1. Update on 2017 housekeeping changes to the Medical Practice Act.

2. Presentation on proposed changes to the Registered Athletic Trainers Practice Act.
   - Draft legislation.
   - Athletic Trainers Modification Act.
   - Athletic Trainers Act Modification, Abstract.

3. Presentation on proposed changes to the Registered Naturopathic Doctors Practice Act.
   - Enclosed copy of current practice act, Minn. Stat. § 147E.
   - Draft legislation.
   - Frequently Asked Questions about Naturopathic Medicine in the USA, by Serina Aubrecht, Immediate Past Chair, Naturopathic Doctor Advisory Board.
   - Naturopathic Formulary Laws by State.
   - 10 Reasons Naturopathic Medicine Lowers Healthcare Costs.
   - Naturopathic Medicine: Cost Saving Disease Prevention and Health Improvement.
   - Framework for Scope of Practice Proposal

4. Presentation on proposals for modifying licensure requirements for Immigrant International Medical Graduates.
   - Proposals discussed by the International Medical Graduate (IMG) Licensure Study Work Group.
   - Proposal(s) for potential recommendation and incorporation into the IMG Stakeholder Group report to the 2017 Legislature.
   - Chapter 71 - S.F. No. 1458, Section 17. [144.1911] International Medical Graduates Assistance Program.
   - IMG Program – www.health.state.mn.us/divs/orhpc/img/.
   - Continuum of Services – Years 1-2 of IMG Assistance Program.
148.7801 CITATION.

Sections 148.7801 to 148.7815 may be cited as the "Minnesota Athletic Trainers Act."

**History:** 1993 c 232 s 2
148.7802 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Approved continuing education program. "Approved continuing education program" means a continuing education program that meets the continuing education requirements in section 148.7812 and is approved by the board.

Subd. 3. Approved education program. "Approved education program" means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by a nationally recognized accreditation agency for athletic training education programs approved by the board.

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

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

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

Subd. 7. Board. "Board" means the Board of Medical Practice.

Subd. 8. Credential. "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to practice as an athletic trainer in this state or any other state.

Subd. 9. Credentialing examination. "Credentialing examination" means an examination administered by the Board of Certification, or the board's recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Subd. 10. Primary employment site. "Primary employment site" means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.

Subd. 11. Primary physician. "Primary physician" means a licensed medical physician who serves as a medical consultant to an athletic trainer.

History: 1993 c 232 s 3; 2014 c 291 art 4 s 14,15
148.7803 DESIGNATION OF ATHLETIC TRAINER.

Subdivision 1. Designation. A person shall not use in connection with the person's name the words or letters registered athletic trainer; licensed athletic trainer; Minnesota registered athletic trainer; athletic trainer; AT; ATR; or any words, letters, abbreviations, or insignia indicating or implying that the person is an athletic trainer, without a certificate of registration as an athletic trainer issued under sections 148.7808 to 148.7810. A student attending a college or university athletic training program must be identified as an "athletic training student."

Subd. 2. Penalty. A person who violates this section is guilty of a misdemeanor and subject to section 214.11.

History: 1993 c 232 s 4; 2014 c 291 art 4 s 16
148.7804 POWERS OF THE BOARD.

The board, acting under the advice of the Athletic Trainers Advisory Council, shall issue all registrations and shall exercise the following powers and duties:

(1) adopt rules necessary to implement sections 148.7801 to 148.7815;

(2) prescribe registration application forms, certificate of registration forms, protocol forms, and other necessary forms;

(3) approve a registration examination;

(4) keep a complete record of registered athletic trainers, prepare a current official listing of the names and addresses of registered athletic trainers, and make a copy of the list available to any person requesting it upon payment of a copying fee established by the board;

(5) keep a permanent record of all its proceedings; and

(6) establish the duties of, and employ, clerical personnel.

History: 1993 c 232 s 5
148.7805 ATHLETIC TRAINERS ADVISORY COUNCIL.

Subdivision 1. Membership. The Athletic Trainers Advisory Council is created and is composed of eight members appointed by the board. The advisory council consists of:

(1) two public members as defined in section 214.02;

(2) three members who are registered athletic trainers, one being both a licensed physical therapist and registered athletic trainer as submitted by the Minnesota American Physical Therapy Association;

(3) two members who are medical physicians licensed by the state and have experience with athletic training and sports medicine; and

(4) one member who is a doctor of chiropractic licensed by the state and has experience with athletic training and sports injuries.

Subd. 2. Administration. The advisory council is established and administered under section 15.059.

Subd. 3. Duties. The advisory council shall:

(1) advise the board regarding standards for athletic trainers;

(2) distribute information regarding athletic trainer standards;

(3) advise the board on enforcement of sections 148.7801 to 148.7815;

(4) review registration and registration renewal applications and make recommendations to the board;

(5) review complaints in accordance with sections 214.10 and 214.13, subdivision 6;

(6) review investigation reports of complaints and recommend to the board whether disciplinary action should be taken;

(7) advise the board regarding evaluation and treatment protocols;

(8) advise the board regarding approval of continuing education programs; and

(9) perform other duties authorized for advisory councils under chapter 214, as directed by the board.

History: 1993 c 232 s 6; 2000 c 260 s 25; 2014 c 286 art 8 s 20; 2014 c 291 art 4 s 17
148.7806 ATHLETIC TRAINING.

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

(a) An athletic trainer shall:

(1) prevent, recognize, and evaluate athletic injuries;

(2) give emergency care and first aid;

(3) manage and treat athletic injuries; and

(4) rehabilitate and physically recondition athletic injuries.

The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site.

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

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

(d) An athletic trainer may:

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

(2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and

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

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

History: 1993 c 232 s 7
148.7807 LIMITATIONS ON PRACTICE.

If an athletic trainer determines that a patient's medical condition is beyond the scope of practice of that athletic trainer, the athletic trainer must refer the patient to a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing and in accordance with established evaluation and treatment protocols. An athletic trainer shall modify or terminate treatment of a patient that is not beneficial to the patient, or that is not tolerated by the patient.

History: 1993 c 232 s 8
148.7808 REGISTRATION; REQUIREMENTS.

Subdivision 1. Registration. The board may issue a certificate of registration as an athletic trainer to applicants who meet the requirements under this section. An applicant for registration as an athletic trainer shall pay a fee under section 148.7815 and file a written application on a form, provided by the board, that includes:

(1) the applicant's name, Social Security number, home address and telephone number, business address and telephone number, and business setting;
(2) evidence satisfactory to the board of the successful completion of an education program approved by the board;
(3) educational background;
(4) proof of a baccalaureate or master's degree from an accredited college or university;
(5) credentials held in other jurisdictions;
(6) a description of any other jurisdiction's refusal to credential the applicant;
(7) a description of all professional disciplinary actions initiated against the applicant in any other jurisdiction;
(8) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;
(9) evidence satisfactory to the board of a qualifying score on a credentialing examination;
(10) additional information as requested by the board;
(11) the applicant's signature on a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and
(12) the applicant's signature on a waiver authorizing the board to obtain access to the applicant's records in this state or any other state in which the applicant has completed an education program approved by the board or engaged in the practice of athletic training.

Subd. 2. [Repealed, 2014 c 291 art 4 s 59]

Subd. 3. Registration by reciprocity. (a) The board may register by reciprocity an applicant who:

(1) submits the application materials and fees required under subdivision 1, clauses (1) to (8) and (10) to (12);
(2) provides a verified copy of a current and unrestricted credential for the practice of athletic training in another jurisdiction that has credentialing requirements equivalent to or more stringent than the requirements under subdivision 1; and
(3) provides letters of verification from the credentialing body in each jurisdiction in which the applicant holds a credential. Each letter must include the applicant's name, date of birth, credential number, date of issuance of the credential, a statement regarding disciplinary actions taken against the applicant, and the terms under which the credential was issued.
(b) An applicant for registration by reciprocity who has applied for registration under subdivision 1 and meets the requirements of paragraph (a), clause (1), may apply to the board for temporary registration under subdivision 4.

Subd. 4. Temporary registration. (a) The board may issue a temporary registration as an athletic trainer to qualified applicants. A temporary registration is issued for 120 days. An athletic trainer with a temporary registration may qualify for full registration after submission of verified documentation that the athletic trainer has achieved a qualifying score on a credentialing examination within 120 days after the date of the temporary registration. A temporary registration may not be renewed.

(b) Except as provided in subdivision 3, paragraph (a), clause (1), an applicant for a temporary registration must submit the application materials and fees for registration required under subdivision 1, clauses (1) to (8) and (10) to (12).

(c) An athletic trainer with a temporary registration shall work only under the direct supervision of an athletic trainer registered under this section. No more than two athletic trainers with temporary registrations shall work under the direction of a registered athletic trainer.

Subd. 5. Temporary permit. The board may issue a temporary permit to practice as an athletic trainer to an applicant eligible for registration under this section if the application for registration is complete, all applicable requirements in this section have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the athletic trainer's application for registration.

History: 1993 c 232 s 9; 1999 c 33 s 7,8; 2014 c 291 art 4 s 18,19
148.7802 DEFINITIONS

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Approved continuing education program. “Approved continuing education program” means a continuing education program that meets the continuing education requirements in section 148.7812 and is approved by the board.

Subd. 3. Approved education program. “Approved education program” means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by a nationally recognized accreditation agency for athletic training education programs approved by the board.

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

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

Subd. 6. Athletic trainer. “Athletic trainer” means a person who engages in athletic training under section 148.7802 and 148.7806 and is licensed registered under section 148.7808.

Subd. 6a. Athletic training. “Athletic training” means the provision of care for the prevention, recognition, evaluation, management, rehabilitation, and reconditioning of human ailments sustained or exacerbated by physical activity, or that limits the patient’s or client’s full return to functional physical activities and wellness. Athletic training does not include the practice of medicine as defined in section 147.081, or the practice of chiropractic as defined in section 148.01, or the practice of podiatric medicine as defined in section 153.01.

Subd. 7. Board. “Board” means the Board of Medical Practice.

Subd. 8. Credential. “Credential” means a license, permit, certification, registration, or other evidence of qualification or authorization to practice as an athletic trainer in this state or any other state.

Subd. 9. Credentialing examination. “Credentialing examination” means an examination administered by the Board of Certification, or the board’s recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Subd. 10. Primary employment site. “Primary employment site” means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.

Subd. 11. Primary physician. “Primary physician” means a licensed medical physician who serves as a medical consultant to an athletic trainer.

History: 1993 c 232 s 3; 2014 c 291 art 4 s 14, 15
148.7803 DESIGNATION OF ATHLETIC TRAINER.

Subdivision 1. **Designation.** A person shall not use in connection with the person’s name the words or letters registered athletic trainer; licensed athletic trainer; Minnesota licensed registered athletic trainer; athletic trainer; AT; ATR; ATC; LAT; or any words, letters, abbreviations, or insignia indicating or implying that the person is an athletic trainer, without a license certificate of registration as an athletic trainer issued under sections 148.7808 to 148.7810. A student attending a college or university athletic training program must be identified as an “athletic training student.”

Subd. 2. **Penalty.** A person who violates this section is guilty of a misdemeanor and subject to section 214.11.

**History:** 1993 c 232 s 4; 2014 c 291 art 4 s 16

148.7804 POWERS OF THE BOARD.

The board, acting under the advice of the Athletic Trainers Advisory Council, shall issue all licenses registrations and shall exercise the following powers and duties:

(1) adopt rules necessary to implement sections 148.7801 to 148.7815;

(2) prescribe license registration application forms, certificate of license registration forms, protocol forms, and other necessary forms;

(3) approve a licensure registration examination;

(4) keep a complete record of licensed registered athletic trainers, prepare a current official listing of the names and addresses of licensed registered athletic trainers, and make a copy of the list available to any person requesting it upon payment of a copying fee established by the board;

(5) keep a permanent record of all its proceedings; and

(6) establish the duties of, and employ, clerical personnel.

**History:** 1993 c 232 s 5
148.7805 ATHLETIC TRAINERS ADVISORY COUNCIL.

Subdivision 1. Membership. The Athletic Trainers Advisory Council is created and is composed of eight members by the board. The advisory council consists of:

(1) two public members as defined in section 214.02;

(2) three members who are licensed registered athletic trainers; one being both a licensed physical therapist and licensed registered athletic trainer as submitted by the Minnesota American Physical Therapy Association; and two as submitted by the Minnesota Athletic Trainers’ Association;

(3) two members who are medical physicians licensed by the state and have experience with athletic training and sports medicine; and

(4) one member who is a doctor of chiropractic licensed by the state and has experience with athletic training and sports injuries.

Subd. 2. Administration. The advisory council is established and administered under section 15.059.

Subd. 3. Duties. The advisory council shall:

(1) advise the board regarding standards for athletic trainers;

(2) distribute information regarding athletic trainer standards;

(3) advise the board on enforcement of sections 148.7801 to 148.7815;

(4) review licensing registration and license registration renewal applications and makes recommendation to the board;

(5) review complaints in accordance with sections 214.10 and 214.13, subdivision 6;

(6) review investigation reports of complaints and recommend to the board whether disciplinary action should be taken;

(7) advise the board regarding evaluation and treatment protocols;

(8) advise the board regarding approval of continuing education programs; and

(9) perform other duties authorized for advisory councils under chapter 214, as directed by the board.

History: 1993 c 232 s 6; 2000 c 260 s 25; 2014 c 286 art 8 s 20; 2014 c 291 art 4 s 17
148.7806 ATHLETIC TRAINING.

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

(b) An athletic trainer shall perform athletic training on the direction of or in collaboration with a person:

(1) Licensed in the state to practice:
   (i) medicine as defined in section 147.081;
   (ii) as an advanced practice nurse as defined in section 148.171;
   (iii) chiropractic as defined in section 148.01;
   (iv) podiatric medicine as defined in section 153.01;
   (v) as a physician assistant as defined in section 147A.01;
   (vi) dentistry as defined in section 150A.05;
   (vii) physical therapy as defined in section 148.65; and

(2) whose license is in good standing.

   (1) prevent, recognize, and evaluate athletic injuries;
   (2) give emergency care and first aid;
   (3) manage and treat athletic injuries; and
   (4) rehabilitate and physically recondition athletic injuries.

The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in primary employment site.

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

(d) At the primary employment site, (c) except in a corporate setting, an athletic trainer may evaluate and treat an individual athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Prevention, wellness, education, or exercise preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for a treatment by a person (1) licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatric medicine as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and (2) whose license is in good standing.
And athletic trainer may:

1. organize and administer an athletic training program including, but not limited to, educating and counseling athletes;

2. monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and

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

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

History: 1933 c 232 s 7

148.7807 LIMITATIONS ON PRACTICE.

If an athletic trainer determines that a patient’s medical condition is beyond the scope of practice of that athletic trainer, the athletic trainer must refer the patient to a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing and in accordance with established evaluation and treatment protocols. An athletic trainer shall modify or terminate treatment of a patient that is not beneficial to the patient, or that is not tolerated by the patient.

History: 1993 c 232 s 8

148.7808 LICENSE REGISTRATION; REQUIREMENTS.

Subdivision 1. Licensure Registration. The board may issue a license certificate of registration as an athletic trainer to applicants who meet the requirements under this section. An applicant for a license registration as an athletic trainer shall pay a fee under section 148.7815 and file a written application on a form, provided by the board that includes:

1. the applicant’s name, Social Security number, home address and telephone number, business address and telephone number, and business setting;

2. evidence satisfactory to the board of the successful completion of an education program approved by the board;

3. educational background;
proof of a baccalaureate or master’s degree from an accredited college or university;

credentials held in other jurisdictions;

da description of any other jurisdiction’s refusal to credential the applicant;

a description of all professional disciplinary actions initiated against the applicant in any other jurisdictions;

any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

evidence satisfactory to the board of a qualifying score on a credentialing examination;

additional information as requested by the board;

the applicant’s signature on a statement that the information in the application is true and correct to the best of the applicant’s knowledge and belief; and

the applicant’s signature on a waiver authorizing the board to obtain access to the applicant’s records in this state or any other state in which the applicant has completed an education program approved by the board or engaged in the practice of athletic training.

Subd. 2. [Repealed, 2014 c 291 art 4 s 59]

Subd. 3. License Registration by reciprocity. (a) the board may license register by reciprocity an applicant who:

(1) submits the application materials and fees required under subdivision 1, clauses (1) to (8) and (10) to (12);

(2) provides a verified copy of a current and unrestricted credential for the practice of athletic training in another jurisdiction that has credentialing requirements equivalent to or more stringent than the requirements under subdivision 1; and

(3) provides letters of verification from the credentialing body in each jurisdiction in which the applicant holds a credential. Each letter must include the applicant’s name, date of birth, credential number, date of issuance of the credential, a statement regarding disciplinary actions taken against the applicant, and the terms under which the credential was issued.

(b) An applicant for a license registration by reciprocity who has applied for a license registration under subdivision 1 and meets the requirements of paragraph (a), clause (1) may apply to the board for temporary license registration under subdivision 4.
Temporary registration. (a) The board may issue a temporary registration as an athletic trainer to a qualified applicant. A temporary registration is issued for 120 days. An athletic trainer with a temporary registration may qualify for full registration after submission of verified documentation that the athletic trainer has achieved a qualifying score on a credentialing examination within 120 days after the date of the temporary registration. A temporary registration may not be renewed.

(b) Except as provided in subdivision 3, paragraph (a), clause (1), an applicant for a temporary registration must submit the application materials and fees for registration required under subdivision 1, clauses (1) to (8) and (10) to (12).

(c) An athletic trainer with a temporary registration shall work only under the direct supervision of an athletic trainer registered under this section. No more than two athletic trainers with temporary registration shall work under the direction of a registered athletic trainer.

Temporary license permit. The board may issue a temporary license permit to practice as an athletic trainer to an applicant eligible for license registration under this section if the application for a license registration is complete, all applicable requirements in this section have been met, and a nonrefundable fee set by the board has been paid. The license permit remains valid only until the meeting of the board at which a decision is made on the athletic trainer’s application for a license registration.

History: 1993 c 232 s 9; 1999 c 33 s 7,8; 2014 c 291 art 4 s 18,19

148.7809 LICENSE REGISTRATION RENEWAL.

Subdivision 1. Requirements for license registration renewal. A licensed registered athletic trainer shall apply to the board for a one-year extension of license registration by paying a fee under section 148.7815 and filing an application on a form provided by the board that includes:

(1) the athletic trainer’s name, Minnesota athletic trainer license registration number, home address and telephone number, business address and telephone number, and business setting;

(2) work history for the past year, including the average number of hours worked per week;

(3) a report of any change in status since initial registration or previous license registration renewal;

(4) evidence satisfactory to the board of national Board of Certification (or recognized successor) current certification and having met the continuing education requirements of section 148.7812;
(5) the athletic trainer’s signature on a statement that a current copy of the protocol form is on file at the athletic trainer’s primary employment site; and

(6) additional information as requested by the board.

Subd. 2. License Registration renewal notice. Before June 1 of each year, the board shall send out a renewal notice to an athletic trainer’s last known address on file with the board. The notice shall include an application for license registration renewal and notice of the fees required for renewal. An athletic trainer who does not receive a renewal notice must still meet the requirements for license registration renewal under this section.

Subd. 3. Renewal deadline. (a) An application for license renewal of registration must be postmarked on or before July 1 of each year. If the postmark is illegible, the application is considered timely if received in the board office by the third working day after July 1.

(b) An application for license renewal of registration submitted after the deadline date must include a late fee under section 148.7815.

Subd. 4. Lapse of license registration status. (a) Except as provided in paragraph (b), an athletic trainer whose license registration has lapsed must:

(1) apply for license registration renewal under this section; and

(2) submit evidence satisfactory to the board from a licensed medical physician verifying employment in athletic training for eight weeks every three years during the time of the lapse in license registration.

(b) The board shall not renew, reissue, reinstate, or restore a license registration that has lapsed after June 30, 1999, and has not been renewed within two annual renewal cycles starting in July 1, 2001. An athletic trainer whose license registration is cancelled for nonrenewal must obtain a new license registration by applying for a license registration and fulfilling all requirements then in existence for an initial license registration.

History: 1993 c 232 s10; 2001 c 31 s 2
148.7810 BOARD ACTION ON APPLICATIONS.

Subdivision 1. Verification of application information. The board or advisory council, with the approval of the board, may verify information provided by an applicant for license registration under section 148.7808 and license registration renewal under section 148.7809 to determine whether the information is accurate and complete.

Subd. 2. Notification of board action. Within 120 days of receipt of the application, the board shall notify each applicant in writing of the action taken on the application.

Subd. 3. Request for hearing by applicant denied license registration. An applicant denied a license registration shall be notified of the determination, and the grounds for it, and may request a hearing on the determination under Minnesota Rules, part 5615.0300, by filing a written statement of issues with the board within 20 days after receipt of the notice from the board. After the hearing, the board shall notify the applicant in writing of its decision.

History: 1993 c 232 s 11

148.7812 CONTINUING EDUCATION REQUIREMENTS.

Subdivision 1. Number of contact hours required. An athletic trainer shall complete during every three-year period at least the equivalent of 60 contact hours of continuing professional postdegree education in programs approved by the board. The board may accept recertification by the Board of Certification, or the board’s recognized successor, in lieu of compliance with the continuing education requirement during the cycle in which recertification is granted.

Subd. 2. Approved programs. The board shall approve a continuing education program that has been approved for continuing education credit by the Board of Certification, or the board’s recognized successor.

Subd. 3. Approval of continuing education programs. A continuing education program that has not been approved under subdivision 2 shall be approved by the board if:

(1) the program content directly relates to the practice of athletic training or sports medicine;

(2) each member of the program faculty shows expertise in the subject matter by holding a degree from an accreditation education program, having verifiable experience in the field of athletic training or sports medicine, having special training in the subject area, or having experience teaching in the subject area;

(3) the program lasts at least one contact hour;

(4) there are specific written objectives describing the goals of the program for the participants; and

(5) the program sponsor maintains attendance records for four years.
Subd. 4. **Verification of continuing education credits.** The board shall periodically select a random sample of athletic trainers and require the athletic trainers to show evidence to the board of having completed the continuing education requirements attested to by the athletic trainer. Either the athletic trainer or state or national organizations that maintain continuing education records may provide to the board documentation of attendance at a continuing education program.

Subd. 5. **Restriction on continuing education topics.** To meet the continuing education requirement in subdivision 1, an athletic trainer may have no more than ten hours of continuing education in the areas of management, risk management, personal growth, and educational techniques in a three-year reporting period.

**History:** 1993 c 232 s 13; 2014 c 291 art 4 s 20

148.7813 DISCIPLINARY PROCESS.

Subd. 1. [Repealed, 2014 c 291 art 4 s 59]
Subd. 2. [Repealed, 2014 c 291 art 4 s 59]
Subd. 3. [Repealed, 2014 c 291 art 4 s 59]
Subd. 4. [Repealed, 2014 c 291 art 4 s 59]

Subd. 5. **Discipline; reporting.** For the purposes of this chapter, licensed registered athletic trainers and applicants are subject to sections 147.091 to 147.162.

**History:** 1993 c 232 s 14; 2014 c 291 art 4 s 21

148.7814 APPLICABILITY.

Sections 148.7801 to 148.7815 do not apply to persons who are certified as athletic trainers by the Board of Certification or the board’s recognized successor and come into Minnesota for a specific athletic event or series of athletic events with an individual or group.

**History:** 1993 c 232 s 15; 2014 c 291 art 4 s 22
148.7815 FEES.

Subdivision 1. **Fees.** The board shall establish fees as follows:

(1) application fee, $50;

(2) annual license registration fee, $100;

(3) temporary license registration fee, $100; and

(4) temporary permit, $50.

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee for registration under section 148.7808. Athletic trainers licensed registered under section 148.7808 are required to pay the full fee upon license registration renewal.

Subd. 3. **Penalty for a late application for license registration renewal.** The penalty for late submission of a license registration renewal application under section 148.7809 is $15.

Subd. 4. **Nonrefundable fees.** The fees in this section are nonrefundable.

**History:** 1993 c 232 s 16; 1999 c 33 s 9, 10
Athletic Trainers Modification Act

Minnesota Board of Medical Practice
Policy & Planning Committee
October 12, 2016

Presented by the Minnesota Athletic Trainers’ Association
What is an Athletic Trainer?

“An AT is a healthcare professional who renders service or treatment, under the direction of or in collaboration with a physician, in accordance with their education and training and the states’ statutes, rules and regulations. As a part of the healthcare team, services provided by ATs comprise, but are not limited to, prevention and education, emergent care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions.” (BOC Standards of Professional Practice)

Recognized as an allied health care profession by:

- American Medical Association (AMA)
- Health Resources Services Administration (HRSA)
- Department of Health and Human Services (HHS)
Practice Settings

• Orthopedics/Sports Medicine practices
• Rehabilitation clinics
• ED & Urgent Care
• Occupational health
• Military
• College/University athletics & health services

• Performing arts
• Olympics & Paralympics
• Professional sports
• Secondary schools
• Industrial/Manufacturing
• Fitness & Wellness
National Agencies

• Board of Certification, Inc. (BOC)
  • Administers credentialing exam & recertification through continuing education requirements for ATs
  • Qualifying exam score is required for registration in MN §148.7808 Subd. 1

• Commission on Accreditation of Athletic Training Education (CAATE)
  • Recognized by the Council for Higher Education Accreditation (CHEA)
  • Defines education standards nationally
  • Measures & accredits AT education programs
  • Approximately 360 accredited programs worldwide

• National Athletic Trainers’ Association (NATA)
  • Professional association with over 49,000 members
  • Collaborates with BOC & CAATE through a formal Strategic Alliance
Demographics

<table>
<thead>
<tr>
<th></th>
<th>1993</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATA Members</td>
<td>≈ 7,500</td>
<td>&gt; 49,000</td>
</tr>
<tr>
<td>Registered ATs in MN</td>
<td>170</td>
<td>966</td>
</tr>
<tr>
<td>Disciplinary or Corrective Actions</td>
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</tr>
<tr>
<td>Accredited AT Education Programs</td>
<td>1</td>
<td>8*</td>
</tr>
</tbody>
</table>

*Two are post-baccalaureate degree programs

Bureau of Labor Statistics predicts an overall increase of **21.1%** in athletic trainer employment by 2024, with estimated **46.9%** growth in the ambulatory care sector.
Education Changes Since 1993

• The past 20 years has seen significant advancement in professional preparation of athletic trainers
  • Program type & degree level
  • Heightened accreditation standards & outcome measures
  • Increased clinical experiences across practice settings

• By 2022 all entry-level education will be at the Master’s degree level

<table>
<thead>
<tr>
<th></th>
<th>1993</th>
<th>2005</th>
<th>2016</th>
<th>2022</th>
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<td>Program type</td>
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<td>Bachelor’s</td>
<td>Bachelor’s or Master’s</td>
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</tr>
</tbody>
</table>
Educational Content – 5th Edition Competencies

- Evidence-based practice
- Prevention & health promotion
- Clinical examination & diagnosis
- Acute care of injury & illness
- Therapeutic interventions
- Psychosocial strategies & referral
- Health care administration
- Professional development & responsibility
Athletic Trainers Modification Act

• Transition from registration to licensure

• Intended to update the scope of practice for athletic trainers in MN
  • Minnesota Athletic Trainers Act was first enacted 1993
  • Minor housekeeping revision since; no definition or scope adjustments despite significant advancement in the professional preparation of ATs

• Further restrict temporary credentialing to only allow for applicants who have successfully completed the BOC credentialing exam
Proposed Revisions – Credential Level

• From Registration to Licensure
  “In MN, as in other jurisdictions, registration is a less restrictive form of credentialing. In order to be a registered health care professional, an individual must meet certain educational, training and examination requirements that he or she is qualified to practice and use the appropriate title to the profession, but other individuals may engage in the practice without the use of the title. Minnesota law provides that registration is the appropriate level of credentialing for athletic trainers and naturopathic doctors.” (Minnesota Board of Medical Practice)

• Given the advancement in AT education, registration is no longer the appropriate level of credentialing & does not mirror the rest of the nation.
49 states & the District of Columbia regulate athletic trainers among regulated states, 43 license ATs. Among regulated states, only 7 require a protocol form signed by a supervising physician.
Create a formal definition of “athletic training” in §148.7802 that reads:

"Athletic training" means the provision of care for the prevention, recognition, evaluation, management, rehabilitation, and reconditioning human ailments sustained or exacerbated by physical activity, or that limits the patient's or client's full return to functional physical activities and wellness. Athletic training does not include the practice of medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, or the practice of podiatric medicine as defined in section 153.01"
Proposed Revisions – Scope of Practice

• Adjusts §148.7806 to identify the patient or client population from only “athletes” to “individuals”

• Asserts that “prevention, wellness, education, or exercise is not considered treatment” which matches the existing exclusion clause in item a(8) of §148.75 in the Physical Therapy Practice Act in regards to preventative care.
Proposed Revisions – Scope of Practice

Assert in §148.7806 that:

“Our athletic trainer shall perform athletic training on the direction or in collaboration with a person: 1). licensed in the state to practice: (i) medicine as defined in section 147.081; (ii) as an advanced practice registered nurse defined in section 148.171; (iii) chiropractic as defined in section 148.01; (iv) podiatric medicine as defined in section 153.01; (v) as a physician assistant as defined in section 147A.01; (vi) dentistry as defined in section 150A.05; (vii) physical therapy as defined in section 148.65; and 2). whose license is in good standing.”
Proposed Revisions – Scope of Practice

• Removes the protocol form signed only by a MD or DO as required in §148.7806 in order to allow for collaboration with the other licensed health professionals previously mentioned.

• The *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations* white paper asserts that “collaboration between healthcare providers should be the professional norm”, especially at a time when the Institute of Medicine considers the development of interdisciplinary care teams as a core competency for all health professions.

• Only 6 other states require a signed protocol form in its regulation of athletic trainers
Proposed Revisions – Temporary Credential

• Repeals the temporary practice provision (§148.7808 Subd. 2) that allows individuals who have not yet successfully completed the national examination from the Board of Certification, Inc. to practice under the supervision of a registered athletic trainer for 120 days.

• Seeking to further restrict new applicants/individuals to the athletic training profession to better protect the public.
Questions & Discussion
Contacts

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Chair, MATA Governmental Affairs Committee
gac@manta.com
ABSTRACT

Statutes 148.7801 – 148.7815, the Minnesota Athletic Trainers’ Act was originally enacted in 1993 and has not received any updates to definitional language or scope of practice since that time. The Athletic Trainers Modification Act seek to modify these statutes to bring definitional language around scope of practice in line with professional practice and mirror the evolution of this health care profession over the past 23 years.

Amy Brugge, EdD, ATR, ATC
Chair, Governmental Affairs Committee
Minnesota Athletic Trainers’ Association

October 1, 2016
Introduction

The Minnesota Athletic Trainers Act (Minn Stat §148.7801 – 148.7815)¹ was enacted in 1993 to regulate athletic trainers in their professional practice in the state. Athletic trainers across Minnesota have been working to update definitional language around athletic training services for over a decade. In 2014, minor housekeeping revisions were made to update the statutes to reflect current credentialing bodies and educational routes, as the 1993 language had been rendered ineffective in regards to education expectations due to the evolution of athletic training as a health care profession. There was a committee hearing on scope of practice updates once in the Minnesota House of Representatives in 2008, and prior to this legislative session there has never been a committee hearing in the Minnesota Senate related to scope. This report serves to provide background around the history of this profession, describe the registration of athletic trainers in Minnesota, delineate the proposed statute revisions in Athletic Trainers Modification Act, and detail why such action is necessary to improve patients’ access to athletic trainers, further protect the public, and better serve the citizens of Minnesota.

Background

When the Minnesota Athletic Trainers’ Act was in enacted in 1993 there were approximately 170 credentialed athletic trainers in Minnesota² and roughly 7,500 athletic trainers nationwide.³ At the time, the minimum education expectation for athletic trainers was completion of a National Athletic Trainers Association (NATA)-approved bachelor’s curriculum or a bachelor’s degree in a related field with an associated internship, in order to be eligible for the national credentialing examination offered through the Board of Certification, Inc. Today there are 966 athletic trainers registered in Minnesota⁴ and more than 49,000 athletic trainers across the United States.⁵ The minimum education required⁶ to be eligible for the Board of Certification, Inc. examination is a bachelor’s or master’s degree from an accredited program, including at least two years of clinical education, and all accredited programs must transition to the master’s degree level by 2022.⁷ As this evolution in professional preparation has occurred, states have moved athletic trainers to the licensure level⁸ and modified scope of practice accordingly, except in Minnesota where athletic trainers are registered, not licensed, and have not had any definitional or scope of practice updates to the laws that regulate them. Like occupational therapists, who no longer prepare patients for only work-related tasks, athletic trainers no longer care only for “athletes”, but instead provide care to physically active patients across the lifespan. Although a change in nomenclature for this provider group may be appropriate, the National Athletic Trainers’ Association has elected to retain the original name of “athletic trainer” after two serious investigations in the 2000s⁹, as updating practice acts across the nation would be a multi-million dollar endeavor.

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¹ Minn Stat §148.7801-148.7815
² Minnesota Board of Medical Practice
³ Board of Certification, Inc.
⁴ Minnesota Board of Medical Practice – data current as of 9/2016
⁵ Board of Certification, Inc.
⁶ National Athletic Trainers’ Association – Athletic Training Education Overview
⁷ Commission on Accreditation of Athletic Training Education
⁸ National Athletic Trainers’ Association (NATA) – State Regulatory Boards
Athletic Trainer Registration in Minnesota

The 1993 statutes for athletic trainer registration do not define “athletic training”, but instead delineate what an athletic trainer shall do in §148.7806. These statutes detail the process by which athletic trainers register in the state, define the composition of the Athletic Trainers Advisory Council under the Board of Medical Practice, designate the credential, set continuing education requirements, and explicate that athletic trainers evaluate “athletes” and treat “athletic injuries”. It is this definition around “athletes” and “athletic injuries” that does not fully encompass the health care services provided by athletic trainers to patients/clients, nor mirrors the conditions athletic trainers are professionally prepared to evaluate, manage, and/or refer given the evolution of athletic training education competencies\(^\text{10}\) and accredited education programs\(^\text{11}\) since 1993. Further, the Revisor’s office feels that “athletic training” is a term that should be defined alongside all other definitions in the Minnesota Athletic Trainers Act in §148.7802.

Proposed Statute Revision

The Athletic Trainers Modification Act seeks to:

1. Create a formal definition of “athletic training” in §148.7802 that reads:

   "Athletic training” means the provision of care for the prevention, recognition, evaluation, management, rehabilitation, and reconditioning human ailments sustained or exacerbated by physical activity, or that limits the patient's or client's full return to functional physical activities and wellness. Athletic training does not include the practice of medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, or the practice of podiatric medicine as defined in section 153.01”

2. Asserts in §148.7806 that

   “An athletic trainer shall perform athletic training on the direction or in collaboration with a person:
   1). licensed in the state to practice: (i) medicine as defined in section 147.081; (ii) as an advanced practice registered nurse defined in section 148.171; (iii) chiropractic as defined in section 148.01; (iv) podiatric medicine as defined in section 153.01; (v) as a physician assistant as defined in section 147A.01; (vi) dentistry as defined in section 150A.05; (vii) physical therapy as defined in section 148.65; and 2). whose license is in good standing.”

3. Repeals the temporary practice provision (§148.7808 Subd. 2) that allows individuals who have not yet successfully completed the national examination from the Board of Certification, Inc. to practice under the supervision of a registered athletic trainer for 120 days. This change seeks to further restrict individuals in the athletic training profession to better protect the public.

4. Removes the protocol form\(^\text{12}\) signed only by a MD or DO as required in §148.7806 in order to allow for collaboration with the other licensed health professionals previously mentioned. The

\(^{10}\) Athletic Training Education Competencies, 5th Edition  
\(^{11}\) Commission on Accreditation of Athletic Training Education (CAATE)—recognized by the Council for Higher Education Accreditation (CHEA)  
\(^{12}\) Minnesota Board of Medical Practice – Athletic Trainer Registration Protocol Form
Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations

white paper asserts that “collaboration between healthcare providers should be the professional norm”, especially at a time when the Institute of Medicine considers the development of interdisciplinary care teams as a core competency for all health professions.

5. Adjusts §148.7806 to identify the patient or client population from only “athletes” to “individuals” and asserts that “prevention, wellness, education, or exercise is not considered treatment” which matches the existing exclusion clause in item a(8) of §148.75 in the Physical Therapy Practice Act in regards to preventative care.

6. Makes no alteration to item (e) in §148.7806 that states “when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65” so as not to conflict with the business interests of the physical therapists who utilize athletic trainers in the provision of physical therapy, and not to contest the legal precedent set via the Toni Lee v. Fairview Health System case of 2004.

The Rationale for Practice Act Revision

The rationale for the proposed revisions is multi-faceted, yet predicated on the overall need to align the Minnesota Athletic Trainers Act of 1993 with current educational preparation and professional practice. Like all health professions, the practice of athletic training has advanced over the decades, demonstrates professional overlap with other peer provider groups, and requires prerequisite knowledge, skills, and abilities from entry-level education, formal post-professional education, and required continuing education. First, it is necessary to define “athletic training” in state statutes.

The proposed definition of athletic training seeks to succinctly summarize what previously existed outside the definition section in §148.7802 of the Minnesota Athletic Trainers Act, and appropriately encompasses all that athletic trainers are prepared to do either with “patients” or with “clients”. It identifies “human ailments” in the scope language, identical to item a(1) of §148.75 in the physical therapy statutes, and addresses the physically active population athletic trainers regularly engage with in professional practice. In particular, it describes an athletic trainer’s ability to return physically active individuals back to a level of function beyond that of normal activities of daily living to promote and maintain overall health and wellness, and therefore prevent future health care expenditures.

The language "on the direction of or in collaboration with" speaks to the interdisciplinary care team that athletic trainers commonly function within, is inclusive of the variety of licensed providers who may seek to incorporate athletic trainers in their private practice, allows athletic trainers to accept referrals from providers beyond a supervising MD or DO, and yet allows individual healthcare organizations to determine if the athletic trainers should perform care “on the direction” of a specific provider. This language is not unique, as it mirrors the language defining the practice of athletic training in the Board of Certification’s Standards of Professional Practice and corresponds with the National Athletic

13 Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations
14 Institute of Medicine – Core Competencies
15 BOC Standards of Professional Practice
Trainers’ Association definition of athletic trainers.\textsuperscript{16} The proposed revision removes the existing protocol form signed by a MD or DO licensed in Minnesota, which is not collected by the Board of Medical Practice as part of the registration process, as this forms limits other provider groups’ ability to employ an athletic trainer and forces the MD or DO to accept liability for the provision of care by the athletic trainer who may not be directly under their employment. Given that the Bureau of Labor Statistics\textsuperscript{17} predicts an overall increase of 21.1\% in athletic trainer employment by 2024, with estimated 46.9\% growth in the ambulatory care sector, it is prudent that non-physicians also be able to incorporate athletic trainers into their private practice and further increase rural access to athletic training services. Although this protocol form may have been more common in 1993, today only 6 states besides Minnesota retain such a protocol form in their athletic training practice acts. Two additional states require a physician to complete a checkbox form in which they accept liability for the athletic trainer, but overall a protocol form is not the standard in states’ regulation of athletic trainers. Removing the protocol form will make the athletic trainer fully liable for the provision of care and may increase liability insurance premiums for athletic trainers in Minnesota, although this has not been the case in other states where athletic trainers are licensed and do not have a protocol form. However, this is something the state’s athletic trainers are willing to accept in order to have greater participation in collaborative interdisciplinary practice in their employment settings. In regards to public safety, the Board of Medical Practice received eight complaints against seven athletic trainers during the last biennium and there have been three disciplinary or corrective actions taken by the Board of Medical Practice since the profession became regulated in Minnesota.\textsuperscript{18}

Despite this record of safe practice among Minnesota’s athletic trainers, repealing the temporary registration provision for individuals who have not yet successfully completed the national credentialing examination is one way to better protect the public and regulate the profession. Currently, a non-certified athletic trainer may work under the supervision of a registered athletic trainer (who functions under the liability of the associated MD/DO) for up to 120 days. As part of the elimination of the protocol form, it is best practice to also eliminate this temporary permitting of individuals who have not yet passed the national examination for athletic trainers. This is stricter than other provider groups. For instance, an applicant for a physical therapy license who has qualified to be eligible for examination may practice under the supervision of a licensed physical therapist for up to 90 days after the next examination (\textit{Minn Stat §148.71}\textsuperscript{19}), and occupational therapists allow for a similar process for up to six months (\textit{Minn Stat §148.6418}\textsuperscript{20}). Repealing \textit{§148.7808 Subd. 2} from the Minnesota Athletic Trainers Act will ensure that all temporary registrants have already successfully completed the national examination prior to interacting with patients and clients in Minnesota.

It is also necessary to exclude “prevention, wellness, education, or exercise as treatment” in the current 30-day patient access period, as the current version of §148.7806 only states that “preventative care after resolution of the injury is not considered treatment” (emphasis added). The difference between these sentences is simple, as the proposed language ensures that athletic trainers are able to provide preventative care, patient/client education, and wellness and fitness activities prior to the development of an ailment without having to refer this otherwise healthy individual into the healthcare

\textsuperscript{16} National Athletic Trainers’ Association Definition of Athletic Trainers
\textsuperscript{17} Bureau of Labor Statistics – Athletic Trainers Job Outlook
\textsuperscript{18} Email correspondence (09/2016) with Ruth Martinez, Executive Director Board of Medical Practice
\textsuperscript{19} Minn Stat §148.71
\textsuperscript{20} Minn Stat §148.6418
system at the 30-day mark. The goal is to keep healthy clients healthy and not be held to a referral when the “client” has not yet become a “patient”.

Summary

The evolution of the athletic training profession since 1993 is inherently equal to that of other provider groups whose education and professional preparation has expanded, yet athletic trainers in Minnesota have not been granted any scope of practice progression in the 23 years since the Minnesota Athletic Trainers Act was written into law. Today in Minnesota, newly credentialed professionals are held to an outdated definition of their field via a law that was enacted prior to their birth, despite considerable evolution of the athletic training profession in the previous two decades. The Athletic Trainers Modification Act seeks to make these appropriate modifications and update existing statutes to mirror current educational competencies in athletic training and the professional practice of athletic trainers with a physically active population.
CHAPTER 147E
REGISTERED NATUROPATHIC DOCTORS

147E.01 DEFINITIONS.

Subd. 1. Applicability. The definitions in this section apply to this chapter.


Subd. 3. Approved naturopathic medical education program. "Approved naturopathic medical education program" means a naturopathic medical education program in the United States or Canada and meets the requirements for accreditation by the Council on Naturopathic Medical Education (CNME) or an equivalent federally recognized accrediting body for the naturopathic medical profession recognized by the board. This program must offer graduate-level full-time didactic and supervised clinical training leading to the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an institution, or part of an institution, of higher education that at the time the student completes the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting agency recognized by the United States Secretary of Education; or

(2) a degree granting college or university that prior to the existence of CNME offered a full-time structured curriculum in basic sciences and supervised patient care comprising a doctoral naturopathic medical education that is at least 132 weeks in duration, must be completed in at least 35 months, and is reputable and in good standing in the judgment of the board.

Subd. 4. Board. "Board" means the Board of Medical Practice or its designee.

Subd. 5. Contact hour. "Contact hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. Homeopathic preparations. "Homeopathic preparations" means medicines prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. Registered naturopathic doctor. "Registered naturopathic doctor" means an individual registered under this chapter.

Subd. 8. Minor office procedures. "Minor office procedures" means the use of operative, electrical, or other methods for the repair and care incidental to superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in the superficial tissues and the use of antiseptics and local topical anesthetics in connection with such methods.
Subd. 9. **Naturopathic licensing examination.** "Naturopathic licensing examination" means the Naturopathic Physicians Licensing Examination or its successor administered by the North American Board of Naturopathic Examiners or its successor as recognized by the board.

Subd. 10. **Naturopathic medicine.** "Naturopathic medicine" means a system of primary health care for the prevention, assessment, and treatment of human health conditions, injuries, and diseases that uses:

(1) services, procedures, and treatments as described in section 147E.05; and

(2) natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. **Naturopathic physical medicine.** "Naturopathic physical medicine" includes, but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous electrical nerve stimulation, and therapeutic exercise.

**History:** 2008 c 348 s 1

147E.05 SCOPE OF PRACTICE.

Subdivision 1. **Practice parameters.** (a) The practice of naturopathic medicine includes, but is not limited to, the following services:

(1) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease;

(2) performing or ordering physical examinations and physiological function tests;

(3) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);

(4) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results;

(5) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and

(6) prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor may admit patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

Subd. 2. **Prohibitions on practice.** (a) The practice of naturopathic medicine does not include:

(1) administering therapeutic ionizing radiation or radioactive substances;
(2) administering general or spinal anesthesia;

(3) prescribing, dispensing, or administering legend drugs or controlled substances including chemotherapeutic substances; or

(4) performing or inducing abortions.

(b) A naturopathic doctor registered under this chapter shall not perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.

(c) A naturopathic doctor shall not practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietician, nutritionist, or any other health care professional, unless the naturopathic physician also holds the appropriate license or registration for the health care practice profession.

History: 2008 c 348 s 2

147E.06 PROFESSIONAL CONDUCT.

Subdivision 1. Informed consent. (a) The registered naturopathic doctor shall obtain a signed informed consent from the patient prior to initiating treatment and after advising the patient of the naturopathic doctor's qualifications including education and registration information; and outlining of the scope of practice of registered naturopathic doctors in Minnesota. This information must be supplied to the patient in writing before or at the time of the initial visit. The registrant shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor must provide a copy of the informed consent form to the board.

Subd. 2. Patient records. (a) A registered naturopathic doctor shall maintain a record for seven years for each patient treated, including:

(1) a copy of the informed consent;

(2) evidence of a patient interview concerning the patient's medical history and current physical condition;

(3) evidence of an examination and assessment;

(4) record of the treatment provided to the patient; and

(5) evidence of evaluation and instructions given to the patient, including acknowledgment by the patient in writing that, if deemed necessary by the registered naturopathic doctor, the patient has been advised to consult with another health care provider.

(b) A registered naturopathic doctor shall maintain the records of minor patients for seven years or until the minor's 19th birthday, whichever is longer.
Subd. 3. Data practices. All records maintained on a naturopathic patient by a registered naturopathic doctor are subject to sections 144.291 to 144.298.

Subd. 4. State and municipal public health regulations. A registered naturopathic doctor shall comply with all applicable state and municipal requirements regarding public health.

History: 2008 c 348 s 3

147E.10 PROTECTED TITLES.

Subdivision 1. Designation. (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," or use, in connection with the individual's name, the letters "R.N.D." or "N.M.D.,” or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered naturopathic doctor unless the individual has been registered as a registered naturopathic doctor according to this chapter.

(b) After July 1, 2009, individuals who are registered under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration in the place of practice.

Subd. 2. Other health care practitioners. Nothing in this chapter may be construed to prohibit or to restrict:

(1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;

(2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;

(3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;

(4) the practice by a naturopathic doctor duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota registered naturopathic doctor; or

(5) individuals not registered by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. Penalty. A person violating subdivision 1 is guilty of a misdemeanor.

History: 2008 c 348 s 4

147E.15 REGISTRATION REQUIREMENTS.

Subdivision 1. General requirements for registration. To be eligible for registration, an applicant must:

(1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:
(i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;

(ii) the name and location of the naturopathic medical program the applicant completed;

(iii) a list of degrees received from other educational institutions;

(iv) a description of the applicant's professional training;

(v) a list of registrations, certifications, and licenses held in other jurisdictions;

(vi) a description of any other jurisdiction's refusal to credential the applicant;

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

(viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

(2) submit a copy of a diploma from an approved naturopathic medical education program;

(3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;

(4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;

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

(6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 2. Registration by endorsement; reciprocity. (a) To be eligible for registration by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:

(1) submit the application materials and fees as required by subdivision 1, clauses (1), (2), and (4) to (6);

(2) have successfully passed either:

(i) the Naturopathic Physicians Licensing Examination; or

(ii) if prior to 1986, the state or provincial naturopathic board licensing examination required by that regulating state or province;

(3) provide a verified copy from the appropriate government body of a current license, registration, or certification for the practice of naturopathic medicine in another jurisdiction that has initial licensing, registration, or certification requirements equivalent to or higher than the requirements in subdivision 1; and
(4) provide letters of verification from the appropriate government body in each jurisdiction in which
the applicant holds a license, registration, or certification. Each letter must state the applicant's name, date
of birth, license, registration, or certification number, date of issuance, a statement regarding disciplinary
actions, if any, taken against the applicant, and the terms under which the license, registration, or certification
was issued.

(b) An applicant applying for license, registration, or certification by endorsement must be licensed,
registered, or certified in another state or Canadian province prior to January 1, 2005, and have completed
a 60-hour course and examination in pharmacotherapeutics.

Subd. 3. Temporary registration. The board may issue a temporary registration to practice as a
registered naturopathic doctor to an applicant who is licensed, registered, or certified in another state or
Canadian province and is eligible for registration under this section, if the application for registration is
complete, all applicable requirements in this section have been met, and a nonrefundable fee has been paid.
The temporary registration remains valid only until the meeting of the board at which time a decision is
made on the registered naturopathic doctor's application for registration.

Subd. 4. Registration expiration. Registrations issued under this chapter expire annually.

Subd. 5. Renewal. To be eligible for registration renewal a registrant must:

(1) annually, or as determined by the board, complete a renewal application on a form provided by the
board;

(2) submit the renewal fee;

(3) provide evidence of a total of 25 hours of continuing education approved by the board as described
in section 147E.25; and

(4) submit any additional information requested by the board to clarify information presented in the
renewal application. The information must be submitted within 30 days after the board's request, or the
renewal request is nullified.

Subd. 6. Change of address. A registrant who changes addresses must inform the board within 30 days,
in writing, of the change of address. All notices or other correspondence mailed to or served on a registrant
by the board are considered as having been received by the registrant.

Subd. 7. Registration renewal notice. At least 45 days before the registration renewal date, the board
shall send out a renewal notice to the last known address of the registrant on file. The notice must include
a renewal application and a notice of fees required for renewal or instructions for online renewal. It must
also inform the registrant that registration will expire without further action by the board if an application
for registration renewal is not received before the deadline for renewal. The registrant's failure to receive
this notice does not relieve the registrant of the obligation to meet the deadline and other requirements for
registration renewal. Failure to receive this notice is not grounds for challenging expiration of registration
status.

Subd. 8. Renewal deadline. The renewal application and fee must be postmarked on or before
December 31 of the year of renewal. If the postmark is illegible, the application is considered timely if
received by the third working day after the deadline.
Subd. 9. **Inactive status and return to active status.** (a) A registrant may be placed in inactive status upon application to the board by the registrant and upon payment of an inactive status fee.

(b) Registrants seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrants whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered naturopathic doctor.

Subd. 10. **Registration following lapse of registration status for two years or less.** For any individual whose registration status has lapsed for two years or less, to regain registration status, the individual must:

1. apply for registration renewal according to subdivision 5;

2. document compliance with the continuing education requirements of section 147E.25 since the registrant's initial registration or last renewal; and

3. submit the fees required under section 147E.40 for the period not registered, including the fee for late renewal.

Subd. 11. **Cancellation due to nonrenewal.** The board shall not renew, reissue, reinstate, or restore a registration that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant whose registration is canceled for nonrenewal must obtain a new registration by applying for registration and fulfilling all requirements then in existence for initial registration as a registered naturopathic doctor.

Subd. 12. **Cancellation of registration in good standing.** (a) A registrant holding an active registration as a registered naturopathic doctor in the state may, upon approval of the board, be granted registration cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant. Such action by the board must be reported as a cancellation of registration in good standing.

(b) A registrant who receives board approval for registration cancellation is not entitled to a refund of any registration fees paid for the registration year in which cancellation of the registration occurred.

(c) To obtain registration after cancellation, a registrant must obtain a new registration by applying for registration and fulfilling the requirements then in existence for obtaining initial registration as a registered naturopathic doctor.

Subd. 13. **Emeritus status of registration.** A registrant may change the status of the registration to "emeritus" by filing the appropriate forms and paying the onetime fee of $50 to the board. This status allows the registrant to retain the title of registered naturopathic doctor but restricts the registrant from actively seeing patients.

**History:** 2008 c 348 s 5

**147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION.**

(a) The board shall act on each application for registration according to paragraphs (b) to (d).
(b) The board shall determine if the applicant meets the requirements for registration under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration if registration is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration period.

History: 2008 c 348 s 6

147E.25 CONTINUING EDUCATION REQUIREMENT.

Subdivision 1. Number of required contact hours. (a) A registrant applying for registration renewal must complete a minimum of 25 contact hours of board-approved continuing education in the year preceding registration renewal, with the exception of the registrant's first incomplete year, and attest to completion of continuing education requirements by reporting to the board.

(b) Of the 25 contact hours of continuing education requirement in paragraph (a), at least five hours of continuing education must be in pharmacotherapeutics.

Subd. 2. Approved programs. The board shall approve continuing education programs that have been approved for continuing education credit by the American Association of Naturopathic Physicians or any of its constituent state associations, the American Chiropractic Association or any of its constituent state associations, the American Osteopathic Association Bureau of Professional Education, the American Pharmacists Association or any of its constituent state associations, or an organization approved by the Accreditation Council for Continuing Medical Education.

Subd. 3. Approval of continuing education programs. The board shall also approve continuing education programs that do not meet the requirements of subdivision 2 but meet the following criteria:

(1) the program content directly relates to the practice of naturopathic medicine;

(2) each member of the program faculty is knowledgeable in the subject matter as demonstrated by a degree from an accredited education program, verifiable experience in the field of naturopathic medicine, special training in the subject matter, or experience teaching in the subject area;

(3) the program lasts at least 50 minutes per contact hour;

(4) there are specific, measurable, written objectives, consistent with the program, describing the expected outcomes for the participants; and

(5) the program sponsor has a mechanism to verify participation and maintains attendance records for three years.

Subd. 4. Accumulation of contact hours. A registrant may not apply contact hours acquired in one one-year reporting period to a future continuing education reporting period.
Subd. 5. **Verification of continuing education credits.** The board shall periodically select a random sample of registrants and require those registrants to supply the board with evidence of having completed the continuing education to which they attested. Documentation may come directly from the registrants from state or national organizations that maintain continuing education records.

Subd. 6. **Continuing education topics.** Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

Subd. 7. **Restriction on continuing education topics.** (a) A registrant may apply no more than five hours of practice management to a one-year reporting period.

(b) A registrant may apply no more than 15 hours to any single subject area.

Subd. 8. **Continuing education exemptions.** The board may exempt any person holding a registration under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

**History:** 2008 c 348 s 7

147E.30 **DISCIPLINE; REPORTING.**

For purposes of this chapter, registered naturopathic doctors and applicants are subject to sections 147.091 to 147.162.

**History:** 2008 c 348 s 8

147E.35 **REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The board shall appoint a seven-member Registered Naturopathic Doctor Advisory Council consisting of one public member as defined in section 214.02, five registered naturopathic doctors who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the board regarding standards for registered naturopathic doctors;

(2) provide for distribution of information regarding registered naturopathic doctors standards;

(3) advise the board on enforcement of sections 147.091 to 147.162;

(4) review applications and recommend granting or denying registration or registration renewal;
(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors;

(6) advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3; and

(7) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

Subd. 4. [Repealed, 2014 c 286 art 8 s 40]

History: 2008 c 348 s 9

147E.40 FEES.

Subdivision 1. Fees. Fees are as follows:

(1) registration application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50; and

(5) temporary permit fee, $25.

Subd. 2. Proration of fees. The board may prorate the initial annual registration fee. All registrants are required to pay the full fee upon registration renewal.

Subd. 3. Penalty fee for late renewals. An application for registration renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. Nonrefundable fees. All of the fees in subdivision 1 are nonrefundable.

History: 2008 c 348 s 10
A bill for an act
relating to health professions; requiring licensure of naturopathic physicians;
modifying scope of practice; amending Minnesota Statutes 2014, sections 147E.01;
147E.05; 147E.06; 147E.10; 147E.15; 147E.20; 147E.25; 147E.30; 147E.35;
147E.40.

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

Section 1. Minnesota Statutes 2014, section 147E.01, is amended to read:

147E.01 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.


Subd. 3. Approved naturopathic medical education program. "Approved naturopathic medical education program" means a naturopathic medical education program in the United States or Canada and meets the requirements for accreditation by the Council on Naturopathic Medical Education (CNME) or an equivalent federally recognized accrediting body for the naturopathic medical profession recognized by the board. This program must offer graduate-level full-time didactic and supervised clinical training leading to the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an institution, or part of an institution, of higher education that at the time the student completes the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting agency recognized by the United States Secretary of Education; or
(2) a degree granting college or university that prior to the existence of CNME offered a full-time structured curriculum in basic sciences and supervised patient care comprising a doctoral naturopathic medical education that is at least 132 weeks in duration, must be completed in at least 35 months, and is reputable and in good standing in the judgment of the board.

Subd. 4. Board. "Board" means the Board of Medical Practice or its designee.

Subd. 5. Contact hour. "Contact hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. Homeopathic preparations. "Homeopathic preparations" means medicines prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. Registered Naturopathic doctor physician. "Registered Naturopathic doctor physician" means an individual registered licensed under this chapter.

Subd. 8. Minor office procedures. "Minor office procedures" means the use of operative, electrical, or other methods for the repair and care incidental to superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in the superficial tissues and the use of antiseptics and local topical or injectable anesthetics in connection with such methods.

Subd. 9. Naturopathic licensing examination. "Naturopathic licensing examination" means the Naturopathic Physicians Licensing Examination or its successor administered by the North American Board of Naturopathic Examiners or its successor as recognized by the board.

Subd. 10. Naturopathic medicine. "Naturopathic medicine" means a system of primary health care for the prevention, assessment, and treatment of human health conditions, injuries, and diseases that uses:

(1) services, procedures, and treatments as described in section 147E.05; and

(2) natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. Naturopathic physical medicine. "Naturopathic physical medicine" includes, but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous electrical nerve stimulation, manipulation, and therapeutic exercise.
Sec. 2. Minnesota Statutes 2014, section 147E.05, is amended to read:

**147E.05 SCOPE OF PRACTICE.**

Subdivision 1. Practice parameters. (a) The practice of naturopathic medicine includes,
but is not limited to, the following services:

1. ordering, administering, prescribing, or dispensing for preventive and therapeutic
   purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes,
   botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines,
   dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and
   Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback,
   dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, and barrier
   devices for contraception, and minor office procedures, including obtaining specimens to
   assess and treat disease;

2. minor office procedures, including obtaining specimens to assess, diagnose, and treat
disease;

3. performing or ordering physical examinations, including but not limited to and
   physiological function tests, speculum examinations, orificial examinations, and phlebotomy;

4. ordering clinical laboratory tests and performing waived tests as defined by the
   United States Food and Drug Administration Clinical Laboratory Improvement Amendments
   of 1988 (CLIA);

5. referring a patient for diagnostic imaging including x-ray, CT scan, MRI,
   ultrasound, mammogram, and bone densitometry to an appropriately licensed health care
   professional to conduct the test and interpret the results;

6. prescribing nonprescription medications and therapeutic devices or ordering
   noninvasive diagnostic procedures commonly used by physicians in general practice; and

7. prescribing pharmacological therapies including schedule III, IV, and V legend drugs
   and controlled substances;

8. administering vaccinations;

9. administering intravenous therapies; and

10. prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor physician may admit patients to a hospital if the
naturopathic doctor physician meets the hospital's governing body requirements regarding
credentialing and privileging process.
Subd. 2. **Prohibitions on practice.** (a) The practice of naturopathic medicine does not include:

1. administering therapeutic ionizing radiation or radioactive substances;
2. administering general or spinal anesthesia; or
3. prescribing, dispensing, or administering legend drugs or controlled substances including chemotherapeutic substances; or
4. performing or inducing abortions.

(b) A naturopathic doctor registered physician licensed under this chapter shall not perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue the repair of superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in superficial tissues.

(c) A naturopathic doctor physician shall not practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietician dietitian, nutritionist, or any other health care professional, unless the naturopathic physician also holds the appropriate license or registration for the health care practice profession.

Sec. 3. Minnesota Statutes 2014, section 147E.06, is amended to read:

**147E.06 PROFESSIONAL CONDUCT.**

Subdivision 1. **Informed consent.** (a) The naturopathic physician shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice. The registered naturopathic doctor physician shall obtain a signed informed consent from the patient prior to initiating treatment and after advising the patient of the naturopathic doctor's qualifications including education and registration information; and outlining of the scope of practice of registered naturopathic doctors in Minnesota. This information must be supplied to the patient in writing before or at the time of the initial visit. The registrant shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor physician must provide a copy of the informed consent form to the board.
Subd. 2. **Patient records.** (a) A registered naturopathic doctor physician shall maintain a record for seven years for each patient treated, including:

1. a copy of the signed informed consent;
2. evidence of a patient interview concerning the patient's medical history and current physical condition;
3. evidence of an examination and assessment;
4. record of the treatment provided to the patient; and
5. evidence of evaluation and instructions given to the patient, including acknowledgment by the patient in writing that, if deemed necessary by the registered naturopathic doctor physician, the patient has been advised to consult with another health care provider.

(b) A registered naturopathic doctor physician shall maintain the records of minor patients for seven years or until the minor's 19th birthday, whichever is longer.

Subd. 3. **Data practices.** All records maintained on a naturopathic patient by a registered naturopathic doctor physician are subject to sections 144.291 to 144.298.

Subd. 4. **State and municipal public health regulations.** A registered naturopathic doctor physician shall comply with all applicable state and municipal requirements regarding public health.

Sec. 4. Minnesota Statutes 2014, section 147E.10, is amended to read:

147E.10 PROTECTED TITLES.

Subdivision 1. **Designation.** (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," "naturopathic medical doctor," "naturopathic physician" or use, in connection with the individual's name, the letters "R.N.D.," "N.D.," or "N.M.D.," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered licensed naturopathic doctor physician unless the individual has been registered licensed as a registered naturopathic doctor physician according to this chapter.

(b) After July 1, 2009, individuals who are registered licensed under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration license in the place of practice.

Subd. 2. **Other health care practitioners.** Nothing in this chapter may be construed to prohibit or to restrict:
6.1 (1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;
6.2 (2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;
6.3 (3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;
6.4 (4) the practice by a naturopathic physician duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota registered physician; or
6.5 (5) individuals not registered by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. Penalty. A person violating subdivision 1 is guilty of a misdemeanor.

Sec. 5. Minnesota Statutes 2014, section 147E.15, is amended to read:

147E.15 REGISTRATION LICENSURE REQUIREMENTS.

Subdivision 1. General requirements for registration for licensure. To be eligible for registration licensure as a naturopathic physician, an applicant must:

(1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:

(i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;

(ii) the name and location of the naturopathic medical program the applicant completed;

(iii) a list of degrees received from other educational institutions;

(iv) a description of the applicant's professional training;

(v) a list of registrations, certifications, and licenses held in other jurisdictions;

(vi) a description of any other jurisdiction's refusal to credential the applicant;
(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and

(viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

(2) submit a copy of a diploma from an approved naturopathic medical education program;

(3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;

(4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;

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

(6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 1a. Transition from registration to licensure. (a) An individual registered as naturopathic doctor on or after July 1, 2009, may be granted a license as a naturopathic physician if the individual:

(1) holds a current, valid registration as a naturopathic doctor that has been issued by the Minnesota Board of Medical Practice; and

(2) is in good standing with the board.

(b) For purposes of this subdivision, "good standing" means that the registered naturopathic doctor is not currently under investigation by the board or advisory council as the result of a complaint, or subject to disciplinary proceedings by the board.

Subd. 2. Registration Licensure by endorsement; reciprocity. (a) To be eligible for registration licensure by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:
(1) submit the application materials and fees as required by subdivision 1, clauses (1),
(2), and (4) to (6);

(2) have successfully passed either:

(i) the Naturopathic Physicians Licensing Examination; or

(ii) if prior to 1986, the state or provincial naturopathic board licensing examination
required by that regulating state or province;

(3) provide a verified copy from the appropriate government body of a current license,
registration, or certification for the practice of naturopathic medicine in another jurisdiction
that has initial licensing, registration, or certification requirements equivalent to or higher
than the requirements in subdivision 1; and

(4) provide letters of verification from the appropriate government body in each
jurisdiction in which the applicant holds a license, registration, or certification. Each letter
must state the applicant's name, date of birth, license, registration, or certification number,
date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant,
and the terms under which the license, registration, or certification was issued.

(b) An applicant applying for license, registration, or certification by endorsement must
be licensed, registered, or certified in another state or Canadian province prior to January
1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.

Subd. 3. **Temporary registration (licensure).** The board may issue a temporary
registration license to practice as a registered naturopathic physician to an applicant
who is licensed, registered, or certified:

(1) holds a current naturopathic license, registration, or certification in another state or
Canadian province, the District of Columbia, or territory of the United States, whose
standards for licensure, registration, or certification are at least equivalent to those of
Minnesota;

and (2) is eligible for registration licensure under this section;

if the application for registration is complete, (3) meets all applicable requirements in
this section have been met, and a nonrefundable fee has been paid.

(4) completes an application for licensure; and

(5) pays the nonrefundable licensure fee.
The temporary registration license remains valid only until the meeting of the board at which time a decision is made on the registered naturopathic doctor's physician's application for registration licensure.

Subd. 4. **Registration License expiration.** Registrations Licenses issued under this chapter expire annually.

Subd. 5. **Renewal.** To be eligible for registration license renewal a registrant licensee must:

1. annually, or as determined by the board, complete a renewal application on a form provided by the board;
2. submit the renewal fee;
3. provide evidence of a total of 25 hours of continuing education approved by the board as described in section 147E.25; and
4. submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

Subd. 6. **Change of address.** A registrant licensee who changes addresses must inform the board within 30 days, in writing, of the change of address. All notices or other correspondence mailed to or served on a registrant licensee by the board are considered as having been received by the registrant licensee.

Subd. 7. **Registration License renewal notice.** At least 45 days before the registration license renewal date, the board shall send out a renewal notice to the last known address of the registrant licensee on file. The notice must include a renewal application and a notice of fees required for renewal or instructions for online renewal. It must also inform the registrant licensee that registration the license will expire without further action by the board if an application for registration license renewal is not received before the deadline for renewal. The registrant licensee's failure to receive this notice does not relieve the registrant licensee of the obligation to meet the deadline and other requirements for registration license renewal. Failure to receive this notice is not grounds for challenging expiration of registration licensure status.

Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or before December 31 of the year of renewal the deadline established by the board. If the postmark is illegible, the application is considered timely if received by the third working day after the deadline.
Subd. 9. Inactive status and return to active status. (a) A registrant licensee may be placed in inactive status upon application to the board by the registrant licensee and upon payment of an inactive status fee.

(b) Registrants Licensees seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrants Licensees whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered licensed naturopathic doctor physician.

Subd. 10. Registration Licensure following lapse of registration licensure status for two years or less. For any individual whose registration licensure status has lapsed for two years or less, to regain registration status a license, the individual must:

1. apply for registration license renewal according to subdivision 5;
2. document compliance with the continuing education requirements of section 147E.25 since the registrant’s licensee’s initial registration licensure or last renewal; and
3. submit the fees required under section 147E.40 for the period not registered licensed, including the fee for late renewal.

Subd. 11. Cancellation due to nonrenewal. The board shall not renew, reissue, reinstate, or restore a registration license that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant licensee whose registration license is canceled for nonrenewal must obtain a new registration license by applying for registration licensure and fulfilling all requirements then in existence for initial registration licensure as a registered naturopathic doctor physician.

Subd. 12. Cancellation of registration licensure in good standing. (a) A registrant licensee holding an active registration license as a registered naturopathic doctor physician in the state may, upon approval of the board, be granted registration license cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant licensee. Such action by the board must be reported as a cancellation of registration licensure in good standing.

(b) A registrant licensee who receives board approval for registration licensure cancellation is not entitled to a refund of any registration fees paid for the registration licensure year in which cancellation of the registration occurred.
(c) To obtain registration licensure after cancellation, a registrant licensee must obtain a new registration license by applying for registration submitting an application and fulfilling the requirements then in existence for obtaining initial registration licensure as a registered naturopathic doctor physician.

Subd. 13. Emeritus status of registration. A registrant licensee may change the status of the registration license to "emeritus" by filing the appropriate forms and paying the onetime fee of $50 to the board. This status allows the registrant licensee to retain the title of registered naturopathic doctor physician but restricts the registrant licensee from actively seeing patients.

Sec. 6. Minnesota Statutes 2014, section 147E.20, is amended to read:

147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION LICENSURE.

(a) The board shall act on each application for registration licensure according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for registration licensure under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration licensure if registration licensure is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration licensure may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration licensure. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration licensure period.

Sec. 7. Minnesota Statutes 2014, section 147E.25, is amended to read:

147E.25 CONTINUING EDUCATION REQUIREMENT.

Subdivision 1. Number of required contact hours. (a) A registrant licensee applying for registration license renewal must complete a minimum of 25 contact hours of board-approved continuing education in the year preceding registration license renewal,
with the exception of the registrant's licensee's first incomplete year, and attest to completion of continuing education requirements by reporting to the board.

(b) Of the 25 30 contact hours of continuing education requirement in paragraph (a), at least five 10 hours of continuing education must be in pharmacotherapeutics.

Subd. 2. Approved programs. The board shall approve continuing education programs that have been approved for continuing education credit by the American Association of Naturopathic Physicians or any of its constituent state associations, the American Chiropractic Association or any of its constituent state associations, the American Osteopathic Association Bureau of Professional Education, the American Pharmacists Association or any of its constituent state associations, or an organization approved by the Accreditation Council for Continuing Medical Education.

Subd. 3. Approval of continuing education programs. The board shall also approve continuing education programs that do not meet the requirements of subdivision 2 but meet the following criteria:

(1) the program content directly relates to the practice of naturopathic medicine;

(2) each member of the program faculty is knowledgeable in the subject matter as demonstrated by a degree from an accredited education program, verifiable experience in the field of naturopathic medicine, special training in the subject matter, or experience teaching in the subject area;

(3) the program lasts at least 50 minutes per contact hour;

(4) there are specific, measurable, written objectives, consistent with the program, describing the expected outcomes for the participants; and

(5) the program sponsor has a mechanism to verify participation and maintains attendance records for three years.

Subd. 4. Accumulation of contact hours. A registrant licensee may not apply contact hours acquired in one one-year reporting period to a future continuing education reporting period.

Subd. 5. Verification of continuing education credits. The board shall periodically select a random sample of registrants licensees and require those registrants licensees to supply the board with evidence of having completed the continuing education to which they attested. Documentation may come directly from the registrants licensees from state or national organizations that maintain continuing education records.
Subd. 6. Continuing education topics. Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

Subd. 7. Restriction on continuing education topics. (a) A registrant licensee may apply no more than five hours of practice management to a one-year reporting period.

(b) A registrant licensee may apply no more than 15 hours to any single subject area.

Subd. 8. Continuing education exemptions. The board may exempt any person holding a registration license under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

Sec. 8. Minnesota Statutes 2014, section 147E.30, is amended to read:

147E.30 DISCIPLINE; REPORTING.

For purposes of this chapter, registered naturopathic doctors physicians and applicants are subject to sections 147.091 to 147.162.

Sec. 9. Minnesota Statutes 2014, section 147E.35, is amended to read:

147E.35 REGISTERED NATUROPATHIC DOCTOR PHYSICIAN ADVISORY COUNCIL.

Subdivision 1. Membership. The board shall appoint a seven-member Registered Naturopathic Doctor Physician Advisory Council consisting of one public member as defined in section 214.02, five registered licensed naturopathic doctors physicians who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.

Subd. 2. Organization. The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. Duties. The advisory council shall:
14.1 (1) advise the board regarding standards for registered licensed naturopathic doctors; 
14.2 (2) provide for distribution of information regarding registered licensed naturopathic 
14.3 doctors physician standards; 
14.4 (3) advise the board on enforcement of sections 147.091 to 147.162; 
14.5 (4) review applications and recommend granting or denying registration license or 
14.6 registration license renewal; 
14.7 (5) advise the board on issues related to receiving and investigating complaints, 
14.8 conducting hearings, and imposing disciplinary action in relation to complaints against 
14.9 registered naturopathic doctors physicians; 
14.10 (6) advise the board regarding approval of continuing education programs using the 
14.11 criteria in section 147E.25, subdivision 3; and 
14.12 (7) perform other duties authorized for advisory councils by chapter 214, as directed by 
14.13 the board.

Sec. 10. Minnesota Statutes 2014, section 147E.40, is amended to read:

147E.40 FEES.

Subdivision 1. Fees. Fees are as follows:

14.18 (1) registration license application fee, $200; 
14.19 (2) renewal fee, $150; 
14.20 (3) late fee, $75; 
14.21 (4) inactive status fee, $50; and 
14.22 (5) temporary permit fee, $25.

Subd. 2. Proration of fees. The board may prorate the initial annual registration license 
fee. All registrants licensees are required to pay the full fee upon registration license renewal.

Subd. 3. Penalty fee for late renewals. An application for registration license renewal 
submitted after the deadline must be accompanied by a late fee in addition to the required 
fees.

Subd. 4. Nonrefundable fees. All of the fees in subdivision 1 are nonrefundable.
FREQUENTLY ASKED QUESTIONS ABOUT NATUROPATHIC MEDICINE IN THE USA

Prepared for the American Medical Student Association

by Serina Aubrecht
Immediate Past Chair, Naturopathic Doctor Advisory Board
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Naturopathic Medicine

WHAT IS NATUROPATHIC MEDICINE?\(^1\)

Naturopathic medicine is a distinct branch of medicine that encompasses modern, traditional, scientific, and empirical methods of diagnosis, treatment, and prevention; is based on the principles of primum non nocere (first do no harm), vis medicatrix naturae (the healing power of nature), tolle causum (treat the whole cause) tolle totum (treat the whole person), docere (doctor as teacher), praevenerre (prevention), and salus (wellness); and emphasizes the inherent self-healing capacity of each person. Naturopathic medicine is a medical specialty.

WHAT IS A BRIEF HISTORY OF NATUROPATHIC MEDICINE IN THE USA, INCLUDING ITS RELATION TO OTHER AREAS OF MEDICINE?\(^4\)

In 1765, John Morgan, MD, founded the first allopathic medical school in the USA in Philadelphia, Pennsylvania, associated with the “College, Academy, and Charity School of Philadelphia” (known today as the “University of Pennsylvania”) – “Medical School”. It is still open today as the oldest allopathic medical school in the USA and is known as the “Perelman School of Medicine at the University of Pennsylvania”. Initially, the school offered a Bachelor of Medicine (MB) degree and a Doctor of Medicine (MD) degree. In 1768, on June 21, ten medical students received MB degrees. In 1771, four of the ten inaugural MB students received MD degrees. In 1792, on March 1, the MB degree was abolished.

In 1844, the “American Institute of Homeopathy” (“AIH”) was formed. It is still in existence today as the oldest national physicians’ organization in the USA.

In 1847, on the evening of May 7, delegates at the national medical convention at the Academy of Natural Sciences in Philadelphia, Pennsylvania approved a resolution to establish the “American Medical Association” (“AMA”). At the meeting, the first code of medical ethics was adopted and the first nationwide standards for preliminary medical education and the degree of “MD” were established.

In 1874, Andrew Taylor Still, MD, developed osteopathic philosophy. Dr. Still is known as the founder of osteopathic medicine and referred to as the “Father of Osteopathy”.

In 1892, Andrew Taylor Still, MD, founded the first osteopathic medical school in the USA in Kirksville, Missouri – the “American School of Osteopathy” (“ASO”). The school offered a Doctor of Osteopathy (DO) degree. It is still open today as the oldest osteopathic medical school in the USA and is known as “A.T. Still University” (“ATSU”). Today, the school offers a Doctor of Osteopathic Medicine (DO) degree.

In 1895, John H. Scheel developed the term “naturopathy”. 
In 1896, Vermont became the first state to license osteopathic physicians to practice osteopathy.

In 1897, the “American Association for the Advancement of Osteopathy” was established.

In 1901, the “American Association for the Advancement of Osteopathy” changed its name to the “American Osteopathic Association” (“AOA”).

In 1901, Benedict Lust, MD, DO, DC, founded the first naturopathic medical school in the USA in New York – the “American School of Naturopathy”. Dr. Lust is known as the founder of naturopathic medicine and referred to as the “Father of Naturopathy”. The school offered a Doctor of Naturopathy (ND) degree.

In 1947, on September 17, the “World Medical Association” (“WMA”) was established.

In 1956, the naturopathic medical school “National College of Naturopathic Medicine” (“NCNM”) was founded. The school offered a Doctor of Naturopathy (ND) degree. It is still open today as the oldest naturopathic medical school in the USA and is known as “National University of Natural Medicine” (“NUMN”). Today, the school offers a Doctor of Naturopathic Medicine (NMD) degree.

In 1985, the “American Association of Naturopathic Physicians” (“AANP”) was established.

In 1989, Nebraska passed legislation that licensed osteopathic physicians to practice osteopathic medicine to the full scope of their training. With the passing of the legislation in Nebraska, the practice of osteopathic medicine was recognized as equivalent to the practice of allopathic medicine in all 50 states in the USA.

In 2004, in December, the “Osteopathic International Alliance” (“OIA”) was established.

In 2014, the “World Naturopathic Federation” (“WNF”) was established.

Scope of Training & Practice

WHAT DIAGNOSTIC AND TREATMENT MODALITIES ARE NATUROPATHIC PHYSICIANS TRAINED IN?²

Naturopathic physicians are trained in conventional, holistic, complementary, integrative, and alternative diagnostic and therapeutic treatment modalities, including nutritional medicine; botanical medicine; homeopathic medicine; pharmaceutical medicine; physical medicine, including osseous and soft tissue manipulative therapy and hydrotherapy; mind-body medicine, including counseling; environmental medicine; lifestyle medicine, including hygiene and diet; minor surgery; phlebotomy; intravenous and injection therapy;
traditional Asian medicine, including acupuncture; public health; imaging; and naturopathic obstetrics. The use of physical medicine treatment modalities by a naturopathic physician is sometimes referred to as “naturopathic physical medicine” and osseous and soft tissue manipulative therapy is sometimes referred to as “naturopathic manipulative medicine” (“NMM”).

Like with all health care professions, as scientific discoveries and developments, such as pharmaceutical medications, have advanced and enhanced the practice of medicine, the scope of training and, thus, the scope of practice of the naturopathic medical profession has changed to reflect the discoveries and developments to protect the safety and the health of the public.

**HOW MANY YEARS OF TRAINING IN MEDICAL SCHOOL DO NATUROPATHIC PHYSICIANS RECEIVE?**

Naturopathic physicians receive 4 years of training in naturopathic medical school.

**WHAT ARE NATUROPATHIC PHYSICIANS WELL-KNOWN FOR?**

Naturopathic physicians are known as experts in drug-herb-nutrient interactions and for emphasizing prevention of disease and overall wellness.

**ARE NATUROPATHIC PHYSICIANS TRAINED TO PRACTICE EVIDENCE-BASED MEDICINE?**

Yes, naturopathic physicians are trained to practice evidence-based medicine.

**ARE NATUROPATHIC PHYSICIANS TRAINED TO PRACTICE “STANDARDS OF CARE”?**

Yes, naturopathic physicians are trained to practice “standards of care”. A naturopathic physician can be held liable for medical malpractice, just like an allopathic or osteopathic physician, if standards of care are not adhered to.

**ARE NATUROPATHIC PHYSICIANS TRAINED TO PRACTICE INDEPENDENTLY?**

Yes, naturopathic physicians are trained to practice independently, without oversight by another health care provider.
ARE NATUROPATHIC PHYSICIANS TRAINED TO WORK WITH AND REFER TO OTHER HEALTH CARE PROVIDERS?\(^{250}\)

Yes, naturopathic physicians are trained to work with and refer to other health care providers.

WHAT PHARMACEUTICAL MEDICATIONS DO NATUROPATHIC PHYSICIANS LEARN AND NEED TO KNOW?\(^{46}\)

Naturopathic physicians learn and need to know over-the-counter (OTC) drugs, legend drugs, and scheduled drugs (pharmaceutical medications containing controlled substances). Pharmacology is an integral and critical part of naturopathic medical education and, like allopathic and osteopathic physicians, to ensure patient safety, naturopathic physicians need to know how to appropriately prescribe pharmaceutical medications, check for medication interactions, and put patients onto and take patients off of medications. Additionally, since naturopathic physicians also study botany and nutrition, to be able to accurately prescribe botanical medications and nutritional medications, naturopathic physicians learn and need to know drug-herb-nutrient interactions.

ARE NATUROPATHIC PHYSICIANS TRAINED IN VACCINE ADMINISTRATION?\(^{3}\)

Yes, naturopathic physicians are trained in vaccine administration as part of their training in pharmaceutical medicine, injection therapy, and public health. Like allopathic and osteopathic physicians, they learn the Centers for Disease Control and Prevention (CDC) immunization recommendations and schedules.

DO NATUROPATHIC PHYSICIANS NEED NPI AND DEA NUMBERS?\(^{47}\)

Yes, naturopathic physicians need U.S. Department of Health & Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) and U.S. Department of Justice U.S. Drug Enforcement Administration (DEA) numbers in order to prescribe pharmaceutical medications.

In some states with regulation of naturopathic medicine and licensure of naturopathic physicians, state law does not yet accurately reflect scope of training of naturopathic physicians and naturopathic physicians are allowed to prescribe pharmaceutical medications classified as legend drugs, but not those classified as scheduled drugs. In those states, to prescribe legend drugs, naturopathic physicians need only an NPI number. A DEA number is needed only if scheduled drugs are prescribed.
WHAT PHARMACEUTICAL MEDICATIONS CAN NATUROPATHIC PHYSICIANS PRESCRIBE?\(^{48}\)

The pharmaceutical medications that naturopathic physicians are able to prescribe completely varies from state to state, depending on how the state legislation was written. The variation in legislation is mainly due to a lack of public education and understanding on the scope of training of naturopathic physicians.

In the state of Washington, *Cannabis* (marijuana), although federally classified as a Schedule I drug, is legal for recreational use and medical use. Naturopathic physicians, along with allopathic physicians, osteopathic physicians, physician assistants, osteopathic physician assistants, and nurse practitioners are allowed to authorize the medical use of marijuana to patients.

In the state of Arizona, *Cannabis* (marijuana) is legal for medical use. Naturopathic physicians, along with allopathic and osteopathic physicians, are allowed to authorize the medical use of marijuana to patients.

WHAT IS THE IMPORTANCE OF PHARMACEUTICAL PRESCRIBING RIGHTS FOR NATUROPATHIC PHYSICIANS THAT ACCURATELY REFLECT THE SCOPE OF TRAINING OF NATUROPATHIC PHYSICIANS?\(^{49}\)

Public safety and health are the most important aspects of pharmaceutical prescribing rights for naturopathic physicians that accurately reflect the scope of training of naturopathic physicians. Since patients may choose to see a naturopathic physician for any symptom or complaint, without pharmaceutical prescribing rights that accurately reflecting scope of training, naturopathic physicians may be unable to prescribe antibiotics for conditions such as strep throat, vaccines for vaccine-preventable diseases, epinephrine injectors for patients with risk of anaphylaxis due to allergic reaction, hormonal contraception, or emergency oxygen for life-threatening hypoxic (low oxygen) situations. It is important that the scope of training of naturopathic physicians is understood so that the scope of practice of naturopathic physicians in each state is consistent and accurately reflects the scope of training.

WHAT LEVEL OF CPR ARE NATUROPATHIC MEDICAL STUDENTS AND PHYSICIANS REQUIRED TO KNOW?\(^{33}\)

Naturopathic medical students and physicians are required to know Basic Life Support (BLS) cardiopulmonary resuscitation (CPR). Depending on the facility where a naturopathic physician works (for example, in a hospital), a naturopathic physician may also be required to know more advanced CPR procedures, such as Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support (PALS).
WHAT ARE THE DIFFERENCES IN TRAINING BETWEEN NATUROPATHIC PHYSICIANS, ALLOPATHIC PHYSICIANS, AND OSTEOPATHIC PHYSICIANS?6

Naturopathic physicians are trained in outpatient family medicine and primary care medicine, with an emphasis on prevention and wellness, through the use of naturopathic treatment modalities. Pharmaceutical medicine and minor surgery are naturopathic treatment modalities.

Comparatively, where allopathic and osteopathic physicians spend time learning in-patient (hospital) medicine, including the treatment modalities of major and minor surgery (and, in the case of osteopathic physicians, osteopathic manipulative medicine [OMM] and osteopathic manipulative treatment [OMT], in preparation for rotations in osteopathic manipulative therapy [OMTh]), naturopathic physicians spend time learning the treatment modalities of nutritional medicine; botanical medicine; homeopathic medicine; pharmaceutical medicine; physical medicine, including osseous and soft tissue manipulative therapy and hydrotherapy; mind-body medicine, including counseling; lifestyle medicine, including hygiene and diet; minor surgery; phlebotomy; intravenous and injection therapy; traditional Asian medicine, including acupuncture; and naturopathic obstetrics. Allopathic, osteopathic, and naturopathic physicians all learn outpatient family medicine and primary care medicine. Thus, for better understanding of the training of naturopathic physicians, as a comparison to specialty areas of the allopathic and osteopathic medical professions, naturopathic physicians can be thought of as outpatient integrative family medicine physicians with an emphasis on natural medical treatment modalities.

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**WHAT ICD-10 CODES DO NATUROPATHIC PHYSICIANS USE FOR OSSEOUS AND SOFT TISSUE MANIPULATIVE MEDICINE AND THERAPY?**

For osseous and soft tissue manipulative medicine and therapy, naturopathic physicians use the same ICD-10 codes that osteopathic physicians use for osteopathic manipulative treatment (OMT). Insurance companies will reject a claim if a chiropractic ICD-10 code is used.

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**Educational & Professional Titles – NMD versus ND**

**WHAT IS THE DIFFERENCE BETWEEN AN “NMD” AND AN “ND” EDUCATIONAL DEGREE AND TITLE?**

Naturopathic medical schools that are accredited or provisionally accredited by the Council on Naturopathic Medical Education (CNME) offer a doctorate degree in naturopathic medicine and grant the educational doctorate degree title as either “Doctor of Naturopathic Medicine” (abbreviated “NMD”) or “Doctor of Naturopathy” (abbreviated “ND”).

Allopathic medical schools that are accredited or provisionally accredited by the Liaison Committee on Medical Education (LCME) offer a doctorate degree in allopathic medicine and grant the educational degree title as “Doctor of Medicine” (abbreviated “MD”).

Osteopathic medical schools that are accredited or provisionally accredited by the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) offer a doctorate degree in osteopathic medicine and grant the educational doctorate degree title as either “Doctor of Osteopathic Medicine” (abbreviated “DO”) or “Doctor of Osteopathy” (abbreviated “DO”).

**WHAT IS THE DIFFERENCE BETWEEN AN “NMD” AND AN “ND” PROFESSIONAL TITLE?**

The protected professional title of a naturopathic physician may be “NMD” (Naturopathic Medical Doctor/Physician) or “ND” (Naturopathic Doctor/Physician), depending on state law, and is independent of the educational degree title of a naturopathic physician. For example, a naturopathic physician may earn an NMD degree and represent her or his education with that title (“Firstname Lastname, NMD”), however, state law may require that the naturopathic physician use the protected professional title of “ND” (“Firstname Lastname, ND”) in the context of communicating to the public that the naturopathic physician is licensed to practice naturopathic medicine. In most states with licensure of naturopathic physicians, professionally using “NMD” and “ND” are restricted to only those who have earned a “Doctor of Naturopathic Medicine” or “Doctor of Naturopathy” degree from a CNME-accredited or CNME-provisionally accredited school.
An example of this in the context of another healthcare profession is that of a physician assistant (PA). A PA may earn a Master of Science (MS) degree in Physician Assistant Studies and thus have an educational degree title that looks like “Firstname Lastname, MS”. Once the PA takes the Physician Assistant National Certifying Exam (PANCE) and passes, the PA can then obtain licensure and use the professional title that looks like, “Firstname Lastname, PA-C”. Thus, a PA can put either “MS” or “PA-C” after the PA’s name, depending on if the PA wants to communicate educational degree title (MS) or protected professional title (PA-C).

Another example of this is that of an acupuncturist. An acupuncturist may earn a Master of Science (MS) degree in Acupuncture and thus have an educational degree title that looks like “Firstname Lastname, MS”. Once the acupuncturist takes the necessary National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) examinations and passes, the acupuncturist can then obtain licensure and use the professional title that looks like, “Firstname Lastname, LAc”. Thus, an acupuncturist can put either “MS” or “LAc” after the acupuncturist’s name, depending on if the acupuncturist wants to communicate educational degree title (MS) or protected professional title (LAc).

An allopathic physician earns an “MD” educational degree and the protected professional title in all states is “MD”. There is no difference between the educational degree title and the protected professional title of an allopathic physician.

An osteopathic physician earns a “DO” educational degree and the protected professional title in all states is “DO”. There is no difference between the educational degree title and the protected professional title of an osteopathic physician.

WHAT ARE PROTECTED PROFESSIONAL TITLES OF NATUROPATHIC PHYSICIANS?24

Depending on the state and how legislation regarding naturopathic physicians was written, the following are all protected professional titles that are used to refer to naturopathic physicians:

- Naturopathic Physician
- Naturopathic Medical Doctor
- Naturopathic Doctor
- Doctor of Naturopathic Medicine
- Doctor of Naturopathy
- Registered Naturopathic Doctor
- N.M.D. or NMD
- N.D. or ND
- R.N.D. or RND
- Naturopath

The variations in the title of a naturopathic physician from state to state can be seen in the legislation for each state that either licenses or registers naturopathic physicians.
HOW DOES THE US DEPARTMENT OF LABOR DEFINE NATUROPATHIC PHYSICIANS?

The US Department of Labor defines naturopathic physicians in the following way:

29-1199.04 – Naturopathic Physicians

Diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals. May use physiological, psychological or mechanical methods. May also use natural medicines, prescription or legend drugs, foods, herbs, or other natural remedies.

The sample of reported job titles include:

Doctor (Dr), Doctor of Naturopathic Medicine, Naturopathic Doctor, Naturopathic Physician, Physician

WHAT LICENSING EXAMINATION DO NATUROPATHIC PHYSICIANS TAKE?

Naturopathic physicians (NMDs/NDs) take the Naturopathic Physicians Licensing Examinations (NPLEX), which consists of two parts – Part I and Part II. NPLEX Part I is the Biomedical Science Examination (BSE) and is administered after the second year of naturopathic medical school. NPLEX Part II is the Core Clinical Science Examination (CCSE) and is administered after the fourth year of naturopathic medical school.

Allopathic physicians (MDs) take the United States Medical Licensing Examination (USMLE), which consists of three steps – Step 1, Step 2 (CK & CS), and Step 3. USMLE Step 1 is administered at the end of the second year of allopathic medical school. USMLE Step 2 CK (Clinical Knowledge) and Step 2 CS (Clinical Skills) is administered during either the third or fourth year of allopathic medical school. USMLE Step 3 is administered during residency.

Osteopathic physicians (DOs) take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), which consists of three levels – Level 1, Level 2, and Level 3. COMLEX Level 1 is administered at the end of the second year of osteopathic medical school. COMLEX Level 2-CE (Cognitive Evaluation) is administered during either the third or fourth year of osteopathic medical school. COMLEX Level 3 is administered during residency. Osteopathic physicians are eligible to take the USMLE.
WHO ADMINISTERS THE LICENSING EXAMINATION (NPLEX)?

The North American Board of Naturopathic Examiners (NABNE) administers the NPLEX to each naturopathic medical student (NMS) and naturopathic physician (NMD/ND).

The National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB) co-sponsor administration of the USMLE to each allopathic medical student (MS) and allopathic physician (MD).

The National Board of Osteopathic Medical Examiners (NBOME) administers the COMLEX-USA to each osteopathic medical student (OMS) and osteopathic physician (DO).

WHO IS ELIGIBLE TO TAKE THE LICENSING EXAMINATION (NPLEX)?

Naturopathic medical students who successfully complete their biomedical science coursework during their first two years are eligible to take the NPLEX Part I BSE. Naturopathic medical students who successfully complete their clinical science coursework and clinical rotations during their second two years and who passed the NPLEX Part I BSE are eligible to take the NPLEX Part II CCSE.

DO NATUROPATHIC PHYSICIANS HAVE BOARD CERTIFICATIONS THAT THEY CAN OBTAIN?

Yes, naturopathic physicians have 2 board certifications that they can obtain. Board certification is not required to practice naturopathic medicine, but may be required by individual employers. There currently is no national board certification organization that oversees naturopathic medical board certifications in specialties and subspecialties.

Fellow of the American Board of Naturopathic Oncology (FABNO)
A naturopathic physician can become board-certified in naturopathic oncology by taking the American Board of Naturopathic Oncology Board of Medical Examiners (ABNOBOMEx) examination, passing it, and meeting all requirements for board certification in naturopathic oncology. Once board certification is attained, a naturopathic physician earns the title “Fellow of the American Board of Naturopathic Oncology” (“FABNO”).

Diplomate of the Homeopathic Academy of Naturopathic Physicians (DHANP)
A naturopathic physician can become board-certified in homeopathy by taking the Homeopathic Board Certification Exam (HBCE), passing it, and meeting all requirements for board certification in homeopathy. Once board certification is attained, a naturopathic physician earns the title “Diplomate of the Homeopathic Academy of Naturopathic Physicians” (“DHANP”).
Osteopathic physicians have 29 primary specialty and 77 subspecialty board certifications that they can obtain from 18 different Specialty Certifying Boards that are overseen by the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists (BOS). Board certification is not required to practice osteopathic medicine in the USA, but may be required by individual employers. The process of board certification for osteopathic physicians is administered by the AOA’s Department of Certifying Board Services.

Allopathic physicians have many specialty and subspecialty board certifications they can obtain from 2 different national board certification organizations – the American Board of Medical Specialties (ABMS) and the American Board of Physician Specialists (ABPS). The ABMS was established in 1933, is not overseen by a medical association, has 24 specialty Member Boards, and is the largest national board certification organization, offering the most specialty and subspecialty board certifications. The ABPS administers board certifications for the American Association of Physician Specialists (AAPS), offering 18 specialty board certifications between 12 Member Boards. Board certification is not required to practice allopathic medicine in the USA, but may be required by individual employers. Osteopathic physicians are able to obtain board certifications from the ABMS and the ABPS.

ARE NATUROPATHIC PHYSICIANS CURRENTLY LICENSED IN EVERY STATE?  

No, naturopathic physicians are not currently licensed in every state. Currently, naturopathic physicians are licensed or registered in 17 USA states; Washington, DC; and the USA territories of Puerto Rico and the Virgin Islands.

ARE LICENSURE REQUIREMENTS CURRENTLY STANDARDIZED IN ALL USA STATES AND TERRITORIES?  

No, licensure requirements are not currently standardized in all USA states and territories. In addition to the NPLEX, some states and territories have jurisprudence examinations that must be passed in order for licensure to be granted. Utah is currently the only state that requires completion of at least 1 year of a naturopathic residency program in order to be eligible for licensure.

IS COMPLETION OF A RESIDENCY PROGRAM REQUIRED FOR LICENSURE?  

At this time, completion of a residency program is not required for licensure, except in the state of Utah, where completion of at least 1 year of a residency program is required.
WHY IS COMPLETION OF A RESIDENCY PROGRAM NOT REQUIRED FOR LICENSURE?\(^{14}\)

Completion of a residency program is not currently required for licensure, other than in Utah, because of how the legislation has been written and passed in states that license or register naturopathic physicians. A current barrier to requirement of completion of a residency program, other than in Utah, is that naturopathic residencies are privately funded and there are more graduating naturopathic physicians each year than there are available naturopathic residencies.

Allopathic and osteopathic residency programs are currently federally- and state-funded, mostly through Medicare, Medicaid, and the Veterans Administration (VA), which is why there are more programs and completion of a residency is able to be required for licensure.

WHAT IS THE IMPORTANCE OF LICENSURE OF NATUROPATHIC PHYSICIANS AND REGULATION OF NATUROPATHIC MEDICINE IN EVERY STATE?\(^ {15}\)

Public safety is the most important aspect of licensure of naturopathic physicians and regulation of naturopathic medicine in every state. Not understanding the difference between naturopathic physicians (NMDs/NDs) who have attended CNME-accredited or provisionally-accredited four-year naturopathic medical schools to specialize in naturopathic medicine, including the practice of naturopathy, and earned a Doctor of Naturopathic Medicine (NMD) or Doctor of Naturopathy (ND) doctoral degree to become licensed naturopathic physicians and lay naturopaths who have earned a diploma, distance-learning diploma, or distance-learning degree in naturopathy from a non-accredited institution can be very confusing to the public. It is critical to the safety of the public that the public is educated on the difference between a naturopathic physician versus a lay naturopath.

Lay naturopaths are not licensed in any USA state or territory to practice naturopathic medicine, as it is not a part of their in-person or online diploma, distance-learning diploma, or distance-learning degree in naturopathy from a non-accredited institution program, however, they have founded their own organizations of which the titles imply that they are trained to do so, which is misleading and dangerous to the public. The American Naturopathic Medical Association (ANMA), the American Naturopathic Medical Accreditation Board (ANMAB), the American Naturopathic Medical Certification Board (ANMCB), American Naturopathic Certification Board (ANCB), and the National Registry of Naturopathic Practitioners (NRNP) are all organizations for lay naturopaths who do not have training in naturopathic medicine. This is very important for the public to understand, as it can be confusing to patients who do not have the education and resources available to them to distinguish between a naturopathic physician and a lay naturopath, but want to see a naturopathic physician (within permissible capacity of state laws) in a state that does not yet have licensure for naturopathic physicians and regulation of naturopathic medicine.
In states without licensure of naturopathic physicians and regulation of naturopathic medicine, there is no educational degree title protection nor are there protected professional titles of naturopathic physicians. This means that, in those states, a naturopathic physician who earned a “Doctor of Naturopathy” (“ND”) doctoral degree from a CNME-accredited naturopathic medical school and a lay naturopath who earned a “Doctor of Naturopathy” online diploma from a non-accredited institution, which includes no medical training, can both use "ND" as initials after their name to signify their education, since there is no regulation of those initials in those states. In many states with licensure of naturopathic physicians and regulation of naturopathic medicine, using “NMD” or “ND” after a person’s name to signify their education is restricted to naturopathic physicians who have earned an NMD or ND degree from a CNME-accredited naturopathic medical school, as those states only recognize the degree from CNME-accredited naturopathic medical schools.

Due to lack of available information, education, and resources, many people do not understand the difference between an educational degree title and a protected professional title. Without licensure of naturopathic physicians and without regulation of naturopathic medicine, a person may see a lay naturopath using the initials “ND”, instead of a naturopathic physician, and not understand the difference in level of education and training.

Additionally, the ANMCB issues certification titles to lay naturopaths, who have taken and passed a “national exam” that has no name, including, “Board Certified Naturopathic Physician” ("BCNP") and “Board Certified Naturopathic Doctor (“BCND”), which are used by lay naturopaths without training in naturopathic medicine in states without licensure for naturopathic physicians and regulation of naturopathic medicine. This is confusing, misleading, and dangerous to patients, as they may think they are seeing a naturopathic physician, but may be actually seeing a lay naturopath. It is important to know that, currently, the only two board certifications available to naturopathic physicians who have graduated from a CNME-accredited naturopathic medical school are in naturopathic oncology (FABNO) and homeopathy (DHANP). If a person is using the title “Board Certified Naturopathic Physician” or “Board Certified Naturopathic Doctor,” that person is a lay naturopath without any medical training, not a naturopathic physician with training in naturopathic medicine.

It is crucial that education and resources are made available to the public to help patients understand the educational background and difference between naturopathic physicians, with training in naturopathic medicine, and lay naturopaths.

**WHAT IS THE IMPORTANCE OF CONSISTENT SCOPE OF PRACTICE IN EACH STATE THAT ACCURATELY REFLECTS THE SCOPE OF TRAINING OF NATUROPATHIC PHYSICIANS?**

Public safety and health are the most important aspects of consistent scope of practice in each state that accurately reflects the scope of training of naturopathic physicians. Like all
health care providers, having proper scope of practice that accurately reflects scope of training allows for safe and effective medical care to be delivered. If proper scope of practice is not in place, for example, if in a state naturopathic physicians do not have pharmaceutical prescribing rights that accurately reflect their scope of training, since patients may choose to see a naturopathic physician for any symptom or complaint, naturopathic physicians may be unable to prescribe antibiotics for conditions such as strep throat, vaccines for vaccine-preventable diseases, epinephrine injectors for patients with risk of anaphylaxis due to allergic reaction, hormonal contraception, or emergency oxygen for life-threatening hypoxic (low oxygen) situations. In emergency situations, deliverance of epinephrine or oxygen may be crucial to saving the life of a patient while emergency medical services (EMS) are on their way. It is important that the scope of training of naturopathic physicians is understood so that the scope of practice of naturopathic physicians in each state is consistent and accurately reflects the scope of training.

DO NATUROPATHIC PHYSICIANS HAVE THE SAME PUBLIC HEALTH DUTIES AS ALLOPATHIC AND OSTEOPATHIC PHYSICIANS?

Yes, like allopathic and osteopathic physicians, naturopathic physicians are held liable for reporting diseases and conditions to a state department of health that are considered to be mandatory reportable diseases.

CAN NATUROPATHIC PHYSICIANS LOSE THEIR LICENSE TO PRACTICE NATUROPATHIC MEDICINE?

Yes, naturopathic physicians can lose their licenses to practice naturopathic medicine, just like allopathic and osteopathic physicians can lose their licenses to practice medicine.

Naturopathic Residency Programs

WHO ACCREDITS NATUROPATHIC RESIDENCY PROGRAMS?

The Council on Naturopathic Medical Education (CNME) accredits naturopathic residency programs.

The Accreditation Council for Graduate Medical Education (ACGME) accredits allopathic and osteopathic residency programs.

The American Osteopathic Association (AOA) Osteopathic Graduate Medical Education (OGME) Development Initiative is transitioning accreditation and matching of osteopathic residency programs to the ACGME and the NRMP.
WHO OVERSEES THE NATUROPATHIC RESIDENCY MATCH PROGRAM? 17

The Naturopathic Post-Graduate Association (NPGA) oversees the matching process for naturopathic physicians applying to CNME-approved naturopathic residency programs. Applications require submission of the “Universal Application for CNME-Approved Naturopathic Residencies” to the directors responsible for processing applications of each sponsoring school of the residencies being applied for.

The National Resident Matching Program (NRMP), also known as “The Match,” oversees the matching process for allopathic and osteopathic physicians (who submit AAMC USMLE scores) applying to ACGME-approved allopathic and osteopathic residency programs. Applicants must submit their applications using the Association of American Medical Colleges (AAMC) Electronic Residency Application Service (ERAS).

The American Osteopathic Association (AOA) sponsors the AOA Intern/Resident Registration program, also known as the “Match” or the “AOA Match,” and oversees the matching process, administered by National Matching Services Inc. on behalf of the AOA, for osteopathic physicians applying to AOA-approved osteopathic residency programs. Applicants must submit their applications using the Association of American Medical Colleges (AAMC) Electronic Residency Application Service (ERAS). Osteopathic physicians have the options of applying to residency programs in the AOA Match only, applying to residency programs in the NRMP only, or applying to residency programs in both the AOA Match and the NRMP.

IS COMPLETION OF A RESIDENCY PROGRAM REQUIRED FOR LICENSURE? 13

At this time, completion of a residency program is not required for licensure, except in the state of Utah, where completion of at least 1 year of a residency program is required.

WHY IS COMPLETION OF A RESIDENCY PROGRAM NOT REQUIRED FOR LICENSURE? 14

Completion of a residency program is not currently required for licensure, other than in Utah, because of how the legislation has been written and passed in states that license or register naturopathic physicians. A current barrier to requirement of completion of a residency program, other than in Utah, is that naturopathic residencies are privately funded and there are more graduating naturopathic physicians each year than there are available naturopathic residencies.

Allopathic and osteopathic residency programs are currently federally- and state-funded, mostly through Medicare, Medicaid, and the Veterans Administration (VA), which is why there are more programs and completion of a residency is able to be required for licensure.
Naturopathic Medical School Accreditation

WHICH US DEPARTMENT OF EDUCATION SPECIALIZED ACCREDITING AGENCY ACCREDITS NATUROPATHIC MEDICINE DEGREE PROGRAMS? 18

The Council on Naturopathic Medical Education (CNME) accredits naturopathic medicine (NMD/ND) degree programs in the USA, Canada, and Puerto Rico.

The Liaison Committee on Medical Education (LCME) accredits allopathic medicine (MD) degree programs in the USA.

The American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) accredits osteopathic medicine (DO) degree programs in the USA.

WHAT SCHOOLS CURRENTLY HAVE CNME-ACCREDITED OR CNME-PROVISIONALLY ACCREDITED PROGRAMS THAT OFFER A DOCTORATE DEGREE IN NATUROPATHIC MEDICINE? 19

The CNME-acccredited schools that offer a doctorate degree in naturopathic medicine are:

- Bastyr University (BU) – Kenmore, Washington, USA
- Bastyr University California (BUC) – San Diego, California, USA
- Boucher Institute of Naturopathic Medicine (BINM) – New Westminster, British Columbia, Canada
- Canadian College of Naturopathic Medicine (CCNM) – Toronto, Ontario, Canada
- National University of Health Sciences (NUHS) – Lombard, Illinois, USA
- National University of Natural Medicine (NUNM) – Portland, Oregon, USA
- Southwest College of Naturopathic Medicine & Health Sciences (SCNM) – Tempe, Arizona, USA
- University of Bridgeport (UB) – Bridgeport, Connecticut, USA

The CNME-provisionally accredited school that offers a doctorate degree in naturopathic medicine is:

- Sistema Universitario Ana G. Méndez (SUAGM) Universidad del Turabo (UT) – Gurabo, Puerto Rico

WHAT DOES IT MEAN IF A NATUROPATHIC MEDICAL PROGRAM IS CNME-PROVISIONALLY ACCREDITED? 20

If a naturopathic medical program is CNME-provisionally accredited, it means that the school has applied for and met accreditation candidacy requirements with the CNME and that the program has had full-time naturopathic medical students enrolled for at least 1 academic year, but that the school has not yet graduated its first class of students in the program.
WHICH US DEPARTMENT OF EDUCATION REGIONAL ACCREDITING AGENCIES ACCREDIT SCHOOLS WITH NATUROPATHIC MEDICINE DEGREE PROGRAMS IN THE USA?\(^{43}\)

The US Department of Education regional accrediting agencies that accredit schools with naturopathic medicine degree programs in the USA are:

- Northwest Commission on Colleges and Universities
  - Bastyr University (BU) – Kenmore, Washington, USA
  - Bastyr University California (BUC) – San Diego, California, USA
  - National University of Natural Medicine (NUNM) – Portland, Oregon, USA
- North Central Association of Colleges and Schools, The Higher Learning Commission
  - National University of Health Sciences (NUHS) – Lombard, Illinois, USA
  - Southwest College of Naturopathic Medicine & Health Sciences (SCNM) – Tempe, Arizona, USA
- New England Association of Schools and Colleges, The Higher Learning Commission
  - University of Bridgeport (UB) – Bridgeport, Connecticut, USA
- Middle States Commission on Higher Education
  - Sistema Universitario Ana G. Méndez (SUAGM) Universidad del Turabo (UT) – Gurabo, Puerto Rico

DO NATUROPATHIC MEDICAL SCHOOLS HAVE A REQUIRED ENTRANCE EXAMINATION THAT IS THE SAME BETWEEN ALL OF THE SCHOOLS?\(^{21}\)

No, there is not currently a required entrance examination, such as the Medical College Admission Test (MCAT), that is the same between all of the naturopathic medical schools. The Association of Accredited Naturopathic Medical Colleges (AANMC) has not developed its own examination for entrance into naturopathic medical schools.

The MCAT was developed and is administered by the Association of American Medical Colleges (AAMC) for entrance into allopathic medical schools.

The American Association of Colleges of Osteopathic Medicine (AACOM) has not developed its own examination for entrance into osteopathic medical schools. Applicants take and submit AAMC MCAT scores.

Most allopathic and osteopathic medical schools in the USA require submission of AAMC MCAT scores as a part of the application and admission process.

WHAT IS THE CENTRAL APPLICATION SERVICE FOR APPLYING TO NATUROPATHIC MEDICAL SCHOOLS?\(^{37}\)

The Doctor of Naturopathic Medicine Centralized Application Service (NDCAS) is the central application service for applying to naturopathic medical schools.

The American Medical College Application Service (AMCAS) is the central application service for applying to allopathic medical schools.
The American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) is the central application service for applying to osteopathic medical schools.

### Naturopathic Medical Organizations

**WHAT ORGANIZATION FURThERS EDUCATIONAL INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?**

The Association of Accredited Naturopathic Medical Colleges (AANMC) furthers educational initiatives of the naturopathic medical profession.

The Association of American Medical Colleges (AAMC) furthers educational initiatives of the allopathic medical profession.

The American Association of Colleges of Osteopathic Medicine (AACOM) furthers educational initiatives of the osteopathic medical profession.

**WHAT ORGANIZATION FURThERS PROFESSIONAL INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?**

The American Association of Naturopathic Physicians (AANP) furthers professional initiatives of the naturopathic medical profession.

The American Medical Association (AMA) furthers professional initiatives of the allopathic medical profession.

The American Osteopathic Association (AOA) furthers professional initiatives of the osteopathic medical profession.

**WHAT ORGANIZATION FURThERS STUDENT INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?**

The Naturopathic Medical Student Association (NMSA) furthers student initiatives of the naturopathic medical profession.

The American Medical Student Association (AMSA) furthers student initiatives of the allopathic and osteopathic medical professions.

The Student Osteopathic Medical Association (SOMA) furthers student initiatives of the osteopathic medical profession.
**WHAT ORGANIZATION FURTHERS GLOBAL HEALTH INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?**

The World Naturopathic Federation (WNF) furthers global health initiatives of the naturopathic medical profession.

The World Medical Association (WMA) furthers global health initiatives of the allopathic medical profession.

The Osteopathic International Alliance (OIA) furthers global health initiatives of the osteopathic medical profession.

**WHAT ORGANIZATION FURTHERS RESEARCH INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?**

The Naturopathic Physicians Research Institute (NPRI) furthers research initiatives of the naturopathic medical profession.

Naturopathic medical research in the USA is also furthered by:
- Bastyr University Research Institute
- National University of Natural Medicine Helfgott Research Institute
- U.S. Department of Health and Human Services (HHS) National Institutes of Health (NIH) National Center for Complementary and Integrative Health

**WHAT ORGANIZATIONS FURTHER CLINICAL LITERATURE INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?**

Naturopathic Doctor News and Review (NDNR) furthers clinical literature initiatives of the naturopathic medical profession.

The Natural Medicine Journal (NMJ) is the official journal of the American Association of Naturopathic Physicians (AANP).

The Journal of the American Medical Association (JAMA) is the official journal of the American Medical Association (AMA). JAMA has affiliated journal publications specific to areas of medicine, including cardiology, dermatology, facial plastic surgery, internal medicine, neurology, oncology, ophthalmology, otolaryngology, pediatrics, psychiatry, and surgery.

The Journal of the American Osteopathic Association (JAOA) is the official journal of the American Osteopathic Association (AOA).
Insurance Coverage

HOW ARE NATUROPATHIC PHYSICIANS CREDENTIALED?\(^{38}\)

Naturopathic physicians are specialized in naturopathic medicine and are trained in outpatient family medicine and primary care medicine, with an emphasis on prevention and wellness through the use of naturopathic treatment modalities. Thus, just like allopathic and osteopathic physicians, naturopathic physicians can be credentialed as either specialists or primary care providers, depending on whether the focus of their practice is specialty care or primary care.

In some states, state laws mandate that naturopathic physicians are credentialed as specialists, whereas, in other states, state laws mandate that naturopathic physicians are credentialed as primary care providers.

DO NATUROPATHIC PHYSICIANS USE CPT CODES?\(^{39}\)


DO NATUROPATHIC PHYSICIANS USE ICD CODES?\(^{40}\)

Yes, naturopathic physicians use the same World Health Organization (WHO) International Classification of Diseases (ICD) codes as allopathic and osteopathic physicians. The current ICD codes being used are from the *International Statistical Classification of Diseases and Health Related Problems 10th Revision* and are known as ICD-10 codes.

WHAT ICD-10 CODES DO NATUROPATHIC PHYSICIANS USE FOR OSSEOUS AND SOFT TISSUE MANIPULATIVE MEDICINE AND THERAPY?\(^{34}\)

For osseous and soft tissue manipulative medicine and therapy, naturopathic physicians use the same ICD-10 codes that osteopathic physicians use for osteopathic manipulative treatment (OMT). Insurance companies will reject a claim if a chiropractic ICD-10 code is used.

DO NATUROPATHIC PHYSICIANS PROVIDE “ESSENTIAL HEALTH BENEFITS” SERVICES SPECIFIED IN THE PPACA?\(^{41}\)

Yes, naturopathic physicians provide “Essential Health Benefits” services specified in Section 1302(b)(1) of the Patient Protection and Affordable Care Act (PPACA), including services in the categories of “Ambulatory patient services,” “Maternity and newborn care,”
“Mental health and substance use disorder services, including behavioral health treatment,” “Prescription drugs,” “Rehabilitative and habilitative services and devices,” “Laboratory services,” “Preventative and wellness services and chronic disease management,” and “Pediatric services, including oral and vision care.” Like allopathic and osteopathic physicians, naturopathic physicians perform ambulatory care services, such as taking routine physical examinations and thorough health histories; perform cardiovascular screenings and Pap smears; and order laboratory tests, imaging procedures, colonoscopies, mammograms, and other diagnostic tests.
FAQ ABOUT NATUROPATHIC MEDICINE IN THE USA

References

1. What is naturopathic medicine?

2. What diagnostic and treatment modalities are naturopathic physicians trained in?

3. Are naturopathic physicians trained in vaccine administration?

Welcome to the PedANP


4. What are naturopathic physicians well-known for?

5. How many years of training in medical school do naturopathic physicians receive?

6. What are the differences in training between naturopathic physicians, allopathic physicians, and osteopathic physicians?

7. What licensing examination do naturopathic physicians take?

8. Who administers the Licensing Examination (NPLEX)?

9. Who is eligible to take the licensing examination (NPLEX)?
FAQ ABOUT NATUROPATHIC MEDICINE IN THE USA

10. Do naturopathic physicians have board certifications that they can obtain?

11. Are naturopathic physicians currently licensed in every state?

12. Are licensure requirements currently standardized in all USA States and Territories?

13. Is completion of a residency program required for licensure?

14. Why is completion of a residency program not required for licensure?

15. What is the importance of licensure of naturopathic physicians and regulation of naturopathic medicine in every state?
16. Who accredits naturopathic residency programs?

- Accreditation Council for Graduate Medical Education. What We Do: Overview. [https://www.acgme.org/What-We-Do/Overview](https://www.acgme.org/What-We-Do/Overview).

17. Who oversees the naturopathic residency match program?

FAQ ABOUT NATUROPATHIC MEDICINE IN THE USA


18. Which US Department of Education specialized accrediting agency accredits naturopathic medicine degree programs?

19. What schools currently have CNME-accredited or CNME-provisionally accredited programs that offer a doctorate degree in naturopathic medicine?

20. What does it mean if a naturopathic medical program is CNME-provisionally accredited?

21. Do naturopathic medical schools have a required entrance examination that is the same between all of the schools?

22. What is the difference between an “NMD” and an “ND” educational degree and title?
23. What is the difference between an “NMD” and an “ND” professional title?

24. How does the US Department of Labor define naturopathic physicians?

25. What are protected professional titles of naturopathic physicians?

26. What organization furthers research initiatives of the naturopathic medical profession?

27. What organization furthers professional initiatives of the naturopathic medical profession?

28. What organization furthers student initiatives of the naturopathic medical profession?

29. What organization furthers research initiatives of the naturopathic medical profession?
30. What organization further clinical literature initiatives of the naturopathic medical profession?

31. Are naturopathic physicians trained to practice evidence-based medicine?

32. Are naturopathic physicians trained to practice “Standards of Care”?

33. What level of CPR are naturopathic medical students and physicians required to know?
FAQ ABOUT NATUROPATHIC MEDICINE IN THE USA

- Southwest College of Naturopathic Medicine & Health Sciences. 4-Year Curriculum. Accessed on 2016 Apr 03. [http://www.scnm.edu/academics/doctor-of-naturopathic-medicine/4-year-curriculum/].

34. What ICD-10 codes do naturopathic physicians use for osseous and soft tissue manipulative medicine and therapy?

35. Do naturopathic physicians have the same public health duties as allopathic and osteopathic physicians?

36. Can naturopathic physicians lose their license to practice naturopathic medicine?

37. What is the central application service for applying to naturopathic medical school?


38. How are naturopathic physicians credentialed?


39. Do naturopathic physicians use CPT codes?


40. Do naturopathic physicians use ICD codes?


41. Do naturopathic physicians provide “Essential Health Benefits” services specified in the PPACA?


42. Are naturopathic physicians trained to practice independently?


43. Which US Department of Education regional accrediting agencies accredit schools with naturopathic medicine degree programs in the USA?


44. What is a brief history of naturopathic medicine in the USA, including its relation to other areas of medicine?


FAQ ABOUT NATUROPATHIC MEDICINE IN THE USA


45. What organization furthers global health initiatives of the naturopathic medical profession?

46. What pharmaceutical medications do naturopathic physicians learn and need to know?
47. Do naturopathic physicians need NPI and DEA numbers?


48. What pharmaceutical medications can naturopathic physicians prescribe?


49. What is the importance of pharmaceutical prescribing rights for naturopathic physicians that accurately reflect the scope of training of naturopathic physicians?

50. Are naturopathic physicians trained to work with and refer to other health care providers?


51. What is the importance of consistent scope of practice in each state that accurately reflects the scope of training of naturopathic physicians?

NATUROPATHIC FORMULARY LAWS BY STATE

As the scope of practice for NDs varies from state to state, so do the laws and regulations regarding prescribing. Ten of the 16 states that license NDs allow NDs to prescribe independently, without any MD/DO supervision or protocol.

STATES WITH LICENSURE OF NATUROPATHIC DOCTORS & PRESCRIPTIVE AUTHORITY, UPDATED 2011

<table>
<thead>
<tr>
<th>State</th>
<th>ND Licensure Enacted</th>
<th># of Current Active NDs</th>
<th>Prescriptive Authority</th>
<th>MD/DO Supervision Required</th>
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<td>Alaska</td>
<td>1986</td>
<td>40</td>
<td>No</td>
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<tr>
<td>Arizona</td>
<td>1935</td>
<td>750</td>
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<tr>
<td>California</td>
<td>2005</td>
<td>450</td>
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<tr>
<td>Connecticut</td>
<td>1920</td>
<td>260</td>
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<td>No</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>2007</td>
<td>28</td>
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</tr>
<tr>
<td>Hawaii</td>
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<td>Idaho</td>
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<tr>
<td>Kansas²</td>
<td>2003</td>
<td>12</td>
<td>Yes</td>
<td>Yes⁴</td>
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<tr>
<td>Maine</td>
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<td>28</td>
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<td>New Hampshire</td>
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<td>North Dakota³</td>
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<tr>
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<td>Washington</td>
<td>1919</td>
<td>802</td>
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</table>

¹ In the State of California, the MD/DO need not be in the same office or need to sign the ND’s charts or prescriptions. A written agreement must be signed for NDs to be able to furnish all drugs with the exception of schedule I-II controlled substances.

² Kansas and Minnesota have registration for Naturopathic Doctors and are regulated under State Board of Healing Arts and the Medical Board's Registered Naturopathic Doctor Advisory Council, respectively.

³ The bill for licensure of NDs in North Dakota just passed this year and therefore, licenses have not yet been issued.
CATEGORIES OF PRESCRIPTIVE MEDICATIONS WITHIN NATUROPATHIC DOCTORS’ SCOPE OF PRACTICE BY STATE

<table>
<thead>
<tr>
<th>Prescription</th>
<th>AK</th>
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<th>CA</th>
<th>CT</th>
<th>DC</th>
<th>HI</th>
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<th>KS</th>
<th>ME</th>
<th>MN</th>
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<td>Antibiotics/ Anti-microbials</td>
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<td>Dermatologicals/ Topicals</td>
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</table>

All checks indicate independent prescriptive authority and asterisk(*) indicates with MD/DO supervision.

Arizona has the broadest formulary in the nation, and able to prescribe all classes of prescription drugs with 4 exceptions: IV medications (except vitamins, chelation therapy, and drugs used in emergency resuscitation and stabilization, which are allowed), controlled substances listed as Schedule I or II (except morphine is allowed), cancer chemotherapeutics classified as legend drugs, and antipsychotics.

Kansas is the only state, other than California, which requires physician supervision for prescribing.

Maine requires one year of a collaborative relationship with an MD/DO.
WEBSITE LINKS TO FORMULARY BY STATE

ARIZONA
http://www.npbomex.az.gov/notice.asp

CALIFORNIA
http://www.naturopathic.ca.gov/laws/regulations.shtml#article6

HAWAII

KANSAS
http://www.ksbha.org/regulations/article72.html

MAINE
www.maine.gov/sos/cec/rules/02/502/502c006.doc

MONTANA

NEW HAMPSHIRE

OREGON

UTAH
http://www.rules.utah.gov/publicat/code/r156/r156-71.htm#T5

VERMONT
http://vtprofessionals.org/opr1/naturopaths/

WASHINGTON
10 Reasons Naturopathic Medicine Lowers Healthcare Costs

1. **Offers more treatment options.**
   Naturopathic physicians provide consumers with a broader range of safe, cost effective care.

2. **Offers less expensive treatment.**
   Naturopathic treatments are inherently less expensive than those in conventional medicine and many naturopathic treatments incur no cost whatsoever.

3. **Reduces need for expensive surgical procedures.**
   Naturopathic physicians offer non-surgical options to patients, while referring for surgery when it is indicated.

4. **Decreases prescription drug costs.**
   Naturopathic physicians typically prescribe less expensive botanical or nutritional supplements to effectively care for medical problems.

5. **Decreases in costs associated with drug prescriptions.**
   About two percent of drug prescriptions result in hospital admission. Adverse drug reactions may add as much as $5 billion annually to health care costs and are considered the 5th leading cause of death in the U.S. 100,000 people died in 2003 of adverse reactions from correctly prescribed pharmaceuticals.

6. **Reduces the incidence of iatrogenic (doctor-induced) illnesses.**
   As many as one-third of patients admitted to hospitals contract another illness while there, resulting in longer stays. Fatal pharmaceutical adverse reactions combined with iatrogenic fatalities are the 3rd leading cause of death in the U.S.

7. **Lowers malpractice rates, resulting in reduced patient costs.**
   Malpractice insurance rates are much lower for naturopathic physicians than they are for conventional doctors. Patients of naturopathic physicians do not have to absorb high malpractice costs.

8. **Addresses the cause of illness thus eliminating expensive ongoing care.**
   By addressing and treating the cause of disease, the need for repeated, expensive and often ineffective symptomatic treatment is eliminated. Naturopathic physicians use state-of-the-art diagnostic testing, through history and complete physical examinations to diagnose underlying causes of disease.

9. **Offers true disease prevention.**
   Naturopathic physicians emphasize health-building practices, reducing the high future cost of preventable degenerative diseases.

10. **Reduces insurance costs.**
    Naturopathic medical billing is far lower per patient than conventional medical billing.
Naturopathic Medicine:  
Cost Saving Disease Prevention and Health Improvement

Naturopathic Medicine Works

**Improved Medical Outcomes**
- Several clinical trials have demonstrated how naturopathic care produces health improvement and risk factor reduction:
  - **Menopausal symptoms**: patients smoked less and exercised more. These patients were *seven times* more likely to report improvement in insomnia and increased energy.  
  - **Anxiety**: improvements in anxiety, fatigue, and quality-of-life.  
  - **Low Back Pain**: less pain, more weight loss, less days off work.  
  - **Heart Disease**: fewer medications, better blood pressure and cholesterol, better mood.  
  - **Diabetes**: improvements in blood sugar, mood, and self-care.  
  - **Multiple Cardiovascular risk factors**: Reduction in Hypertension, High Cholesterol, Obesity, Smoking, Inactivity and Excessive Stress.

**Improved Community Health Outcomes**
- Patients receiving CAM services were significantly more likely to have obtained commonly used preventive services, including blood pressure and cholesterol testing, complete physical exams, and breast cancer screening.

**Improved Patient Satisfaction**
- Patient satisfaction with services: 92% CAM vs. 44% conventional services.
- Bastyr Center for Natural Health – the teaching clinic of the naturopathic medical school in Seattle – ranked in the top 3 among 46 Seattle-area primary care clinics for overall patient satisfaction.

Naturopathic Medicine Saves Money

**Naturopathic Care Reduces need for more-costly Conventional Medical care**
- 55% of CAM users report a slight to substantial reduction of their use of conventional medical care
- 61% of CAM users report a slight to substantial reduction in their use of prescription drugs.
- The Diabetes Prevention Trial demonstrated that diet and lifestyle treatments to prevent type 2 diabetes were more effective (and cost effective) than early drug therapy in high-risk patients.
- Williamson et al. recently recommended increased incorporation of diet and lifestyle therapy into the health system in their review of health policy for diabetes prevention.
- Blue Shield’s internal study found that a naturopathic-centered managed care program could cut the costs of chronic and stress related illness by up to 40%, and lower costs of specialist utilization by 30%
- Naturopathic care to treat diabetics led to improvements in blood sugar, mood, and patient self care.

**Naturopathic Care Reduces Employee Sick Days and Cost, while Improving Productivity**
- Employees of the Canadian Postal Service receiving naturopathic care for low back pain or heart disease showed reductions in lost work days and improvements in productivity while at work.
- These improvements in workplace productivity actually made naturopathic medicine a *COST-SAVINGS* approach. In other words, adding naturopathic care for employees showed an actual return-on-investment.
- Vermont Auto Dealers Association use of naturopathic care for employees saved $2.10 in medical costs for every dollar spent, and $8.20 in total costs per employee for every dollar spent.

**Naturopathic Medicine is not an “add-on,” but Primary Care**
- 67.7% patients in Washington State who receive Naturopathic care do not receive concurrent care from an MD/DO for their RFV (reason for visit). In most cases Naturopathic care is not “add-on” care.
Naturopathic care has negligible cost

- A 2004 analysis of payers found that in WA State CAM services cost approximately $0.20-$0.19 per member per month in HMO and PPO plans respectively.\textsuperscript{15}
- A 2006 analysis attempting to quantify the impact of the WA State “Every Category of Provider” law found that the impact on insurance premiums was “modest,” representing about 2.9% of total expenditures.\textsuperscript{16}
- According to Lafferty et al. in 2004, approximately 7.6% of cancer patient records sampled had claims for naturopathic services amounting to <2% of overall medical bills for cancer care for over 7,000 patients. The average amount billed per cancer patient for Naturopathic services was $413.00; the average amount billed for conventional care for the same patients was $40,728.\textsuperscript{17}

References:

National Conference of State Legislatures (NCSL) and National Governors Association (NGA)
Framework for Scope of Practice Proposal

The Minnesota Association of Naturopathic Physicians (MNANP)

Part 1- Proposal Overview

1) State the profession/occupation
   a) Profession: Naturopathic Medicine
   b) Occupation: Naturopathic Physicians (called Naturopathic Medical Doctors in Minnesota)

2) For existing professions, briefly describe the proposed statutory change in scope of practice.
   a) Modernize scope of practice to accurately reflect the scope of training of naturopathic physicians:
   b) Add pharmaceutical prescribing rights to accurately reflect scope of training and address public health and safety issues - public safety access issues that will be solved: antibiotics, vaccines, birth control, etc.
   c) Add IV, IM, and subcutaneous administration rights
   d) Protect the practice of “naturopathic medicine” (can diagnose and treat illness) by moving registration of naturopathic physicians to licensure - the practice of “naturopathy” (cannot diagnose and treat illness) will still be protected by Minnesota Statute Chapter 146A.

Part 2- Proposal Details

A. Public Safety
   1. Describe, using evidence, how the proposed scope and regulation ensures public safety?
      a. Naturopathic doctors are overseen by the Board of Medical Practice. Stringent educational requirements are in place and a process already exists to discipline naturopathic physicians. Please see section below for safety statistics on naturopathic physicians.
   2. Is there any research evidence the proposed change might endanger the public? Please cite.
      a. No there is no evidence that the proposed changes might endanger the public.
         In states that already have legislation in place providing naturopathic physicians their full scope of practice, naturopathic physicians maintain a better safety record than medical physicians and osteopathic physicians.
      b. Since 2008 when naturopathic physicians became registered in Minnesota there have been no complaints to the Board of Medical Practice.
      c. In 2013, the federal government acknowledged the safety and effectiveness of naturopathic medicine by passing a resolution designating the week of October 7-13 as Naturopathic Medicine Week to “recognize the value of naturopathic medicine in providing safe, effective, and affordable health care.” (S.Res.135. Congress.gov, http://beta.congress.gov/bill/113th/senate-resolution/135)
      d. The California and nationwide data undeniably support the US government's 2013 resolution. California’s nearly 500 practicing naturopathic physicians have a pristine safety record – there have been no cases of patient harm caused by naturopathic physicians in California since licenses were first issued in 2005.
      e. Throughout the US, naturopathic physicians have maintained an excellent history of patient safety. In Washington, a state that began licensing NDS in the 1930s and has a broad scope of practice that includes minor office procedures and independent prescription rights, has had only 25 disciplinary actions
against naturopathic physicians in the last 10 years. This represents 0.5% of the ND population in Washington. During the same time period, there were 23,317 disciplinary actions taken against medical physicians, representing 0.64% of Washington MDs. Osteopathic physicians were also cited more frequently than NDs; there were 56 actions against DOs from 2001-2011, representing 0.95% of the population – nearly double the rate of naturopathic physicians. Other states with broad scopes of practice for NDs boast similar rates.

f. Malpractice insurance claims can be used to further assess the risk of updating the scope of practice for naturopathic physicians in California. According to NCMIC, the leading provider for naturopathic malpractice insurance, premium rates for naturopathic physicians average approximately 30-40% lower than primary care medical physicians. Furthermore, NCMIC has never opened a claim based on an allegation against a naturopathic physician involving prescription medications. Bruce Beal, Vice President of Claims at NCMIC, wrote the following in a 2010 letter: “[NCMIC] entered into the ND market in 2001 offering [malpractice] coverage to NDs in all states that recognize and license the profession. I believe that to be 15 states plus the District of Columbia at the present time. In addition, NCMIC insures four of the five naturopathic colleges in the United States. In the years that NCMIC has been insuring Naturopathic physicians and the colleges, we have never opened a claim based on an allegation against a Naturopathic physicians involving prescription medications. We have seen several claims involving adverse reactions to herbals or a combination of herbals reacting with a drug prescribed by a medical physician.” The National Practitioner Databank, a statistical database maintained by the US Department of Health and Human Services, has no records of malpractice claims against naturopathic physicians in the United States. According to the Databank, there were 16,925 malpractice payments made in California from 2002-2012, amounting to more than $2.7 billion. None of those malpractice payments were attributed to naturopathic physicians. A 2013 nationwide search by Verdict-Search also found no records of malpractice suits against naturopathic physicians. Safety is an important factor to consider when new legislation is being proposed. Based on the national safety data, updating the proposed legislation allowing naturopathic physicians to practice to the full extent of their training and education will increase patient access to safe, effective primary care.

3. Describe the proposed disciplinary measures to safeguard against unethical/unfit professionals. How can consumers access this information?

a. Complaint and disciplinary process for Registered Naturopathic physicians
   i. 147E.30 DISCIPLINE; REPORTING. For purposes of this chapter, registered naturopathic doctors and applicants are subject to sections 147.091 to 147.162.
   ii. If there is any concern about the conduct of a registered naturopathic doctor it can filed with the Minnesota Board of Medical Practice. Complaint forms are available at https://mn.gov/boards/medical-practice/public/complaints/complaint-registration-form.jsp or by calling 612-617-2130. To initiate a formal review the forms must be completed with a notarized signature and returned to the Board.
   iii. Once a complaint is filed the Board’s staff gathers information from a variety of sources, starting with the information you included in the complaint. The staff will gather medical records, collect data and may interview those involved, If it is appropriate, the staff will also obtain a
response from the physician involved. When the information gathering is completed the Registered Naturopathic Advisory Council reviews the information per statute 147E.35 Subd. 3. The Advisory Council reviews the materials and submits a recommendation the Board of Medical Practice who ultimately makes a ruling and decide if disciplinary action is required per 147.091 to 147.162

B. Regulation
1. Describe if a regulatory entity/board currently exists or will be proposed. Does/will it have statutory authority to develop rules related to a changed/expanded scope or emerging profession, including authority to discipline practitioners, determine standards for training programs, assessment of practitioners’ competence levels? If not, why not?

See existing statute below:
Naturopathic physicians in Minnesota are under the regulation of the Minnesota Board of Medical Practice who is advised, currently, by the Registered Naturopathic Advisory Council

a. 147E.35 REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.
   i. Subdivision 1.Membership.
      1. The board shall appoint a seven-member Registered Naturopathic Doctor Advisory Council consisting of one public member as defined in section 214.02, (PUBLIC MEMBER, DEFINED) five registered naturopathic doctors who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.
   ii. Subd. 2.Organization.
      1. The advisory council shall be organized and administered under section 15.059, (ADVISORY COUNCILS AND COMMITTEES)
      2. Section 15.059, subdivision 2, (MEMBERSHIP TERMS), does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.
   iii. Subd. 3.Duties.
      1. The advisory council shall:
         1. advise the board regarding standards for registered naturopathic doctors;
         2. provide for distribution of information regarding registered naturopathic doctors standards;
         3. advise the board on enforcement of sections 147.091 (GROUNDS FOR DISCIPLINARY ACTION) to 147.162; (MEDICAL CARE FACILITIES; EXCLUSION)
         4. review applications and recommend granting or denying registration or registration renewal;
         5. advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors;
         6. advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3.
7. perform other duties authorized for advisory councils by chapter 214, (EXAMINING AND LICENSING BOARDS) as directed by the board.

2. **Do other states apply regulatory oversight? If so, describe briefly.**
Yes, 16 other states (total of 17), the District of Columbia, and the US territories of Puerto Rico and the Virgin Islands regulate naturopathic physicians.

3. **Is there consensus model legislation available at the national level? If so, which states have adopted it?**
The American Association of Naturopathic Physicians (AANP) has a model bill that is available to state chapters as they pursue licensure, however, in the 16 other states, the District of Columbia, US territories of Puerto Rico and the Virgin Islands where there is licensure, the laws vary on some details like ongoing CE requirements and prescribing.

4. **Does the proposed scope conflict with the current scope of practice for other professions/practitioners? If so, describe the areas of conflict**
No, this bill does not prohibit or change any other professions/practitioners’ scope of practice it only regulates licensed naturopathic physicians.

C. **Education**
Describe the training, education, or experience that will be required for this professional.
A licensed naturopathic physician (ND) attends a four-year, graduate-level naturopathic medical school and is educated in all of the same basic sciences as an MD, but also studies holistic and nontoxic approaches to therapy with a strong emphasis on disease prevention and optimizing wellness. In addition to a standard medical curriculum, the naturopathic physician also studies clinical nutrition, homeopathic medicine, botanical medicine, psychology, and counseling. A naturopathic physician takes rigorous professional board exams so that he or she may be licensed by a state or jurisdiction as a primary care general practice physician.

**Academic Prerequisites**
There are currently seven accredited naturopathic schools in North America. These belong to the Association of Accredited Naturopathic Medical Colleges (AANMC), and require a base of undergraduate science courses that include biology as well as general and organic chemistry. Anatomy, biochemistry, botany, developmental psychology, and physiology courses may also be specified.

**Academic Curriculum**
Naturopathic medicine students learn to treat all aspects of family health and wellness, from pediatrics to geriatrics. During their first two years of study, the curriculum focuses on basic and clinical sciences and diagnostics, covering:

- Anatomy
- Biochemistry
- Human physiology
- Histology
- Human pathology
- Immunology
- Macro- and microbiology
- Neuroscience
• Pharmacology
For at least the final two years of their medical program, students intern in clinical settings under the close supervision of licensed professionals, learning various therapeutic modalities including:
8) Botanical medicine
9) Clinical nutrition
10) Counseling
11) Homeopathy
12) Laboratory & clinical diagnosis
13) Minor surgery
14) Naturopathic physical medicine
15) Nutritional science

Some member schools in the AANMC actually require more hours of basic and clinical science than many top allopathic medical schools. Students of naturopathic medicine use the Western medical sciences as a foundation on which to build a thorough knowledge of holistic, non-toxic therapies and develop skills in diagnosis, disease prevention and wellness optimization.

Accredited Programs (http://www.cnme.org/programs.html)

**Bastyr University**

Naturopathic Medicine Program (Washington State campus)
14500 Juanita Drive, N.E.
Kenmore, Washington 98028-4966
phone number 425.823.1300

Naturopathic Medicine Program (California campus)
4106 Sorrento Valley Boulevard
San Diego, California 92121
phone number 425.823.1300

Accreditation was initially granted in April 1987 and last reaffirmed in October 2013. The next full-scale evaluation is scheduled for winter/spring of 2019, with a decision on continued accreditation to be made in fall of 2019. The university has institutional accreditation with the Northwest Commission on Colleges and Universities, a U.S. Department of Education-recognized regional accrediting agency.

**Boucher Institute Of Naturopathic Medicine**

Naturopathic Medicine Program
Suite 300
435 Columbia Street
New Westminster, BC V3L 5N8
Canada
phone number 604.777.9981

Initial accreditation was granted in December 2008 and last reaffirmed in May 2015. The next full-scale evaluation visit is scheduled for fall 2017, with a decision on continued accreditation to be made in spring 2018. The college is recognized by all Canadian
provinces that license naturopathic practitioners.

**Canadian College of Naturopathic Medicine**

Naturopathic Medicine Program  
1255 Sheppard Avenue East  
North York, Ontario M2K 1E2  
Canada  
phone number 416.498.1255

Accreditation was initially granted September 2000, and last reaffirmed in May 2013. The next full-scale evaluation visit is scheduled for fall 2019, with a decision on continued accreditation to be made in spring 2020. The college is recognized by all Canadian provinces that license naturopathic practitioners.

**National University of Natural Medicine**

Naturopathic Medicine Program  
049 S.W. Porter  
Portland, Oregon 97201  
phone number 503.552.1660

Accreditation was initially granted April 1991 and last reaffirmed in May 2015. The next full-scale evaluation visit is scheduled for fall 2021, with a decision on continued accreditation to be made in spring 2022. The college has institutional accreditation with the Northwest Commission on Colleges and Universities, a U.S. Department of Education recognized regional accrediting agency.

**National University of Health Sciences**

Naturopathic Medicine Program  
200 E. Roosevelt Road  
Lombard, Illinois 60148  
phone number 800.826.6285

Initial accreditation granted in October 2012. The next full-scale evaluation visit is scheduled for spring 2016, with a decision on continued accreditation to be made in fall 2016. The university has institutional accreditation with the Higher Learning Commission, a U.S. Department of Education recognized regional accrediting agency.

**Southwest College of Naturopathic Medicine & Health Sciences**

Naturopathic Medicine Program  
2140 E. Broadway Road  
Tempe, Arizona 85282  
phone number 480.858.9100

Accreditation was initially granted in 1999, and last reaffirmed in May 2013. The next full-scale evaluation visit is scheduled for fall 2018, with a decision on continued accreditation to be made in spring 2019. The college has institutional accreditation with the North
Central Association of Colleges and Schools, a U.S. Department of Education recognized regional accrediting agency.

University of Bridgeport College of Naturopathic Medicine

Naturopathic Medicine Program
60 Lafayette Street
Bridgeport, Connecticut 06604
phone number 203.576.4109

Initial accreditation was granted in March 2006 and last reaffirmed in May 2014. The next full-scale evaluation visit is scheduled for fall 2017, with a decision on continued accreditation to be made in spring 2018. The university has institutional accreditation with the New England Association of Schools and Colleges, a U.S. Department of Education recognized regional accrediting agency.

All AANMC member institutions have been accredited by one of the regional accrediting agencies approved by the U.S. Department of Education. In addition, all of the naturopathic medicine programs of the member schools have been accredited by the Council on Naturopathic Medical Education (CNME), the recognized accreditor for naturopathic medical programs in North America.

Every state, province, and other jurisdiction that licenses naturopathic physicians as primary care health practitioners relies on CNME program accreditation and standards to quality applications for state or province licensure. Naturopathic professional schools and associations in North America rely on the CNME to establish and maintain the highest standards for naturopathic education. This is similar to the way standard medical schools rely on the Association of American Medical Colleges and the American Medical Association to sponsor a national accrediting authority for their medical programs.

CNME evaluators conduct periodic campus visits and staff/faculty interviews in order to monitor the school’s activity on an ongoing basis.

Graduation from a naturopathic medicine program that is accredited or is a candidate for accreditation guarantees eligibility to sit for the Naturopathic Physicians Licensing Examinations (NPLEX), the passage of which is required to obtain licensure. CNME is also the only naturopathic accreditor with membership in the Association of Specialized and Professional Accreditors (ASPA). This organization accepts as members those accreditors recognized by the Secretary of Education or that meet ASPA’s own criteria. Among the almost 50 agencies that belong to ASPA are the recognized accreditors for allopathic (M.D.), osteopathic (D.O.), chiropractic (D.C.), acupuncture (L.Ac.), and dental programs. Other naturopathic accrediting agencies accredit correspondence and other schools that do not prepare students to practice as licensed naturopathic physicians. None is recognized by the Secretary of Education, and none of the schools or programs they accredit has institutional accreditation from a recognized regional accrediting agency.

Naturopathic Medical Education Comparative Curricula

The First Two Years: A Strong Science Background
Naturopathic medical education is imbued with a unique philosophy grounded in the six principles of naturopathic medicine, which include holistic, nontoxic approaches, along with an emphasis on disease prevention and optimizing wellness. Accordingly, ND school curricula include certain areas of study not covered in conventional medical school, such as clinical nutrition, homeopathic medicine and psychological counseling. However, future NDs also receive training in many of the same biomedical and diagnostic sciences as their MD counterparts, and the result is a comprehensive and well-rounded medical education.

The general educational structure is very similar for both ND and MD students. In both programs, the first year emphasizes the biomedical sciences, such as anatomy and biochemistry. During the second year, classes focus on the diagnostic sciences, including areas like evidence-based medicine and physiological assessment. Both programs progressively increase students’ problem-based learning and integrated coursework, allowing students to comprehend how the different learned concepts affect one another.

During the first two years, ND students’ credit loads are almost identical to those of MD students. In nearly every biomedical science, ND students are required to complete as many credits as MD students. Specifics vary by school, but a 2010 course comparison of the University of Washington’s MD program and Bastyr University’s ND program shows that during the first two years, University of Washington MD students completed a total of 150 credits and Bastyr ND students completed 151.5 credits, most of them in comparable biomedical and diagnostic science courses.

Credit Comparison
ND & MD Programs: The first two years

Some key aspects of ND education reflected in the bar graph:
• The first two years of the ND curriculum also include early introduction to naturopathic modalities, such as homeopathy, nutrition and botanical medicine. This exposure occurs in many different courses over these two years, and therefore is not called out separately in the ND school course catalogue.
• While many conventional medical schools use a systems-based approach to medical education, most naturopathic medical programs currently do not. In a systems-based approach, anatomy, physiology, pathology and diagnostic skills are each taught individually for each body system (i.e., respiratory, digestive, nervous system, etc.). And although some ND schools may be moving toward a more systems-based approach to education, classes in a typical ND program are not divided by system, but rather focus on how a symptom in one part of the body may affect the patient’s entire anatomy and well-being.
• Some ND school curricula also begin clinical training during the first and second years, just as some MD school curricula initiate observational shifts at that time.

Third and Fourth Years: Hands-on Experience via Clinical Training
After the first two years, both ND and MD curricula focus on applying medical knowledge to real-life situations; simultaneous classroom studies support this training. Both curricula strive to maximize the synchronization of classroom and clinical training during these key years, thereby improving the quality and practicality of the students’ educations.

However, it is during these later years that MDs’ educations begin to differ noticeably from those of NDs. MDs complete clerkships, which are courses in various medical specialties, and although MD students see plenty of patients during these clerkships, their roles are primarily observational: they are not primarily responsible for patient care.

Third- and fourth-year ND students have increasing opportunities for hands-on clinical training and practice, often at their schools’ teaching clinics and off-site clinics, which offer diverse patient populations. This period of clinical training goes well beyond the observation and is absolutely essential to NDs’ educations – so much so that clinical training is now being introduced during the first and second years of education at several AANMC-member schools. As a result, naturopathic medical students graduate prepared to begin practice and to diagnose and treat patients, whereas MD students are required to complete residencies after graduation in order to gain clinical experience.

B. Describe any needed course of study and resulting credential. Is the education program available, or what is the plan to make it available? Is accreditation or other approval available for the education program?

<table>
<thead>
<tr>
<th>FIRST YEAR</th>
<th>FOURTH YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal Anatomy I &amp; II</td>
<td>Clinic X-Ray Practicum</td>
</tr>
<tr>
<td>Organ System A &amp; P I, II &amp; III</td>
<td>Clinic Senior Lab Post</td>
</tr>
<tr>
<td>Anatomy Lab I, II &amp; III</td>
<td>Clinic Primary Shifts 1-13</td>
</tr>
<tr>
<td>Cellular Systems w/Tutorial I, II &amp; III</td>
<td>Clinic Field Observations 1-6</td>
</tr>
<tr>
<td>Medical Histology</td>
<td>Clinic Community Service</td>
</tr>
<tr>
<td>Basic Science Clinical Correlate I, II &amp; III</td>
<td>Eye, Ears, Nose, Throat</td>
</tr>
<tr>
<td>Naturopathic Med Phil and Ther I, II &amp; III</td>
<td>Environmental Medicine</td>
</tr>
<tr>
<td>Research and Statistics</td>
<td>Dermatology</td>
</tr>
<tr>
<td>Microbiology/Public Health I &amp; II</td>
<td>Psychological Assessment</td>
</tr>
<tr>
<td>Hydrotherapy w/Lab</td>
<td>Geriatrics</td>
</tr>
<tr>
<td>Palpation I &amp; II Lab</td>
<td>Exercise Therapeutics</td>
</tr>
<tr>
<td>Doctor Patient Communication I w/Lab</td>
<td>Clinic Grand Rounds/Clinic Ed/I-III</td>
</tr>
<tr>
<td>Pathology I</td>
<td>Neurology</td>
</tr>
</tbody>
</table>
Introduction to Clinic
Medical Ethics
Stress Management

SECOND YEAR
Chinese Medicine I & II
Clinical/Physical Diagnosis I
Physical Diagnosis Lab I, II & III
Pathology II, III & IV
Intro Homeopathy
Clinical Case Presentations I, II & III
Office Orthopedics I & II
Clinical Rotation Hydro/Massage
Botanical Materia Medicia I & II
Clinical/Physical Diagnosis II & III
Homeopathy I & II
Clinical Rotation Hydro/Massage
Nutrition I

THIRD YEAR
Botanical Materia Medica III
Diagnostic Imaging I-III
Homeopathy III-IV
Naturopathic Man.Ther. II-IV w/lab II-V
Gynecology
Nutrition II-IV
Obstetrics I
Clinic Secondary Shift # 1-6
Clinic Grand Rounds/Clinic Ed
Clinic Lab Practicum
Business Practice Seminar I
Cardiology
Pediatrics
Minor Surgery II with lab
First Aid & Emergency Medicine
Gynecology Lab
Clinic Grand Rounds/Clinic Ed
Clinic Lab Practicum

Urology
Proctology
Endocrinology
Counseling Tech.
Thesis
Clinic Education
Medical Genetics
Jurisprudence
Business Practice Seminar II
Oncology

ELECTIVES
Advanced Minor Surgery
Chronic Viral Disease
Colonics
Homeopathy V-VIII
Northwest Herbs I-III
Naturopathic Manipulative
Ther I w. Lab
I
Northwest Herbs II
Advanced Bot Med I-II
Advanced Bot Med II
Obstetrics II-VII
Natural Pharmacology
Bodywork I Massage Foundations
Bodywork II Advanced Massage
Somatic Re-Education I-V
Clinical Case Presentation IV
TCM III Part A & B
IV Therapy
The Liver in Health & Disease
Advanced Pediatrics
Nature Cure

HOUR SUMMARY

Class Hours 2460
Lab Hours 828
Clinic Hours 1548
Total Required Hours 4836
Total Elective Hours 930

Examination Board Comparison

ND students must sit for and pass two board exams known as the Naturopathic Physicians Licensing Exam (NPLEX) before qualifying for licensure. The NPLEX Part I, biomedical science examination is equivalent to USMLE Step 1 and COMLEX Level 1. These are systems based exams taken upon successful completion of graduate level training in anatomy, physiology, biochemistry, genetics, microbiology, immunology and pathology. They are clinically oriented examinations requiring the synthesis of all basic sciences.

The NPLEX Part II is comparable to USMLE (Steps 2 and 3) and COMLEX (Level 2 and 3) with an emphasis on the knowledge needed to begin practice as a solo practitioner. NPLEX Part II is taken after graduation from a CNME approved naturopathic medical school. It is a case based exam requiring the synthesis and application of knowledge of the clinical sciences the Naturopathic Physicians must have in order to practice safely.
C. What provisions exist or are being proposed to ensure that practitioners maintain competency in the provision of services?
Naturopathic physicians are required to maintain continuing education credits to renew their license annually. This bill proposes 30 hours annually for naturopathic physicians.

D. Describe the recommended level/type of supervision for this practitioner - independent practice collaborative practice (needing formal Agreements), supervised practice? If this practice will be supervised, state by whom, the level, extent, nature, terms of supervision.
The recommended level for this practitioner is independent practitioner.

D. Reimbursement and Fiscal Impact
1. Describe how and by whom will the new or expanded services be compensated? What costs and what savings would accrue and to whom (patients, insurers, payers?)
a. In Minnesota, services provided by naturopathic physicians are paid for by patients. Patients are able to use their health savings account or flex spending accounts. Currently no insurers in Minnesota credential naturopathic physicians. Naturopathic physicians utilize dietary and lifestyle changes and focus strongly on preventative medicine. This emphasis on prevention reduces the need for medication and expensive surgical procedures. In addition, malpractice rates are much lower for naturopathic physicians than they are for conventional medical physicians this results in reduced patient costs.

b. Naturopathic medical care reduces the need for more costly conventional medical care.

2. The most significant reduction in total medical expenditure made by using CAM, is seen in patients with the greatest disease burden, who tend to be the most expensive patients. (Sarnat, Richard L. et al: Clinical Utilization and Cost Outcomes From and Integrative Medicine Independent Physician Association: An Additional 3-Year Update. J Manipulative Physiol Ther 2007; 30: 263-269)


5. The Diabetes Prevention Trial demonstrated that diet and lifestyle treatments to prevent type 2 diabetes were more effective (and cost effective) than early drug therapy in high-risk patients. (Herman WH, Hoerger TJ, Brandle M, et al. The cost-effectiveness of lifestyle modification or metformin in preventing type 2 diabetes in adults with impaired glucose tolerance. Ann Intern Med. Mar 1 2005;142(5):323-332.)


7. Blue Shield's internal study found that a naturopathic-centered managed care program could cut the costs of chronic and stress related illness by up to 40%, and lower costs of specialist utilization by 30%. (Phase I Final Report: Alternative Healthcare Project. King County Medical Blue Shield; 1995.)


9. A Blue Shield of Washington study found that utilizing NDs would reduce cost for chronic and stress related illness up to 40% and cut costs of specialist utilization by 30%. (Henry. 1995. King County Medical Blue Shield Phase I Final Report. Alternative Healthcare Project Steering Committee. August 5, 1995.)


12. Naturopathic Medical care reduces employee sick days and cost, while improving productivity.

14. Vermont Auto Dealers Association use of naturopathic care for employees saved $2.10 in medical costs for every dollar spent, and $8.20 in total costs per employee for every dollar spent. (Dr. Bernie Noe’s Jumpstart to Better Health Program: American Association of Naturopathic Physicians; 2005.)

2. Describe whether third party reimbursement is available for these services in other states?
   a. We are still gathering data on this topic. Insurance coverage is likely more robust than what is listed below.
   b. Oregon, Vermont and Washington have the most insurance coverage for naturopathic physicians including medicaid and other public health insurance plans. Naturopathic physicians are in-network providers in these states with third party insurance companies.
   c. Alaska, Arizona, Connecticut, Maine, Montana, and New Hampshire also have third party insurance companies that reimburse for naturopathic medical services.

3. What are the projected regulatory costs to state government, and how does the proposal include revenue to offset these costs?
   a. We do not foresee any increased regulatory costs as the Naturopathic Advisory Council and the Board of Medical Practice already exist.

4. Fiscal impact of the proposed bill?
   a. No

E. Reporting
1. Describe the proposed frequency and content of progress reports to the legislature including timeframe (2 years-5 years or 10 years)
Will report with whatever frequency is requested. Suggest that we report within 2 years then every 5 years.

F. Workforce Impacts
   a. Describe what is known about the projected supply/how many individuals are expected to practice under the proposed scope? If possible, also note geographic availability (by county/economic development areas) of proposed providers/services. Cite any sources used.
### Increase in Number of NDs in States with Regulation

<table>
<thead>
<tr>
<th>State</th>
<th>Year Regulated</th>
<th># of NDs In First Year of Regulation</th>
<th># of NDs in 2016*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>1986</td>
<td>5</td>
<td>57</td>
</tr>
<tr>
<td>Arizona</td>
<td>1935</td>
<td>unknown</td>
<td>883</td>
</tr>
<tr>
<td>California</td>
<td>2003</td>
<td>129</td>
<td>600+</td>
</tr>
<tr>
<td>Colorado</td>
<td>2013</td>
<td>84</td>
<td>121</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1920</td>
<td>unknown</td>
<td>350</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>2005</td>
<td>7</td>
<td>49</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1925</td>
<td>unknown</td>
<td>121</td>
</tr>
<tr>
<td>Kansas</td>
<td>2003</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Maine</td>
<td>1995</td>
<td>7</td>
<td>46</td>
</tr>
<tr>
<td>Maryland</td>
<td>2014</td>
<td>25</td>
<td>30 by Dec. 2016**</td>
</tr>
<tr>
<td>Minnesota</td>
<td>2008</td>
<td>21</td>
<td>69</td>
</tr>
<tr>
<td>Montana</td>
<td>1991</td>
<td>14</td>
<td>93</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1994</td>
<td>11</td>
<td>88</td>
</tr>
<tr>
<td>North Dakota</td>
<td>2011</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Oregon</td>
<td>1927</td>
<td>20</td>
<td>700</td>
</tr>
<tr>
<td>Utah</td>
<td>1997</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>Vermont</td>
<td>1995</td>
<td>10</td>
<td>337</td>
</tr>
<tr>
<td>Washington</td>
<td>1919</td>
<td>17</td>
<td>1,200</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>2004</td>
<td>4</td>
<td>13</td>
</tr>
</tbody>
</table>


** Licenses are in the process of being issued (June 2016, ongoing).

* Estimates based on information provided by state ND associations and individual state/territory regulatory authorities, including online searches of regulatory authority databases, June 2016. The total # of licensed or registered NDs includes out-of-state NDs.

a. Naturopathic physicians prefer to practice in states where they have the ability to use their education and training. Once a state passes legislation licensing naturopathic physicians the number of naturopathic physicians in the state increases. The chart above outlines the number of ND’s in various states as of June 2016.

b. Minnesota currently has 60 (not including 11 inactive licenses) naturopathic doctors in practice in the following geographic locations:
The Board of Medical Practice has the most up to date and accurate list of registered naturopathic doctors.
b. Describe, with evidence where possible, how the new/modified scope of practice will contribute to balancing the supply of the proposed services with the current/projected demand for these services.

The current naturopathic physicians practicing in Minnesota are under a heavy demand. Many have lengthy waiting lists and patients are waiting several weeks for care. An updated and modernized scope of practice would entice more naturopathic physicians to move their practice to Minnesota as well as encourage new graduates to start their practice in Minnesota.

c. Describe whether any other occupations perform the activities proposed? If so, describe how the proposed services are similar or complementary to those now performed by other occupations.
   a. Other occupations have prescriptive rights including, but not limited to, allopathic physicians, osteopathic physicians, physician assistants, advanced practice registered nurses, and midwives.
   b. No other occupation provides naturopathic medical care aside from naturopathic physicians. Traditional naturopaths only practice naturopathy.

d. Has there been an evidence based risk benefit analysis of the proposed scope of practice change? If so, please describe.
   a. No there is no evidence that the proposed changes might endanger the public. In states that already have legislation in place providing naturopathic physicians their full scope of practice, naturopathic physicians maintain a better safety record than medical physicians and osteopathic physicians.
   b. Since 2008 when naturopathic physicians became registered in Minnesota there have been no complaints to the Board of Medical Practice.
   c. In 2013, the federal government acknowledged the safety and effectiveness of naturopathic medicine by passing a resolution designating the week of October 7-13 as Naturopathic Medicine Week to “recognize the value of naturopathic medicine in providing safe, effective, and affordable health care.” (S.Res.135. Congress.gov, http://beta.congress.gov/bill/113th/senate-resolution/135)
d. The California and nationwide data undeniably support the US government's 2013 resolution. California's nearly 500 practicing naturopathic physicians have a pristine safety record – there have been no cases of patient harm caused by naturopathic physicians in California since licenses were first issued in 2005.

e. Throughout the US, naturopathic physicians have maintained an excellent history of patient safety. In Washington, a state that began licensing NDs in the 1930s and has a broad scope of practice that includes minor office procedures and independent prescription rights, has had only 25 disciplinary actions against naturopathic physicians in the last 10 years. This represents 0.5% of the ND population in Washington. During the same time period, there were 23,317 disciplinary actions taken against medical physicians, representing 0.64% of Washington MDs. Osteopathic physicians were also cited more frequently than NDs; there were 56 actions against DOs from 2001-2011, representing 0.95% of the population – nearly double the rate of naturopathic physicians. Other states with broad scopes of practice for NDs boast similar rates.

f. Malpractice insurance claims can be used to further assess the risk of updating the scope of practice for naturopathic physicians in California. **According to NCMIC, the leading provider for naturopathic malpractice insurance, premium rates for naturopathic physicians average approximately 30-40% lower than primary care medical physicians.** Furthermore, NCMIC has never opened a claim based on an allegation against a naturopathic physician involving prescription medications. Bruce Beal, Vice President of Claims at NCMIC, wrote the following in a 2010 letter: “*[NCMIC] entered into the ND market in 2001 offering [malpractice] coverage to NDs in all states that recognize and license the profession. I believe that to be 15 states plus the District of Columbia at the present time. In addition, NCMIC insures four of the five naturopathic colleges in the United States. In the years that NCMIC has been insuring Naturopathic physicians and the colleges, we have never opened a claim based on an allegation against a Naturopathic physicians involving prescription medications. We have seen several claims involving adverse reactions to herbals or a combination of herbals reacting with a drug prescribed by a medical physician.**” The National Practitioner Databank, a statistical database maintained by the US Department of Health and Human Services, has no records of malpractice claims against naturopathic physicians in the United States. According to the Databank, there were 16,925 malpractice payments made in California from 2002-2012, amounting to more than $2.7 billion. None of those malpractice payments were attributed to naturopathic physicians. A 2013 nationwide search by Verdict-Search also found no records of malpractice suits against naturopathic physicians. Safety is an important factor to consider when new legislation is being proposed. **Based on the national safety data, updating the proposed legislation allowing naturopathic physicians to practice to the full extent of their training and education will increase patient access to safe, effective primary care.**

### Access, Cost, Quality, Care Transformation Implications

1. **Describe the unmet healthcare needs of the population that can be served under this proposal and how the proposal will contribute to meeting these needs. Describe how the proposed changes will affect the availability, accessibility, cost, delivery and quality of health care.**

   a. Our nation and our state is in significant primary care shortage. Naturopathic physicians are trained as primary care providers and poised to help fill this gap. The proposed changes will allow naturopathic physicians to administer vaccines and use basic medications required to operate as primary care providers. Naturopathic physicians already order lab work, imaging, perform physical exams and diagnose patients. When a naturopathic...
physician determines that a vaccine or medication is required the patient must be referred to another provider. This reduces continuity of care and adds hurdles for the patient in receiving quality care.

b. Increasing levels of chronic disease including: diabetes, heart disease, cancer and obesity, have created a multi-trillions dollar financial burden on the medical system. Naturopathic medicine reduces the need for expensive conventional care while promoting health and decreasing the need for medical interventions over the long term. It is estimated that if the current level of preventive intervention continues the US will end up spending $9.5 trillion dollars over the next 30 years caring for Cardiovascular disease, diabetes and congestive heart disease alone. By adding in greater preventive strategies cost could be reduced approx. $904 billion or almost 10%. (Kahn, Richard. The Impact of Prevention on Reducing the Burden of Cardiovascular Disease. J Circulation 2008, 118:576–585)

c. Use of natural health products (NHP) has the potential to improve health outcomes and reduce cost compared to conventional treatment by anywhere from 3.7–73%. (Kennedy, Deborah A. et al. Cost Effectiveness of Natural Health Products: A Systematic Review of Randomized Clinical Trials. eCAM 2009; 6(3) 297-304 (5))


e. One year of lifestyle intervention for patients with coronary artery disease not only improved all health outcomes and reduced the need for surgery but also cost significantly less then conventional treatment ($7,000 vs $31,000 –$46,000). (Ornish, Dean. Avoiding Revascularization with Lifestyle Changes: The Multicenter Lifestyle Demonstration Project. Am J Cardiol 1998;82:72T–76T)


g. Although the initial cost of prevention is sometimes similar to conventional care the benefits gained by avoiding disease and their associated costs are invaluable and much preferred by patients. (Woolf, Steeve. A Closer Look at the Economic Argument for Disease Prevention. JAMA 2009; 301 (5) 356–3)

2. Please describe whether the proposed scope includes provisions to encourage or require practitioners to serve underserved populations.

a. This proposal will not require naturopathic physicians to serve underserved populations.

b. Underserved populations require more primary care coverage and this proposal will add at minimum 50 primary care providers, several of whom currently practice in rural Minnesota.

Proposal Supporters/Opponents

1. What organizations and groups have been involved in developing the proposal?
The Minnesota Association of Naturopathic Physicians (MNANP) has been the most active organization in developing this proposal.

2. Note any associations, organizations, or other groups representing the occupation seeking regulation and the approximate number of members in each in Minnesota.
The Minnesota Association of Naturopathic Physicians (MNANP) is the professional organization for naturopathic physicians in Minnesota and currently has 30 members.

3. Please describe the position professional associations of the impacted professions (including opponents) have taken regarding the proposal.
The MNANP is in full support of the proposal and naturopathic physicians are the only impacted profession.
4. State what actions have been undertaken to minimize or resolve any conflict or disagreement with those opposing the proposal.

We will be hosting informational webinars this Fall and welcome written feedback about the proposed legislation. We are happy to meet with any interested parties.
IMG Assistance Program – Stakeholder Advisory Group
Licensure Group
Potential Recommendations

**Decision Making Criteria:**

- Does recommendation require statutory changes?
- Is the recommendation controversial?
- How much progress would it produce?
- What is the impact on health equity?

**Timeline:**

- August: Work group meeting
- September: Work group meeting, Finalize recommendations
- October: Present recommendations to the stakeholder group
  - Present recommendations to BMP
  - Policy/Planning Committee (October 12, 4:30pm)
- November: Presentation to BMP
  - Draft of Report which will include recommendations to legislators.
- January: final report due

General note: There were statements in licensure group meetings that immigrant physicians are a special interest group that should be required to meet all licensing requirements in current law. Related statements were made that if new paths to licensure are provided to immigrant physicians, inquiries and expectations will increase from others requesting variances from the current process, and that this will increase the workload of the Board of Medical Practice.

In response it was noted that immigrant physicians have a unique potential to contribute to improving health equity in Minnesota, and that this potential is a central basis of Minnesota Statutes section 144.1911, the International Medical Graduates Assistance Program, which was established “to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.” Among other provisions, M.S. 144.1911 requires the Commissioner of Health to study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system, and to make recommendations to the legislature.

It was agreed that the need for new funds to cover any increased workload should be included in recommendations.
There was also discussion that negative consequences that may occur if changes are made to licensing requirements without explicitly addressing all potential contingencies, and that changes should not be recommended until provisions for preventing all potential consequences are identified and included in recommendations.

In response it was noted that current law does not address all potential aspects of the supervision and practice of residents and physicians, which are the responsibility of training sites and employers.

**Proposals for consideration**

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Pros/Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. IMG Primary Care Integration License</td>
<td>Pros/Cons</td>
</tr>
<tr>
<td>1. IMG registers with MDH</td>
<td>Pros:</td>
</tr>
<tr>
<td>2. IMG demonstrates that s/he has a minimum of 7 years of prior medical practice including residency and fellowships. Observerships do not qualify.</td>
<td>• Fast. Gets objectively qualified physicians into the system quickly.</td>
</tr>
<tr>
<td>3. IMG passes USMLE step 1, 2 and 3 within 3 attempts; becomes ECFMG certified</td>
<td>• Does not require residency positions.</td>
</tr>
<tr>
<td>4. IMG participates in clinical assessment at U of M; participates in 6 months of clinical experience; undergoes post assessment with an established assessment provider similar to PACE or CPEP – receives a certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected general milestones of the next accreditation system)</td>
<td>• Very cost effective. May need money for clinical post assessment and clinical experience.</td>
</tr>
<tr>
<td>5. IMG obtains employer sponsorship. Employer must provide supervision and mentorship outlined in a supervision agreement. Employer must be in “rural” or “underserved” community as defined by Minn Stat. 144.1911. Scope of practice limited to primary care as described in Minn Stat. 144.1911.</td>
<td>• Increases state revenue from new doctors paying taxes.</td>
</tr>
<tr>
<td>6. Once sponsorship is obtained, IMG applies for an IMG integration License – a restrictive license renewable annually with recommendation to renew from employer.</td>
<td>• Helps with health disparities and primary care shortages</td>
</tr>
<tr>
<td>7. Participant can apply for an unrestricted license after 4 years of successful renewals (5 years total of effective practice)</td>
<td>Cons:</td>
</tr>
<tr>
<td></td>
<td>• May require new level of effort for Board of Medical Practice and new revenue.</td>
</tr>
<tr>
<td></td>
<td>• Doctors with this restricted license may get paid less than other doctors with a traditional unrestricted license.</td>
</tr>
<tr>
<td></td>
<td>• #5, 6, 7. MAPA objected to these components prior to the passing</td>
</tr>
</tbody>
</table>
8. The Board shall take disciplinary action against a licensee and supervisor for violations of the limitations on the license.

- MAPA’s position is that creating a “sponsored or supervised” restricted IMG integration license for IMG physicians will create professional role confusion for healthcare systems and patients, specifically with regards to how they would be similar to or vary from the PA profession.
- Unless clearly defined, this could create confusion for who can supervise a PA during the restricted licensure periods and potentially after unrestricted license is obtained regarding proper PA/Physician relationships.
- Such a program will create potential challenges to full licensure by other professions as well.
- Reimbursement and the ability to obtain liability coverage are unknowns. These issues have been identified in similar programs that sought to create alternative licensing categories—such as Missouri’s Assistant Physician program.
- Other physicians who would not meet minimum requirements will view this as arbitrary and preferential, and will demand equal opportunity under the law.

B. Amend 147.037 to include Waiver for primary care in a rural or underserved area. The board may waive any requirement for more than one year of approved graduate medical education, as set forth in the Physicians Practice Act, if the applicant has served at least one year of graduate medical education approved by the board and if the following conditions are met:

(a) The applicants meets all other qualifications for a medical license
   (i) The applicants submits satisfactory proof that issuance of a license based on the waiver requirement of more than one year of approved graduate medical education will not jeopardize the health, safety, and welfare of the citizens of this state.
   Satisfactory proof would include participation in clinical assessment at U of M;

   Pros:
   Similar to pros listed above

   Cons:
   B(b)(i) This sections has similar concerns to the above regarding clarity of licensure title and potential supervision of other professions such as nursing, PAs Etc.
participation in 6 months of clinical experience and post assessment with an
established assessment service provider similar to PACE or CPEP – receipt of
certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected
general milestones of the next accreditation system); and

(b) The applicant submits proof – such as an employment contract - that he or she will
enter into the practice of medicine in primary care in a rural or underserved
community as defined by Minn stat. 144.1911 immediately upon obtaining a license
to practice medicine based upon a waiver of the requirement for more than one year
of graduate medical education.

(i) A license issued on the basis of such a waiver shall be subject to the limitation that
the licensee continue to practice primary care in a rural or underserved community as
defined by Minn stat. 144.1911 and such other limitations, if any, deemed
appropriate under the circumstances, which may include, but shall not be limited to,
supervision by a medical practitioner, training, education, and scope of practice. After
two years of practice under a limited license issued on the basis of a waiver of the
requirement of more than one year of graduate medical education, a licensee may
apply to the Board for removal of the limitations. The Board may grant or deny such
application or may continue the license with limitations.

(ii) The Board shall take disciplinary action against a license granted on the basis of a
waiver of the requirement of more than one year of graduate medical education for
violation of the limitations on the license.
Task Force on Foreign-Trained Physicians

Minnesota Department of Health
Report to the Minnesota Legislature 2015

January 2015
Task Force on Foreign-Trained Physicians:
Report to the Minnesota Legislature

January 2015

For more information, contact:
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Office of Rural Health & Primary Care
Minnesota Department of Health
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St. Paul, MN 55164-0882
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Fax: 651-201-3830

As requested by Minnesota Statute 3.197: This report cost approximately $35,500 to prepare, including staff time, printing and mailing expenses.

To obtain this information in a different format, call 651-201-3838. Printed on recycled paper.
January 23, 2015

The Honorable Matt Dean
Chair, Health and Human Services Finance
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

The Honorable Tara Mack
Chair, Health and Human Services Reform
545 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

The Honorable Tony Lourey
Chair, Health and Human Services Finance
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St. Paul, MN 55155

The Honorable Kathy Sheran
Chair, Health, Human Services and Housing
Capitol, Room G-12
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Honorable Chairs:

I am pleased to present this report from the Task Force on Foreign-Trained Physicians, offering its recommended strategies for integrating refugee, asylee and other immigrant physicians into the Minnesota health care delivery system, as authorized by 2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12.

At its first meeting six months ago, I urged Task Force members to think boldly and creatively about how the state could tap the talents of these clinicians. I likened the possibilities to the innovation that created the dental therapist profession in Minnesota: a situation where our state thought beyond the limits of the existing system to meet the health needs of its citizens and make the most of its talented workforce. In these recommendations, the Task Force has risen to that challenge, bringing us thoughtful, feasible and groundbreaking strategies that could fortify our physician workforce for years to come.

Once again, Minnesota could lead the nation in health care innovation. We have both an opportunity and an obligation to address this issue, as much for these professionals so eager to serve their state as for the thousands of citizens who would benefit from their care and the disparities and costs this diverse workforce could help reduce.

I urge you to consider these recommendations in the next legislative session, and welcome your questions and thoughts on how we can work together to strengthen Minnesota’s health workforce.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

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MDH staff would like to thank the members and chair of the Task Force on Foreign-Trained Physicians for their dedication and collaboration over the past six months. So many gave so much, all on a volunteer basis and all in the spirit of helping our state break new ground in expanding health access and health equity. Many others deserve recognition and thanks, too, including our colleagues at the Board of Medical Practice and the Department of Employment and Economic Development, the Refugee Health Program at MDH, New Americans Alliance for Development and Women’s Initiative for Self Empowerment staff and volunteers, and the representatives from health care associations, hospitals, insurers and providers who followed the work of the Task Force and offered suggestions. We would also like to express special thanks to the numerous immigrant physicians who attended Task Force meetings, participated in the Task Force survey, and shared their stories.
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Executive Summary

Background

Pursuant to 2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12, in July 2014 the commissioner of health convened an advisory task force to develop strategies to integrate refugee, asylee and other immigrant physicians into the Minnesota health care delivery system.

The challenge of integrating foreign-trained physicians is complex and long-standing. In Minnesota, the issue has recently gained urgency as policy makers seek to address several major issues facing the state:

- Shortages in the supply of physicians.
- An aging and diversifying population.
- Persistent health disparities.
- Rising health care costs.

Integrating more immigrant physicians into Minnesota’s health workforce could help address each of these issues.

Findings

The Task Force completed the following tasks assigned by the Legislature:

1. **Comparison of the licensed physician workforce to the population overall.**
   - The licensed physician workforce is older than Minnesota’s population.
   - The physician workforce does not mirror the state’s racial and ethnic composition.
   - Licensed foreign-trained physicians represent 16 percent of the physician workforce, but most of Minnesota’s largest immigrant and refugee communities are underrepresented.

2. **Identification of immigrant physicians seeking to enter the health workforce.**
   - Minnesota is currently home to an estimated 250-400 unlicensed immigrant physicians.
   - In a survey of the state’s immigrant physicians, 87 percent of respondents were interested in entering medical practice or other health careers in Minnesota.
   - Among the survey respondents, 37 countries were represented and over 30 languages.
   - Just over half of the survey respondents were eligible to apply for medical residency, but only a small minority (17 percent) has been accepted into a residency program.

3. **Identification of barriers to practice.** Immigrant physicians face a range of barriers, with the following most significant:
   - *Growing competition for limited residency spots:* While 95 percent of seniors in U.S. medical schools get into medical residency, most immigrant physicians do not. This competition will get even tougher with the “residency bottleneck”: increasing numbers of medical graduates competing for a capped number of residency slots.
• “Recency” of graduation from medical school: Most U.S. residency programs consider only those who have recently graduated from medical school (within 3-5 years). Consequently, many of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the path to licensure.

• Lack of recognized clinical experience: Most American residency programs prefer or even require that applicants have clinical experience acquired in the U.S., but such hands-on experience is nearly impossible to obtain outside of medical school or residency.

• Complexity and costs of testing and other steps needed to qualify for residency: Foreign-trained physicians often need assistance in English proficiency, exam preparation and navigating the path to licensure. Assistance programs are crucial, but will continue to have only limited success if other structural barriers go unaddressed.

4. Exploration of alternative professions. Most immigrant physicians would prefer to practice as physicians, but 64 percent of respondents to the Task Force survey said they would also be interested in exploring other health professions. The physician assistant profession is likely the best alternative for most considering non-physician occupations. Barriers and costs should be removed or diminished, however, so these physicians can appropriately meet physician assistant education and licensure standards more quickly and cost effectively.

5. Identification of costs and possible funding sources. It currently costs $7,500-$15,000 for a foreign-trained physician to get as far as applying to residency programs, and even then, most fail to secure a residency and therefore never become licensed to practice. The strategies recommended by the Task Force would entail greater initial investments – from $10,000-$60,000 per immigrant physician depending on his/her skills and readiness for residency – but are expected to bring significantly more physicians into the workforce and therefore a greater return on investment.

Possible funding sources include (1) new State funding; (2) private funding and (3) philanthropic support.

Recommendations

The Task Force recommends the following strategies, which it concludes will produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota:

• Create a statewide council on immigrant physician integration.
• Provide gateway and foundational support to immigrant physicians.
• Develop a standardized and rigorous assessment process to evaluate the readiness of immigrant physicians.
• Create a Minnesota certificate of clinical readiness.
• Develop a clinical preparation program for those needing it.
• Create dedicated Minnesota primary care residency positions for immigrant physicians willing to serve in rural or underserved areas of the state.
• Encourage or require Minnesota medical residency programs to revise their graduation “recency” guidelines to take into account other measures of readiness.
• Develop a structured apprenticeship program for highly experienced immigrant physicians willing to serve in rural or underserved areas.
• Develop new licensing options for immigrant physicians.
• Explore and facilitate more streamlined pathways for non-physician professions, including the physician assistant role.
Background

Charge

Pursuant to 2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12 (Appendix A), in July 2014 the commissioner of health convened an advisory task force to develop strategies to integrate refugee, asylee and other immigrant physicians into the Minnesota health care delivery system.

Within this overall charge, the Task Force undertook the following tasks, as outlined in the law:

1. Analyze demographics of current medical providers compared to the population of the state.
2. Identify, to the extent possible, foreign-trained physicians living in Minnesota who are refugees or asylees and interested in meeting the requirements to enter medical practice or other health careers.
3. Identify costs and barriers associated with integrating foreign-trained physicians into the state workforce.
4. Explore alternative roles and professions for foreign trained physicians who are unable to practice as physicians in the Minnesota health care system.
5. Identify possible funding sources to integrate foreign-trained physicians into the state workforce as physicians or other health professionals.

The Task Force included representatives from health care, higher education, community-based organizations, workforce development, finance and government, as well as foreign-trained physicians themselves (see Appendix B). The Minnesota Department of Health (MDH) provided staff support, with additional support from the Board of Medical Practice (BMP) and the Department of Employment and Economic Development (DEED).

Between July and December 2014, the Task Force met monthly. It also held an open forum attended by over 50 immigrant physicians, and additional discussions with the Legislative Health Care Workforce Commission; the Minnesota delegation to the Health Care Workforce Policy Academy of the National Governors Association; immigrant community leaders; and the University of Minnesota’s Graduate Medical Education Committee.

In addition, the Task Force convened four working groups that met between monthly meetings, including a group that examined strategies already in place to integrate immigrant physicians in Minnesota, in other states in the U.S., and in other countries, including Canada, Germany and Australia. The group investigated the nature and outcomes of these programs and pathways, distilled those most applicable to the Minnesota context, and used these findings as the basis from which to develop recommended strategies. A summary of these is provided in Appendix F, “Promising programs and pathways.”

Detailed materials from the Task Force meetings are also available on the Task Force website.
Definitions

At its first meeting in July 2014, the Task Force moved to use the terms "Immigrant International Medical Graduate (IIMG)" or "immigrant physician" rather than "foreign-trained physician" to describe more precisely the population of physicians referred to in the session law. Foreign-trained physicians, also known as International Medical Graduates (IMGs), are defined as individuals who obtained their basic medical degree outside the U.S. and Canada.\textsuperscript{1} IMGs in the U.S. include several distinct subsets: (1) U.S.-born citizens who obtained their medical degree overseas (most commonly in the Caribbean or Central America); (2) IMGs who are foreign-born and reside in the U.S. on non-immigrant visas (such as J-1, O-1 or H1-B visas) and (3) IMGs who are immigrants to the U.S. classified as either permanent residents ("green card" holders), U.S. citizens, asylees or refugees.

Pursuant to the law authorizing it, the task focused specifically on category (3) - referred to in this report as immigrant physicians\textsuperscript{2} - and specifically immigrant physicians not licensed to practice medicine in the U.S.

Current Pathway to Licensure

To practice in the U.S., foreign-trained physicians must complete an intensive process that takes an average of 3-5 years (sometimes as long as 10 years) and costs roughly $7,500-15,000.\textsuperscript{3}

Figure 1 depicts the steps an immigrant physician currently must complete to practice in Minnesota. The four overall stages are as follows:

A. **Certification from the Educational Commission for Foreign Medical Graduates (ECFMG).**

   The ECFMG is a U.S. nonprofit formed in 1956 to certify foreign-trained physicians as ready to enter American residency or fellowship programs. To be certified, a foreign-trained physician must (a) obtain "primary source" verification of their diploma and transcripts from their medical school, which must be included in the International Medical Education Directory; and (b) pass two of three "steps" in the United States Medical Licensing Exams (USMLEs). Becoming ECFMG certified takes an average of four years for foreign-trained physicians generally, but can take much longer for immigrant physicians specifically.\textsuperscript{4}

B. **Completion of at least two years of graduate clinical medical training (most commonly, a medical residency) in the U.S. or Canada.**

   This includes securing a medical residency permit from the Board of Medical Practice if the residency program is in Minnesota. Most U.S. residency programs require applicants to be recent graduates of medical school, typically defined as graduation within 3-5 years of applying for residency.

C. **Passing Step 3 of the United States Medical Licensing Exams.**

D. **Application for a Minnesota license.**

   Minnesota statutes require completion of all the steps above before a foreign-trained physician can apply for licensure.
Figure 1. Pathway requirements for an immigrant physician to obtain a physician license in Minnesota.

<table>
<thead>
<tr>
<th>EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG)</th>
<th>U.S. or CANADIAN GRADUATE MEDICAL EDUCATION (GME)</th>
<th>MN LICENSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain certification from the Educational Commission for Foreign Medical Graduates (ECFMG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Primary-source verification” of medical education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key barrier point</td>
<td>Key barrier point</td>
<td></td>
</tr>
<tr>
<td>Diplomas from school in IMED (International Medical Education Directory)</td>
<td>Transcripts</td>
<td></td>
</tr>
<tr>
<td>Pass Steps 1-2 of the U.S. Medical Licensing Examination (USMLE) (or certain older equivalents)</td>
<td>Secure medical residency</td>
<td></td>
</tr>
<tr>
<td>Can be taken in any order but all within 7 years. Minnesota law also requires that they be passed in no more than 3 attempts. NAAD recommends that IMGs take Step 3 at this stage as well.</td>
<td>Apply to residency programs through the Electronic Residency Application Service (ERAS)</td>
<td></td>
</tr>
<tr>
<td>Key barrier point</td>
<td>Register with the National Resident Matching Program (&quot;the Match&quot;)</td>
<td></td>
</tr>
<tr>
<td>Costs of tests and test preparation, English proficiency</td>
<td>AND/OK</td>
<td></td>
</tr>
<tr>
<td>Not a recent medical graduate, lack of clinical experience in U.S., limited residency spots</td>
<td>Interview with residency programs (when invited)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residencies offered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pass Step 3 of USMLE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete required residency minimum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MN law requires that IMGs have a minimum of 2 years U.S. or Canadian graduate clinical medical training (residency)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(U.S. graduates need minimum of 1 year)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apply for license</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes verification of diploma, ECFMG certificate, residency training, and exam scores</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain license</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes Continuing Education reqs.</td>
<td></td>
</tr>
</tbody>
</table>

1 Some exceptions for physicians who are licensed in other states and are board certified (they are allowed four attempts in any one step of the USLME).
2 Does not apply to an applicant admitted as an immigrant under certain conditions on or before October 1, 1991 as “a person of exceptional ability in the sciences or as an outstanding professor or research.” Also does not apply to applicants licensed in other states under certain conditions. Minnesota Statutes Section 147.037, subdivision 1, paragraph (d).
3 Combinations of FLEX, National Board, and USMLE may be accepted only if approved by the Board of Medical Practice as comparable to existing exam sequences, and all exams are completed prior to the year 2000. Minnesota Statutes Section 147.02, subdivision 1, paragraph (c).
Immigrant physicians face a range of challenges along this pathway, which at key points can disqualify even those with extensive graduate medical training overseas (what is known in the U.S. as residency) and those who have practiced for many years internationally.

These challenges will be discussed in more detail under Findings.

**Policy Drivers**

The challenge of integrating foreign-trained physicians into the health care system is complex and long-standing. The number of foreign-trained physicians in the U.S. has ebbed and flowed over the past 70 years, largely in response to demographic shifts, workforce needs and immigration policies, and has been intertwined in many ways with the evolution of American graduate medical education.\(^5\) Since 2005, various efforts at both state and national levels have sought to facilitate integration of foreign-trained physicians into the health workforce, including a similar task force in Massachusetts that issued recommendations toward this goal in December 2014.\(^6\)

To date, such efforts have fallen into two main categories: (1) support services for immigrant physicians as they navigate the many steps and costs toward licensure, and (2) educational programs, including pre-residency preparation programs. As discussed in more detail under Findings, these initiatives have had limited success in integrating immigrant physicians.

In Minnesota, the issue has gained urgency as policy makers seek to address several major, interconnected issues facing the state:

- Shortages in the supply of physicians.
- An aging and diversifying state population.
- Persistent health disparities.
- Rising health care costs.

**Physician shortage**

Various academic, government, professional and industry organizations have projected shortages of physicians in Minnesota over the next 5-15 years, as summarized in Figure 2.
Analysts base these projections on variables such as medical school and residency cohort sizes, changing or growing demand for physician services, and changing work hour preferences by younger physicians.

The most important factor in the impending physician shortage is the aging of the U.S. population, which is expected to affect both demand (as a population with more seniors uses more health services) and supply (as a greater proportion of physicians age out of the workforce than will be replaced through the existing pipeline).

As Minnesota’s state demographer has recently noted, this aging of the Baby Boomer generation will slow the labor force growth rate considerably, not only here in Minnesota but across the U.S. and in most developed countries. As a result, “there will be heightened international competition for labor, particularly talented workers that can take on the mantle of highly skilled and complex job functions. … Immigrant workers will be increasingly necessary to supply the labor force in Minnesota with ready hands and talented minds.”

This may be especially true in the physician workforce. In Minnesota, more than one-third (37 percent) of licensed physicians are 55 or older, and roughly 40 percent of primary care physicians say they intend to practice only 10 years or less into the future. This is high relative to U.S. occupations overall, where only 21 percent are 55 or older (Figure 3), and higher than the overall state population (of which 26 percent of Minnesotans are 55 or older).
Beyond any future deficits, Minnesota already has physician shortages in many parts of the state, particularly in rural areas. A common indicator of geographic availability is the federal government’s Health Professional Shortage Area designation. Substantial areas of Greater Minnesota are designated shortage areas in the fields of primary care, dentistry and mental health, as shown in the maps in Appendix C.

If key barriers can be addressed, integrating more immigrant physicians into Minnesota’s health workforce could help fill the most pressing of these shortages in a relatively short period of time. Foreign-trained physicians are more likely than U.S. medical graduates to provide primary care and to work in underserved and rural areas, including in very isolated rural communities and Critical Access Hospitals. In 2002, over half of the nation’s Critical Access Hospitals employed at least one foreign-trained physician on their medical staff, including 62 percent of CAHs located in “persistent poverty” rural counties.

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*Minnesota has a shortage of doctors coming. We can solve that. There are hundreds of immigrant medical graduates ready for residency here to contribute to their full capacity and serve Minnesota. We can be a solution to Minnesota’s medical problems.*

*Immigrant physician at community meeting hosted by the Task Force*
Demographic shifts
Minnesota’s population is undergoing major shifts, and will continue to do so over the next 15-20 years. As noted above, the state’s aging population is growing rapidly, with the number of adults age 65+ expected to nearly double between 2010 and 2030, and to surpass the school-age population of the state for the first time.\textsuperscript{12}

This will have enormous implications for the state’s health care system. Not only will it affect the health workforce supply as described above, it will create unprecedented demand for health care services, particularly primary care. On average, seniors need and use health care services much more than those younger than 55; health care spending on Americans between the ages of 65 and 74 averages $9,017 per year compared to $2,747 for those between 25 and 34.\textsuperscript{13} The number of people with chronic conditions will also increase dramatically, as discussed in more detail under Costs. Overall, as Minnesota’s senior population grows, the burden on the state’s health care system – including its publicly supported health care programs – will balloon, just as its physician workforce is shrinking.

At the same time, Minnesota’s population is growing increasingly diverse (Figure 4).

\textbf{Figure 4.}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure4.png}
\caption{Persons of Color as a percent of the total population}
\end{figure}

\textit{Source: Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census and Population Estimates, as compiled by Minnesota Compass.}
The state’s immigrant and refugee population is growing especially quickly (Figure 5):

- **Minnesota’s foreign-born population is increasing faster than the national average.** Since 1990, the foreign-born population has doubled nationally but tripled in Minnesota.\(^{14}\)
- Among the state’s youngest children (0-4), nearly one in every five is a child of an immigrant.\(^{15}\)
- Minnesota has one of the largest African-born populations in the U.S., including the largest Somali and Liberian communities in the country.\(^{16}\)
- The state is home to 33,000 refugees, representing 8.9 percent of Minnesota’s immigrants, a far greater portion than the national average of 1.7 percent.\(^ {17}\)
- Last year, Minnesota was 13\(^{th}\) in the nation for the number of refugees resettled, and 1\(^{st}\) for secondary refugee resettlement (secondary refugees are refugees who originally resettled to another state before moving to Minnesota).\(^ {18}\)

**Figure 5.** Foreign-born population and their children, Minnesota, 1980-2012

![Graph showing foreign-born population and their children in Minnesota, 1980-2012.](image)

*Source: Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey, as compiled by Minnesota Compass.*

Minnesota is different from other states in that it has a lot of immigrants and refugees. These immigrants really need doctors who can represent and help them. A lot of messes come from using only interpreters, and this creates significant disparities.

Survey respondent originally from Ethiopia

This influx of immigrants has shaped Minnesota’s labor force as well. According to the state demographer, it is only because of new international arrivals that Minnesota experiences positive total migration of workers each year. The state loses 12,000 residents between the ages of 16 and 64 annually due to domestic migration, but because of 20,000 international immigrants, gains about 8,000 working-age people overall.\(^ {19}\) These immigrants tend to be younger, too: 60 percent of Minnesota’s foreign-born population is in the prime working years of 25-54, compared to 40 percent of its U.S.-born population.\(^ {20}\)
Figure 6. Foreign-born as a percentage of Minnesota’s workforce, 1980-2010

The immigrant workforce tends to be concentrated at two ends of the spectrum, in low- and high-skill industries, and in occupations and geographies that have difficulty attracting sufficient numbers of qualified native-born residents. In 2013, roughly one-third of Minnesota’s immigrants held a four-year college degree or higher, a similar proportion as the overall population. Overall, Minnesota immigrants contribute an estimated $793 million in state and local taxes and bring a purchasing power of $5 billion to the state.

Despite this growing diversity and high-skilled immigrant workforce, however, Minnesota’s current physician workforce does not mirror the racial and ethnic composition of the state’s population, in some part because immigrant physicians have struggled to join the physician workforce. Currently only 14 percent of the state’s physicians are individuals of color, and certain racial and ethnic groups are especially underrepresented, including most of Minnesota’s largest refugee and immigrant communities. This imbalance is discussed in greater detail under Findings.

Health disparities
Despite Minnesota’s relatively high ranking in key health measures, significant racial disparities persist. For some populations of color, rates of certain chronic diseases, sexually transmitted infections, and health risk behaviors can be as much as five times worse as those for the population groups with the best rates.

Examples of these disparities include the following:
African American and American Indian babies die in the first year of life at twice the rate of white babies in Minnesota. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years.

The rate of HIV/AIDS among African-born persons is nearly 16 times higher than among white, non-Hispanic Minnesotans.

American Indian, Hispanic/Latino and African American youth have the highest rates of obesity.

African American and Hispanic/Latino women in Minnesota are more likely to be diagnosed with later-stage breast cancer.

Nationally, foreign-born individuals are significantly less likely to receive cancer screening and other preventive health services. Minnesota-specific studies have found Somali immigrants experience disparities in diabetes management and have significantly lower rates of colorectal cancer screening, mammography, pap smears and influenza vaccination than non-Somali patients.

These disparities have been stubbornly persistent. As a recent report to the Legislature on health equity in Minnesota put it: “Multiple efforts have been made to try to close the significant gaps in health outcomes across populations, but essentially we have been running in place.”

Adding more immigrant physicians to the Minnesota health workforce offers an opportunity to tackle these disparities in more effective ways. Research suggests that greater diversity in the health workforce, particularly better racial and cultural “concordance,” or similarity between health care providers and the patients they serve, can improve clinical outcomes for racial minorities.

Evidence suggests this can happen in two ways. First, there is ample evidence that minority physicians are more likely to be accessible to diverse or underserved communities. Minority physicians are more likely than their white counterparts to practice primary care. And while communities of color (Black and Hispanic communities, for example) are far more likely to face physician shortages, physicians of color are more likely to locate their practice in areas of ethnic and racial diversity, and to serve patients not only of their own race but of other populations of color as well. One study indicates that race is a stronger predictor than even socioeconomic status of the share of Medicaid or uninsured patients a physician treats.

The second way a diverse physician workforce leads to better health outcomes is through patient-practitioner “concordance.” That is, physicians who are “like” their patients in certain key ways can be better positioned to provide culturally competent, patient-centered care. There is a large and growing body of work studying the relationship between cultural similarities and health care access, quality and outcomes. This literature supports an association between racial concordance and health care quality and outcomes, and an even stronger association between language concordance and health care access/utilization, quality and outcomes. A provider speaking the same language as his/her patient can lead to better outcomes through increased trust and better comprehension of care instructions.

I am available and eager to contribute with my knowledge and skills to the U.S. health system. For all Hispanic/Latino groups, linguistic isolation can pose barriers.
to access the health system. Having invested many years in health services in Venezuela and worked many years as clinical researcher in Mayo Clinic, I am passionately committed to helping patients in my community who would benefit most from my expertise. I trust that the Minnesota health system could help foreign-trained physicians get into the system.

Survey respondent originally from Venezuela

This research has prompted many, including the Association of American Medical Colleges (AAMC), to recommend increasing the racial and ethnic diversity of the physician workforce as a way of addressing health disparities. The Institute of Medicine specifically recommends increasing the diversity of language ability, background and experience, and notes that increasing health care provider diversity improves the cultural competence of health professionals and health systems both directly and indirectly: not only through the care delivered by providers of diverse backgrounds, but through the educational experiences those providers make possible for their colleagues.

**Integrating more of Minnesota’s diverse immigrant physicians offers a direct way to diversify the physician workforce and thereby help address the state’s long-standing goal of reducing health disparities.** As the Sullivan Commission, a bipartisan initiative that examined diversity in the U.S. health workforce, put it 10 years ago: “The fact that the nation’s health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans.”

Right now we can’t give back to the community. We have a lot to offer. We are Minnesota residents willing to do what we can to solve the problems of disparities and inequity.

Immigrant physician at community meeting hosted by the Task Force

**Rising health care costs**

Health care is increasingly expensive, both in the costs of its services and in the training required of its providers. **Greater integration of immigrant physicians could have an impact in these realms as well.**

**Health care costs.** In 2011, health care spending in Minnesota grew to $38.3 billion, accounting for 13.6 percent of the state’s economy, and is projected to more than double over the next decade if no changes occur in the drivers of health care spending or reforms to curb spending growth.

A significant portion of these costs come from potentially preventable hospitalizations – those caused by deficits in timely access to high quality care in primary care settings, patient education and/or compliance with provider recommendations. The Agency for Healthcare Research and Quality has stated that “reducing preventable hospitalization rates is crucial to controlling health care costs.” In Minnesota, such cases resulted in roughly 53,000 potentially avoidable
hospitalizations in 2007 alone, at a cost of about $400 million, or 8 percent of inpatient cost for Minnesota adults.42

A related, but even more substantial, portion of U.S. health care costs are associated with chronic medical conditions. A majority of adult and youth populations in Minnesota exhibit at least one risk factor for chronic diseases, and obesity is rising in Minnesota as it is nationwide, as are rates of diabetes.43 Such conditions account for 85 percent of the nation’s health care costs overall, 44 including half (51 percent) of the potentially preventable hospitalizations in Minnesota noted above.45 Treatment costs for chronic disease in Minnesota are estimated at $5 billion annually.46 A higher priority on prevention and preventive care is widely seen as critical to controlling these costs, particularly since the number of Americans with such conditions is expected to grow dramatically (Figure 7).47

**Figure 7. Number of people with chronic conditions in U.S., 1995-2030 (in millions)**

Immigrant physicians could play a powerful role in reducing costs in both of these areas – preventable hospitalizations and chronic disease care – particularly since the rates of such hospitalizations are higher among patients of color and low-income individuals, and patients of color with chronic conditions are more likely to receive conflicting advice, duplicate tests or conflicting prescriptions, all issues that can be exacerbated by language barriers and cultural factors.48

Immigrant physicians could also improve health care access and outcomes more broadly, particularly in Minnesota’s sizeable immigrant and refugee communities, where the ability to provide care in the same language could lead to better patient follow-through, diminished complications and fewer visits to health care facilities. While many health care settings use interpreters to accommodate non-English speaking patients, the presence of an interpreter is not as effective as direct communication between patient and provider. A 2004 study, for example, found that language concordance for Hispanic individuals improved physician-patient agreement
with regard to physician-recommended changes in patient-health behavior.\textsuperscript{49} In another, Asian patients in visits with interpreters avoided asking questions more often than patients in visits where the patient and the doctor spoke the same language.\textsuperscript{50}

Apart from the efficacy of care provided, one study concluded that simply by integrating more foreign-trained physicians to address existing physician shortages in areas designated as underserved, Minnesota could save $62.56 million.\textsuperscript{51}

**Training costs.** For the Class of 2013, the median in-state four-year cost of medical school in the U.S. (including tuition, fees and living expenses) was $228,200. The median debt upon graduation was $170,000, with 86 percent of graduates carrying some level of debt.\textsuperscript{52} A medical graduate must then complete a clinical residency, which in Minnesota in 2012 averaged roughly $153,000 per trainee (costs borne by the training site, which pays each resident a salary plus benefits, and incurs additional costs for their training and supervision).\textsuperscript{53}

These high costs are often cited as one of the main reasons for the decline in the number of primary care physicians.\textsuperscript{54} Primary care specialties pay less than other medical specialties, yet medical students considering practicing primary care shoulder the same student debt levels as all other medical students.\textsuperscript{55}

**Immigrant physicians, in contrast, enter the U.S. health workforce pipeline with a medical degree already completed, and many wish to practice primary care.** The cost of preparing them for licensed practice is limited to the expense of becoming certified by the Educational Commission for Foreign Medical Graduates (which includes taking the first two steps of the United States Medical Licensing Exams); any related test preparation, coaching and support; and medical residency application fees. Currently, these expenses come to $7,500-15,000 for an individual physician. They must then complete at least two years of medical residency, costs also required for U.S. medical graduates (USMGs), although in Minnesota, foreign-trained physicians are required to have at least two years of graduate clinical medical training while USMGs technically need only one.\textsuperscript{56}

With new, more efficient pathways to licensure, these training costs could be further reduced. These options are discussed in more detail under Findings and Recommendations.

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This could be a big win. A win for the Minnesota medical community, a win for Minnesotans needing culturally appropriate health care, a win for immigrant physicians, and a win for all taxpayers.

Immigrant physician at community meeting hosted by the Task Force
Findings

In developing its recommendations, the Task Force completed the following specific tasks assigned by the Legislature:

Demographic Analysis

As context to the issue of unlicensed foreign-trained physicians, the Legislature requested that the Task Force also examine the demographics of the physicians who are licensed and compare those to the state’s population. The Task Force examined data from a variety of sources to conduct this analysis, including licensing data from the Minnesota Board of Medical Practice (BMP), physician workforce surveys MDH conducts in partnership with the BMP, U.S. Census and refugee resettlement data, and immigrant community estimates.

Overall, foreign-trained physicians represent 16 percent of the state’s licensed physician workforce (this includes all foreign-trained physicians, including U.S.-born physicians who went to medical school overseas and foreign-trained physicians who came to the U.S. on a visitor visa for their residency) (Figure 8). This is somewhat low compared to the U.S. overall, where foreign-trained physicians represent approximately 25 percent of the overall licensed physician workforce. It is also important to note that few of the licensed doctors are the immigrant physicians who are the subject of this report and who often arrive unexpectedly in the U.S. due to hardship (the category of physicians educated outside the U.S. and Canada also includes American-born citizens who went to foreign medical schools, and international medical graduates who come to the U.S. on non-immigrant visas, such as J-1, O-1 or H1-B visas).

Figure 8. Share of Minnesota-licensed physicians educated outside U.S./Canada, 2014.

Source: May 2014 licensing data from the Minnesota Board of Medical Practice. The chart includes 21,669 Minnesota-licensed physicians, 90 of whom did not report a country of education.
As discussed under Background, the state’s physician workforce is older than the state’s population overall: Over one-third (37 percent) of Minnesota’s licensed physicians are age 55 or older (Figure 3), compared to a quarter (26 percent) of the state’s population.57

The Task Force also compared race and ethnicity data. Overall, the state’s licensed physician workforce does not mirror the racial and ethnic composition of its population. This is true even though the total proportion of licensed Minnesota physicians of color is roughly equal to the state’s populations of color overall (14 percent of licensed physicians vs. 14.7 percent of the state population).

As in the case of the state’s health disparities, it is in looking more closely – at specific racial and ethnic groups – that imbalances emerge. Two major racial groups are underrepresented in the current (licensed) physician workforce: African-Americans (2 percent of physicians vs. 5 percent of the population) and Latinos (2.4 percent of physicians vs. 5 percent of the population).

A similar dynamic is true in the case of the foreign-born population. Overall, foreign-born licensed physicians appear to over represent the state’s foreign-born population: 14 percent of licensed physicians were born outside the U.S., compared to 8 percent of the Minnesota population. However, most of Minnesota’s largest immigrant and refugee communities are significantly underrepresented (Table 2).

It is important to note that population estimates based on U.S. census data likely undercount immigrant and refugee communities. As the state demographer cautions: “These estimates … likely underestimate the size of our immigrant populations because trust and language issues depress response rates to Census surveys.”58 For this reason, estimates from community-based sources were included as well (Table 2). Data from additional countries from which immigrants come to Minnesota, and the number of currently licensed physicians from those countries, are provided in Appendix D.
### Table 2. Minnesota immigrant populations compared to Minnesota licensed physicians

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated foreign-born populations in Minnesota, 2010-2012</th>
<th>Number of MN-licensed physicians educated in these countries</th>
<th>Number of MN-licensed physicians born in these countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexico</td>
<td>70,988&lt;sup&gt;1&lt;/sup&gt;</td>
<td>87&lt;sup&gt;8&lt;/sup&gt;</td>
<td>43</td>
</tr>
<tr>
<td>Laos</td>
<td>24,408&lt;sup&gt;1&lt;/sup&gt;-66,200&lt;sup&gt;2&lt;/sup&gt;</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Somalia</td>
<td>21,227&lt;sup&gt;1&lt;/sup&gt;-77,000&lt;sup&gt;2&lt;/sup&gt;</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Vietnam</td>
<td>18,548&lt;sup&gt;3&lt;/sup&gt;</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>Thailand</td>
<td>15,014&lt;sup&gt;1&lt;/sup&gt;</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>Liberia</td>
<td>12,216&lt;sup&gt;1&lt;/sup&gt;-35,000&lt;sup&gt;3&lt;/sup&gt;</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>12,503&lt;sup&gt;1&lt;/sup&gt;-45,000&lt;sup&gt;4&lt;/sup&gt;</td>
<td>20</td>
<td>35</td>
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<tr>
<td>Burma (Myanmar)</td>
<td>4,183&lt;sup&gt;1&lt;/sup&gt;-8,200&lt;sup&gt;5&lt;/sup&gt;</td>
<td>10&lt;sup&gt;9&lt;/sup&gt;</td>
<td>15&lt;sup&gt;9&lt;/sup&gt;</td>
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<tr>
<td>El Salvador</td>
<td>7,233&lt;sup&gt;1&lt;/sup&gt;</td>
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<tr>
<td>Honduras</td>
<td>4,534&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>1</td>
</tr>
<tr>
<td>Cambodia (Kampuchea)</td>
<td>3,045&lt;sup&gt;1&lt;/sup&gt;-8,000&lt;sup&gt;6&lt;/sup&gt;</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

The Task Force concludes that the imbalances between Minnesota’s population and its physician workforce are significant and warrant new and innovative action.

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<sup>1</sup> Sources for table:


4. Population estimate from the Ethiopian Community in Minnesota (ECM), correspondence from Mesfin Negia, Vice President and Board Member, December 23, 2014. Another source has estimated the Minnesota Oromo community alone (an ethnic group that makes up an estimated 34-40 percent of the population in Ethiopia) at 40,000, cited by Hirsi, I., in MinnPost, “Killings in Ethiopia outrage Minnesota’s Oromo community.” May 8, 2014. Available at: [http://www.minnpost.com/community-sketchbook/2014/05/killings-ethiopia-outrage-minnesota-s-oromo-community](http://www.minnpost.com/community-sketchbook/2014/05/killings-ethiopia-outrage-minnesota-s-oromo-community).


7. Number of Minnesota licensed physicians comes from Minnesota Board of Medical Practice licensing data, October 2014. Note these totals may overstate the number of physicians from each country currently in active practice in Minnesota. Some physicians choose to maintain a Minnesota license even if they now practice in another state, have retired or are in a medical residency or fellowship program.

8. Includes a significant number of non-Mexican individuals (including U.S. citizens) who attended medical school in Mexico.

9. Experts on the Minnesota Burmese community report only eight physicians from Burma are currently practicing in Minnesota. Personal correspondence from Mimi Oo, December 23, 2014.
Identification of Foreign-Trained Physicians Living in Minnesota

The Task Force estimates that Minnesota is currently home to between 250 and 400 immigrant physicians who are not able to practice because of barriers to licensure. New Americans Alliance for Development (NAAD), in partnership with the Women’s Initiative for Self-Empowerment (WISE), two community-based nonprofits with extensive experience serving immigrant physicians in Minnesota since 2005, estimates that of the 300,000 refugees and immigrants who have made Minnesota their home since 1990, an estimated 300 are trained physicians who practiced in their home countries and of these, only about 20 have been able to practice as licensed physicians in Minnesota (leaving approximately 280 unlicensed). A 2006 report estimated that 80 percent of African immigrants with medical training are “relegated to entry-level medical positions such as nursing aides – or, worse, unskilled jobs such as taxi drivers or parking attendants – simply because they lack the necessary licensing required for professional medical employment.”

Another important source of information on Minnesota immigrant physicians is the Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED). This program currently funds two sets of organizations – one in the Twin Cities (WISE in partnership with NAAD) and one in Rochester (Workforce Development Inc.) – to assist foreign-trained physicians and other health care professionals in obtaining licenses and certifications. As of December 2014, 146 immigrant physicians were enrolled in these programs. This total, however, does not include immigrant physicians who have previously participated in these programs (the two organizations have worked with over 300 physicians since 2006) or the many immigrant physicians who have never contacted the organizations, either because they are recent arrivals to Minnesota or because they arrived in the state before the programs were established and have been working in other occupations.

The Task Force is confident in its estimate of the number of unlicensed immigrant physicians living in the state. However, because there is currently no official, ongoing count of the total number of unlicensed immigrant physicians living in the state, the Task Force is recommending that a central roster be created (see Recommendations).

The Task Force also conducted a statewide survey of immigrant physicians between August and December 2014 to obtain deeper qualitative information about this population. A total of 69 immigrant physicians participated in the survey (out of 275 invited). Of these, 87 percent (60 individuals) indicated an interest in “meeting the requirements to enter medical practice or other health careers” in Minnesota.

Just over half of the survey respondents have been certified by the Educational Commission for Foreign Medical Graduates (ECFMG), and are therefore eligible to apply for medical residency training. The great majority (83 percent), however, have not been accepted into a residency program. This is the most common and often impenetrable barrier for immigrant physicians, as will be discussed in more depth below under Barriers.
The survey also demonstrated the great diversity of skills and experience that Minnesota’s immigrant physicians bring to the state. Among the survey respondents, 37 countries are represented and over 30 languages spoken (Figures 9 and 10). Nearly half (43 percent) of the immigrant physicians surveyed speak more than three or more languages.

Figure 9. Countries of birth, Task Force survey respondents, by count

- India
- Iraq
- Sudan
- Colombia
- Cuba
- Ethiopia
- Nigeria
- Burma
- China
- Dominican Republic
- Bangladesh
- Togo
- Russia
- Somalia
- US
- Honduras
- Liberia
- Mexico
- DRC
- Venezuela
- UAE
- Armenia
- Germany
- Uganda
- Jordan
- Tanzania
- Morocco
- Syria
- Pakistan
- Peru
- Iran
- Egypt
- Vietnam
- Kenya
- Hong Kong
- Uzbekistan
- Eritrea
The immigrant physicians responding to the survey on the whole are younger than the current population of licensed physicians in Minnesota, with only 6 percent over 55 (Figure 11).
Most survey respondents are trained as general practitioners, though over a third have credentials in specialties as well, and these span a large range of practice areas (Figure 12).

![Figure 11. Specialty credentials of survey respondents]

More survey results are discussed below and in Appendix E.

Foreign-trained physicians also shared their experiences at each Task Force meeting, and the Task Force held one evening and one weekend public forum to hear from foreign physicians. The information collected at these meetings is consistent with the survey results.

*America is home. We have the education and have been struggling to stay within the health care industry so we can make a difference. Help us get back to doing what we love most: being a doctor.*

Survey respondent originally from Tanzania

**Barriers to Integrating Foreign-Trained Physicians**

The Task Force identified a range of barriers faced by immigrant physicians seeking to practice. It then analyzed these barriers according to where they obstruct the pathway to licensure and at what level they might be addressed: at the individual level, within the higher education system, within state policy, or at the federal or national level. The following table summarizes these findings.
### Table 3. Barriers along pathway to licensure

<table>
<thead>
<tr>
<th>EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATION</th>
<th>U.S. or CANADIAN GRADUATE MEDICAL EDUCATION (GME)</th>
<th>MN LICENSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BARRIERS</strong> – Faced at individual level</td>
<td><strong>BARRIERS</strong> – Faced at individual level</td>
<td><strong>BARRIERS</strong> – Faced at individual level</td>
</tr>
<tr>
<td>- Expense of obtaining and translating credentials.</td>
<td>- Cost of test preparation courses/materials and test fees (including any repeat tests needed), and cost of registering with ECFMG.</td>
<td>- Cost of license application and renewal fees.</td>
</tr>
<tr>
<td>- Difficulties accessing home country medical school transcripts/credentials.</td>
<td>- Loss of income while preparing for and taking tests, and other financial stresses (e.g., lack of other employment, and past debt), often exacerbated when IIMGs have family obligations and arrive impoverished.</td>
<td>- Costs associated with certifications and assessments.</td>
</tr>
<tr>
<td>- Limited English proficiency (and fees + time needed for classes).</td>
<td>- Limited English proficiency (and fees + time needed for classes).</td>
<td></td>
</tr>
<tr>
<td>- Need to refresh clinical knowledge if didn’t graduate or practice recently.</td>
<td>- Need to refresh clinical knowledge if didn’t graduate or practice recently.</td>
<td></td>
</tr>
<tr>
<td>- Unfamiliarity with U.S. medical culture, vocabulary, treatment methods, protocols and technology.</td>
<td>- Unfamiliarity with U.S. medical culture, vocabulary, treatment methods, protocols and technology.</td>
<td></td>
</tr>
<tr>
<td>- Need for social and emotional support amid stress of extended personal and professional dislocation.</td>
<td>- Need for social and emotional support amid stress of extended personal and professional dislocation.</td>
<td></td>
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</tbody>
</table>

#### “Primary-source verification” of medical education

- Diploma from school in IMED (International Medical Education Directory)
- Transcripts

#### Pass Steps 1-2 of the U.S. Medical Licensing Examination (USMLE) (or certain older equivalents)

- Can be taken in any order but all within 7 years. Minnesota law also requires that they be passed in no more than 3 attempts. NAAD recommends that IIMGs take Step 3 at this stage as well.

#### Secure medical residency

- Register with the National Resident Matching Program (“the Match”)
- Interview with residency programs (when invited)
- Residencies offered

#### Apply for license

- Includes verification of diploma, ECFMG certificate, residency training, and exam scores

- Apply for license

- Includes verification of diploma, ECFMG certificate, residency training, and exam scores

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- Includes verification of diploma, ECFMG certificate, residency training, and exam scores
<table>
<thead>
<tr>
<th>BARRIERS – Within higher education system</th>
<th>EDUCAITONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATION</th>
<th>U.S. or CANADIAN GRADUATE MEDICAL EDUCATION (GME)</th>
<th>MN LICENSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of mentors/coaches and professional networks.</td>
<td>• Lack of mentors/coaches and professional networks.</td>
<td>• “Recency” of graduation: Many residency programs require graduation from medical school within 3-5 years (many IIMGs have been out far longer).</td>
<td></td>
</tr>
<tr>
<td>• Difficulty navigating complex certification and testing process.</td>
<td>• Difficulty navigating complex certification and testing process.</td>
<td>• Fierce competition for limited residency spots; the worsening “residency bottleneck.”</td>
<td></td>
</tr>
<tr>
<td>• Other practical barriers: Lack of computer skills, transportation.</td>
<td>• Other practical barriers: Lack of computer skills, transportation.</td>
<td>• Reported preference given to USMGs and other IMGs, and/or bias against IIMGs.</td>
<td></td>
</tr>
<tr>
<td>• Time limit (7 years) on completing all certification steps.</td>
<td>• Time limit (7 years) on completing all certification steps.</td>
<td>• Lack of recognition for prior clinical experience (often have extensive experience in home country but not in U.S.), and lack of opportunities to obtain experience that will carry weight in applications.</td>
<td></td>
</tr>
<tr>
<td>• Confusion/lack of transparency over application and selection process, including lack of info on Match and ranking criteria, and non-Match options.</td>
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<td>• Confusion/lack of transparency over application and selection process, including lack of info on Match and ranking criteria, and non-Match options.</td>
<td></td>
</tr>
<tr>
<td>BARRIERS – State policy</td>
<td></td>
<td>• Regulatory issues limiting hands-on clinical experience prior to residency.</td>
<td></td>
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<tr>
<td>• Minnesota requirement that USMLEs be passed in more than 3 attempts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BARRIERS – National &amp; federal policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home country medical school not included in IMED.</td>
<td>• Time limit (7 years) on completing all certification steps.</td>
<td>• Limited residency spots with Medicare cap; the worsening “residency bottleneck.”</td>
<td></td>
</tr>
</tbody>
</table>

25
Among these barriers, the following are the most significant:

- Growing competition for limited residency spots.
- “Recency” of graduation from medical school.
- Lack of recognized clinical experience.
- Complexity and costs of testing and other steps needed to qualify for residency.

**Growing competition for limited residency spots**

As discussed under Background, a key requirement for medical licensure in Minnesota is graduate clinical medical training in a U.S. or Canadian program accredited by a national accrediting organization approved by the state Board of Medical Practice. **With rare exceptions, immigrant physicians are required to complete at least two years of such training, typically in a residency program, regardless of whether they completed similar clinical training outside the U.S.**

Obtaining such a position, however, is a difficult feat for a variety of reasons. One is the sheer number of medical graduates vying for an essentially static number of residency positions. Medicare funding for residency training (which covers about 25 percent of GME costs in the U.S.) has been capped at the number of slots that existed in 1997, and funding by Medicare is less than what it costs to provide care and training, according to the Metro Minnesota Council on Graduate Medical Education. Even as the number of slots remains capped, however, the number of medical school graduates is increasing as many schools expand enrollments in anticipation of the physician shortages. Sometimes referred to as the “residency bottleneck,” this is a major reason cited by both the University of Minnesota and Mayo medical schools for why they do not plan to expand their medical school class sizes.

Foreign-trained physicians who immigrate to the U.S. following medical school or international practice do not generally fare well in this competition. **The Task Force found that most immigrant physicians repeatedly fail to be accepted into a medical residency program through the National Resident Matching Program (“the Match”), while nearly all (95 percent) of seniors in U.S. medical schools find a “match.”**

Foreign-trained physicians often get screened out even before the interview or “ranking” phases of the Match. **Nearly all (99 percent) of residency program directors in 2014 reported interviewing and ranking U.S. medical seniors, but only half said they typically do so for foreign-trained physicians.**

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† Foreign students graduating from international medical schools frequently apply to U.S. residency programs and, if admitted, come to the U.S. on a visitor, or “J-1” visa. These physician trainees must return to their home country upon finishing their studies. Some of these foreign physicians are allowed to remain in the U.S. for three years on a “J-1 visa waiver” if they practice in underserved areas. The residency match data for medical students applying while residing in their home countries shows that 50 percent of these applicants are accepted into residency.

The immigrant foreign-trained physicians who are the subject of this report are those who did not have the opportunity to pursue medical careers through this prearranged route, but who arrived in the U.S. due to hardship without access to the J-1 visa career path.
The odds of a foreign-trained physician getting into a U.S. residency program, even if he or she has high USMLE scores and has become a U.S. citizen, are poor enough that the American Medical Association recommends that foreign-trained physicians apply to a minimum of 25 residency programs (U.S. medical graduates typically apply to 5-10).65

*Being an International Medical Graduate instantly puts you into a different category regardless of your own attributes.*

Survey respondent originally from Nigeria

The University of California-San Francisco echoes many schools when it explains that foreign-trained physicians are at a disadvantage “partly because of large variation in the formal training and clinical experiences offered by foreign medical schools, when compared to the relatively uniform curriculum and clinical requirements offered by U.S. medical schools.”66

Representatives from the University of Minnesota Medical School described similar challenges to the Task Force, explaining the difficulties program directors face in choosing a relatively small number of residents from a very large pool. Their goal is to choose applicants who will successfully complete residency, and because they are not as familiar with non-U.S. systems, they feel unequipped to judge whether an immigrant physician’s education and training have prepared them adequately. In contrast, they know the relatively standard U.S. medical education system well.

The Task Force found that policies and processes within the current graduate medical education system – even those created with the best intentions to be as fair and objective as possible – have unintended consequences that advantage U.S. medical graduates and create structural inequities for immigrant physicians. For example, residency programs receive up to 100 applications for each residency position, which can mean 2,000 applications for a 20-resident program, and need efficient approaches to screen out all but the most competitive candidates for interview invitations. Residency programs often set a preference for recent medical school graduates, for example, as a screening criteria (more on this below). The effect of this screening is that the experience of immigrant physicians may be automatically excluded from consideration, and immigrant physician applicants don’t have the opportunity to communicate their unique abilities to admissions personnel.

There are also reports of preference given to USMGs and non-immigrant IMGs (such as those who arrive in the U.S. on a J-1 visitor visa) in the residency selection process, and associated biases against immigrant physicians based on assumptions about the quality of their medical education or other factors. These findings67 and related concerns prompted the American Medical Association (AMA) to create a policy encouraging medical school admissions officers and residency program directors to “select applicants on the basis of merit, without considering an ethnic name as a negative factor.”68

The Task Force concluded that developing a way to assess and certify an immigrant physician’s readiness for clinical training and practice is critical for an immigrant physician integration effort to be successful, and its recommendations include a system that
would make Minnesota a national leader in addressing this major barrier (see Recommendations).

I am a foreign graduate, and the obstacle is to get a residency position. Programs should not look only at fresh graduates. Rather, they should consider the year of the USMLE Step 3 exam because this is a reflection of current clinical knowledge.

Survey respondent originally from Bangladesh

“Recency” of graduation
One of the main reasons immigrant physicians struggle to secure a medical residency is one out of their control: Most U.S. residency programs consider only “recent” graduates from medical school, typically requiring graduation within 3-5 years of application to residency.

As a result, some of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the pathway to licensure. The Task Force learned that the primary rationale for this guideline is the need for residents to be as up-to-date as possible on medical knowledge, treatment methods and protocols, and technology, particularly given how swiftly the health care field is changing.

As will be discussed under Recommendations, the Task Force concludes that these valid concerns could be addressed in new, more effective ways that would benefit residency programs and immigrant physicians alike. These innovations alone could go a long way toward integrating more immigrant physicians into the health workforce.

The program directors put the criterion [requiring applicants to be recent medical school graduates] which is beyond any human being, as I am unable to change my age. The war and economic factors made me an old graduate involuntarily. Unfortunately, they do not take into consideration my naturalized American citizenship and being integrated within the American community for many years.

Minnesota immigrant physician from Iraq

Lack of recognized clinical experience
Another major reason immigrant physicians are not accepted into residency programs, and also one largely out of their control given the current system, is a lack of hands-on clinical experience in the U.S.

Most American residency programs give preference to applicants with clinical experience acquired in the U.S. or Canada. However, such hands-on experience with patients is nearly impossible to obtain outside of U.S. medical school or residency, particularly since patient privacy and security regulations were strengthened under the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Because of these barriers, immigrant physicians are generally limited to other ways of attempting to demonstrate clinical experience, such as volunteering in medical settings as volunteers,
working as researchers or interpreters, or participating in observership rotations (programs in which medical graduates observe licensed physicians as they diagnose and treat patients, but do not examine patients or provide any care themselves). The AMA specifically recommends that foreign-trained physicians participate in observerships before application to residency, but many residency programs specifically state that these do not qualify as clinical experience.

The lack of U.S.-based clinical experience weakens another key part of immigrant physicians’ applications to residency: letters of recommendations. Unable to obtain letters from U.S.-based supervisors with first-hand knowledge of their clinical skills, they must rely on recommendations either from individuals who know them only in non-clinical situations or from physicians who directed their clinical work overseas. The latter are often based on older experience (as immigrant physicians typically have lived in the U.S. for at least two years before being able to apply for residency), which in turn makes them less competitive to residency program directors, who prefer letters that measure an applicant’s most current knowledge and skills.

The Task Force concludes that opportunities for hands-on clinical experience for immigrant physicians should be developed to address this major barrier toward licensure. As further discussed under Recommendations, the Task Force proposes that a clinical preparation program be developed based in part on the past experience of the Preparation for Residency Program at the University of Minnesota, which provided seven months of orientation and clinical experience for immigrant physicians from 2010-2012, and similar programs at the University of California-Los Angeles and elsewhere (see Appendix F, “Promising Practices and Pathways”).

The biggest barrier for me has been a lack of accredited clinical experience – not being able to get any experience in any capacity except as an interpreter or a medical assistant.

Survey respondent originally from India

Complexity and costs of testing and other steps needed to qualify for residency

Practicing medicine in the U.S. requires a wide range of skills and knowledge, some specific to the rapidly changing and highly complex American health care system. Even immigrant physicians with extensive clinical skills and experience overseas have much to learn in order to qualify for residency and practice effectively in the U.S. In addition to passing the rigorous and highly technical USMLE licensing exams required for ECFMG certification, they must demonstrate to residency programs that their English proficiency, technological skills and understanding of U.S. medical culture make them qualified to train successfully in a graduate clinical setting and beyond.

The Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED) currently provides many Minnesota immigrant physicians with support for these foundational skills and the many steps needed to qualify for residency, particularly assistance with English language proficiency, preparation for the USMLEs, and help navigating the ECFMG certification and residency application processes,
as well as important social and peer support during the often grueling and lengthy experience of pursuing a residency. This program was funded with a one-time state appropriation for fiscal years 2014 and 2015, and will end on June 30, 2015.72

The Task Force investigated the impact of such programs – here in Minnesota and elsewhere around the world – and found they are very successful in helping immigrant physicians pass the USMLEs and become ECFMG certified (see Appendix F, “Promising Practices and Pathways”). This finding was supported by the Task Force’s statewide survey, in which the majority of respondents – most of whom have worked with the current DEED grantees – have passed these tests successfully (see Figures 13-15).

**Figures 13-15.** Share of immigrant physician survey respondents passing USMLE steps 1-2.

Just over half (55 percent, or 38 immigrant physicians) of those surveyed are fully certified through the ECFMG. Many have also gone on to pass Step 3 of the USMLEs, which is technically not required for ECFMG certification and is usually taken during residency, and most did so on their first try (Figure 16-17).

*“I had to work at minimum wage jobs at Walmart in order to support myself but I passed all the exams, thankfully.”*

Survey respondent originally from Bulgaria

**Figures 16-17.** Share of immigrant physician survey respondents passing USMLE step 3.
Few graduates of these programs are actually then admitted to residency, however, due to the barriers to residency described above. One of the Minnesota nonprofit organizations in the Foreign-Trained Health Care Professionals program reports that of the 275 Minnesota immigrant physicians it has worked with since 2006, only about 35 (13 percent) have been able to obtain residency positions. This is consistent with other, similar programs in the U.S., such as the Welcome Back Initiative program now operating in 10 states. (See Appendix F, “Promising Practices and Pathways,” for more detail on these and other programs the Task Force consulted).

*It is not about passing the USMLE exams. The problem is after you pass, you have to compete with recent graduates to get a residency program space. It is very difficult to get a spot.*

Survey respondent originally from Honduras

The Task Force concludes that such programs are a key component of integrating immigrant physicians into the health workforce, but will have only limited success unless there are changes elsewhere in the medical education system. Evidence suggests that such programs will have a far greater impact if they work in concert with other key partners (including the medical education system, health care providers and employers, and regulatory bodies) and if key barriers on the pathway can be addressed (including opportunities for clinical experience and mechanisms for assessing clinical readiness) (see Appendix F). The Task Force’s recommendations therefore propose continuing support for these foundational programs but doing so within a coordinated statewide system, along with exploring new pathways to licensure.

*I am double certified in surgery and oncology and I am considered among the top surgeons in my home country. I am able to speak fluently in five languages. I have passed the USMLE Step 1 and 2 exams. Now I am looking for a residency. I know I have the knowledge, skills and ability to be a good doctor in any country plus I have the drive and determination.*

Minnesota immigrant physician originally from Russia

**Alternative Roles and Professions for Foreign-Trained Physicians**

The Task Force heard repeatedly that most immigrant physicians would prefer to practice the profession they spent years training to perform: physician. Some feel this preference quite strongly, such as the immigrant physician from Morocco who wrote: “I worked hard to become a pediatrician and would like to achieve my dream.”

Still, **64 percent of the immigrant physician survey respondents said they would be interested in exploring other health professions.** Of these, the largest group responded they would be interested in exploring the physician assistant (PA) role, with others indicating interest in serving as a nurse practitioner or registered nurse, or working in research, public health or medical counseling.
Based on these findings, and acknowledging that additional immigrant physicians may need or prefer an alternative profession in which to contribute their skills and experience, the Task Force studied the opportunities for some to become physician assistants, nurse practitioners or other advanced practice registered nurses in Minnesota.

The Task Force noted that nursing and medicine are two different yet complementary disciplines. Before becoming a nurse practitioner, candidates must first be or become a registered nurse; requirements for entrance into physician assistant programs tend to be much more flexible, with a range of degrees accepted. Currently, no expedited pathways into the advanced practice nursing field exist in Minnesota for foreign-trained physicians, and if they start at the beginning of this path, it will take longer than the 27-31 months of traditional physician assistant education. In addition, nursing’s focus on helping individuals manage their health in the context of their environment, family and community is different than the medical focus on diagnosing and treating disease, with which immigrant physicians and all physicians are most familiar. The physician assistant curriculum and approach are based on and similar to medical education and practice, offering a potentially better alignment with the expertise of immigrant physicians.

The Task Force concluded that the physician assistant profession would be the best alternative profession for most immigrant physicians considering non-physician occupations, if current barriers to entry can be removed or diminished so these physicians can appropriately meet physician assistant education and licensure standards as quickly and cost effectively as possible.

Both Task Force members and immigrant physicians who contributed to this project concluded that assisting interested immigrant physicians to become physician assistants should be the initial alternative pathways strategy for those immigrant physicians who will not be pursuing physician practice (see Recommendations).

**Costs and Possible Funding Sources to Integrate Foreign-Trained Physicians**

The Task Force was charged with identifying both the costs and possible funding sources for integrating foreign-trained physicians into the health workforce. In doing so, it sought to paint as complete a picture as possible of what would be needed to bring a significant number of such clinicians fully into the Minnesota workforce. It concluded that such a system will need to be comprehensive and coordinated, and as such will require greater investment and innovation than past efforts. But it also concluded that such action is worth taking. The Task Force believes the potential return on investment will far outstrip the initial costs, and will come in the form not just of financial benefits but also better health outcomes and greater health equity in the state. It also concludes that this return will be greatest if public and private entities join forces to coordinate and fund the new system.

**Costs and return on investment**

As discussed under Barriers, integrating immigrant physicians into the health workforce does entail initial costs. Some of these expenses – such as those required to prepare for the U.S.-
specific licensing exams (the USMLEs) or to improve English language skills to clinical-level proficiency – will likely be necessary regardless of the integration strategies implemented. Others – such as the expense of repeatedly applying to numerous residency programs or the costs of public assistance to support unemployed or underemployed physicians unable to practice – could be reduced or potentially even eliminated depending on the pathways developed.

As noted above, it currently costs $7,500-$15,000 for a foreign-trained physician to get as far as applying to residency programs, and even after making such expenditures, most fail to secure a residency position and therefore cannot become licensed to practice, as discussed under Barriers. Clearly the current system is only working for a relatively small number of physicians – a lost opportunity at a time when Minnesota cannot afford to limit its physician workforce, particularly when that untapped pool is uniquely qualified to serve the fastest growing segments of the state’s population and is willing to serve in its rural and underserved communities.

The strategies recommended by the Task Force would entail greater initial investments – from $10,000-$60,000 per immigrant physician depending on his/her skills and readiness for residency – but are expected to produce a much higher return on investment. That is, by investing in more effective, coordinated strategies, rather than the piecemeal efforts that have allowed relatively few immigrant physicians into practice, Minnesota could produce a significant increase in and diversification of its physician workforce, particularly in primary care.

It is also worth noting that some of these integration costs could be further reduced with more fundamental changes to the physician licensure pathway, which the Task Force is also recommending be explored (see Recommendations). Even at the levels required under the current pathway, however, the proposed investments would still be far less than the average expense of $228,000 to train a U.S. undergraduate to the same point (up to residency). While those U.S. medical school costs are largely paid by graduates themselves and other private sources, there is still a significant level of public subsidy involved, including state and federal funding of medical schools, publicly funded scholarships, and public student loans.

The investments proposed by the Task Force are expected to bring significant benefits to Minnesota. Two analyses of existing programs reviewed by the Task Force illustrate the impact foreign physician integration efforts can have. The Welcome Back Initiative, now operating in 10 states and providing educational case management and other support services to foreign-trained health care professionals who are unemployed or underemployed, found that internationally trained nurses experienced a six-fold increase in earnings after graduating from their program. Locally, Wilder Research estimated that the Foreign Trained Health Professionals Program (FTHP) of the Women’s Initiative for Self Empowerment (WISE), operated in partnership with NAAD (formerly known as the African American Friendship Association for Cooperation and Development of Minnesota or AAFACD), generated $358,003 in net benefits and a prospective return of $2.56 per every dollar invested in the program should a physician successfully become fully licensed.

As discussed under Policy Drivers, licensed immigrant physicians can also bring a variety of cost savings to Minnesota’s overall health care system, including its government-funded health care programs, by providing a more culturally adept and better distributed physician workforce.
capable of helping reduce the costly hospitalizations and health disparities that have persisted for so long.

In addition, employing immigrant physicians to their full abilities would allow the state to take fuller advantage of the tremendous resources – both human and economic – that remain untapped in Minnesota’s immigrant communities and are increasingly needed throughout the state. An estimated 21 percent of Minnesota’s college-educated, foreign-born population is currently underutilized in the labor force, meaning they are either unemployed or underemployed in unskilled “survival jobs,” a phenomenon also sometimes referred to as “brain waste” within the workforce.77

In contrast to such “brain waste,” developing better pathways for immigrant physicians to practice their profession would bring the state the many economic and social benefits known to come when highly skilled immigrants are successfully employed and well-integrated into their professions.78 A 1997 study found that highly educated immigrants in the U.S. averaged a net per capita benefit of $198,000 to society, and subsequent studies have confirmed that such immigrants confer a significant net benefit to the U.S.79 One Minnesota-specific analysis estimated that the state’s 2007 population of 40,638 immigrants with graduate or professional degrees would generate lifetime earnings of $134 billion.80

Possible funding sources

The Task Force explored a variety of possible funding sources for its recommended strategies. It concluded that the most effective approach will be a public-private partnership, at both the governance and funding levels. State support and funding will be necessary, but the Task Force also believes it is important that the private sector also contribute to its operations, as well as immigrant physicians themselves.

1. Current Federal (Medicare) and State (MERC) Graduate Medical Education funding

The Task Force finds that current federal (Medicare) and state (MERC) Graduate Medical Education funding is not a realistic source of support for activities recommended in this report. Current funding does not fully support the current level of physician training, and redirecting it would reduce rather than expand the training capacity needed to meet growing demand. Financial resources to support additional primary care clinical training capacity for candidates such as immigrant physicians is already limited for clinics and other ambulatory settings best suited for primary care training because, among other reasons, the majority of Graduate Medical Education funds flow to hospital-based training.
2. New state funding

The Task Force believes additional State investments should be considered to implement its recommendations and achieve the goal to integrate immigrant physicians into the state’s workforce as physicians or other health professionals. Successfully integrating foreign-trained physicians into the state’s workforce will yield public benefit by better meeting the health care needs of citizens, contributing to state goals for health system improvement and contributing to economic development by more fully employing this group of underemployed professionals.

3. Private funding

Physician employers such as hospitals, clinics and health systems are working to add culturally competent providers to better serve their increasingly diverse patient populations. Though some health care employers may be experiencing financial stress, the Task Force believes it is in the interest of health care employers to invest through public-private partnerships in the type of cost-effective workforce diversity strategies offered in this report.

Immigrant physicians themselves could also be an important source of support. The Task Force heard from many physicians willing and even eager to “pay back” into a system that would allow them to practice their profession. Several of the strategies recommended therefore include both return-of-service obligations (in which participating physicians would commit to practicing in a rural or underserved area for a certain length of time, similar to obligations now built into loan forgiveness and repayment programs for U.S. medical graduates) and reimbursement obligations (in which the physicians would contribute to the costs of a given program, typically by receiving a graduated salary that increases with each year of service, though other reimbursement arrangements such as a revolving loan program may be feasible as well).

4. Philanthropic support

Several Minnesota private foundations have provided support to advance the goal of integrating foreign-trained physicians into the state workforce as physicians or other health professionals. The Task Force sees potential for further private and corporate foundation investment in implementing activities needed to implement this goal.

One specific effort already under way: In 2014, the Bush Foundation awarded a two-year Community Innovation Grant for a collaborative of Minnesota nonprofits and other health care stakeholders, led by the Women’s Initiative for Self-Empowerment (WISE) and New Americans Alliance for Development (NAAD), to develop a public-private partnership initiative to fund additional medical residency opportunities for immigrant physicians. This group intends to use the Task Force’s recommendations as a basis for its partnership development, and its work will leverage any public funding with additional private investment from Minnesota health care institutions, businesses and philanthropy.

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We are ready to work in the health care system. Working as a health care provider is my only American dream. I bring passion, integrity and a pledge to work hard to bring my dream to reality.

Survey respondent originally from India
Recommendations

The Task Force concludes that Minnesota has a valuable and underused resource in its population of immigrant physicians, many of whom stand willing and qualified to serve as primary care providers in rural and underserved communities of the state. These physicians currently face multiple barriers to practice, but these obstacles could be addressed effectively with strategic, coordinated, public-private action. When implemented, these strategies could produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota.

Guiding Principles

In developing these recommendations, based on its findings, the Task Force adopted a set of guiding principles:

- Programs must be comprehensive (providing career direction, academic experiential and related activities and support) and provide multiple pathways to appropriate licensing and employment.
- Ideal programs will be collaborations between public and private entities.
- Admission procedures and criteria for services and programs should fully and objectively capture the knowledge, skills and experience of applicants.
- Programs should be affordable to participants.
- Participants who meet specified outcomes must have a reasonable assurance that they will be able to continue toward their goal of working as a physician, physician assistant or similar health professional, within the limits of the resources available for support services and programs.
- Programs and policies should include competency assurances comparable to Minnesota physician licensing requirements.
- Priority should be given to immigrant physicians who have lived in Minnesota at least 2 years and limited to those legally able to work.
- Programs should include return-of-service requirements, through which participants who succeed in becoming practicing physicians or similar professionals are obligated to work in an underserved area and/or contribute to funding ongoing services.

Specifically, the Task Force recommends the following set of strategies, which would work in concert as depicted in Figure 16. The recommendations are presented as a comprehensive system of linked strategies, rather than isolated tactics, to address the key barriers in a cohesive, cost-effective way, and to allow multiple pathways into the workforce depending on a physician’s qualifications, interests and level of readiness to practice.

Importantly, key stakeholders in the state’s health care system have been actively involved in developing these innovative solutions and have expressed interest in implementing them. The chair of the Task Force, Dr. Edwin N. Bogonko of St. Francis Regional Medical Center, represented the Minnesota Medical Association, and the medical schools of both the University of Minnesota and Mayo Clinic were active Task Force and work group members. Essentia
Health, a major hospital and clinic system with many facilities in rural Minnesota, served on the Task Force from the perspective of a rural health care employer already facing challenges finding physicians and other health care providers to fill vacancies within its system. Mayo, Hennepin County Medical Center, Fairview Health Services, North Memorial Health Care and other providers have also expressed interest in participating in the proposed clinical preparation program, and the Minnesota Hospital Association is interested in convening other member hospitals to facilitate their participation as well.
Figure 18. Proposed Minnesota immigrant physician system

- **MN Clinical Assessment & Certification**
  - Standardized, rigorous assessment of clinical skills and experience.
  - Independent assessors would recommend certification (or additional preparation) to a governing council or the Board of Medical Practice.
  - Immigrant physician must have lived in MN at least 2 years to receive certificate.

  - **Gateway roster & navigation**
    - USMLE prep & foundational skill development
      - USMLEs

  - **ECFMG Certification**
    - Alternative profession pathways
      - USMLE prep & foundational skill development
        - ECFMG Certification

  - **Residency**
    - MN certificate certifies clinical readiness, regardless of recency of graduation or U.S. clinical experience.

  - **Clinical Preparation Program**
    - If needed.
    - PRP-like but focused on clinical experience.
    - 6 months full-time w/stipends.

  - **Apprenticeship**
    - Eligibility: MN-certified immigrant physicians with 7+ years clinical experience (U.S. or international).
    - Apprentices would practice with a limited license under physician supervision.
    - Length: 4 years in primary care in rural or underserved area of MN.

  - **Traditional residency**
    - (Match System)

  - **Sponsored residency**
    - (Privately funded slots for IIMGs)

  - **MN underserved primary care residency**
    - Publicly funded spots reserved for immigrant physicians and others willing to serve in underserved areas of MN.
    - Return of service obligation (5-7 years in rural or underserved area).
    - Reimbursement obligation (participant would pay back some portion of program costs over time).

  - **Apprenticeship**
    - Eligibility: MN-certified immigrant physicians with 7+ years clinical experience (U.S. or international).
    - Apprentices would practice with a limited license under physician supervision.
    - Length: 4 years in primary care in rural or underserved area of MN.

  - **Physician Assistant**
    - PA programs allow USMLE to fulfill certain science prerequisites.
    - Alternative PA tracks developed for IIMGs, including a possible pilot program.

  - **Researcher, professor, nurse practitioner, other role**

  - **Full MD license**

  - **Permanent limited MD license** (optional)
Note: Any funding amounts provided are general figures only, not formal state government fiscal notes, and are provided so as to be scalable, allowing the adjustment of program sizes and funding amounts as needed.

Strategy 1: Statewide coordinating council

The Task Force recommends the Legislature authorize the creation of a statewide Council on International Medical Graduates to provide overall coordination for the planning, implementation and evaluation of a comprehensive system to integrate immigrant physicians into the Minnesota health care system. The Council would be charged with addressing the barriers faced by immigrant physicians and facilitating pathways for their integration into the Minnesota health care delivery system. Specifically, the Council would be responsible for implementing and evaluating the outcomes of Strategies 2-10 below, with an overall goal of increasing access to primary care in rural and underserved areas of the state.

As part of its duties, the Task Force also recommends that the Council develop and maintain, in partnership with the Board of Medical Practice and community organizations working with immigrant physicians, a centralized, voluntary roster of those interested in entering the Minnesota health workforce. This would equip the Council with better and more consistent information about the pool of immigrant physicians in the state and their qualifications and interests, which could in turn guide Council planning and program administration for maximum impact.

The Council should include members from key stakeholders, including the following:
- State agencies (including MDH, the Board of Medical Practice, the Office of Higher Education, and the Department of Employment and Economic Development).
- Representatives from the health care industry (including a health care employer from a rural or underserved area and a health insurer).
- Community-based organizations, including those serving immigrant and refugee communities, such as the partnership between New Americans Alliance for Development and the Women’s Initiative for Self-Empowerment.
- Higher education (including the University of Minnesota, the Mayo Clinic School of Health Professions and/or Medical School, a graduate medical education program not located at the University of Minnesota or Mayo, and a physician assistant education program).
- Immigrant physicians.

Recommended action: Authorize the Commissioner of Health to develop a statewide council, in collaboration with the Board of Medical Practice and key stakeholders, to design, implement and coordinate a comprehensive system for the integration of immigrant physicians into the Minnesota health care system. The authorization should include appropriation of funding for the programs and operations of the council (see Recommendations 2-10).
Strategy 2: Gateway and foundational support

The Task Force recommends that a state grant program be established to maintain and expand career guidance and support services for immigrant physicians, building on the current Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED). The program should seek to accomplish the following:

- Maintain and expand career guidance and support for immigrant physicians, including information on training and licensing requirements for physician and non-physician health care professions, and guidance in determining which pathway is best suited for an individual foreign-trained physician based on his/her skills, experience, resources and interests.
- Provide support to build foundational skills needed to practice in the U.S., including English health care terminology and information technology proficiency.
- Provide support for USMLE test preparation and expenses.
- Provide support for immigrant physicians interested in pursuing alternative professions, including a clearinghouse on pathway options and educational programs available.
- Register all participating immigrant physicians in the Council’s Minnesota Immigrant Physician roster.

**Recommended action:** Allocation of $500,000/year for grant(s) to Minnesota nonprofit(s) to serve 50 immigrant physicians per year (at an average of $10,000 per immigrant physician served), coordinated through the proposed Council on International Medical Graduates, with the initial round of grants distributed by December 2015. This amount does not include administrative costs for the grant program. The Task Force bases this funding recommendation on costs of similar programs (particularly the existing Foreign-Trained Health Care Professionals program), but recommends providing additional funding to allow for more intensive, coordinated support services than is currently available.

Strategies 3 and 4: Clinical assessment & certification

The Task Force recommends that Minnesota develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians. Key features should include the following:

- Standardized and rigorous assessment of clinical skills.
- Prerequisite that immigrant physicians first be certified by the ECFMG.
- Prerequisite that immigrant physicians have lived in Minnesota for at least two years.
- Upon successfully passing the assessment, physicians would receive Minnesota certification of clinical readiness for either residency or apprenticeship.
- The Council should further explore whether the assessment program could be extended to assess clinical readiness to practice medicine (assessment toward full licensure without the requirement of medical residency experience or an apprenticeship) (see also Recommendation 9).

**Recommended action:** Authorize the proposed Council on International Medical Graduates to work with the Commissioner of Health and the Board of Medical Practice, in consultation with
key stakeholders and experts, to develop a plan by December 31, 2015 for implementing an assessment and certification system, including proposed legislation, a proposed budget, and an implementation schedule that allows for assessment and certification of immigrant physicians by June 2016.

**Strategy 5: Clinical preparation program**

The Task Force recommends that a state grant program be established to support clinical training sites in providing hands-on experience and other preparation for Minnesota immigrant physicians needing additional clinical preparation or experience to become certified as ready for residency or apprenticeship. The grant program should include the following:

- Development of training curricula and associated policies and procedures for clinical training sites.
- Monthly stipends for participating physicians.
- Prerequisite that eligible participating physicians must have lived in Minnesota for at least two years and be certified by the ECFMG.
- Successful completion of the program would lead to Minnesota certification of clinical readiness for either residency or an apprenticeship (based on clinical assessment following program completion).
- Priority should be given to primary care sites in rural or underserved areas of the state, and participating physicians should have to commit to serving at least five years in a rural or underserved community of the state.

**Importantly, several Minnesota hospitals, clinics and medical education programs have expressed preliminary interest in participating in such a program**, including the following who have stepped forward to date:

- Fairview Health Services
- Hennepin County Medical Center
- Mayo Clinic College of Medicine
- Minnesota Department of Human Services (DHS) – Direct Care and Treatment (State Operated Services)
- North Memorial Health Care
- University of Minnesota Medical School, Department of Family Medicine and Community Health

The Minnesota Hospital Association has also expressed interest in working with its member hospitals, particularly those in rural and underserved areas of the state, to facilitate their participation in the program.

**Recommended action**: Authorize the proposed Council on International Medical Graduates to develop policies and procedures for a clinical preparation program by December 2015, including an implementation schedule that allows for grants to clinical preparation programs beginning in June 2016. Allocate $750,000/year for grants to training programs to serve and provide stipends to 15 immigrant physicians/year (two 6-month cohorts/year, at an average cost of $50,000 per participant). This amount does not include administrative costs for the grant.
program. The Task Force bases this funding recommendation on historic costs and testimony provided by the administrators of the previous Preparation for Residency Program at the University of Minnesota, and the cost-per-physician experience of the similar University of California-Los Angeles International Medical Graduate program. The Task Force estimates that the average cost per immigrant physician would be $50,000, which would include a total stipend amount of $12,000 to the participant ($2,000/per month for six months) plus program costs (including expenses incurred by the clinical site for the training provided) totaling $38,000.

**Strategy 6: Dedicated residency positions**

The Task Force recommends that dedicated Minnesota primary care residency positions be created for immigrant physicians who are Minnesota residents and are willing to serve in rural or underserved areas of the state. These positions should be developed with the following key features:

- Prerequisite that participating physicians must have lived in Minnesota for at least two years and be certified by both the ECFMG and the Minnesota Council on International Medical Graduates.
- Participating physicians would commit to providing primary care for at least five years in a rural or underserved area of Minnesota.
- In addition to this return-of-service obligation, the residencies would also include some level of reimbursement obligation (with the participating physician committing to pay back a portion of program costs).
- Ideally, these new residency positions would be funded through a combination of public and private funding, including the following:
  - Sponsored (privately supported) primary care residency spots dedicated for immigrant physicians.
  - State-funded primary care residency spots reserved for immigrant physicians and others willing to serve in rural or underserved areas.

**Recommended action:** Allocation of $2.25 million/year for 15 primary care residency positions dedicated to immigrant physicians living in Minnesota, for implementation beginning in June 2016, and the development of sponsored (privately funded) residency slots. The Task Force bases this funding recommendation on the average cost of residency training in Minnesota, which according to the Metro Minnesota Council on Graduate Medical Education is currently $150,000 per resident (which includes $50,000 annual salary and benefits for the resident). This amount does not include administrative costs for the grant program.

**Strategy 7: Changing “recency” guidelines**

The Task Force recommends that Minnesota residency programs be encouraged or required to revise their graduation recency guidelines to take into account other measures of readiness. Specifically, instead of looking only at the recency of graduation from medical school, residency programs should consider:

- When an immigrant physician passed the USMLEs and/or became certified by the ECFMG.
When an immigrant physician has been certified through the proposed Minnesota clinical assessment and certification program.

**Recommended action:** Charge the proposed Council on International Medical Graduates to work with Minnesota residency programs to accept the Minnesota immigrant physician certification and/or ECFMG certification as a measure of readiness for residency, regardless of recency of graduation or U.S. clinical experience.

**Strategy 8: Apprenticeship program**

The Task Force recommends that Minnesota develop a structured apprenticeship program for highly experienced immigrant physicians willing to serve in rural or underserved areas. The program should include the following features:

- Prerequisite that participating physicians have lived in Minnesota for at least two years and are certified by both the ECFMG and the Minnesota Council on International Medical Graduates.
- Prerequisite that eligible participating physicians would have at least seven years of clinical experience, in the U.S. or internationally.
- Development of a time-limited apprenticeship licensure by the Board of Medical Practice to allow an apprentice to practice under supervision of a licensed physician (see also Strategy 9).
- Apprentices would serve four years under physician supervision.
- In addition to this return-of-service obligation, apprenticeships would include a reimbursement obligation (with apprentices to receiving graduated salaries over the four-year period, with their salaries increasing with each year of service).
- Training sites would be part of a network of primary care clinics in rural and underserved areas and would receive $20,000/year per apprentice for their costs.
- Upon successful completion, participating physicians could choose to apply for (1) a full medical license, or (2) a permanent limited license, for practice under supervision of another physician.
- Participating physicians would commit to providing primary care for at least five years in a rural or underserved area of Minnesota.

**Recommended action:** Authorize the proposed Council on International Medical Graduates to develop and administer, in consultation with the Board of Medical Practice and other partners, an apprenticeship program for qualified immigrant physicians. The Council should work with the Board to develop policies and procedures for the program, including any additional admissions criteria, and proposed legislation for licensing changes needed, a proposed budget, and an implementation schedule that allows for the enrollment of eligible immigrant physicians as apprentices by June 2017. Allocate $100,000/year for the program to apprentice five immigrant physicians each year (providing for $20,000 grants annually to each of the five participating clinical sites). These grants would support the sites’ costs of supervision and staffing (including salary and benefits for the apprentice, whose salary amount would gradually
increase with each year of service as part of their reimbursement obligation to the program. This amount does not include administrative costs for the program.

Strategy 9: New licensure options

The Task Force recommends that Minnesota develop new licensing options for immigrant physicians, in coordination with new programs and pathways developed by the Council on International Medical Graduates and key stakeholders. These new licensing options would not require completion of medical residency experience. Specific licensing options that should be explored include the following:

- Time-limited apprenticeship licensure, to practice under supervision in the apprenticeship program recommended under Strategy 8.
- Permanent limited licensure to practice under supervision, for those physicians choosing this option following the apprenticeship program described under Strategy 8.
- Full licensure following successful completion of the apprenticeship program.
- If deemed feasible by the Board of Medical Practice and the Council based on more in-depth study, the development of a full licensure option based on a clinical assessment process recommended under Strategy 3 (with the certificate of clinical readiness serving in whole or part as evidence a candidate is clinically qualified to practice medicine).
- In all cases, the participating physicians must be certified by both the ECFMG and the Minnesota Council on International Medical Graduates, pass all USMLE tests and be clinically qualified to practice medicine.

Recommended action: Authorize the Board of Medical Practice to work with the proposed Council on International Medical Graduates and other key stakeholders to develop and propose legislation to grant qualified immigrant physicians time-limited apprenticeship licensure, limited licensure to practice under supervision, and full licensure. The legislation need not require that candidates obtain United States medical residency experience. The Council and Board should submit recommendations and proposed legislation by December 15, 2016.

Strategy 10: Streamline paths to alternative professions

The Task Force recommends that Minnesota explore and facilitate more streamlined pathways for immigrant physicians to serve in non-physician professions in the Minnesota health workforce. Specifically, it recommends the following:

- Strengthening career counseling resources for alternative health professions for foreign-trained physicians, particularly through the community organizations providing the gateway and foundational skill support in Strategy 2.
- Working with physician assistant training programs in Minnesota to explore alternatives for admission requirements for foreign-trained physicians, including allowing a foreign-trained physicians scores on the United States Medical Licensing Exams to fulfill basic and higher science prerequisites in physician assistant program admissions.
- Working with at least one interested physician assistant education program in Minnesota, in partnership with the Board of Medical Practice and national physician
assistant accreditation and certification bodies, to create a program track that meets
the existing professional standards for physician assistants, but is designed to meet
the unique needs of the immigrant physician who wishes to practice as a physician
assistant, including expedited training and specially designed clinical rotations.

**Recommended action:** Authorize the proposed Council on International Medical Graduates to
work with physician assistant programs on alternatives for admission requirements for foreign-
trained physicians, and to work with at least one interested physician assistant program based in
Minnesota to develop a new or pilot FTP-to-PA track to include expedited training during the
academic phase and specifically designed clinical rotations. Allocate $450,000 to support
program development and accreditation of the new program track over two years, developing a
program design by July 1, 2017 and any needed legislation for the program proposed by
December 31, 2016, with an enrollment target of September 2017. This funding recommendation
is based on a two-year development period requiring two full-time faculty (one to develop the
didactic curriculum and one to secure clinical placements) plus one full-time administrative
support person, and is based on historic costs and time required to develop Physician Assistant
programs and secure accreditation from the appropriate national accreditation and certification
bodies. This amount does not include administrative costs for the grant program.

A summary of these recommendations follows.
## Summary of Recommended Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Recommended action</th>
<th>Funding and timetable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 1: Statewide coordinating council</strong></td>
<td>Authorize the Commissioner of Health to develop a statewide council, in collaboration with the Board of Medical Practice and key stakeholders, to design, implement and coordinate a comprehensive system for the integration of immigrant physicians into the health care workforce.</td>
<td>Funding for the operations of the council beginning in June 2015.</td>
</tr>
<tr>
<td><strong>Strategy 2: Gateway &amp; foundational support</strong></td>
<td>Establish a state grant program to maintain and expand career guidance and support services for immigrant physicians, building on the current Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED).</td>
<td>$500,000/year for grants to nonprofits to serve 50 immigrant physicians/year, with initial grants distributed by December 2015.</td>
</tr>
<tr>
<td><strong>Strategies 3 and 4: Clinical assessment &amp; certification</strong></td>
<td>Develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians.</td>
<td>Develop a plan by December 31, 2015, including proposed legislation, a proposed budget, and an implementation schedule that allows for assessment and certification of immigrant physicians by June 2016.</td>
</tr>
<tr>
<td><strong>Strategy 5: Clinical preparation program</strong></td>
<td>Establish a state grant program to support clinical training sites in providing hands-on experience and other preparation to Minnesota immigrant physicians needing additional clinical preparation or experience to qualify for residency or apprenticeship.</td>
<td>Develop policies and procedures by December 2015, including an implementation schedule that allows for grants to programs beginning in June 2016, allocating $750,000/year for grants to train 15 immigrant physicians/year.</td>
</tr>
<tr>
<td><strong>Strategy 6: Dedicated residency positions</strong></td>
<td>Develop dedicated residency positions for immigrant physicians, through both state and private funding.</td>
<td>$2.25 million/year for 15 primary care residency positions dedicated to immigrant physicians, for implementation beginning in June 2016, and the development of sponsored (privately funded) residency slots.</td>
</tr>
<tr>
<td><strong>Strategy 7: Changing “recency” requirements</strong></td>
<td>Encourage or require Minnesota medical residency programs to revise their graduation recency requirements to accept the Minnesota immigrant physician certification and/or ECFMG certification as a</td>
<td>Council will report progress on this and other activities in its annual report, due December 31, 2015.</td>
</tr>
</tbody>
</table>

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1 Funding amounts provided are general figures only, not formal state government fiscal notes, and are provided so as to be scalable, allowing the adjustment of program sizes and funding amounts as needed. Amounts do not include grant program and other administrative costs.
<table>
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<th>Strategy</th>
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<th>Funding and timetable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 8: Apprenticeship program</strong></td>
<td>Authorize the Council to develop and administer, in consultation with the Board of Medical Practice and other partners, a structured apprenticeship program for highly experienced immigrant physicians willing to serve in rural or underserved areas.</td>
<td>Develop policies and procedures for the program, including admissions criteria, and proposed legislation for licensing changes needed, a proposed budget, and an implementation schedule that allows for the enrollment of eligible immigrant physicians by June 2017. $100,000/year for the program to apprentice five immigrant physicians each year beginning in 2017.</td>
</tr>
<tr>
<td><strong>Strategy 9: New licensure options</strong></td>
<td>Develop new licensing options for immigrant physicians -- including a time-limited apprenticeship licensure, limited licensure to practice under supervision, and full licensure -- that does not require U.S. medical residency experience.</td>
<td>Submit recommendations and proposed legislation by December 15, 2016.</td>
</tr>
</tbody>
</table>
| **Strategy 10: Streamline paths to alternative professions** | Authorize the Council on International Medical Graduates to explore and facilitate more streamlined pathways for immigrant physicians to serve in non-physician professions in the Minnesota health workforce, including:  
  - Alternatives for foreign-trained physicians in admission requirements for physician assistant (PA) programs.  
  - A new (or pilot) immigrant physician-to-PA track to include expedited training during the academic phase and specially designed clinical rotations. | Work with PA programs on alternatives for admission requirements for foreign-trained physicians, and include progress in annual report due December 31, 2015. $450,000 to support program development and accreditation of a new PA program track over two years, developing a program design by July 1, 2017 and any needed legislation for the program proposed by December 31, 2016, with an enrollment target of September 2017. |
Appendices

A. Task Force session law
B. Task Force membership
C. Minnesota health professional shortage areas
D. Demographic analysis, additional detail
E. Survey findings, additional detail
F. Promising practices and pathways
Appendix A: Task Force Charge

2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12

(1) The commissioner of health shall appoint members to an advisory task force by July 1, 2014 to develop strategies to integrate refugee and asylee physicians into the Minnesota health care delivery system. The task force shall:

   (a) analyze demographic information of current medical providers compared to the population of the state;
   (b) identify, to the extent possible, foreign-trained physicians living in Minnesota who are refugees or asylees and interested in meeting the requirements to enter medical practice or other health careers;
   (c) identify costs and barriers associated with integrating foreign-trained physicians into the state workforce;
   (d) explore alternative roles and professions for foreign trained physicians who are unable to practice as physicians in the Minnesota health care system;
   (e) identify possible funding sources to integrate foreign-trained physicians into the state workforce as physicians or other health professionals.

(2) The commissioner shall provide assistance to the task force, within available resources.

(3) **By January 15, 2015, the task force must submit recommendations** to the commissioner of health. The commissioner shall report findings and recommendations to the legislative committees with jurisdiction over health care by January 15, 2015.
## Appendix B: Task Force Members

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Title and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yende Anderson</td>
<td>Executive Director and Co-Founder, New Americans Alliance for Development</td>
</tr>
<tr>
<td>Edwin Bogonko, Chair</td>
<td>Chair, Physician, St. Francis Regional Medical Center Representative for the MN Medical Association</td>
</tr>
<tr>
<td>Donna DeGracia</td>
<td>Curriculum Director/Academic Coordinator, Master of Physician Assistant (PA) Studies Program, St. Catherine University School of Health</td>
</tr>
<tr>
<td>Sue Field</td>
<td>Nursing Accreditation Consultant, HealthForce Minnesota</td>
</tr>
<tr>
<td>Jane Graupman</td>
<td>Executive Director, International Institute of Minnesota</td>
</tr>
<tr>
<td>Michael Grover</td>
<td>Assistant Vice President, Federal Reserve Bank of Minneapolis</td>
</tr>
<tr>
<td>Wilhelmina Holder</td>
<td>International Medical Graduate, Executive Director, Women’s Initiative for Self-Empowerment, Inc., Co-Founder, New Americans Alliance for Development</td>
</tr>
<tr>
<td>Barbara L. Jordan</td>
<td>Administrator, Mayo Clinic College of Medicine, Office for Diversity</td>
</tr>
<tr>
<td>Tedla Kefene</td>
<td>International Medical Graduate, Board Member, New Americans Alliance for Development</td>
</tr>
<tr>
<td>Christine Mueller</td>
<td>Professor &amp; Assoc. Dean for Academic Programs, University of Minnesota, School of Nursing</td>
</tr>
<tr>
<td>Kris Olson</td>
<td>Vice President, Physician and Professional Services, Essentia Health</td>
</tr>
<tr>
<td>Mimi Oo</td>
<td>International Medical Graduate, Program Director/Coordinator, New Americans Alliance for Development, Foreign-Trained Health Care Professionals Program</td>
</tr>
<tr>
<td>James Pacala</td>
<td>Associate Department Head, University of Minnesota, Family Medicine &amp; Community Health</td>
</tr>
<tr>
<td>Jinny Rietmann</td>
<td>Program Coordinator, Foreign-Trained Healthcare Professionals Workforce Development Inc.</td>
</tr>
<tr>
<td>Michael Scandrett</td>
<td>Minnesota Safety Net Coalition</td>
</tr>
</tbody>
</table>
Appendix C: Health Professional Shortage Areas
MN Rational Service Areas - Mental Health
Geographic HPSA Designations

Designated 4/2012

Designated 12/2012

Designated 3/2012

Designated 11/2012

Region Name:
- Central Region
- Crest Region
- Metro Region
- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7E
- S Central Region
- SW Central Region

Source: Minnesota Department of Health
Office of Rural Health, June 2014
HPSA designations 8_2014.mxd

MINNESOTA
MDH
DEPARTMENT OF HEALTH
Health Professional Shortage Areas
Low Income Dental HPSA Designations

Legend
Not Designated
Designated

Data Source:
Minnesota Department of Health
Office of Rural Health and Primary Care
State DD HPSA Nov 2014
Appendix D: Demographic analysis, additional detail

Race and ethnicity of licensed physicians in Minnesota

Race

<table>
<thead>
<tr>
<th>Economic Development Region</th>
<th>Share of physicians of color in the region*</th>
<th>Share of persons of color in region’s population, 2010 Census</th>
<th>Total number of licensed physicians in region†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>11%</td>
<td>6%</td>
<td>1,070</td>
</tr>
<tr>
<td>Northeast</td>
<td>7%</td>
<td>7%</td>
<td>917</td>
</tr>
<tr>
<td>Northwest</td>
<td>15%</td>
<td>8%</td>
<td>724</td>
</tr>
<tr>
<td>7-County Minneapolis/St. Paul metro</td>
<td>14%</td>
<td>21%</td>
<td>8,632</td>
</tr>
<tr>
<td>Southeast</td>
<td>12%</td>
<td>9%</td>
<td>3,064</td>
</tr>
<tr>
<td>Southwest</td>
<td>23%</td>
<td>7%</td>
<td>570</td>
</tr>
<tr>
<td>Statewide</td>
<td>14%</td>
<td>14.7%</td>
<td>14,977</td>
</tr>
</tbody>
</table>

* Source: 2013 MDH Physician Workforce Survey. 1,399 out of 10,809 (14 percent) did not answer the survey question about race. “Physicians of color” include American Indian, Asian, Black, Native Hawaiian physicians who identify as multiple races, and “other” races. † Source: May 2014 licensing data from the Minnesota Board of Medical Practice. The data in this column includes only those physicians who provided a business address in Minnesota (excludes physicians working out of state and who did not provide a business address to the Board.)

Source: 2013 MDH Physician Workforce Survey. Respondents may choose not to answer certain questions on the survey. 1,399 out of 10,809 (14 percent) did not answer the survey question about race. 1,388 (13.9 percent) of respondents did not answer the survey question about ethnicity.
### Foreign-trained licensed physicians by Minnesota region

<table>
<thead>
<tr>
<th>Economic Development Region</th>
<th>Number of U.S. or Canadian-trained physicians in region</th>
<th>Number of foreign-trained physicians in region</th>
<th>Total number of licensed physicians in region</th>
<th>Share of foreign-trained physicians in region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>943</td>
<td>124</td>
<td>1,070</td>
<td>12%</td>
</tr>
<tr>
<td>Northeast</td>
<td>844</td>
<td>69</td>
<td>917</td>
<td>8%</td>
</tr>
<tr>
<td>Northwest</td>
<td>606</td>
<td>112</td>
<td>724</td>
<td>15%</td>
</tr>
<tr>
<td>Seven County Minneapolis/St. Paul</td>
<td>7,75</td>
<td>1,116</td>
<td>8,632</td>
<td>13%</td>
</tr>
<tr>
<td>Southeast</td>
<td>2,473</td>
<td>585</td>
<td>3,064</td>
<td>19%</td>
</tr>
<tr>
<td>Southwest</td>
<td>432</td>
<td>135</td>
<td>570</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Statewide</strong></td>
<td><strong>12,773</strong></td>
<td><strong>2,141</strong></td>
<td><strong>14,977</strong></td>
<td><strong>14%</strong></td>
</tr>
</tbody>
</table>

Source: May 2014 licensing data from the Minnesota Board of Medical Practice. Not all licensed physicians are working as physicians. This chart includes only those physicians who provided a business address that was in Minnesota (excludes 6,692 physicians who were working out of state and/or who did not provide a business address to the Board).

### Minnesota physicians by rural-urban location

<table>
<thead>
<tr>
<th>Rural-Urban Location</th>
<th>U.S-trained Physicians (n= 12,541)*</th>
<th>Foreign-trained physicians (n=2,141)*</th>
<th>Share of Population in Area**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>87%</td>
<td>87%</td>
<td>70%</td>
</tr>
<tr>
<td>Micropolitan/Large Rural</td>
<td>8%</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Small Town/Small Rural</td>
<td>4%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Rural/Isolated</td>
<td>1%</td>
<td>1%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Note:** Rural-urban categories are based on Rural-Urban Commuting Areas (RUCAs). See [Defining Rural, Urban and Underserved Areas in Minnesota](#).

**Sources:**
- Minnesota Board of Medical Practice licensing data, current through May 2014. A total of 2,445 physicians did not provide a business address.
- **U.S. Census.**
Currently licensed physicians vs. Minnesota immigrant communities, by region of the world

The population estimates in this section are all from Minnesota Compass, which in turn used data from Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010. Available from: http://usa.ipums.org/usa/. The number of Minnesota-licensed physicians by education country and birth country comes from the MN Board of Medical Practice licensing data from May and October 2014, respectively.

Note: The population estimates here are based on U.S. Census estimates only. It is important to note that such estimates likely undercount immigrant and refugee communities. As the state demographer cautions: “These estimates … likely underestimate the size of our immigrant populations because trust and language issues depress response rates to Census surveys.” For community-based estimates of some of the largest immigrant and refugee communities in Minnesota in addition to these census-based data, see Table 2 on Page 19.

### Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>21,227</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>12,503</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Liberia</td>
<td>12,216</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Kenya</td>
<td>7,295</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td>Sudan</td>
<td>3,327</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Cameroon</td>
<td>1,303</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Eritrea</td>
<td>1,197</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Tanzania</td>
<td>1,028</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>772</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
## Southeast Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laos</td>
<td>24,408</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Vietnam</td>
<td>18,548</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>Thailand</td>
<td>15,014</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>Philippines</td>
<td>6,346</td>
<td>146</td>
<td>158</td>
</tr>
<tr>
<td>Burma (Myanmar)</td>
<td>4,183</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Cambodia (Kampuchea)</td>
<td>3,045</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Indonesia</td>
<td>N/A*</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

*A value of N/A indicates that the number of people sampled in a given year was too small to provide a reliable estimate.

## South Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>26,273</td>
<td>783</td>
<td>914</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1,556</td>
<td>256</td>
<td>248</td>
</tr>
<tr>
<td>Sri Lanka (Ceylon)</td>
<td>1,038</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>897</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Nepal</td>
<td>812</td>
<td>34</td>
<td>37</td>
</tr>
</tbody>
</table>
### East Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>13,634</td>
<td>90</td>
<td>155</td>
</tr>
<tr>
<td>Korea</td>
<td>13,419</td>
<td>39</td>
<td>138</td>
</tr>
<tr>
<td>Other Asia*</td>
<td>5,335</td>
<td>98</td>
<td>64</td>
</tr>
<tr>
<td>Taiwan</td>
<td>2,994</td>
<td>12</td>
<td>66</td>
</tr>
<tr>
<td>Japan</td>
<td>1,983</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>1,361</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Malaysia</td>
<td>714</td>
<td>1</td>
<td>18</td>
</tr>
</tbody>
</table>

*Includes all other Asian countries, not just those in East Asia.

### Latin America

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexico</td>
<td>70,988</td>
<td>87</td>
<td>43</td>
</tr>
<tr>
<td>El Salvador</td>
<td>7,233</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Colombia</td>
<td>5,116</td>
<td>43</td>
<td>56</td>
</tr>
<tr>
<td>Guatemala</td>
<td>4,594</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Honduras</td>
<td>4,534</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ecuador</td>
<td>4,080</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Guyana/British Guiana</td>
<td>2,447</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Haiti</td>
<td>1,358</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>423</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>
### Middle East

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td>1,711</td>
<td>44</td>
<td>112</td>
</tr>
<tr>
<td>Egypt/United Arab Republic</td>
<td>1,122</td>
<td>60</td>
<td>69</td>
</tr>
<tr>
<td>Turkey</td>
<td>940</td>
<td>49</td>
<td>41</td>
</tr>
<tr>
<td>Iraq</td>
<td>665</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>Lebanon</td>
<td>582</td>
<td>55</td>
<td>63</td>
</tr>
<tr>
<td>Israel/Palestine</td>
<td>N/A*</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td>Jordan</td>
<td>N/A*</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Kuwait</td>
<td>N/A*</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Syria</td>
<td>N/A*</td>
<td>68</td>
<td>70</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>N/A*</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*A value of N/A indicates that the number of people sampled in a given year was too small to provide a reliable estimate.

### Eastern Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russia/Other Former USSR</td>
<td>6,710</td>
<td>26</td>
<td>83</td>
</tr>
<tr>
<td>Ukraine</td>
<td>3,766</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Byelorussia/Belarus</td>
<td>2,737</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Poland</td>
<td>1,898</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>Bosnia</td>
<td>1,624</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Romania</td>
<td>1,385</td>
<td>41</td>
<td>52</td>
</tr>
<tr>
<td>Latvia</td>
<td>567</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Hungary</td>
<td>531</td>
<td>24</td>
<td>16</td>
</tr>
</tbody>
</table>
### Western Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>7,617</td>
<td>83</td>
<td>155</td>
</tr>
<tr>
<td>England</td>
<td>4,161</td>
<td>59</td>
<td>68</td>
</tr>
<tr>
<td>Sweden</td>
<td>1,141</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Italy</td>
<td>1,063</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td>Norway</td>
<td>1,057</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Netherlands</td>
<td>824</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>Finland</td>
<td>691</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Denmark</td>
<td>602</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Ireland</td>
<td>579</td>
<td>79</td>
<td>54</td>
</tr>
<tr>
<td>Greece</td>
<td>519</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>Scotland</td>
<td>424</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Spain</td>
<td>N/A*</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Portugal</td>
<td>N/A*</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*A value of N/A indicates that the number of people sampled in a given year was too small to provide a reliable estimate.

### Oceania

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Foreign-Born Population in Minnesota, 2010-2012</th>
<th>Number of MN Licensed Physicians Educated in this Country</th>
<th>Number of MN Licensed Physicians Born in this Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>627</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Australia</td>
<td>913</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>
Appendix E: Survey findings

From August-December 2014, the Task Force conducted a statewide survey of foreign-trained physicians with the goal of obtaining a better understanding of the immigrant physician population and their needs. MDH reached out to 275 immigrant physicians during the four months with a 25 percent survey completion rate.

Demographics

Survey respondents came from 37 different countries. Sixty-eight (68) percent of respondents were 35-54 years old, and the gender makeup was almost 50/50. Fifteen (15) percent of survey respondents identified as refugees or asylees.

The figure below shows the racial diversity of the respondents.
The trend of immigrant physician arrivals in Minnesota is difficult to discern, but appears relatively stable. Based on the survey responses, there was a notable spike in 2009 of 10 immigrant physicians.

The majority (71 percent of respondents, or 51 individuals) are trained as general practitioners and do not hold any additional medical credentials. The variety amongst those who do is seen below.
Respondents have a wide breadth of clinical experience outside of the U.S., from 0-28 years.

Number of years practiced outside the U.S.

Medical residency

While there is an overwhelming interest in “meeting the requirements to enter medical practice or other health careers” in Minnesota (87 percent), the majority of respondents have not been accepted into a residency program (83 percent).
Of the seven respondents who have completed residency, five have a license to practice in Minnesota.

Of those who have not completed residency, 32 percent have spent less than a year looking for residency programs. The average search time has been 1.5 years, although two immigrant physicians have spent over 5 years trying. Respondents who have completed or are currently in residency programs stated that the most helpful factors throughout the application process were: (1) U.S. clinical experience and (2) having connections with people who can attest to your clinical skill set.

**Licensing Exams**

The majority of respondents who attempted any or all of the three United States Medical Licensing Exams (USMLE) steps passed, usually on their first attempt.

![USMLE Pass Rate Chart](chart)

Respondents cited the following challenges in preparing for the licensing exams (challenges listed by order of frequency of response).

- A. Money/financial barriers
- B. Lack of resources, including but not limited to: preparation materials, government, institutional, and social support
- C. Working and studying at the same time
- D. Exam and exam prep fees
- E. Language barriers
- F. Lack of time
- G. Residency barriers, including a lack of US clinical experience and recency requirements
- H. Household problems
- I. Exam rigor
- J. Studying and taking care of children at the same time
- K. Settlement issues, including legal barriers
L. Isolation
M. Political climate in home country

Only four respondents explicitly stated that there were no barriers to testing. The top three resources utilized were the USMLE website/Qbank (34 percent), Kaplan prep materials (19 percent), and New Americans Alliance for Development (NAAD) (9 percent).

Alternative Professions

Just over one-third (35 percent of respondents or 24 individuals) were not interested in pursuing alternative medical professions. Of those 24 respondents, 15 explicitly stated they were determined to go down the physician route. Among the 65 percent interested in exploring alternative professions, just over half (58 percent) expressed interest in the physician assistant role.

Interest in Alternative Professions

![Pie chart showing interest in alternative professions: PA: 58%, NP: 4%, PA or NP: 38%]

Most (37 out of 45 respondents) are currently employed in the health field (excluding the physician profession). These positions include researcher (8), medical interpreter (6), medical assistant (4), and health service manager/administrator (4).

Suggested Solutions

44 respondents suggested possible solutions:

- 15 suggested creating training programs (like the former Preparation for Residency Program at the University of Minnesota).
- 11 suggested clinical spots/opportunities for hands-on experience.
- 7 mentioned willingness to work in rural communities.
- 7 expressed interest in entering the PA/NP profession with limited to no extra training.
- 6 asked for support services (including financial).
- 5 explicitly asked for access to residency slots.
- 2 wanted to waive or lower recency requirements.
- 2 felt licensing/certification requirements overall needed to be changed.
- 2 wanted appropriate committees to count education and experience abroad.
- 2 voiced concerns about opportunities for the utilization of appropriate skills.
### Appendix F: Promising practices and pathways

<table>
<thead>
<tr>
<th>KEY FEATURES</th>
<th>OUTCOMES</th>
<th>LEAD ORG.</th>
<th>IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U.S.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcome Back Initiatives (various sites)</td>
<td>Educational and professional assessment and guidance.</td>
<td>Good success in validating credentials (27%) and passing Board exams (16%).</td>
<td>Nonprofits (with government and other grant funding)</td>
</tr>
<tr>
<td></td>
<td>Courses and workshops to address key barriers.</td>
<td>Low success rate in securing residencies (2.5% of the 4,022 physicians assisted between 2001 and 2011 at all Welcome Back sites, and 7-8% at the original site in San Francisco).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group activities and support.</td>
<td>Another 20% have pursued other health care professions.</td>
<td></td>
</tr>
<tr>
<td>NAAD + Workforce Development Inc. (Minnesota)</td>
<td>Career counseling and pathway navigation.</td>
<td>Good success in IMGs passing USLMEs and becoming ECFMG certified.</td>
<td>Nonprofits (with state grant and other grant funding)</td>
</tr>
<tr>
<td></td>
<td>Social and financial support.</td>
<td>Fairly low success rates in securing residencies (13%).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Test preparation support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>English proficiency support, and other workshops/learning sessions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group activities and support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCLA IMG Program (California)</td>
<td>9-21 month program.</td>
<td>High success rate in placing graduates in residency (75-95%).</td>
<td>University (with funding from foundations, health systems and corporations), possibly also state Medicaid reform funding.</td>
</tr>
<tr>
<td></td>
<td>Prep for Steps 1-3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical observership and hands-on clerkship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialized courses in English.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stipends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counseling and prep for FM residencies in California, incl. 2 letters of recommendation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited to Spanish speakers.</td>
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</table>
### KEY FEATURES

- After residency, IMGs commit to practicing for 2-3 years in a Calif. Medically Underserved Area.

<table>
<thead>
<tr>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>High success rate in participants securing residency (nearly 100%).</td>
</tr>
<tr>
<td>Low # of applicants and participants.</td>
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<table>
<thead>
<tr>
<th>Lead Org.</th>
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<tbody>
<tr>
<td>University (with state grant and/or internal funding)</td>
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<table>
<thead>
<tr>
<th>Implementation Issues – What Would Be Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding (original program required $150,000+/year to support 3-4 participants; U’s “ideal” PRP estimated at $550K for 4 participants, not including costs to hospitals/clinics that participate).</td>
</tr>
<tr>
<td>Ways of finding and assessing qualified candidates.</td>
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<tr>
<td>Support for English and typing skills.</td>
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<tr>
<td>Issue of limited residency slots, competition w/ better-known USMGs.</td>
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</tbody>
</table>

### Canada

#### Alberta IMG Program

- Competitive application process.
- Pre-residency clinical assessment.
- Residency positions reserved for IMGs in the program and aligned with provincial physician needs.
- Residency positions are in a variety of disciplines, with half in family medicine and

Each year, 40 participants placed in designated IMG residency positions (20 at the University of Alberta and 20 at the University of Calgary).

<table>
<thead>
<tr>
<th>Lead Org.</th>
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<tbody>
<tr>
<td>University (with funding from the Alberta government)</td>
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<thead>
<tr>
<th>Implementation Issues – What Would Be Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding.</td>
</tr>
<tr>
<td>Partnership with medical school(s) to do pre-residency clinical assessments and add designated residency positions.</td>
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<tr>
<td>UNIVERSITY OF BRITISH COLUMBIA</td>
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<tr>
<td>-------------------------------</td>
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<tr>
<td><strong>KEY FEATURES</strong></td>
</tr>
<tr>
<td>- Competitive application process.</td>
</tr>
<tr>
<td>- Pre-residency clinical assessment over 8 week period.</td>
</tr>
<tr>
<td>- Residency positions reserved for IMGs in the program.</td>
</tr>
<tr>
<td>- Participants can do just the clinical assessment and then compete in the overall match, or apply for the residencies reserved for IMGs.</td>
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<tr>
<td>- Return-of-service obligation (1 year of service for every year of residency, up to 3 years).</td>
</tr>
<tr>
<td><strong>OUTCOMES</strong></td>
</tr>
<tr>
<td>- Serves 60 IMGs each year.</td>
</tr>
<tr>
<td>- In 2014, 50% of the IMGs matched into a Canadian residency slot went through this clinical assessment program.</td>
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<tr>
<td><strong>LEAD ORG.</strong></td>
</tr>
<tr>
<td>- University (with funding from the British Columbia govt)</td>
</tr>
<tr>
<td><strong>IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?</strong></td>
</tr>
<tr>
<td>- Funding (British Columbia govt pays the University of British Columbia $108,000 CAD per year per IMG residency slot).</td>
</tr>
<tr>
<td>- Partnership with medical school(s) to do pre-residency clinical assessments and add designated residency positions.</td>
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</tbody>
</table>

**PATHWAYS CANADA**

**COLLEGE DES MEDICINS DU QUEBEC (CMQ) – RESTRICTIVE PERMIT**

<table>
<thead>
<tr>
<th><strong>KEY FEATURES</strong></th>
</tr>
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<tbody>
<tr>
<td>- IMGs register with the RSQ at the Quebec health ministry, which serves as the “portal of entry” for IMGs who wish to practice.</td>
</tr>
<tr>
<td>- IMG undergoes a 3-month clinical assessment in a University-based or other approved site. Also must pass language test and a 3-hr class on Quebec health care system.</td>
</tr>
<tr>
<td>- RSQ helps the IMG find facility in underserved region willing to sponsor the IMG.</td>
</tr>
<tr>
<td>- Once an employer sponsorship is obtained, the IMG applies to the CMQ for restrictive permit.</td>
</tr>
<tr>
<td>- IMG issued restrictive permit for one year, which may be renewed each year or converted to a regular permit (after 1 year after passing an exam, or after 5 years with no exam).</td>
</tr>
<tr>
<td><strong>OUTCOMES</strong></td>
</tr>
<tr>
<td>- About 60 restrictive permits have been issued each year since 2010, with about 13% of these in Family Medicine, though this number has been increasing (21% in 2013).</td>
</tr>
<tr>
<td><strong>LEAD ORG.</strong></td>
</tr>
<tr>
<td>- Govt agencies -- regulatory agency and health ministry</td>
</tr>
<tr>
<td>- Universities and other clinical sites (for assessments)</td>
</tr>
<tr>
<td>- Employers</td>
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<tr>
<td>- ECFMG (for verification of credentials)</td>
</tr>
<tr>
<td><strong>IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?</strong></td>
</tr>
<tr>
<td>- Mechanism for registry and matching to underserved sites.</td>
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<tr>
<td>- Partnerships with universities and other clinical sites for clinical assessments.</td>
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<tr>
<td>- Changes in licensing system – creation of new restrictive permit/licensing option.</td>
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<tr>
<td>KEY FEATURES</td>
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<tr>
<td><strong>AUSTRALIA</strong></td>
</tr>
<tr>
<td>Standard pathway – AMC Exams</td>
</tr>
<tr>
<td>Standard pathway – Workplace-based assessments</td>
</tr>
<tr>
<td>Competent Authority Pathway</td>
</tr>
<tr>
<td>KEY FEATURES</td>
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</tbody>
</table>
| **IMG is eligible to apply for general registration.**
  - Process was streamlined as of July 2014 (previously the Australian Medical Council did assessment and issued a certificate at the end of the 12 months of supervised practice). | | | |
| **Specialist Pathway – Specialist recognition**
  - After verification of medical credentials, the IMG applies to a relevant specialist medical college, which assesses whether the IMG is (a) not comparable to Australian-trained specialists in that field; (b) substantially comparable; or (c) partially comparable.
  - If deemed not comparable, the IMG can take Standard Pathway or Competent Authority Pathway.
  - If deemed partially or substantially comparable, the IMG secures an employment offer and applies for limited or provisional registration.
  - Depending on the specifics of the college’s assessment, the IMG may need to undertake a period of peer review (oversight), which may involve a workplace-based assessment, or a period of supervised practice and further training.
  - After completing the steps identified by the college, awarded a college fellowship or advised by college as eligible for fellowship.
  - Applies to MBA for specialist registration. | AMC + ECFMG (for verification of creds)
MBA (for registration)
Specialist medical colleges (for assessment) | • Assessment fees vary by specialist college, but seem to average about $5,000-6,000 (USD). Additional fees for AMC/MBA steps.
• Partnerships with specialist programs to conduct assessments.
• Mechanisms for follow-up assessments, training, etc.
• Changes in licensing system – creation of new restrictive permit/licensing option. |
| **Specialist Pathway – Area of Need**
  - An employer IDs a specialist position needed and works with a specialist college to prepare the job description and criteria. | AMC (for verification of creds) | Same as specialist pathway above. |
<table>
<thead>
<tr>
<th><strong>KEY FEATURES</strong></th>
<th><strong>OUTCOMES</strong></th>
<th><strong>LEAD ORG.</strong></th>
<th><strong>IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• The employer works with the state or territory health authority to have the position declared an area-of-need position.</td>
<td></td>
<td>MBA (for registration)</td>
<td>Mechanism for approving/declaring positions in “areas of need” (could be similar to current designations under National Health Service Corps).</td>
</tr>
<tr>
<td>• The IMG secures an employment offer for the position.</td>
<td></td>
<td>Specialist medical colleges (for assessment)</td>
<td></td>
</tr>
<tr>
<td>• The IMG obtains verification of medical credentials and applies to the relevant specialist medical college.</td>
<td></td>
<td>Employer (to develop position)</td>
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<tr>
<td>• The college assesses the IMG’s qualifications and experience against the requirements of the specific position.</td>
<td></td>
<td>State or territory health authority (to authorize area of need position)</td>
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<tr>
<td>• If deemed qualified, the IMG applies for limited registration to practice.</td>
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<tr>
<td>• This pathway does not necessarily lead to specialist recognition. To obtain that, the IMG must complete the requirements for that recognition (see above). Alternatively, they can pursue the Standard Pathway.</td>
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**GERMANY**

Pathway to licensure (approbation)

- Citizens of the European Union (EU) (with the exception of Bulgaria and Romania), the European Economic Area (EEA) and Switzerland are automatically recognized and allowed to practice.
- An IMG trained in another country (outside the EU, EEA or Switzerland) may apply for an equivalency review. The state (regional) health authority evaluates whether the basic medical training and qualifications are equivalent to training in Germany. Significant differences in qualifications can be offset by relevant professional experience.
- If deemed equivalent and other requirements are met (such as German

This is a relatively new system – a product of the 2012 German Recognition Act (an “Act to improve the assessment and recognition of foreign professional qualifications”). Before then it was more difficult for IMGs to become licensed in Germany.

- State health authorities (for assessment, testing and licensing)
- State chambers of physicians (for specialty assessment)

- Mechanism for equivalency review and testing.
- Changes in licensing system – creation of new licensing option based on equivalency review and testing.
<table>
<thead>
<tr>
<th>KEY FEATURES</th>
<th>OUTCOMES</th>
<th>LEAD ORG.</th>
<th>IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>language proficiency), the IMG is granted an Approbation (license).</td>
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<tr>
<td>• If the health authority finds substantial differences between the IMG’s qualifications and Germany’s, the IMG may take an assessment test (a 60-90 minute clinical-practical test with patient presentation) to prove the equivalence of his/her professional knowledge. If they pass, they are granted a license (Approval). Until the test is passed and a license is obtained, the IMG may obtain a provisional license for up to 2 years to work under supervision.</td>
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<tr>
<td>• Other requirements:</td>
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<tr>
<td>o Proof of spoken and written German. Some states require a “Medical German” test be passed as well.</td>
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<tr>
<td>o A certificate stating they are entitled to work as a doctor in their country.</td>
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<tr>
<td>o Documents proving they intend to practice in Germany – including confirmation of employment by a hospital or clinical employer.</td>
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<tr>
<td>• Specialists are assessed by specialty associations. They assess whether the content and duration of the IMG’s training complies with German training regulations for that specialty. Specialists must also complete at least 12 months of specialty training in Germany.</td>
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</tbody>
</table>
Notes

1 Educational Commission for Foreign Medical Graduates [Internet]. Definition of an IMG. Available from: http://www.ecfmg.org/certification/definition-img.html. As the ECFMG notes, it is the location of the medical school that determines whether the physician is an IMG. Hence, if a non-U.S. citizen obtains their degree in the U.S., s/he is not considered an IMG.

2 For the purposes of this report, “physician” refers to an individual with a medical degree from any part of the world, regardless of whether s/he is licensed to practice in Minnesota. It should be noted, however, that the designation “physician” has a specific, protected meaning under the Minnesota Medical Practice Act (Minnesota Statutes section 147.081, subdivision 3, Available from: https://www.revisor.mn.gov/statutes/?id=147.081).


15 Ibid.


18 U.S. Office of Refugee Resettlement: https://www.acf.hhs.gov/sites/default/files/orr/orr_populations_served_sorted_by_state.xlsx. A secondary arrival is a refugee who is no longer residing in the state listed as the initial point of destination with U.S. Citizenship and Immigration Services. Refugees are free to move from state to state, but sponsors, resettlement agencies, and state health departments are designed to serve only newly arrived primary refugees to the state.


21 Ibid.

22 Minnesota Compass, Workforce – Educational Attainment – Graph: Percent (age 25+) with a bachelor’s degree or higher by nativity, Minnesota 2006-2013, citing U.S. Census Bureau, American Community Survey. Available from: http://www.mncompass.org/workforce/educational-attainment#1-6813-g.
35 Recent studies remind us, for example, that providers and patients can be concordant or discordant (e.g., race, ethnicity, immigration status or language) in a variety of ways, and patients themselves bring a variety of culturally informed viewpoints and expectations to a clinical encounter. Those viewpoints shape and are shaped by the encounter in ways that are not always determined by a single status (such as race). Additionally, they operate differently across different cultural groups. For example, one qualitative study of Vietnamese and Mexican immigrants suggested that the Vietnamese patients exhibited a preference for white physicians because they themselves had assumed bias in favor of the dominant group. This was not the case for the Mexican immigrants in...
the study. These patterns of preference and expectations may be affected by education and socioeconomic status of the patient, as well.

34 In general, the relationship between concordance and health care access, quality and outcomes is strongest in the practice of mental health.


56 Minnesota Statutes Section 147.02.


61 Minnesota Statutes section 147.0377, subdivision 1 (d). Available from: https://www.revisor.mn.gov/statutes/?id=147.037. The statute provides exceptions for people of exceptional ability in the sciences or as outstanding professors or research. Also does not apply to applicants licensed in other states under certain conditions. Minnesota Statutes Section 147.037, subdivision 1, paragraph (d).


69 American Medical Association, Residency Program Requirements (part of online guide for International Medical Graduates). Available from: http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates/practicing-medicine/residency-program-requirements.page?
See, for example, the University of Wisconsin, School of Medicine and Public Health, Department of Family Medicine [Internet]. “How to apply to our residency program,” Available from: https://www.fammed.wisc.edu/residency/apply#elig


This program built on earlier, similar programs in Minnesota. In 2005, the state legislature appropriated a one-year funding also administered by DEED for a pilot project for the Foreign Trained Health Care Professionals (FTHCP) Program that provided funding to three organizations: AAFACD (currently know as NAAD), the Minnesota International Institute and Rochester Workforce, Inc. This program was also funding and supported for six consecutive years (2006-2012) by the Federal Office of Refugee Resettlement (ORR). The FTHCP program was in turn planned and developed based on a needs and assets assessment conducted with three annual grants and technical support from the U.S. Department of Labor from 2003 to 2006.

Personal correspondence from Mimi Oo, Program Director of New Americans Allied for Development (NAAD), December 19, 2014.

In the Welcome Back Initiative, of the roughly 4,000 foreign-trained physicians participating between 2001 and 2011, only about 2.5 percent (100 out of 4,022) of the participating physicians secured residency training. Krupa C. “Foreign-trained health professionals put on path to practice in U.S.” American Medical News, July 25, 2011. American Medical Association [Internet]. Available from: http://www.amednews.com/article/20110725/profession/307259952/2/


Sec. 17. [144.1911] INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1. Establishment. The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Subd. 2. Definitions. (a) For the purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. Program administration. In administering the international medical graduates assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;
(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. Career guidance and support services. (a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and
(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. Clinical preparation. (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. International medical graduate primary care residency grant program and revolving account. (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.
(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. Voluntary hospital programs. A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. Board of Medical Practice. Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. Consultation with stakeholders. The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

(ii) a health plan company;

(iii) the Minnesota Medical Association;

(iv) licensed physicians experienced in working with international medical graduates; and

(v) the Minnesota Academy of Physician Assistants;

(3) community-based organizations:
(i) organizations serving immigrant and refugee communities of Minnesota;

(ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and

(iii) the Minnesota Association of Community Health Centers;

(4) higher education:

(i) University of Minnesota;

(ii) Mayo Clinic School of Health Professions;

(iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and

(iv) Minnesota physician assistant education program; and

(5) two international medical graduates.

Subd. 10. Report. The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

From appropriations rider:

International Medical Graduate Assistance Program. (a) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the health care access fund for the grant programs and necessary contracts under Minnesota Statutes, section 144.1911, subdivisions 3, paragraph (a), clause (4), and 4 and 5. The commissioner may use up to $133,000 per year of the appropriation for international medical graduate assistance program administration duties in Minnesota Statutes, section 144.1911, subdivisions 3, 9, and 10, and for administering the grant programs under Minnesota Statutes, section 144.1911, subdivisions 4, 5, and 6. The commissioner shall develop recommendations for any additional funding required for initiatives needed to achieve the objectives of Minnesota Statutes, section 144.1911. The commissioner shall report the funding recommendations to the legislature by January 15, 2016, in the report required under Minnesota Statutes, section 144.1911, subdivision 10. The base for this purpose is $1,000,000 in fiscal years 2018 and 2019.

(b) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the health care access fund for transfer to the revolving international medical graduate residency account established in Minnesota Statutes, section 144.1911, subdivision 6. This is a onetime appropriation.
International Medical Graduate (IMG) Program

The Minnesota Department of Health is supporting the integration of international medical graduates (IMG) through the implementation of the International Medical Graduate Assistance Program. The Minnesota Legislature established this program in 2015 Minnesota Session Laws, Chapter 71, Article 8, Section 17, to address barriers to practice and facilitate pathways to assist immigrant international medical graduates (IIMG) to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Read the International Medical Graduate Assistance Program: Report to the Minnesota Legislature, January 2016 (PDF)

This comprehensive approach to IIMG integration into the Minnesota health care delivery system requires MDH to:

- Develop and maintain a voluntary roster of IIMGs interested in entering the Minnesota Health workforce.
- Develop clinical readiness assessment of eligible IIMGs to serve in a residency program.
- Award grants to nonprofit organizations to provide career guidance and support services to IIMGs seeking to enter the Minnesota health workforce.
- Award grants to support clinical preparation for Minnesota IIMGs needing additional clinical preparation or experience to qualify for residency.
- Award grants to support primary care residency positions designated for Minnesota IIMGs who are willing to serve in rural or underserved areas of the state.
- Collaborate with graduate clinical medical training programs to address barriers faced by IIMGs in securing residency positions in Minnesota.
- Explore and facilitate more streamlined pathways for IIMG to serve in non-physician professions in the Minnesota Workforce.
- Study in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of IIMG in the Minnesota health care delivery system.

http://www.health.state.mn.us/divs/orhpc/img/
International Medical Graduate Assistance Program: Report to the Minnesota Legislature

JANUARY 2016
International Medical Graduate Assistance Program:
Report to the Minnesota Legislature

January 2016

As requested by Minnesota Statute 3.197: This report cost approximately $4,000.00 to prepare, including staff time, printing and mailing expenses.

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March 9, 2016

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The Honorable Kathy Sheran
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Honorable Chairs:

I am pleased to present this report of the International Medical Graduate (IMG) Assistance Program, as authorized by 2015 Minnesota Statutes, Section 144.1911.

In the last few months, MDH and stakeholders have made great strides in establishing a strong foundation for the IMG Assistance program by engaging additional stakeholders, working across state agencies, issuing grants, and developing programmatic policies and procedures.

Once again, Minnesota is leading the nation in health care innovation as the first state to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, workforce shortages and rising health care costs. This program is an important strategy to improve health equity in Minnesota.

I thank you for your commitment to Minnesota and all who live here. I welcome your questions and thoughts on how we can work together to strengthen Minnesota’s health workforce and improve health equity for new Americans and the entire population.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
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Acknowledgements

MDH staff would like to thank the members and chair of the IMG Assistance Program Stakeholder Group and other key partners for their dedication and collaboration. So many continue to give so much, all on a volunteer basis and all in the spirit of helping our state break new ground in expanding health access and health equity. For a full list of Members of the Stakeholder Group, see Appendix C on pages 28-30.
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Executive Summary

Background

While Minnesota’s population is growing and becoming increasingly diverse, the state’s primary care workforce is not keeping pace. Currently, 19% of Minnesota’s population is comprised of minority and immigrant communities, but just 13% of the primary care workforce is from minority and immigrant communities. At the same time, Minnesota is projected to experience a shortage of primary care providers in the next decade.

In addition, Minnesota has among the worst health disparities in the nation, with minority and immigrant populations experiencing poorer health outcomes and poorer general health than their white counterparts.

Studies suggest that greater diversity in the health workforce, specifically increased cultural and linguistic competency, leads to improved clinical outcomes for racial minorities and immigrant populations. One strategy to increase both the number and diversity of primary care providers is to integrate people trained as physicians in other countries into medical practice or an alternate health profession in Minnesota.

In response to these issues, the 2014 Legislature created a task force on foreign trained physicians, whose report documented the significant and longstanding barriers immigrant physicians face in securing medical residency and becoming licensed physicians. The task force also made recommendations to integrate these physicians into the health care workforce, which became the basis for the 2015 Legislature’s creation of the International Medical Graduate (IMG) Assistance Program.

The IMG Assistance Program makes a powerful statement about the value that these individuals can provide in terms of both expanding access to care and diversifying Minnesota’s health care workforce. It is also an innovative complement to other health care workforce development programs in Minnesota, which can address barriers to practice and facilitate pathways to assist the integration of IMGs into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state and decreasing health disparities.

Activities to Date

In the initial six months since the IMG Assistance Program was created by the Legislature, MDH has implemented the following program elements:

Program Administration
The program is being implemented in consultation with a stakeholder group including representatives from state agencies (the Board of Medical Practice, the Office of Higher Education, Minnesota Department of Employment and Economic Development), the healthcare industry, provider associations including the Minnesota Academy of Physician Assistants, community-based organizations, higher education, and the Immigrant International Medical Graduate (IIMG) community. The stakeholder group has met twice to date.

Program Components

1) Roster: With the help of community organizations, the new IMG program has developed an initial list of 99 immigrant physicians currently interested in entering the Minnesota healthcare workforce. As the program becomes more established, the number of IMG on the list is expected to grow. (It is estimated that there are approximated 250-400 IMGs living in Minnesota.)

2) Collaboration to address barriers to residency: A major barrier to residency is the recency of the year of graduation from medical school. Stakeholders have surveyed primary care residency program directors at the University of Minnesota and all reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they passed a rigorous clinical assessment and participated in an in-depth clinical experience in the US.

3) Clinical Assessment: Statute directs MDH to establish a process to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. MDH has conducted the background research and as of January 2016 is beginning the process to contract with a qualified entity to develop the Minnesota IIMG Clinical Assessment.

4) Career Guidance and Support: This component of the program includes information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests; support in becoming proficient in medical English; support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology; and support for increasing knowledge of and familiarity with the United States health care system and preparation for the licensing exams.
The MN Department of Employment and Economic Development (DEED) and MDH executed an interagency agreement which will supplement funds at MDH for these activities. MDH will invite eligible nonprofits to submit proposals for the 2016 IMG Career Guidance and Support Grant Program in January 2016.

5) **Clinical Preparation and Experience**: MDH and stakeholders have developed the policies and procedures for the clinical preparation and experience. The prerequisite to participation is completing the clinical assessment, which will determine the length of the clinical experience. IMGs will then participate in a post assessment which will lead to a certificate of clinical readiness.

6) **Dedicated Residency Positions**: The University of Minnesota Pediatric Residency Program was selected as the first recipient of funding from the International Medical Graduate Primary Care Residency Grant Program and is in the process of selecting a resident. The resident will begin in March 2016.

**Conclusion**

Minnesota is the first state in the nation to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important and innovative first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities and workforce shortages.

In the last few months, MDH and stakeholders have made great strides in establishing a strong foundation for the IMG Assistance program by engaging additional partners, working across state agencies, issuing grants, and developing policies and procedures.

This program is positioned to have great impact, both for the individual immigrant medical graduates who participate in it and for the future patients that they may serve. However, MDH and stakeholders also realize that its reach may be limited, given the number of IMGs in Minnesota and those likely to arrive in the future. MDH and stakeholders look forward to implementing the next steps, including developing strategies to leverage additional funding sources and continuing to explore changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system.
Introduction

While Minnesota’s population is growing and becoming increasingly diverse, the state’s primary care workforce is not keeping pace. Currently, 19% of Minnesota’s population is comprised of minority and immigrant communities, but just 13% of the primary care workforce is from minority and immigrant communities. At the same time, Minnesota is projected to experience a shortage of primary care providers in the next decade.

In addition, Minnesota has among the worst health disparities in the nation, with minority and immigrant populations experiencing poorer health outcomes and poorer general health than their white counterparts.

Studies suggest that greater diversity in the health workforce, specifically increased cultural and linguistic competency, leads to improved clinical outcomes for racial minorities and immigrant populations. One strategy to increase both the number and diversity of primary care providers is to integrate people trained as physicians in other countries into medical practice or an alternate health profession in Minnesota.

In response to these issues, the 2014 Legislature created a task force on foreign trained physicians, whose report documented the significant and longstanding barriers immigrant physicians face in securing medical residency, which is required to become a Minnesota licensed physician. The task force also made recommendations to integrate these physicians into the health care workforce, which became the basis for the 2015 Legislature’s creation of the International Medical Graduate (IMG) Assistance Program.

The International Medical Graduate (IMG) Assistance Program (2015 Minnesota Statutes, Section 144.1911 https://www.revisor.mn.gov/statutes/?id=144.1911) is designed to address barriers to practice and facilitate pathways to assist immigrant IMGs to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Pursuant to subdivision 10 of that law, this report represents the Department’s annual report on the progress of IMG integration activities, including recommendations on actions needed for continued progress integrating IMGs.

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2 Id.
In collaboration with a multidisciplinary stakeholder group, community-based grantees, contractors, medical schools and medical residency programs, the IMG Assistance Program works to provide the following services (see Appendix B for the continuum of services):

- Gateway and Navigation (roster enrollment, career navigation, United States Medical Licensing Exam (USMLE) prep and ECFMG certification)
- Foundational Skill Building (medical English training, orientation to U.S. health care system, IT/typing skills training)
- Clinical Assessment
- Clinical Preparation (clinical instruction, clinical experience, letters of reference)
- Clinical Certification
- Residency Application Assistance
- Residency positions

Detailed information about the IMG Assistance Program is available on the IMG Assistance Program website (http://www.health.state.mn.us/divs/orhpc/img/index.html).

This legislation reflected many of the recommendations presented in the Task Force on Foreign-Trained Physicians Report to the Minnesota Legislature in January 2015 (http://www.health.state.mn.us/divs/orhpc/workforce/iimg/finalrpt.pdf). (See Appendix C for a summary of the recommendations and how those compare to the final law). The Task Force report provides rich background on the rationale, policy drivers and potential of the new program. Additional background information is available on the Task Force website (http://www.health.state.mn.us/divs/orhpc/workforce/iimg/meetings.html).
Background

The challenge of integrating foreign-trained physicians is complex and long-standing. In Minnesota, the issue has recently gained urgency as policy makers seek to address several major issues facing the state:

- Shortages in the supply of physicians
- An aging and diversifying population
- Persistent health disparities
- Rising health care costs

The Task Force concluded that integrating more immigrant physicians into Minnesota’s health workforce could help address each of these issues, based on the following findings:

1. **Comparison of the licensed physician workforce to the population overall**
   - The licensed physician workforce is older than Minnesota’s population.
   - The physician workforce does not mirror the state’s racial and ethnic composition.
   - Licensed foreign-trained physicians represent 16 percent of the physician workforce, but most of Minnesota’s largest immigrant and refugee communities are underrepresented.

2. **Identification of immigrant physicians seeking to enter the health workforce**
   - Minnesota is currently home to an estimated 250-400 unlicensed immigrant physicians.
   - In a survey of the state’s immigrant physicians, 87 percent of respondents were interested in entering medical practice or other health careers in Minnesota.
   - Among the survey respondents, 37 countries were represented and over 30 languages.
   - Just over half of the survey respondents were eligible to apply for medical residency, but only a small minority (17 percent) has been accepted into a residency program.

3. **Identification of barriers to practice.** Immigrant physicians face a range of barriers, with the following most significant:
   - *Growing competition for limited residency spots:* While 95 percent of seniors in U.S. medical schools get into medical residency, most immigrant physicians do not. This competition will get even tougher with the “residency bottleneck:” increasing numbers of medical graduates competing for a capped number of residency slots,
   - *“Recency” of graduation from medical school:* Most U.S. residency programs consider only those who have graduated from medical school within three to five years. Consequently, many of the most highly qualified immigrant physicians – those
who have practiced extensively since medical school – are essentially disqualified at this point in the path to licensure.

- **Lack of recognized clinical experience**: Most American residency programs prefer or even require that applicants have clinical experience acquired in the U.S., but such hands-on experience is nearly impossible to obtain outside of medical school or residency.

- **Complexity and costs of testing and other steps needed to qualify for residency**: Foreign-trained physicians often need assistance in English proficiency, exam preparation and navigating the path to licensure. Assistance programs are crucial, but will continue to have only limited success if other structural barriers go unaddressed.

The Task Force concluded that Minnesota has a valuable and underused resource in its population of immigrant physicians, many of whom stand willing and qualified to serve as primary care providers in rural and underserved communities of the state. It also concluded that Minnesota could effectively address the obstacles faced by those physicians if it undertook strategic, coordinated, public-private action. When implemented, these strategies could produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota. These findings are discussed in greater detail in the 2014 Task Force report, available at: http://www.health.state.mn.us/divs/orhpc/workforce/iimg/finalrpt.pdf

**Definitions**

International Medical Graduates (IMGs) are defined as individuals who obtained their basic medical degree outside the U.S. and Canada.¹ IMGs in the U.S. include several distinct subsets: (1) U.S.-born citizens who obtained their medical degree overseas (most commonly in the Caribbean or Central America); (2) foreign-born individuals who reside in the U.S. on non-immigrant visas (such as J-1, O-1 or H1-B visas) and (3) immigrants to the U.S. classified as either permanent residents (“green card” holders), U.S. citizens, asylees or refugees.

Pursuant to the law authorizing it, the **IMG Assistance Program focuses specifically on category (3), herein referred to as Immigrant IMGs (IIMGs), and specifically IIMGs not licensed to practice medicine in the U.S.**

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¹ Educational Commission for Foreign Medical Graduates. Definition of an IMG. Available from: http://www.ecfmg.org/certification/definition-img.html. As the ECFMG notes, it is the location of the medical school that determines whether the physician is an IMG. Hence, if a non-U.S. citizen obtains their degree in the U.S., s/he is not considered an IMG.
Activities to Date

The International Medical Graduate (IMG) Assistance Program is the first multi-component state program in the U.S. to assist immigrant international medical graduates (IIMGs) with integrating into the health care delivery system. As such, much of its start-up work in the first year, particularly establishing an administrative foundation and developing program elements with an eye to maximum long-term impact and value for the state of Minnesota, has had few or no existing models to draw from. Despite the challenges of scaling the program to available funds and designing a first-of-its-kind program from scratch, the program has accomplished much in its first seven months and is well-positioned to help integrate growing numbers of IIMGs in their quest to serve in Minnesota’s health care system.

Program Administration

Funding for the program became available in July 2015 and a coordinator was hired in September 2015.

The program is being implemented in consultation with a variety of stakeholders, guided by a highly engaged stakeholder group that builds on the success of the 2014 Task Force, which brought together an unprecedented combination of individuals and organizations. The membership of the stakeholder group includes representatives from state agencies including the Board of Medical Practice and the Office of Higher Education, the health care industry, provider associations including the Minnesota Academy of Physician Assistants, community-based organizations, higher education, and the IIMG community. (See Appendix D: Roster of stakeholder group). The IIMG Assistance Program Stakeholder group meets quarterly and has subgroups or workgroups which meet in between the quarterly meetings. The workgroups are:

- Clinical Assessment and Experience
- Nonphysician Professions
- Licensing
- Financial Aid

These work groups include additional stakeholders beyond those serving on the overall stakeholder group, and include additional representatives from the Minnesota Medical Association and Board of Medical Practice.
Program Components

1. Roster

Legislative charge: [D]evelop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota. (M.S. 144.1911, subd. 3, clause (2))

Last year’s Task Force estimated that Minnesota is home to approximately 250-400 immigrant physicians who are not able to practice here because of barriers to licensure. This estimate was made without the benefit of any official, ongoing count of the total number of unlicensed immigrant physicians living in the state. This led to the recommendation that a centralized, voluntary roster of those interested in entering the Minnesota health workforce be created to provide better and more consistent information about the pool of immigrant physicians in the state and their qualifications and interests. This would, in turn, guide planning and program administration for maximum impact.

Progress to Date
With the help of community organizations, the new IMG program has developed an initial database of 99 immigrant physicians currently interested in entering Minnesota health care workforce. This initial database is simply the starting point and will be used to build the full IMG Roster, which will collect the following information:

- Name
- Home Country
- Country of Medical Education
- Date of Medical School Graduation
- Specialty / Area of Practice
- Date of Entry into the US
- Date of Entry into Minnesota
- Minnesota County of Residency
- Current Employment
- Languages Spoken
- Desire to pursue US Medical Licensure (Y/N)
- USMLE tests taken and scores
- ECFMG Certified (Y/N)
- Have you applied for Residency
- If so, how many times? Any interviews? Did you secure a residency position (Y/N)
- If you secured a residency position, what was the specialty area of practice?
Have you completed residency in the US? If so what is your current area of practice? Is it in a rural or underserved area?

The program is currently reviewing the technology options available to build and host the IMG Roster. The current options are minimal, static and do not allow for continual interaction and updates. The ability to interact and update the data will not only help identify IMGs in Minnesota but will help the program track their progress of integration into the health care system and will offer a recruitment pool for medical residency programs and other alternative professional opportunities, such as internships for the expansion of the public health workforce.

The next step is to continue populating the current database as we invite more IMGs to participate through outreach and recruitment with our partners and through the application and intake process of the grant programs. We will also explore funding options to build a more robust, interactive IMG Roster that could include features such as an initial self-assessment to quickly direct people to next steps. An enhanced Roster could also be an official source of information on health professionals who have unique skills such as competency in particular cultures, specific language skills, etc., that would be available to potential pre-residency employers, residency and Physician Assistant programs. It could also serve as a platform for identifying and working with immigrants in other health occupations.

2. Collaboration to address barriers to residency

Legislative charge: [W]ork with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. (M.S. 144.1911, subd. 3, clause (3)).

One of the main reasons immigrant physicians struggle to secure a medical residency is out of their control: most U.S. residency programs consider only “recent” graduates from medical school, typically requiring graduation within three to five years of application to residency. As a result, some of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the pathway to licensure.

The primary rationale for these “recency” guidelines is the need for residents to be as up-to-date as possible on medical knowledge, treatment methods and protocols, and technology, particularly given how swiftly the health care field is changing. The 2014 Task Force concluded these valid concerns could be addressed in new, more effective ways that would benefit residency programs and immigrant physicians alike, and that these innovations alone could go a long way toward integrating more immigrant physicians into the health workforce.
Progress to Date
As indicated earlier, one of the workgroups of the Stakeholder group is Clinical Assessment and Clinical Preparation. Collaborating with clinical medical training programs to address the recency issue falls within the purview of this workgroup.

As an initial step, the work group conducted a survey of the six primary care residency program directors at the University of Minnesota and asked:

a) Does your program eligibility include:
   • Graduation for medical school within five years of date of program application and;
   • U.S. clinical experience?

b) Under what circumstances are you willing to relax those requirements?

The responses confirmed that a majority of the programs require applicants to have graduated from medical school within the last five years. One program requires applicants to have graduated from medical school within the last five years or practiced medicine within the last three years. Two programs evaluate the year of graduation on a case-by-case basis. However, they reported that the applications of those who graduated from medical school more than five years ago are under increased scrutiny.

All program directors reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they had passed a rigorous clinical assessment and participated in an in-depth clinical experience in the United States.

We also learned that all program directors value IMGs and the cultural competencies IMGs add to the practice of medicine in Minnesota. Many work with IMGs. However, they generally work with IMGs who are on J-1 or H1-B visas$^4$ and not IMGs who have immigrated to Minnesota (the focus of this program).

To address this opportunity, the program will next work to finalize the clinical assessment and clinical experience program (described below) and work with the program directors to ensure that its components meet the requirements of being rigorous and in-depth. Our partners at the University of Minnesota are also conducting a review of past IMG applications to residency programs to identify the impact of the recency issue in obtaining a residency position and to identify ways in which IMGs can highlight their competencies and be more competitive in the residency application process.

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$^4$ J-1 visa is a non-immigrant visa issued by the United States to scholars, professionals or others to participate in cultural exchange in the US, including obtaining medical training. H1-B visa is also a nonimmigrant visa issued by the United States to high skilled workers. It allows US employers to temporarily employ foreign workers to specialty occupations. Both visas require a sponsor and are costly to obtain.
3. Clinical Assessment

Legislative Charge: [D]evelop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. (M.S. 144.1911, subd. 3, clause (4))

The current system of certification from the Educational Commission on Foreign Medical Graduates (ECFMG), needed for admission to residency and for licensure, requires that IMGs pass a part of the United States Medical Licensing Exam (USMLE) that assesses a medical graduate’s clinical skills. However, the 2014 Task Force heard repeatedly – including from residency program directors directly – that ECFMG certification alone does not give them enough information about a candidate’s clinical aptitude to know if they will succeed in a U.S. medical residency program. The Task Force therefore recommended, and the IMG Program Assistance program provides, that Minnesota develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians, and therefore allow IIMGs to compete more fully with U.S. medical graduates for limited residency spots.

Progress to Date
As noted above, one of the workgroups of the Stakeholder group is the Clinical Assessment and Clinical Preparation group. In designing this component of the IMG program staff worked with the Interprofessional Education and Resource Center (IERC) and Academic Health Center (AHC) Simulation Center at the University of Minnesota. Staff there conduct simulations designed to meet assessment needs for professional accreditation as well as develop and promote interprofessional education and collaborative practice, and foster the development of clinical skills and patient communication. ([http://www.simulation.umn.edu/about](http://www.simulation.umn.edu/about)) Staff also has past experience conducting assessments for IMG’s in collaboration with the University of Minnesota’s Preparation for Residency Program which ended in [year].

The Simulation Center has provided concepts for building and implementing an assessment which will be presented to the Stakeholder Group in early 2016 for review and direction regarding contracting and implementation. MDH will then solicit bids and contract with a qualified entity to develop a Minnesota IIMG Assessment.

4. Career Guidance and Support

Legislative Charge:
(a) The commissioner shall award grants to eligible nonprofits organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce.
(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015. (M.S. 144.1911, subd. 4)
Practicing medicine in the U.S. requires a wide range of skills and knowledge, some specific to the rapidly changing and highly complex American health care system. Even immigrant physicians with extensive clinical skills and experience overseas have much to learn in order to qualify for residency and practice effectively in the U.S. In addition to passing the rigorous and highly technical USMLE licensing exams required for ECFMG certification, they must demonstrate to residency programs that their English proficiency, technological skills and understanding of U.S. medical culture make them qualified to train successfully in a graduate clinical setting and beyond.

The Task Force examined existing programs, including the Foreign-Trained Health Care Professionals program funded by the legislature in three of the last ten years and administered by the Minnesota Department of Employment and Economic Development (DEED), that seek to support IMGs with career navigation, language assistance and test preparation. It concluded that such programs are a key component of integrating immigrant physicians into the health workforce, but will have a far greater impact if they work in concert with other key partners (including the medical education system, health care providers and employers, and regulatory bodies) and if key barriers on the pathway can be addressed (including opportunities for clinical experience and mechanisms for assessing clinical readiness).

The Task Force’s recommendations therefore proposed, and the new program provides, for continuing support for these foundational programs, but doing so within a coordinated statewide system.

Progress to Date
In the interests of interagency coordination, DEED and MDH executed an interagency agreement that will transfer from DEED to MDH most of the $200,000 DEED was allocated by the 2015 Legislature for its Foreign-Trained Health Care Professionals program. This will supplement funds at MDH for these activities.

Staff and work group members also concluded that the program should expand traditional career guidance and support to also include trauma support and coaching. Many of the immigrant IMGs did not plan to leave their countries of origin but rather have uprooted their families, lost their physical belongings, professions and a sense of self-worth due to political persecution, civil unrest or war. As a result, they have experienced significant trauma. This is further compounded by the disappointment of loss of the ability to use their skills and talents in their new home. Many have tried for years to enter the health workforce and are experiencing failure to reach goals for the first time in their lives. Many hold on at all cost to the dream of practicing medicine. While this is an option for some, others could add value to the health workforce in MN by considering other alternatives including working in public health or in the Physician Assistant (PA) profession. Part of the problem is that they are not fully aware of these opportunities and what they entail. Combining trauma support and coaching including information on alternative pathways would be essential in helping IMGs deal with past trauma.
and providing the necessary information and tools to help them make informed professional decisions.

The next step in developing these services is to issue a request for proposals from non-profit organizations to provide the necessary career guidance and support.

5. Clinical Preparation and Experience

Legislative Charge
(a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency.
(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016. (M.S. 144.1911, subd. 5)

The 2014 Task Force concluded another major reason immigrant physicians are not accepted into residency programs is a lack of hands-on clinical experience in the U.S. Most American residency programs give preference to applicants with clinical experience acquired in the U.S. or Canada. However, such hands-on experience with patients is nearly impossible to obtain outside of U.S. medical school or residency, particularly since patient privacy and security regulations were strengthened under the 1996 Health Insurance Portability and Accountability Act (HIPAA). This led to the recommendation, and resulting law, calling for a state grant program to support clinical training sites in providing hands-on experience and other preparation for Minnesota immigrant physicians needing additional clinical preparation or experience to become certified as ready for residency.

Progress to Date
The Clinical Assessment and Clinical Preparation work group has been working to develop the policies, procedures, evaluation and outcomes for a grant program to support clinical preparation.

The group studied two basic types of clinical preparation: UCLA International Medical Graduate Program [http://fm.mednet.ucla.edu/IMG/img_program.asp](http://fm.mednet.ucla.edu/IMG/img_program.asp) and the former University of Minnesota Preparation for Residency Program (PRP). The program at UCLA is narrowly tailored to serve only Spanish speaking IMGs -not all IIMGs - who graduated from an international medical institution within the last four years. The PRP program was a broader program.

Based on its study of those programs, the work group has developed the following recommendations, which it will present to the overall Advisory stakeholder group in January 2016:

a) The Clinical Preparation should serve a broad range of IIMGs and should not be limited to specific languages, ethnicities or year of graduation for medical school.
b) A prerequisite for the clinical preparation should be the new Minnesota clinical assessment.
c) The length of the clinical preparation should be based on the outcome of the clinical assessment. Standard preparation time is six months. A high pass on the assessment should result in a shorter preparation time and a low pass, a longer preparation time. Individuals who fail the assessment will be counseled on possible alternative opportunities.
d) After the clinical preparation, an IIMG will be required to participate in a post-assessment conducted by an assessment preceptor.
e) Passing the post-assessment will result in a certificate of clinical readiness.

The next step is to finalize the policies and procedures for the program and prepare a Request for Proposals for clinical preparation programs.

6. Dedicated Residency Positions

Legislative Charge: The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. (M.S. 144.1911, subd. 6)

A key requirement for medical licensure in Minnesota is graduate clinical medical training in a U.S. or Canadian program accredited by a national accrediting organization approved by the state Board of Medical Practice. With rare exceptions, immigrant physicians are required to complete at least two years of such training, typically in a residency program, regardless of whether they completed similar clinical training outside the U.S.

Obtaining such a position, however, is a difficult feat for a variety of reasons. One is the sheer number of medical graduates vying for an essentially static number of residency positions. Medicare funding for residency training (which covers about 25 percent of GME costs in the U.S.) has been capped at the number of slots that existed in 1997, and funding by Medicare is less than what it costs to provide care and training, according to the Metro Minnesota Council on Graduate Medical Education. Even as the number of slots remains capped, however, the number of medical school graduates is increasing as many schools expand enrollments in anticipation of the physician shortages. Sometimes referred to as the “residency bottleneck,” this is a major reason cited by both the University of Minnesota and Mayo medical schools for why they do not plan to expand their medical school class sizes.

Given this need for additional residency spots and the unique qualifications many IIMGs bring to serve the fastest growing segments of the state’s population and their willingness to serve in rural and underserved communities, the IMG Program includes grants to establish new residency slots dedicated specifically to immigrant physicians. The enabling legislation also established a revolving international medical graduate residency account to accept funds from the public and private sectors to sustain grants for dedicated residency positions. In addition to the commitment to serve in a rural or underserved community for at least five years, an IIMG
accepted into a residency position funded by this grant program is required to pay the lesser of $15,000 or ten percent of their annual compensation into the revolving account for five years, beginning in the second year of post residency employment.

**Progress to Date**

In September, MDH invited Minnesota primary care residency programs to apply for such grant funding through the 2016 Immigrant International Medical Graduate Primary Care Residency Grant Program.

The University of Minnesota facilitated two informational meetings with primary care program directors to review the grant, answer any questions, and brainstorm on how to implement this grant and remain in compliance with the policies of post graduate medical education.

One program, the University of Minnesota Pediatric Residency Program, responded with an application for funding. The application was approved for funding and will include:

a) An assessment-based recruitment process.
b) Preliminary preparation period with more targeted and mentored orientation.
c) A training program with additional retention and career preparation activities through mentorship. We are in the process of finalizing the contract with the University of Minnesota Pediatric Residency Program.

In December, 2015, the University of Minnesota Pediatric Residency Program issued a call for applications for this new IMG residency. As of the time of this report, they had received 26 applications. One individual will be selected to fill the residency position, for training between 2016 and 2019. The individual should begin serving in a rural or underserved community in July 2019 and will start making payments into the revolving fund in July 2020.
Conclusion

The creation of the IMG Assistance Program was an important milestone. Minnesota is now the first state in the nation to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important and innovative first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, access to healthcare and workforce shortages.

In the last few months, MDH and stakeholders have made great strides in establishing a strong foundation for the IMG Assistance program by engaging additional stakeholders, working across state agencies, issuing grants, and developing programmatic policies and procedures. This program is positioned to have great impact in lowering healthcare cost by increasing the use of primary care; eliminating healthcare disparities through diversifying the healthcare workforce with culturally and linguistically appropriate care; and increasing the number of physicians in rural and underserved areas of the state.

However, as implementation begins and the program’s resources are committed, MDH also realizes the limited reach the program may have, given the number of IMGs in Minnesota and those likely to arrive in the future. MDH and stakeholders look forward to implementing the next steps detailed above, including developing strategies to leverage existing resources and continuing to explore changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system.

Minnesota law establishing the program requires the commissioner to develop and report recommendations for additional funding needed to achieve the objectives of this program. Although specific funding amounts needed have not yet been identified and reviewed by the program’s stakeholder group, current funding is only sufficient to successfully serve 60 - 85 of the 250 – 400 immigrant physicians in Minnesota, and the short term funding appropriated will only support dedicated residency positions for two or three immigrant physicians.
Appendices

A. IMG Assistance Program Legislation
B. Continuum of Services
C. Stakeholder Group Membership
Appendix A: IMG Assistance Program Legislation

2015 Minnesota Session Laws, Chapter 71, Article 8, Section 17

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1. Establishment.
The international medical graduate assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Subd. 2. Definitions.
(a) For the purposes of this section, the following terms have the meanings given.
(b) "Commissioner" means the commissioner of health.
(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.
(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.
(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.
(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.
(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. Program administration.
In administering the international medical graduate assistance program, the commissioner shall:
(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;
(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning
and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. Career guidance and support services.

(a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate’s skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;
(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and
(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.
(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. Clinical preparation.
(a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:
   (1) proposed training curricula;
   (2) Associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and
   (3) Monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.
(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. International medical graduate primary care residency grant program and revolving account.
(a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:
   (1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;
   (2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that
participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and (3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of post residency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;
(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and
(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. Voluntary hospital programs.
A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. Board of Medical Practice.
Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.
Subd. 9. **Consultation with stakeholders.**
The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

1. **State agencies:**
   - (i) Board of Medical Practice;
   - (ii) Office of Higher Education; and
   - (iii) Department of Employment and Economic Development;

2. **Health care industry:**
   - (i) a health care employer in a rural or underserved area of Minnesota;
   - (ii) a health plan company;
   - (iii) the Minnesota Medical Association;
   - (iv) licensed physicians experienced in working with international medical graduates; and
   - (v) the Minnesota Academy of Physician Assistants;

3. **Community-based organizations:**
   - (i) organizations serving immigrant and refugee communities of Minnesota;
   - (ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and
   - (iii) the Minnesota Association of Community Health Centers;

4. **Higher education:**
   - (i) University of Minnesota;
   - (ii) Mayo Clinic School of Health Professions;
   - (iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and
   - (iv) Minnesota physician assistant education programs; and

5. **Two international medical graduates.**

**Subd. 10. Report.**
The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.
Appendix B: Continuum of Services

Continuum of Services – Years 1-2 of IMG Assistance Program

<table>
<thead>
<tr>
<th>Gateway &amp; navigation</th>
<th>Foundational skill building</th>
<th>Clinical assessment</th>
<th>Clinical preparation</th>
<th>Residency application</th>
<th>Residency</th>
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<td>List of services:</td>
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<td></td>
<td>• Roster enrollment</td>
<td>• Medical English</td>
<td>• Clinical instruction</td>
<td>• Assistance with application &amp; match</td>
<td>• Dedicated primary care residency positions</td>
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<td>• Career navigation</td>
<td>• Orientation to U.S. health care system</td>
<td>• Clinical instruction</td>
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<td>• USMLE prep</td>
<td>• IT/typing</td>
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<td>• ECFMG certification</td>
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<td>• Letters of reference</td>
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<td>Community-based</td>
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<td>Contractor</td>
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<td>Community-based</td>
<td>Residency programs</td>
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<td>programs</td>
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## Appendix C: Stakeholder Group

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Member</th>
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</thead>
<tbody>
<tr>
<td>Board of Medical Practice</td>
<td><strong>Ruth Martinez</strong>&lt;br&gt;Executive Director&lt;br&gt;Board of Medical Practice</td>
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<tr>
<td></td>
<td><strong>Molly Shwanz</strong>&lt;br&gt;Supervisor, Licensure Unit&lt;br&gt;Board of Medical Practice</td>
</tr>
<tr>
<td>Office of Higher Education</td>
<td><strong>Diane O’Connor</strong>&lt;br&gt;Deputy Commissioner&lt;br&gt;Office of Higher Education</td>
</tr>
<tr>
<td>Dept of Employment and Economic Dev</td>
<td><strong>Annie Welch</strong>&lt;br&gt;Senior Planner&lt;br&gt;MN Department of Employment and Economic Development</td>
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<td></td>
<td><strong>Sarah Sinderbrand</strong>&lt;br&gt;Planner&lt;br&gt;MN Department of Employment and Economic Development</td>
</tr>
<tr>
<td>Health care employer in rural or underserved area</td>
<td><strong>James Volk, MD</strong>&lt;br&gt;Chief Medical Officer&lt;br&gt;Sanford Health</td>
</tr>
<tr>
<td>Health plan</td>
<td><strong>Julie Cole</strong>&lt;br&gt;GME&lt;br&gt;Health Partners</td>
</tr>
<tr>
<td>MN Medical Association (MMA)</td>
<td><strong>Armit Singh, MD</strong>&lt;br&gt;MN Medical Association</td>
</tr>
<tr>
<td>MN Academy of Physician Assistants (MAPA)</td>
<td><strong>Leslie Mittleer</strong>&lt;br&gt;President&lt;br&gt;Minnesota Academy of Physician Assistants (MAPA)</td>
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<tr>
<td>Stakeholder Group</td>
<td>Member</td>
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<tr>
<td>Licensed physicians experienced in working with IMGs</td>
<td>Edwin Bogonko, MD, Chair</td>
</tr>
<tr>
<td></td>
<td>Physician</td>
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<tr>
<td></td>
<td>St. Francis Regional Medical Center</td>
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<tr>
<td></td>
<td>Representative for the MN Medical Association</td>
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<tr>
<td>Organizations serving the IMG community, such as NAAD and WISE</td>
<td>Wilhelmina Holder</td>
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<td></td>
<td>Executive Director</td>
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<tr>
<td></td>
<td>Women’s Initiative for Self Empowerment (“WISE”)</td>
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<td></td>
<td>Mimi Oo</td>
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<td></td>
<td>Program Director/Coordinator</td>
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<td>New Americans Alliance for Development (“NAAD”)</td>
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<td></td>
<td>Jinny Rietmann</td>
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<td></td>
<td>Program Coordinator</td>
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<td>Foreign-Trained Healthcare Professionals</td>
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<td></td>
<td>Workforce Development Inc.</td>
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<td></td>
<td>Jane Graupmann</td>
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<td></td>
<td>Executive Director</td>
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<td>International Institute of Minnesota</td>
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<tr>
<td>MN Assoc of Community Health Centers (MNACHC)</td>
<td>Christopher Reif, MD</td>
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<td></td>
<td>Director of Clinical Services</td>
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<td>Community University Health Care Clinic</td>
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<td>University of MN</td>
<td>James Pacala, MD</td>
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<td></td>
<td>Associate Department Head</td>
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<td>University of Minnesota, Family Medicine &amp; Community Health</td>
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<tr>
<td>Mayo School of Health Sciences</td>
<td>Barbara Jordan</td>
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<tr>
<td></td>
<td>Administrator</td>
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<td>Mayo Clinic College of Medicine Office for Diversity</td>
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<td>GME programs not at U or Mayo</td>
<td>Meghan Walsh, MD</td>
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<td></td>
<td>Chief Medical Education Officer</td>
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<td></td>
<td>Associate Medical Director</td>
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<td>Hennepin County Medical Center</td>
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<tr>
<td>PA education program</td>
<td>Donna DeGracia</td>
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<tr>
<td></td>
<td>Curriculum Director/Academic Coordinator</td>
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<tr>
<td>Stakeholder Group</td>
<td>Member</td>
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<tr>
<td></td>
<td>Master of PA Studies Program</td>
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<tr>
<td></td>
<td>St. Catherine University, School of Health</td>
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<tr>
<td>Two IMGs</td>
<td>Tedla Kefene</td>
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<tr>
<td></td>
<td>International Medical Graduate</td>
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<tr>
<td></td>
<td>Nadia Rini</td>
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<td>International Medical Graduate</td>
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In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,\(^1\) and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is the Next Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

Self-regulation is a fundamental professional responsibility, and the system for educating physicians answers to the public for the graduates it produces.\(^2\) As the accreditor for graduate medical education (GME), the ACGME serves this public trust by setting and enforcing standards that govern the specialty education of the next generation of physicians. In this article, we discuss the NAS, including elements and attributes of interest to stakeholders (program directors, leaders of sponsoring institutions, ACGME's partner organizations, residents, and the public). The ACGME's public stakeholders have heightened expectations of physicians. No longer accepting them as independent actors, they expect physicians to function as leaders and participants in team-oriented care. Patients, payers, and the public demand information-technology literacy, sensitivity to cost-effectiveness, the ability to involve patients in their own care, and the use of health information technology to improve care for individuals and populations; they also expect that GME will help to develop practitioners who possess these skills along with the requisite clinical and professional attributes.\(^3-7\)

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education\(^8\) and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Performance on certifying examinations has improved, residents are prepared to deal with the dramatically increasing volume and complexity of information in their specialty, and graduates and academic institutions have contributed to clinical advances and innovation that the public enjoys today.\(^9,10\) In addition, the role of the program director has been established as an educational career path, and the formal teaching and assessment of residents and fellows have improved substantially.

Yet success has come at a cost. Program requirements have become prescriptive, and opportunities for innovation have progressively disappeared. As administrative burdens have grown, program directors have been forced to manage programs rather than mentor residents, with a recent study reporting administrative tasks related to compliance as a factor in burnout among directors of anesthesiology programs.\(^11\) Finally, educational standards often lag behind delivery-system changes. The introduction of innovation through accreditation is limited and is often viewed as an unfunded mandate.
The Next Accreditation System

In July 2013, the NAS will be implemented by 7 of the 26 ACGME-accredited core specialties (emergency medicine, internal medicine, neurologic surgery, orthopedic surgery, pediatrics, diagnostic radiology, and urology). In the remaining specialties and the transitional year (a year of preparatory education for specialties such as ophthalmology and radiology that accept residents at the second postgraduate year), the NAS will be implemented in July 2014. Educational milestones (developmentally based, specialty-specific achievements that residents are expected to demonstrate at established intervals as they progress through training) have been completed or nearly completed for the seven specialties in the first phase of implementation. The residency review committees in these specialties will be in an excellent position to begin to collect milestone data during the 2012–2013 academic year to create a baseline data set for the NAS.

The NAS moves the ACGME from an episodic “biopsy” model (in which compliance is assessed every 4 to 5 years for most programs) to annual data collection. Each review committee will perform an annual evaluation of trends in key performance measurements and will extend the period between scheduled accreditation visits to 10 years. In addition to the milestones, other data elements for annual surveillance include the ACGME resident and faculty surveys and operative and case-log data. The NAS will eliminate the program information form, which is currently prepared before a site visit to describe compliance with the requirements. Programs will conduct a self-study before the 10-year site visit, similar to what is done by other educational accreditors. It is envisioned that these self-studies will go beyond a static description of a program by offering opportunities for meaningful discussion of what is important to stakeholders and showcasing of achievements in key program elements and learning outcomes.

Ongoing data collection and trend analysis will base accreditation in part on the educational outcomes of programs while enhancing ongoing oversight to ensure that programs meet standards for high-quality education and a safe and effective learning environment. Programs that demonstrate high-quality outcomes will be freed to innovate by relaxing detailed process standards that specify elements of residents’ formal learning experiences (e.g., hours of lectures and bedside teaching), leaving them free to innovate in these areas while continuing to offer guidance to new programs and those that do not achieve good educational outcomes.

The Educational Milestones

A key element of the NAS is the measurement and reporting of outcomes through the educational milestones, which is a natural progression of the work on the six competencies. Starting more than 10 years ago, the ACGME, in concert with the American Board of Medical Specialties (ABMS), established the conceptual framework and language of the six domains of clinical competency and introduced them into the profession’s lexicon, mirroring the move toward outcomes and learner-centered approaches in other domains of education.12

In each specialty, the milestones result from a close collaboration among the ABMS certifying boards, the review committees, medical-specialty organizations, program-director associations, and residents. The earliest efforts involved internal medicine, pediatrics, and surgery,13-15 and by late 2011, milestones were being developed in all specialties. The aim is to create a logical trajectory of professional development in essential elements of competency and meet criteria for effective assessment, including feasibility, demonstration of beneficial effect on learning, and acceptability in the community.16

Programs in the NAS will submit composite milestone data on their residents every 6 months, synchronized with residents’ semiannual evaluations. Although the internal collection of milestone data may be more comprehensive, the data submitted to the ACGME will consist of 30 to 36 dimensions that represent the consensus of the assessment committee on the educational achievements of residents, informed by evaluations the program has performed. Table 1 shows a sample of generic milestones for professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. The milestones are based on the published literature on these competencies17-22 and were developed by an expert panel with representation from the specialties in the early phase for use in milestone development.

At the completion of training, the final milestones will provide meaningful data on the per-
<table>
<thead>
<tr>
<th>Table 1. Four Selected General Milestones in the Next Accreditation System.*</th>
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<tbody>
<tr>
<td><strong>Milestone</strong></td>
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<tr>
<td>Professionalism</td>
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<td>Interpersonal and communication skills</td>
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<tr>
<td>Practice-based learning and improvement</td>
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<td>Systems-based practice</td>
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* The four listed milestones, which were developed by an ACGME expert panel, reflect the following expected levels of performance: level 1, typical graduating medical student; levels 2 and 3, resident during the program; level 4, graduating resident; and level 5, advanced, specialist resident or practicing physician. NA denotes not applicable, and PICO patient, population, or problem; intervention; comparison (alternative to intervention); and outcome.
formance that graduates must achieve before entering unsupervised practice. This process moves the competencies "out of the realm of the abstract and grounds them in a way that makes them meaningful to both learners and faculty." The final milestones also create the entry point into the maintenance of certification and licensure phase of lifelong learning. The initial milestones for entering residents will add a performance-based vocabulary to conversations with medical schools about graduates' preparedness for supervised practice. Over time, the milestones will reach into undergraduate medical education to follow the adoption of the competencies by many medical schools. This will contribute to a more seamless transition across the medical-education continuum.

Another key element of the NAS is emphasis on the responsibility of the sponsoring institutions for the quality and safety of the environment for learning and patient care, a key dimension of the 2011 common program requirements. This will be accomplished through periodic site visits to assess the learning environment. Institutions will see their results, and the first visit will establish a baseline for self-comparison over time. The process will generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation.

**Benefits and Limitations**

The visits to sponsoring institutions will ensure that residents are exposed to an appropriate learning environment, and the milestones will ensure that they demonstrate readiness for independent practice and possess the attributes that the public deems to be important in physicians. As future competencies emerge, the milestones will enhance the ability of the ACGME to ensure their successful incorporation into the physician's armamentarium. The NAS will enhance education focused on physician competencies that are deemed to be relevant to the health of individuals and populations. Through this, the NAS will benefit employers of new graduates and the public by enhancing the competence of future physicians in areas that are relevant to a well-performing, efficient, and cost-effective health care system and that have been recommended by experts and stakeholder groups.

In the context of our aspirations for the NAS, it is important to note the limits of accreditation. Much has been written about the constrained environment for GME, including threatened reductions in support for physician training and increased productivity pressures on academic institutions and their faculties. The development of the NAS is sensitive to these factors, since they are characteristics of the environment in which GME programs, sponsoring institutions, and the ACGME operate. At the same time, accreditation is not a panacea, and no accreditation model by itself can effectively compensate for the overuse of resources, inefficiencies, and disparities that characterize aspects of the nation's health care system. It would be presumptuous to expect accreditation to effectively resolve these problems. Rather, its roles are to arm the next generation of physicians with knowledge, skills, and attributes that will enhance care in the future and to expand the traditional role of residents in the care of underserved populations to an enhanced understanding of the problem of health disparities and how to eradicate them.

Finally, although accreditation must be sensitive to the burden it creates on programs, institutions, and individuals, it would be dangerous to expect accreditation to reduce its expectations to accommodate the host of other pressures on the system of physician training. Any move to create a reductionist model of accreditation to avoid burdening the system may further erode public support for physician education and public trust in the physicians the system produces. Constrained finances and future threats of reductions make it even more important for accreditation to ensure that learners are not unduly burdened with service obligations that do not meaningfully contribute to their education and that education and patient care proceed in an environment that complies with requirements for duty hours, supervision, and other elements important to the safety of patients and residents. This makes the visits to sponsoring institutions a critical component of the NAS in the untoward event of serious cuts in support for GME.
Key benefits of the NAS include the creation of a national framework for assessment that includes comparison data, reduction in the burden associated with the current process-based accreditation system, the opportunity for residents to learn in innovative programs, and enhanced resident education in quality, patient safety, and the new competencies. Over time, we envision that the NAS will allow the ACGME to create an accreditation system that focuses less on the identification of problems and more on the success of programs and institutions in addressing them.

Although the ACGME has not piloted the NAS in its entirety, pivotal elements of the system have been tested successfully in the Educational Innovation Project in internal medicine and in a multiyear pilot in emergency medicine. Besides testing annual data collection, the Educational Innovation Project provided the ACGME with insight into standards that could be relaxed for high-performing programs (i.e., a 40% reduction in requirements for the internal medicine program, which went into effect in July 2009). Knowledge about acquisition of data elements around the milestones is being gained from the ACGME’s international accreditation effort in Singapore and will benefit the implementation of the NAS. Finally, the learning gained from the first phase of the NAS will benefit the specialties that will implement the NAS in the second phase.

Much work remains to be done. The next step in moving toward the NAS will involve informing the GME community about the NAS, with a particular focus on the milestones. This work will continue in close collaboration with program-director organizations, the ABMS boards, the specialty colleges, and related academic organizations. The ACGME will continue its role in educating program directors, faculty, and others by building on its annual conference, with a focus on faculty development that is sensitive to time and financial constraints for many faculty members.

The NAS will support the education of physicians to provide care for Americans into the middle of the century. This requires an enduring system that takes the best of the current system and enhances it with a more explicit focus on attributes of the learning environment that carry over into a lifetime of practice in a clinical specialty. By encouraging high-performing programs to innovate, the system will open the quality ceiling and produce new learning. Simultaneously, an ongoing process-based approach for programs with less-than-optimal performance will continue to raise the floor for all programs.

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