands that this Agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this Agreement and any letter of satisfaction are classified as public data.

8. Respondent hereby acknowledges having read and understood this Agreement and having voluntarily entered into it. This Agreement contains the entire agreement between

the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise,
which varies the terms of this Agreement.

Dated: August 11, 2016

David F. Labadie M.D.
DAVID F. LABADIE, M.D.
Respondent

Dated: August 16, 2016

[Signature]
FOR THE COMMITTEE

