



State of Minnesota

Medical Practice Act Work Group Report

January 2013

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Thank you

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Executive Summary

The Medical Practice Act work group was created by the 2012 Minnesota Legislature. The group's task was to ensure the Medical Practice Act (the Act) "effectively protects the safety and well-being of the citizens of the state and allows transparency." The 15-member work group represented physicians, academia, health services consumers, medical practice experts and state policy makers.

The work group analyzed an extensive amount of information to build a common understanding and lay the groundwork for recommendation development. Two major factors enhanced the value of the task force's proposals. First, members represented a variety of interests and perspectives, so that recommendations take into account complicated and sometimes conflicting operational, political, legal and other considerations. Second, the recommendations built upon the members' experience and knowledge in the fields of peer review, legislation, medical regulation and consumer interests.

Management Analysis & Development, a division of Minnesota Management & Budget, facilitated work group meetings and report preparation. The Board of Medical Practice (the Board), Minnesota Department of Health (MDH) staff, work group members, and other related parties presented the work group with in-depth information on a variety of pertinent topics. Additionally, MDH maintained online information regarding task force meetings and information at <http://www.health.state.mn.us/topics/medpractice/index.html>.

Summary Findings and Conclusions

In assessing whether the Act sufficiently protects the public's safety and well-being and allows for transparency, the work group compared it to other states' Acts and to the Federation of State Medical Boards' Model Act, identifying a list of issues and concerns about the Act and related processes.

The work group found that there are no meaningful public safety or transparency gaps or issues regarding the Act.

The work group concluded that there may be opportunities to enhance public understanding and confidence in the Act and its processes and procedures through the following:

- 1) Identifying and collecting aggregate data that informs interested parties about medical professionals and other related topics;
- 2) Providing analyses of identified data in a way that is meaningful and understandable for a broad audience;
- 3) Disseminating information about the Act and related processes for public consumption; and
- 4) Enhancing communication, particularly in creating partnerships among entities that can help coordinate activities to proactively identify and address emerging needs.

In addition, the work group identified a number of areas where housekeeping legislation could aid the general public with navigating the Act and specific health-related laws. Recommended language that was developed with the assistance of the Office of the Revisor of Statutes could be taken up by the Board with the Revisor and/or through housekeeping legislation.

Finally, the work group identified three additional items they thought were significant, though beyond the scope of its charge. They were: 1) the evolution of Telehealth and its impact in the delivery of care; 2) opportunities for coordinated activities with the nursing and pharmacy boards in anticipation of team-based care models; and 3) concerns regarding the rise in opioid abuse and addiction and how this impacts the prescribing of such drugs.

The work group concluded that, although work needs to be done with respect to transparency, the Act and the Board protect the well-being and safety of the public.

Recommendations

In fulfilling its charge, the work group developed 12 recommendations to ensure the Act effectively protects the safety and well-being of the citizens of the state and allows for transparency. Additional rationale for each recommendation may be found in the body of the report. The recommendations included:

Recommendation 1.1: The Board and MDH should encourage greater participation in the MDH physician workforce survey.

Recommendation 1.2: The Board should disseminate aggregate data in a manner that is readily accessible and understood by the general public and other interested parties.

Recommendation 1.3: The Board should regularly provide and disseminate trend analyses on aggregate data.

Recommendation 1.4: The Board and MDH should coordinate efforts to identify data needs and emerging workforce trends and promote better communication with the public of the processes in place in accordance with the Act.

Recommendation 1.5: The Act sufficiently addresses questions raised about delegation for licensed individuals and there is no need to modify the Act.

Recommendation 2.1: The work group recommends amending section 147.001 of the *Minnesota Statutes*, per the following underlined language, to read:

147.001 SCOPE AND PURPOSE.

Subdivision 1. Scope. Sections 147.01 to 147.37 may be cited as the Minnesota Medical Practice Act.

Subdivision 2. Purpose. The primary responsibility and obligation of the Board of Medical Practice is to protect the public.

In the interest of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the license to practice medicine.

Recommendation 2.2: The work group recommends amending chapter 147 of the Act with a new section to read:

[147.61] OVERSIGHT OF ALLIED HEALTH PROFESSIONS. The board has responsibility for the oversight of the following allied health professions: physician assistants under chapter 147A; acupuncture practitioners under chapter 147B; respiratory care practitioners under chapter 147C; traditional midwives under chapter 147D; registered naturopathic doctors under chapter 147E; and athletic trainers under chapter 148.7801-148.7815.

Recommendation 2.3: The work group recommends adding the following statutory language to chapter 147 to clarify the purpose of the HPSP program as well as who may participate in it to read:

[147.0911] DIVERSIONARY PROGRAM.

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

Recommendation 2.4: The Board should meet with the Revisor prior to the codification and printing of Minnesota Statutes 2014 and review whether and how to improve the citations within the Act that group licensing and disciplinary actions separately. The work group acknowledges that this could run the risk of creating other unintended consequences and recognizes that this effort would require the expertise of the Office of the Revisor of Statutes.

Recommendation 2.5: The work group recommends that the relevant language in section 147.01, subdivision 1 be changed from “one member shall” to “not less than one member shall” be a doctor of osteopathy.

Recommendation 2.6: The work group recommends that relevant language be changed in section 147.02 sub.(e) from “shall” to “may”.

Recommendation 2.7: The work group recommends that “National Board of Osteopathic Examiners (NBOME)” be added to the list of comprehensive examination options in Minnesota Statute 2012, 147.02, subdivision 1.

Recommendation 2.8: The work group recommends that "Osteopathic candidates who are taking the College of Osteopathic Medical Licensure Examination (COMLEX), must pass all three steps within 6 attempts." be added to the list of comprehensive examination options in Minnesota Statute 2012, 147.02, subdivision 1.

Recommendation 2.9: Based on their review and ensuing discussions, the work group did not find any meaningful gaps or issues that warranted revisions to the Minnesota Medical Practice Act.

Introduction

The purpose of the report is to assess whether Minnesota's Medical Practice Act effectively protects the safety and well-being of Minnesota citizens and allows for transparency.

During the 2012 legislative session, the Board of Medical Practice (the Board) was one of many organizations under review by the Minnesota Legislature's Sunset Advisory Commission. In addition to conducting a sunset review, this commission also held hearings in response to a Star Tribune newspaper article about the Board.¹ The article raised concerns about Minnesota's medical practice law, the availability of data about medical practitioner enforcement actions, and how complaints against licensed practitioners are addressed by the Board. A result of these hearings was legislation establishing a work group to be convened by the Minnesota Department of Health (MDH) to evaluate the state's Medical Practice Act found under *Minnesota Statutes* chapter 147 (the Act or Chapter 147). The work group was specifically charged with ensuring the Act "effectively protects the safety and well-being of the citizens of the state and allows transparency."² Within this charge, the work group was required to compare the Minnesota Act with the Federation of State Medical Boards' Model Act (the Model Act)³ and related acts in other states.

The Minnesota Department of Health submitted the report to the 2013 Minnesota Legislature. The work group's legislative authority expires the day following submission of the report.

In conducting its assessment and developing its recommendations, the work group reviewed:

- Medical practice acts of other selected states;
- Conduct resulting in disciplinary action;
- The impact of data privacy legislation on the Board's disciplinary process;
- Reporting requirements; and
- The availability and transparency of data relating to the Board's responsibilities and reporting processes.

¹ Glenn Howatt and Richard Meryhew, "Doctors who err escape penalties." *StarTribune*, February 5, 2012.

² *Laws of Minnesota* 2012, Regular Session, chapter 278, art. 2, sec. 33.

³ See website at <http://www.health.state.mn.us/topics/medpractice/index.html> for a list of these materials

The work group represented a wide range of expertise, experience and perspectives. Per statute, members included:

- **Board of Medical Practice designees:** Jon V. Thomas, M.D., and Joseph R. Willett, D.O.
- **Minnesota Medical Association appointments:** Terence Cahill, M.D. and Linda Van Etta, M.D.
- **Academic appointments:** Barbara Gold, M.D., University of Minnesota; Darrell Pardi, M.D., Mayo Clinic
- **Majority Leader of the Senate’s appointment,** Senator David Hann, District 42
- **Minority Leader of the Senate’s appointment,** Senator Kathy Sheran, District 23
- **Speaker of the House of Representative’s appointment,** Representative Bob Barrett, District 17B
- **Minority Leader of the House of Representative’s appointment,** Representative Carolyn Laine, District 50A
- **Commissioner of Health,** Edward Ehlinger, M.D.
- **Commissioner of Health’s consumer appointments:** Malcolm Mitchell, work group Chair, and Thomas Webber
- **Commissioner of Health’s medical practice appointments:** Kathleen Brooks, M.D. and Jack Davis

Methodology

The Medical Practice Act work group met six times between August and December 2012. During this period, the work group undertook the following activities to develop information and gather needed perspectives and insights to develop its recommendations:

- **Use of a neutral facilitator and online support** – The work group engaged Management Analysis & Development, a division of Minnesota Management & Budget to facilitate its deliberations and organize its final report. The Minnesota Department of Health maintained work group information at <http://www.health.state.mn.us/topics/medpractice/index.html>.
- **Selection of work group chair and development of purpose and scope** – Work group members selected a consumer member as chair at their first meeting and agreed upon a common purpose and scope to carry out the legislative directive (see Appendix A).
- **Identification and prioritization of key issues for consideration** – The work group identified and prioritized key issues to review and evaluate. This assisted in focusing research, meeting agendas and discussion, and provided the basis for the development of effective and practical recommendations (see Appendix B).

- **Review and analysis of information provided by Board, MDH staff and member presentations** – Board, MDH staff, and work group members presented the work group with in-depth information on topics ranging from an overview of the state’s data privacy laws to data collected by MDH’s Health Care Workforce Analysis program. Additional presentations included an overview of the state’s Health Professionals Service program (HPSP); the work being done in anticipation of possible implementation of a Maintenance of Licensure process in Minnesota over the next decade; and a briefing by the Legislative Auditor on his October 23, 2012 *Board of Medical Practice: Complaint Resolution Process* report to the Legislature (see Appendix D).
- **Examination of national data and best practices** – Most notably, the group compared Minnesota’s Act to the Federation of State Medical Boards’ Model Act (the Model Act)⁴ and related acts in Wisconsin, Washington and Massachusetts. A high-level chart summarizing the comparison of these acts can be found at the website <http://www.health.state.mn.us/topics/medpractice/index.html>.
- **Analysis and discussion at work group meetings of the most significant issues** – This included opportunities for work group members to ask follow-up questions and receive additional information and analysis from MDH and Board staff.
- **Development of final recommendations** – The work group refined draft recommendations based upon member feedback, further analysis and discussion, and iterative reviews of the draft report and selected a series of recommendations to address the issues raised.
- **Opportunity for public comment** – The work group meetings were open to the public and at the conclusion of each of its six meetings, members of the public were given the opportunity to provide comments and input on the work group’s charge.

⁴ See website at <http://www.health.state.mn.us/topics/medpractice/index.html> for a list of these materials

Medical Practice Act Work Group Purpose and Scope

Purpose

The 2012 Minnesota Legislature established a work group, convened by the Minnesota Department of Health, to evaluate the Medical Practice Act and suggest legislation to modify.

Scope

The work group must ensure that the Act effectively protects the safety and well-being of the citizens of the state and allows for transparency.

The work group will consider practice acts in other states and the model practice acts, and consider conduct that may result in disciplinary action.

Approach

The Minnesota Department of Health will provide legal and technical assistance to the work group. Minnesota Management and Budget, Management Analysis and Development (MAD) will facilitate the work group. At its first meeting, a preliminary work plan will be reviewed and approved, with modifications as necessary. The final work plan will identify plans to:

- Build common knowledge of model practice acts and what other states have adopted;
- Review appropriate practice act language for Minnesota; and
- Submit a report to the legislature of the group's results and, if needed, develop legislation to modify the practice act for consideration by the 2013 legislature.

Final Report

A final report will be submitted to the 2013 Legislature.

Minnesota Medical Practices Act

The authority and responsibility of the Board of Medical Practice to license and regulate Minnesota’s physicians is codified in *Minnesota Statutes* chapter 147 (chapter 147), which is often referred to as Minnesota’s “Medical Practice Act.”⁵

According to chapter 147, the “primary responsibility and obligation of the Board of Medical Practice (Board) is to protect the public...from the unprofessional, improper, incompetent, and unlawful practice of medicine...”⁶ The Act achieves this in a variety of ways, including granting the Board authority to license individuals who are qualified to practice medicine as well as take disciplinary action against a professional under its jurisdiction.⁷ The Act defines 27 different grounds under which the Board may take disciplinary action, including:

- Inability to practice medicine with reasonable skill and safety to patients.
- Unethical or unprofessional conduct.
- Improper management of medical records.
- Unlawfully revealing privileged communications from or about a patient.
- Aiding in a suicide or attempted suicide.
- Sexual conduct or seductive communications with a patient.

In carrying out its licensing responsibility in protecting the public, chapter 147 mandates that the Board has 16 members: 10 must hold a doctor of medicine degree and must be licensed to practice in Minnesota, 1 must hold a doctor of osteopathy degree, and 5 must be “public members.” All Board members are appointed by the Governor to four-year terms and no member may serve longer than eight consecutive years. Physician members must come from each of Minnesota’s eight congressional districts and must, as a whole, reflect the broad mix of expertise of physicians practicing in Minnesota.⁸

As the Board responds to complaints, the Act provides the Board with seven forms of disciplinary actions it may take.⁹ The Board has the ability to choose one or more of the following:

- Revoking a license;
- Suspending a license;
- Revoking or suspending registration to perform interstate telemedicine;
- Imposing limitations or conditions on the physician’s practice of medicine, including limiting the scope of practice to designated field specialties;

⁵ The descriptor “Medical Practices Act” while commonly used to describe *Minnesota Statutes* chapter 147, is not found in Minnesota session laws or statute. One recommendation of this report is to clearly define *Minnesota Statutes* sections 147.01 through 147.37 as the “Medical Practices Act” to distinguish it from other forms of health care regulation.

⁶ *Minnesota Statutes* 2011, section 147.001.

⁷ *Minnesota Statutes* 2011, section 147.091.

⁸ *Minnesota Statutes* 2011, section 147.01, subd. 1.

⁹ *Minnesota Statutes* 2011, section 147.141.

- Imposing civil penalties;
- Ordering the physician to provide unremunerated professional service; and
- Censuring or reprimanding the licensed physician.

State law also provides, that, as an alternative to disciplinary action, the Board “may attempt to correct improper activities and redress grievances through education, conferences, conciliation and persuasion...”¹⁰ Consistent with this provision, the Board of Medical Practice has communicated its approach to discipline as follows:

While the Medical [Practice] Board has the authority to suspend or revoke licenses, it is believed that requiring education and putting restrictions on a physician’s license can solve many problems so the public is protected while maintaining valuable community resources.

Over the past ten years, the Board of Medical Practice has received an average of 840 complaints against individual physicians each year (ranging from a low of 770 in 2008 and a high of 941 in 2004). Most complaints come from patients and patients’ family members. State law obligates medical institutions, medical societies, licensed professionals, insurers, and others to report information to the board that might indicate a basis for disciplinary action against a licensed physician, and it obligates physicians to “self-report” information about events that they were involved in that could lead to disciplinary action.¹¹

In the early 1990s, the Board restructured its approach to processing complaints to accommodate an increase in complaints and a growing backlog of unresolved cases. The Board’s goal was to establish a “triage system” that would allow the Board to assess and sort complaints as to their severity and urgency. It is essentially the same system the Board currently uses, and it is the one the work group examined.

The Board’s complaint resolution process includes the following steps:

- Information is received by Board staff from mandated reporters, patients, family of patients, etc., which results in a complaint being logged into the Board’s complaint file management system. The system checks for other complaints against the same physician and adds them to the complaint file.
- Complaint is reviewed by Board’s Complaint Review Unit supervisor and assigned to a medical regulations analyst, who contacts individuals (including the physician(s) named in the complaint), institutions, and others for additional information and documentation.
- Complaint file is reviewed by a medical coordinator (a physician working on contract for the Board) who summarizes the medical aspects of a case and makes recommendations or requests additional information. Medical coordinators may also request the Board contract with a medical specialist to review the case. They may also recommend a physician named in a complaint be brought in for what is referred to as a “medical

¹⁰*Minnesota Statutes* 2011, section 214.10, subd. 2.

¹¹*Minnesota Statutes* 2011, section 147.111.

coordinator conference,” which can be a combination of education for the physician on an issue and evaluation of the physician’s state of mind or acceptance of the complaint and need for corrective action. Medical coordinators may also request an investigation or legal counsel from an attorney at the Minnesota Office of the Attorney General.

- Complaint file is assigned for review and action to one of the Board’s two complaint review committees (composed of two Board members who are physicians and one public member). Each review committee meets once a month for most of the day. The committees may dismiss a complaint and close the case, request more information, and/or require a physician named in a complaint to meet with the committee at a future date. The committee may also propose a “corrective action agreement” with a physician or recommend disciplinary action against a physician. If a physician agrees to a proposed corrective action agreement, it does not go to the full board for ratification; however, proposed disciplinary actions do require ratification by the Board.
- In addition to taking action on proposed disciplinary actions, the full Board hears oral arguments after an administrative hearing when a physician does not accept a complaint review committee’s proposed corrective action agreement or disciplinary action. If the Board and physician cannot agree on a resolution, either the Board or the physician may request a “contested case” hearing under the state’s Administrative Procedures Act. Contested case hearings are conducted by an administrative law judge from the Office of Administrative Hearings. The position of the complaint review committee is presented by an attorney from the Office of the Attorney General. The physician’s position may be presented either by the physician or the physician’s legal counsel. The Board receives a report and recommendation(s) from the presiding administrative law judge, but the final decision on how to resolve a complaint remains with the Board.

Additional details about the complaint review process can be found on the Board’s website at: <http://mn.gov/health-licensing-boards/medical-practice/public/complaints/complaint-review.jsp>.

An important option the Board may employ to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine is a diversion program known as the Health Professionals Services Program (HPSP) which is also available to other health care professionals under *Minnesota Statutes*, chapter 214. The HPSP was created in 1994 as an alternative to Board discipline, offering a proactive way to fulfill reporting requirements and get confidential help for illnesses, including chemical dependence, physical problems or mental health issues.¹²

By law, health practitioners and employers can report a potential impairment to a licensing Board or to HPSP. If individuals choose to enter HPSP, HPSP will monitor treatment progress, work quality, and medications, along with attendance at support groups and random urine screens, if alcohol or drug use is part of the illness. HPSP might also require counseling, work limitations or other individualized conditions that address a person’s needs and public safety. Typically, HPSP agreements are for thirty-six months. When participants comply with program expectations and successfully meet the conditions of their monitoring plans, they shall be

¹²HPSP website – www.hpssp.state.mn.us

discharged from HPSP. However, if participants do not comply with their monitoring plan, or if they choose to discontinue monitoring, a report shall be filed with their licensing Board.

Together, the disciplinary licensing sanctions of *Minnesota Statutes*, chapter 147 and the referral of impaired physicians to the HPSP program under *Minnesota Statutes*, chapter 214 provide the Board with important ‘stick and carrot’ tools to mitigate the health risk that individual physicians may cause Minnesotans. However, because both of these regulatory tools involve contested case resolution of licensing authority, and/or private data on individuals and their chemical abuse, each is subject to the data protection requirements of the Minnesota Data Practices Act which regulates governmental data for all Minnesota governmental entities.

Specifically, the Minnesota Government Data Practices Act of *Minnesota Statutes*, chapter 13 (The Data Practices Act) classifies data as private, confidential or public. Data under the “private” classification would include data submitted by an applicant as well as inactive investigative hearings and applications or complaints that are withdrawn, denied or administratively closed. Unless the applicant has signed a release, only the applicant or subject of the complaint and the Board may have access to private data.

Data under the “confidential” classification includes data submitted by anyone other than the applicant, including active investigative hearings. Confidential information is accessible only to the Board and may not be disclosed to the public without authorization from the entity that provided the data. Public data is all data that is not made private or confidential by law, such as disciplinary orders and corrective actions taken by the Board. Public data includes applicant’s name and address and application data submitted by individuals who are subsequently licensed.

In reviewing the question of whether the Medical Practices Act “allows transparency”, the work group understood and interpreted the legislative directive to mean that it should review the Act consistent with the general data privacy requirements of the Data Practices Act. To do otherwise would require either significant changes to the Data Practices Act or replacing license-specific contested case regulation of physicians with some other form of regulation. The work group recommends that a committee comprised of a cross-section of all licensed professionals – not only physicians – be convened if it is the legislature’s intent to consider modifications to the Data Practices Act.

Office of the Legislative Auditor's Report

Coincident with the creation of the work group to review the Medical Practices Act to determine whether it could be improved, the Legislature also charged the Office of the Legislative Auditor (OLA) with conducting an investigation of the Minnesota Board of Medical Practice and its implementation of the Act.¹³

In doing so, the OLA investigated the Board's complaint resolution process, with the primary objective of determining if there were indicators that the Board's complaint resolution process has significant deficiencies that need to be examined and disclosed through an OLA investigation. The OLA's secondary objective was to determine what other actions might help resolve concerns about the Board's complaint review process if they determined an immediate investigation by OLA was not going to occur.

At the conclusion of its investigation, the OLA issued a report on October 23, 2012 summarizing the results of its investigation, *Board of Medical Practice: Complaint Resolution Process*. The Legislative Auditor appeared before the working group in November, 2012 and presented his findings, concluding that the Board's complaint resolution process contained the elements of "due diligence needed to achieve factually-supported and legally-grounded regulatory decision making" and there is not a need at this time for an OLA investigation of the Board's complaint resolution process.

Is the Act Effective?

In carrying out its charge of assessing whether the Act sufficiently protects the public's safety and well-being and allows for transparency, the work group adopted an approach that consisted of: 1) comparing the Act to other states' Acts and to the Model Act; and 2) identifying a list of issues and concerns about the Act and related processes. In comparing the Act to the Model Act and other states' Acts, the Acts of the states of Washington, Wisconsin and Massachusetts were reviewed because of their, respectively, demographic, geographic and regulatory format similarity to Minnesota. This discussion and related recommendation are contained in Section C.

In identifying a list of issues and concerns about the Act and related processes, the work group divided the topics into the following categories:

- Highest priority items the work group felt they could address within the project's scope and timeframe;
- Housekeeping items composed of issues ranging from statutory references to minor statutory language changes that members felt could readily be resolved outside work group meetings and brought to the full work group for review and approval; and
- Items that were considered out of scope.

¹³*Laws of Minnesota* 2012, Regular Session, chapter 278, art. 2, sec. 34.

The work group labeled the following three topics as “high priorities” and are discussed in detail in Section A:

- 1) What information about medical professionals should be made available to the public?
- 2) How does the public learn about physician or industry concerns and issues that may impact its safety and well-being and may need to be addressed in statute or the implementation process?
- 3) Should there be a limit on a physician’s delegating authority to and/or an expectation of on-site supervision of individuals that are separately licensed by the State?

The following items were grouped into the Housekeeping category and are discussed in detail in Section B:

- 1) Consider reordering the licensing and disciplinary sections of chapter 147 to a more logical and consistent structure;
- 2) Consider further developing the definition section;
- 3) Place all historical references in chapter 147 into an appendix as footnotes;
- 4) Clarify Board membership to lessen difficulties in filling Board vacancies; and
- 5) Clarify the circumstances under which face-to-face meetings may occur.

Out of scope items are discussed in Section C. A full list of all issues identified for consideration by the work group can be found in Appendix B.

A. Public Safety, Well-Being, and Transparency Discussion and Recommendations

- 1. What information about medical professionals should be made available to the public?**
- 2. How does the public learn about physician or industry concerns and issues that may impact its safety and well-being and may need to be addressed either in statute or the implementation process?**

Discussion

In comparing the Act to the Model Act and other states’ Acts, the work group recognized that, while the focus of the Act is on licensure, there may be opportunities to further enhance the public’s safety and well-being as well as opportunity for greater transparency, thereby enhancing public understanding and confidence in the Act and related processes and procedures.

Under its transparency charge, members developed an understanding of what information is currently available to the public. Following presentations on data privacy by the Board, the Program Manager of the Health Professionals Services Program (HPSP), and Dr. Jon Thomas on

the possible future implementation of a Maintenance of Licensure process in Minnesota for physicians and the MDH's annual physician survey, the group focused specifically on what information currently exists that is provided to the public, what information is legally allowed to be made public and what information does the public need versus what it wants.

The work group acknowledged that the Act is largely silent on transparency and does not directly address this concept. Further, the group agreed the following elements were important in ensuring the Act allows for transparency:

- 1) Identifying and collecting aggregate data that informs interested parties about medical professionals and other related topics;
- 2) Providing analyses of identified data in a way that is meaningful and understandable for a broad audience;
- 3) Disseminating information about the Act and related processes for public consumption; and
- 4) Enhancing communication, particularly in creating partnerships among entities that can help coordinate activities to proactively identify and address emerging trends.

Several pieces of information about medical professionals are currently available to the public. This includes the Minnesota Department of Health's annual physician survey, information on the Board's complaint resolution process, various reports published by the HPSP on illnesses monitored and participation by medical area (e.g. nurses, physicians), and information gathered about potential implementation of a Maintenance of Licensure (MOL) process for physicians in Minnesota. In addition, each licensee's demographic information, including address, phone number, training, board certification status and any history of disciplinary action taken by the Board, is available on the Board's website.

Discussion centered on the concern that, while this information exists, it is not readily available to the general public, nor is there a system to comprehensively collect information regarding issues, difficulties or concerns about the design and implementation of the Act and the Board. Further, where information is gathered, little analysis is provided that might lead to clarity of understanding of the information. It was noted, that, while the Board's biennial report includes information on the number of complaints received, there is no analysis that would help the public readily discern how any of the complaints were ultimately handled. In addition, some members voiced concern that the public is not aware of or does not fully appreciate what the Board does to protect the public and provide a pathway to encourage reporting and self-correction, thereby increasing the need for public education and transparency about how the Act protects the public safety.

Given the conversation and the impetus for the work group's creation, it was agreed that the underlying concern with transparency was the need to build public trust in the design and implementation of the Act, the Board and related reporting practices. Members agreed with the Legislative Auditor that the Board's complaint resolution process provides the elements of due diligence needed to achieve factually supported and legally grounded regulatory decision making. However, they concluded that in today's environment of greater consumer awareness and demand for transparency, it is important that the Medical Board, in its licensure and

complaint resolution process, identify aggregate information to the public in a meaningful and readily accessible manner. The work group agreed that additional actions could be taken to increase transparency about Board and other processes, and build trust with the public that their safety and well-being are being sufficiently protected by the processes and mechanisms currently in place.

The work group developed the following recommendations to address this issue:

Recommendation 1.1: Encourage greater participation in the MDH physician workforce survey.

Participation in the physician workforce survey is an MDH required component of licensure renewal. However, the MDH statute does not provide a penalty for non-compliance, so MDH relies on voluntary participation. The Board and MDH are collaborating to raise the participation rate by moving the MDH survey to an earlier step of the Board's online renewal process, through which each licensee will be required to participate in the MDH survey in order to complete licensing or relicensing. The Board and MDH anticipate this will raise the participation rate. The work group recommends the Board and Commissioner of Health should consider additional action if this effort does not lead to improvement from the current 55 percent response rate. Such improvement would provide valuable information on who is practicing medicine in Minnesota and the extent of coverage in specialty and primary care areas throughout the state. In addition, data from the survey will help inform resource investment decisions for schools of medicine and other stakeholders and will advance transparency concerns regarding the Act.

Outcomes expected with the implementation of this recommendation include:

- Transparency
- Inform resource investment decisions for schools of medicine and other stakeholders

Recommendation 1.2: Disseminate aggregate data in a manner that is readily accessible and understood by the general public and other interested parties.

The Board is a regulatory organization which requires that it be a forward-thinking organization. It currently collects and publishes aggregate information on its work and processes in several publications, including its biennial report. However, the work group concluded that the information is not easily accessible to the public. The work group recommends that the Board consider ways to provide this information to the public in a manner that is more consumer-friendly. Examples include enhancing its website so it includes information on its front page such as a FAQ icon, information outlining its licensure and complaint review processes and/or a direct link to its reports and other related organizations or programs (e.g. HPSP).

Outcomes expected with the implementation of this recommendation include:

- Transparency
- Public safety
- Dissemination of information to the public in a consumer-friendly manner

Recommendation 1.3: Regularly provide and disseminate trend analyses on aggregate data.

One of the key discussion points concerning the availability of data focused on the need to have analyses conducted on existing aggregate data. The work group noted that this information is vital in protecting public safety and well-being in that it provides meaning and context to the information and helps build the public's trust that its safety and well-being is protected by the mechanisms currently in place.

The work group recommends that, where it exists, aggregate data should include analyses that identifies trends over time and highlights what the Board is doing to help protect the public's safety.

Outcomes expected with the implementation of this recommendation include:

- Transparency
- Public safety
- Dissemination of information to the public in a consumer-friendly manner

Recommendation 1.4: The Board and MDH should coordinate efforts to identify data needs and emerging workforce trends and promote better communication with the public of the processes in place in accordance with the Act.

An essential component of transparency involves communication, particularly educating the public about the work being done to protect the public safety. The work group recognizes that the Board's work focuses on licensure and complaint review processes and analyzing that information to improve the licensing and disciplinary review process to recommend policy and procedure changes. MDH's work focuses on analyzing larger workforce trends. To help facilitate this, MDH utilizes data collected by the Board. The Board and MDH have begun to collaborate more closely on identifying and collecting data elements of most interest to policy makers and the public. For example, the Board and MDH are working together to adopt a new national minimum data set for state medical boards so that it meets both agencies' needs and meshes with historic and ongoing data collection. The work group encourages the Board and MDH to continue and strengthen this type of coordination to reduce any gaps in Board or MDH data needed to analyze the physician workforce within a larger workforce framework. This will make it easier to proactively identify and address emerging trends and disseminate related information for public consumption.

Outcomes expected with the implementation of this recommendation include:

- Transparency
- Public safety
- Greater public understanding of process and data
- Enhanced coordination of activities and ability to identify and address emerging trends

In closing, the work group concludes that, although work needs to be done in the areas of communication, data identification, gathering and analysis, disseminating information, and coordinating activities to proactively identify and address emerging trends, the Act and Board protect the well-being and safety of the public by:

1. Board representation in national organizations that allows it to stay abreast of emerging issues;
2. Implementation of the HPSP as a successful process for impaired physicians so they can get the help and oversight they need in a timely manner; and
3. Conclusion by the Legislative Auditor that the Board's complaint resolution process contains the elements of due diligence needed to achieve factually supported and legally grounded regulatory decision making.

3. Should there be a limit on a physician's delegating authority to and/or an expectation of on-site supervision of individuals that are separately licensed by the State?

Discussion

One concern the work group raised was the perception that treatment of different conditions may be delegated to people in a physician's office without any requirement for direct supervision or verification of appropriate training. Certain treatments, including invasive procedures (e.g. injections or liposuction), may be delegated to individuals at the discretion of the license holder who then falls under the jurisdiction of the applicable medical Board. Until problems or issues occur, there is no way to track either the frequency or type of these occurrences.

Section 147A.09 of the Act addresses the scope practice and delegation for physician assistants. In addition, section 147.091 gives the Board discretion to address disciplinary situations on a case-by-case basis.

Recommendation 1.5: After a review of these sections, a comparison to related sections in the Model Act, and member discussion, the work group concluded the Act sufficiently addresses delegation for licensed individuals and there is no need to modify the Act.

B. Housekeeping Discussion and Recommendations

Some of the original statutes of the Medical Practices Act were passed in 1905. Since that time, this body of law has undergone numerous edits, revisions and deletions as the practice of medicine has changed and citizen safety and well-being has been redefined.

The work group identified a number of areas where further clarification would aid the general public in navigating the Act¹⁴. After receiving input from staff of the Office of the Revisor of Statutes (the Revisor), the work group makes the following recommendations that could be taken up by the Board with the Revisor and/or through simple legislation.

1. The Medical Practices Act should be defined in statute.

Although *Minnesota Statutes*, chapter 147 is commonly referred to as the Medical Practices Act, this convention is not codified in Minnesota Laws. To increase awareness of what is – and is not – a part of the Medical Practices Act, language should be amended to include new language.

Recommendation 2.1: The work group recommends amending section 147.001 of the *Minnesota Statutes*, per the following underlined language, to read:

147.001 SCOPE AND PURPOSE.

Subdivision 1. Scope. Sections 147.01 to 147.37 may be cited as the Minnesota Medical Practice Act.

Subdivision 2. Purpose. The primary responsibility and obligation of the Board of Medical Practice is to protect the public.

In the interest of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the license to practice medicine.

2. Clarify that the Board has responsibilities beyond the Medical Practices Act and that they are found in other chapters of *Minnesota Statutes*.

In addition to chapter 147, the Board has responsibility for many other health care related matters. To clarify and provide awareness of this legislative delegation, it is recommended that *Minnesota Statutes*, chapter 147 be amended with a new section.

¹⁴ There were additional items on the list that received fewer votes and were not discussed. A complete list of all items generated can be found in Appendix B.

In addition, there was confusion among members of the public about the relationship between the HPSP program and the Board's license enforcement and disciplinary authority and role. The Revisor recommended language, which the work group endorsed, that would clarify this relationship.

Recommendation 2.2: The work group recommends amending chapter 147 of the Act with a new section to read:

[147.61] OVERSIGHT OF ALLIED HEALTH PROFESSIONS. The board has responsibility for the oversight of the following allied health professions: physician assistants under chapter 147A; acupuncture practitioners under chapter 147B; respiratory care practitioners under chapter 147C; traditional midwives under chapter 147D; registered naturopathic doctors under chapter 147E; and athletic trainers under chapter 148.7801-148.7815.

Recommendation 2.3: The work group recommends adding the following statutory language to chapter 147 to clarify the purpose of the HPSP program as well as who may participate in it to read:

[147.0911] DIVERSIONARY PROGRAM.

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

3. Consider reordering the licensing and disciplinary sections of chapter 147.

The work group considered three housekeeping items that impact the readability and flow of chapter 147. First, chapter 147 contains interspersed references to license requirements and disciplinary options. For instance, sections 147.02 through 147.09 deal primarily with licensing. Then sections 147.091 through 147.51 deal primarily with discipline, and the chapter then returns to licensing fees for osteopaths.

Second, definitions used throughout the Act are not contained in the definition section 147.011. Presumably, this occurred over time as new sections were added to chapter 147 and within each section, new definitions were created as needed.

Third, there are numerous historical references throughout the Act. These references help the reader navigate to the original statute and understand the intent of the enacting legislation. The work group considered moving the references to the end of the Act as footnotes to help make the Act as accessible and understandable as possible for the general public.

Following the Revisor's advice, the work group agreed to recommend that the Board should work with the Revisor to consider how the order of the Act can be structured in a more logical and consistent manner. The work group also agreed that, due to the complexity involved with

creating a separate and distinct definition section within the Act, it would not recommend further developing or amending the Act's definition section. Finally, the work group agreed with the Revisor's recommendation to maintain the references as they currently exist and not move them to the end of the Act as footnotes.

Recommendation 2.4: The Board should meet with the Revisor prior to the codification and printing of Minnesota Statutes 2014 and review whether and how to improve the citations within the Act that group licensing and disciplinary actions separately. The work group acknowledges that this could run the risk of creating other unintended consequences and recognizes that this effort would require the expertise of the Office of the Revisor of Statutes.

4. Clarify Board membership.

Current language at section 147.01, subdivision 1 states that "one member shall be a doctor of osteopathy." Over the years, the Board has sometimes had difficulty in filling a vacancy due to the lack of applicants. This has been a particularly acute for the doctor of osteopathy seat, as Minnesota statute currently limits the Board to a one member from this profession. On the other hand, when such a professional is on the Board, others are disqualified.

Recommendation 2.5: The work group recommends that the relevant language in section 147.01, subdivision 1 be changed from "one member shall" to "not less than one member shall" be a doctor of osteopathy.

5. Clarify the circumstances under which face-to-face meetings may occur.

The Board, in licensing physicians, is required to conduct a face-to-face meeting with each licensee candidate under section 147.02 subdivision (e), as a security feature to ensure the applicant is who they say they are. In some cases, such as when the face-to-face meeting requirement would be a prohibitive factor for an applicant, this requirement may be fulfilled through the use of technology, such as a video conference. The work group considered whether statutory language should be changed from, "The applicant shall make arrangements with the executive director to appear in person before the board or its designated representative" to, "The applicant may make arrangements with the executive director to appear in person before the board or its designated representative."

Recommendation 2.6: The work group recommends that relevant language be changed in section 147.02 subdivision (e) from "shall" to "may".

With the assistance of the Revisor of Statutes, Recommendations 2.1 through 2.6 have been drafted as a bill for an act relating to health; making changes to the Medical Practice Act; amending Minnesota Statutes 2012, sections 147.001; 147.01, subdivision 1; 147.02, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 147. This language may be found at Appendix F.

6. Clarify the Osteopathic language in the Act.

The National Board of Osteopathic Examiners (NBOME) is recognized as an appropriate Board to provide testing towards licensure for Osteopathic physicians in all 50 states. They should be added to the list of comprehensive examination options in Minnesota Statute 2012, 147.02, subdivision 1, the applicant needs to pass to have a license issued.

Recommendation 2.7: The work group recommends that “National Board of Osteopathic Examiners (NBOME)” be added to the list of comprehensive examination options in Minnesota Statute 2012, 147.02, subdivision 1.

Additionally, language should be inserted to address the Osteopathic physicians’ medical licensing exam (College of Osteopathic Medical Licensure Examination - COMPLEX). The COMPLEX exam is accepted by the Federation of State Medical Boards as well as all 50 states and is now a requirement towards graduation from all Osteopathic Medical Schools. Although an Osteopathic candidate may take the United States Medical Licensing Examination (USMLE), many (almost 90%) will be taking only COMPLEX as their licensure examinations. In Minnesota we accept the COMPLEX as an appropriate pathway to licensure.

Recommendation 2.8: The work group recommends that "Osteopathic candidates, who are taking the College of Osteopathic Medical Licensure Examination (COMPLEX), must pass all three steps within 6 attempts." be added to the list of comprehensive examination options in Minnesota Statute 2012, 147.02, subdivision 1.

The Osteopathic language was identified after the other housekeeping language was sent to the Revisor’s Office for drafting. It is not included in the language in Appendix F but should be considered for inclusion in that language.

C. Variations from Model Act and Medical Practice Acts in selected states

The statute that created the work group required it “evaluate the state’s Medical Practice Act...” and “...consider practice acts in other states...”¹⁵ To fulfill this requirement, the work group compared the Minnesota Act to the Federation of State Medical Boards, Essentials of a State Medical and Osteopathic Practice Act, Thirteenth Edition (the Model Act) to identify any meaningful variations or gaps. The work group also agreed to compare the Act to other states’ acts to identify significant differences. MAD consultants provided research support for these two directives.

To assess the difference between the Act and the Model Act, members were presented with a high-level comparison of the Act and the Model Act. In addition, based on recommendations from Board members, Board staff and the Minnesota Attorney General’s Office, MAD consultants presented the work group with a high level comparison of the Act and acts from the

¹⁵Laws of Minnesota 2012, Regular Session, chapter 278, art. 2, sec. 33

states of Wisconsin, Massachusetts and Washington. Work group members were asked to review the comparisons and determine if there were any significant differences that would warrant revisions to the Minnesota Act.

In researching the FSMB Model Act, it was noted that the Minnesota Act was actually used as an example for development of the FSMB act. Additionally, it was mentioned that the Board has a Policy and Planning Committee whose function is to ensure that the Board remains a high quality board by keeping abreast of current trends and reviewing licensing innovations that occur elsewhere.

Recommendation 2.9: Based on their review and ensuing discussions, the work group did not find any meaningful gaps or issues that warranted revisions to the Minnesota Medical Practice Act.

D. Issues identified but deemed out of scope

During work group deliberations three items thought significant were raised by members. They were: 1) the evolution of Telehealth and the impact of technology in the delivery of care; 2) opportunities for coordinated activities with the nursing and pharmacy boards in anticipation of the concept of team-based care models; and 3) concerns regarding the rise in opioid abuse and addiction.

However important, the three items were considered out of scope because they were too broad for the group's immediate charge and/or because the group felt they were not issues that could be adequately and appropriately addressed, given the group's time, subject matter limitations and charge.

For Telehealth the primary concern was whether the Act sufficiently addresses issues and concerns related to the evolving field. With regards to nursing, pharmacy and other health licensing agencies, the concern was whether the statutory language allows for the relationship, communication and flexibility to ensure the public health and safety of the citizens of Minnesota.

The work group agreed these two issues were out of its scope but considered them critical enough to bring forward for further discussion and study by the various boards, the Department of Health and key legislators.

Finally, with regards to the rise in opioid addiction, the concern was whether the Act sufficiently addresses the malprescription of opioids by licensed physicians. The work group was informed of the Medical Board's longstanding awareness of the rise in opioid addiction, as well as its educational and outreach efforts to combat opioid malprescription. Additionally, a work group member commented that some physicians are no longer willing to treat chronic pain because of possible regulatory actions for being in violation of state and/or federal laws. However, the work group recognized that the Board's effort is only one prong of a multipronged strategy to address the issue. The topic is broad in scope and is being reviewed by several state agencies, including law enforcement. While the Act, per se, does not specifically enumerate best practices with regards to opioid prescribing, it delegates sufficient authority to the Board to review any complaints of malprescribing.

Public Comment Opportunities

The workgroup offered opportunities for the public to be informed on their work and to provide input related to its charge. Each of the six meetings was open to the public and, except for the first meeting, time was set aside for public comment. Meeting minutes and related handouts were made available on the MDH website.¹⁶ Visitors to this website could also submit comments or suggestions to the work group.

No one commented via the website. One person e-mailed comments to the work group, and another presented multiple times at work group meetings.

One public comment asked that the Act be amended to clarify and recognize that its complaint investigation process and license determination constitute a medical relationship between the physician under investigation and the Board.

Public comments were also submitted stating that the Act does not provide quality assurance measures.

The final area of public comment dealt with whether medical procedures were being performed without appropriate training. More detail on the comments can be found in the meeting notes contained on the MDH website.¹⁷

¹⁶ <http://www.health.state.mn.us/topics/medpractice/index.html>

¹⁷ Ibid.

Appendix A: Legislation

Laws of Minnesota 2012, Chapter 278, Article 2, Sections 33 and 34

Sec. 33. MEDICAL PRACTICE ACT; STUDY.

(a) The commissioner of health shall convene a working group to evaluate the state's Medical Practice Act to ensure that it effectively protects the safety and well-being of the citizens of the state and allows transparency. In this evaluation, the working group shall consider practice acts in other states, including conduct that may result in disciplinary action.

(b) The working group shall consist of 15 members, comprised and appointed as follows:

(1) two members of the Board of Medical Practice appointed by the Board of Medical Practice;

(2) two practicing physicians appointed by the Minnesota Medical Association;

(3) two medical educators, one representing the University of Minnesota and appointed by the commissioner of health and one representing the Mayo Clinic and appointed by the commissioner of health;

(4) two senators, one appointed by the subcommittee on committees, and one appointed by the senate minority leader, and two members of the house of representatives, one appointed by the speaker and one appointed by the house minority leader;

(5) the commissioner of health;

(6) two consumers appointed by the commissioner of health; and

(7) two experts in the field of medical practice appointed by the commissioner of health. The majority of the working group must be composed of members who have no current or past affiliation with the Board of Medical Practice. For purposes of this section, being licensed by the Board of Medical Practice does not constitute "affiliation."

(c) Compensation for working group members is subject to Minnesota Statutes, section 15.059, subdivision 3, and must be paid from the operating funds of the Board of Medical Practice. The costs incurred by the commissioner of health to convene and support the working group must be paid from the operating funds of the Board of Medical Practice.

(d) The working group must elect a chair from its members.

(e) Meetings of the working group shall be open to the public.

(f) No later than January 1, 2013, the commissioner shall submit the report of the working group and legislation modifying the practice act for consideration during the 2013 legislative session.

(g) The working group expires the day following submission of the report. **EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 34. **BOARD OF MEDICAL PRACTICE REVIEW.**

The legislative auditor is requested to conduct a special investigation of the Minnesota Board of Medical Practice and its implementation of the Medical Practice Act. The legislative auditor is requested to submit the results of the investigation to the Legislative Audit Commission, the Sunset Advisory Commission, and the chairs and ranking minority members of the senate and house of representatives policy committees having jurisdiction over the board by January 1, 2013.

Appendix B: List of Member-Generated Issues to Consider

A.	The definition section definitely needs to be developed.	Housekeeping
B.	Where possible I would strongly recommend we move related statutes into the medical practice act . Certain statues such as the HPSP program (214) and the HIV, HBV, HBC statue (214 and 6950) need to stay separate since they involve multiple health boards, not just the BMP.	Housekeeping
C.	We need to rearrange some of the order of the sections so that everything having to do with licensing is in the licensing section and likewise for the disciplinary section. At present, the first 16 pages have to do with licensing, then the next 15 pages or so discusses disciplinary action, then page 33 discusses registration fees for osteopaths, then we discuss PA statutes, CME, emeritus registration which is more a licensing issue, then go back to the disciplinary process again on age 44. The way the medical practice act reads at present is very confusing for both our licensees and the public.	Housekeeping
D.	Recommend all of the historical references be placed in an appendix at the end as footnotes.	Housekeeping
E.	As far as policy changes, I would favor us changing the requirement that all physicians/osteopaths successfully complete a residency program prior to obtaining a Minnesota medical license . We would still have the residency permit, but they could no longer be licensed after one year in residency.	2 votes
F. & K.	Professionals that are treated in non BMP programs, (HPSP e.g.) do not have any tracking done by the Board until they fail the program they are in. Theoretically they could be practicing, placing people at risk while they are showing noncompliance with the program they are in. Should there be a reporting requirement that should occur that can be expunged once the professional has shown successful completion?	12 votes
G.	Delegation for treatment of different conditions may be delegated to people in an office without any requirement for supervision. Cosmetic treatments such as Botox, cutaneous laser treatment for minor vein lesions, even invasive procedures such as injections or liposuction can be delegated to non-licensed office people (technicians, receptionists, etc.) at the discretion of the license holder. Until problems occur, there is no way to track this. Should there be a limit on delegating authority by the physician to those who are separately licensed in the state? Should there be an expectation of on-site supervision?	7 votes

Appendix B: List of Member-Generated Issues to Consider

H.	Should there be a process that can show physicians are investing in continuous improvement or education that does not require specialty board certification ? Could health care systems be certified to provide physician oversight and monitoring as the initial step rather than passing board certification testing?	1 vote
I.	We are enabling people with less training to do more in providing care (community paramedics, NPs as hospitalists, etc.). How does the MPA need to reflect the physician role in this changing environment?	1 vote
J.	<p>Lack of a system to comprehensively collect information regarding issues, difficulties, or concerns about the design and implementation of the Medical Practice Act and Board.</p> <p>At the meeting on August 20th, several members spoke to the fact that the only systematic collection of information relates to the complaint process (e.g. survey data and statistics on complaints and their disposition). How does the Department of Health, this study group or the public learn about other concerns and issues that may be causing problems or are issues and need to be addressed in statute or the implementation processes?</p> <ul style="list-style-type: none"> Require collection of demographic data on physicians (it is currently voluntary) 	9 votes
K. & F.	<p>What information, when should information be made available and how should information on physician practice and behavior be available to the public.</p> <p>Over time, the public has demanded more transparency into what is happening within professionals and their organizations. Maintaining the public's confidence in licensure and review of physician performance means that appropriate information needs to be collected and available for public review. What changes, if any, are needed in the Medical Practice Act and operations of the Medical Practice Board to collect and report appropriate information?</p>	(Combined)
L.	The Board of practice also discussed and requested that our committee consider changing the language as to the composition of the board . As it currently is written ONLY one Osteopath can be on the board. Over the years (Mr. Leach will also concur) it sometimes is very hard to fill a vacancy due to the lack of applicants. When there is a sitting DO member, any DO who would wish to serve is disqualified because of the practice act language. We therefore can't consider a qualified applicant and have a hard time to fill the vacancy.	Housekeeping

Appendix B: List of Member-Generated Issues to Consider

	<p>The BMP has suggested the new language should read instead of "one member shall be a DO" to read "Not less than one shall be a DO" By No means does this mean there has to be more than one but if there are more than one qualified applicants for the seat they could be considered. In our state at least 90-95% of all our practicing DO's are members of the MMA.</p>	
<p>Additional ideas generated at Sept 17th meeting</p>		
	<ul style="list-style-type: none"> • Gaps in Minnesota Medical Practice Act from model act 	<p>Required by legislation</p>
	<ul style="list-style-type: none"> • Face-to-face meetings 	<p>Housekeeping</p>
	<ul style="list-style-type: none"> • Pass USMLE within 3 tries/4 tries 	<p>Removed</p>
	<ul style="list-style-type: none"> • Re-entry into medicine after a period of time away; gather data; guidelines vs. law 	<p>0 votes</p>
	<ul style="list-style-type: none"> • Relationship with nursing, pharmacy and other health licensing agencies 	<p>Out-of-scope (too big of an issue)</p>
	<ul style="list-style-type: none"> • Malprescription of opioids by licensed physicians 	<p>Out-of-scope (too big of an issue)</p>
	<ul style="list-style-type: none"> • Tel-a-health 	<p>3 votes</p>
	<ul style="list-style-type: none"> • New or additional definitions 	<p>TBD</p>

Appendix C: High-Level Comparison of Minnesota’s Act to the Model Act

Item	Category	Model Act	Minnesota
1.	Rationale	Sec. I - Statement of Purpose	147.001 - Purpose
2.	Governance	Sec. III - The State Medical Board	147.01 - Board of Medical Practice
3.	Definitions	Sec. II - Definitions	147.011 - Definitions
4.	Licensing	Sec. IV – Examinations Sec. V – Requirements for Full Licensure Sec. VI – Graduates of foreign medical schools Se4c. VII – Licensure by endorsement, expedited licensure by endorsement, and temporary and special licensure Sec. VIII – Limited licensure for Physicians in Postgraduate training	147.02 - Examination; Licensing 147.025 - Evidence of past sexual conduct 147.03 - Licensure by endorsement; reciprocity; temporary permit 147.031 - Examinations and licenses of Osteopaths 147.032 - Interstate practice of telemedicine 147.035 - Malpractice history (from practice in another state) 147.037 - Licensing of foreign medical school graduates; temporary permit 147.0391 – Residency permit
5.	Cancellation of License		147.038 - Cancellation of license in good standing 147.0381 – Cancellation of credentials under disciplinary order 147.039 - Cancellation of license for nonrenewal
6.	License limitations (other states)		147.04 - Retaliatory provisions

Item	Category	Model Act	Minnesota
7.	Penalties - Discipline	Sec. IX – Disciplinary action against licensees Sec. XI – Impaired physicians Sec. XII – Discompetent and Incompetent licensees Sec. XV – Unlawful practice of medicine: violations and penalties	147.081 - Practicing without license; penalty 147.09 - Exemptions (to practicing w/o license) 147.141 - Forms of disciplinary action
8.	Review Process	Sec. X – Procedures for enforcement and disciplinary action Sec. XIII – Compulsory reporting and investigation Sec. XVI – Periodic renewal	147.091 - Grounds for disciplinary action 147.092 - Probable cause hearing; sexual misconduct 147.111 - Reporting obligations (duty to report violations) 147.121 - Immunity (from liability for reporting suspected violation) 147.131 - Physician cooperation (required)
9.	Reporting – Records	Sec. XIV – Protected action and communication	147.151 - Disciplinary record on judicial review (sealed) 147.155 - Reports to Commissioner of Health 147.161 - Physician accountability (board keep copy of complaints) 147.162 - Medical care facilities; exclusion (Physicians must file lit of facilities where s/he has privileges) 147.21/147.22 - Osteopath annual registration and record transfer to Bd. 147.37 - Information provision; Pharmaceutical assistance programs

Item	Category	Model Act	Minnesota
10.	Miscellaneous	Sec. XVIII – Rules and regulations (authority to promulgate) Sec. XIX – Funding and fees	147.231 - Released persons; prescriptions (no civil liability re former prisoner regarding use/nonuse of prescriptions) 147.37 - Information provision; pharmaceutical assistance programs (patient advisory regarding no cost drugs)
11.	Physician Assistants	Sec. XVII – Physician assistants	Chapter 147A – Physician assistants

Appendix D: Office of the Legislative Auditor's Report



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

PRELIMINARY ASSESSMENT

**Board of Medical Practice:
Complaint Resolution Process**

October 23, 2012

Office of the Legislative Auditor
Centennial Building – Suite 140
658 Cedar Street – Saint Paul, MN 55155
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OFFICE OF THE LEGISLATIVE AUDITOR

State of Minnesota • James Nobles, Legislative Auditor

October 23, 2012

Members of the Legislative Audit Commission

Members of the Sunset Advisory Commission

Members of the Board of Medical Practice

This report is in response to a request from the Sunset Advisory Commission for the Office of the Legislative Auditor to conduct a “special investigation” of the Board of Medical Practice.

The Board of Medical Practice cooperated fully with our review.

Sincerely,

A handwritten signature in black ink that reads "James R. Nobles".

James R. Nobles
Legislative Auditor

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Background

During the 2012 legislative session, the Board of Medical Practice was one of many organizations under review by the Sunset Advisory Commission. In addition to conducting a sunset review, the commission also held hearings in response to a newspaper article about the board.¹ The article raised concerns about Minnesota's medical practice law, the availability of data on actions taken against medical practitioners, and how the Board of Medical Practice has responded to complaints against the practitioners it licenses. At the conclusion of the commission's hearings, the chair and vice chair of the Sunset Advisory Commission requested that the Office of the Legislative Auditor (OLA) conduct an evaluation of the Board of Medical Practice.²

The request for an OLA evaluation was presented to the Legislative Audit Commission on March 19, 2012, but it was not approved.³ Members of the Legislative Audit Commission decided that OLA's Program Evaluation Division had a full schedule of work based on evaluation topics that had been reviewed and recommended by the commission's Topic Selection Subcommittee. The chair and vice chair of the Sunset Advisory Commission then sought other ways to obtain an OLA review of the Board of Medical Practice, which resulted in a request in law for OLA to conduct a "special investigation" of the board.⁴ Given the history of the request, we understood that we were being asked to investigate the board's complaint resolution process.

Objective, Scope, and Methods

When OLA receives a request to conduct an investigation, we first conduct a preliminary assessment to determine whether an OLA investigation is needed or

¹ Glenn Howatt and Richard Meryhew, "Doctors who err escape penalties," *StarTribune*, February 5, 2012.

² Representative Mary Kiffmeyer, Chair, and Senator Terri Bonoff, Vice Chair, Sunset Advisory Commission, letter to Representative Mike Beard, Chair, and Senator Roger Reinert, Vice Chair, Legislative Audit Commission, March 19, 2012.

³ *Minnesota Statutes* 2011, 3.97, subd. 3a, provides that "The [legislative audit] commission shall periodically select topics for the legislative auditor to evaluate.... Legislators and legislative committees may suggest topics for evaluation, but the legislative auditor shall only conduct evaluations approved by the commission."

⁴ *Laws of Minnesota* 2012, Regular Session, chapter 278, art. 2, sec. 34. Section 33 of the law required the Minnesota Commissioner of Health to convene a working group to "evaluate the state's Medical Practice Act to ensure that it effectively protects the safety and well-being of the citizens of the state and allows transparency." The law specifically directed the working group to compare Minnesota's Medical Practice Act to those in other states, "including conduct that may result in disciplinary action."

whether a different response would be more appropriate.⁵ OLA will move forward with an investigation if the preliminary assessment finds indications of improper activity that needs to be promptly disclosed. With respect to the request to conduct a special investigation of the Board of Medical Practice, our primary objective was to determine if there are indications that the board's complaint resolution process has significant deficiencies that need to be promptly examined and disclosed through an OLA investigation. Our secondary objective was to determine what other actions might help resolve concerns about the board's complaint review process if we determined that an immediate investigation by OLA was not going to occur.

The scope of our preliminary assessment included the board's process for receiving and resolving complaints against medical practitioners. The board's other key regulatory function—licensing physicians—as well as its other ancillary functions were not within our scope.

To conduct our preliminary assessment, we did the following:

- Observed the complaint resolution process by attending meetings of Complaint Review Committees and the full board (meetings which were not open to the public);
- Reviewed a sample of complaint files (independently selected by OLA);
- Interviewed board staff about their roles in the complaint review process;
- Reviewed board meeting minutes and reports; and
- Reviewed the laws, rules, and policies that govern the board's complaint process.

While the objectives, scope, and methods of our preliminary assessment were limited, our access to information, people, and events was not. OLA has statutory authority to access all information related to the operation of state government, including all information classified as “not public.” In addition, by law, all public agencies—including the Board of Medical Practice—must cooperate fully with an OLA review. As a result, we had access to information in board files and from various proceedings that is not available to the Sunset Advisory Commission, media personnel, or the general public.

In reviewing individual cases, we did not attempt to judge whether the board made the “right” decision, nor did we attempt to judge whether, over all, the board's use of disciplinary actions to resolve cases was appropriate. As stated previously, we assessed the board's process for responding to complaints to

⁵ OLA generally conducts investigations in response to allegations that a particular individual or organization has inappropriately used public money or other public resources (e.g., property). However, OLA sometimes responds to broader concerns with a “special review.” Both investigations and special reviews provide OLA with a way to respond to allegations and concerns when it is not possible or appropriate to respond through a financial audit or program evaluation.

determine whether the process contained the elements of “due diligence” needed to achieve factually-supported decision making.

Conclusions

We concluded there is not a need at this time for an OLA investigation of the complaint resolution process at the Board of Medical Practice. Based on the cases we reviewed, the interviews we conducted, and the observations we made, we concluded that the board seeks to render judgments based on relevant facts, expert advice, and objective, professional staff support. We observed open, candid, and respectful discussions by board members about complaints, evidence, and what action(s) would be an appropriate response. In short, we found that the board’s complaint resolution process contained the elements of “due diligence” needed to achieve factually-supported and legally-grounded regulatory decision making.⁶

While our review did not identify deficiencies in the board’s complaint resolution process, we will again submit the board’s complaint resolution process to the Legislative Audit Commission for consideration as a topic for evaluation by OLA’s Program Evaluation Division. In an evaluation, OLA would examine more individual files, attend more proceedings, interview more individuals, review relevant court decisions, and compare the board’s complaint process and disciplinary experience with other health-related regulatory boards in Minnesota and other states. Given the importance, complexity, and sensitivity of the board’s role in regulating medical practitioners, a more comprehensive review by OLA may be justified.

Additional Information

Board of Medical Practice. The board is governed primarily by *Minnesota Statutes* 2011, chapter 147, which is often referred to as Minnesota’s “Medical Practice Act.” It mandates that the board has 16 members; 10 must hold a doctor of medicine degree and must be licensed to practice medicine in Minnesota, 1 must hold a doctor of osteopathy degree, and 5 must be “public members.”⁷ All board members are appointed by the Governor to four-year terms and no member

⁶ Our conclusion is consistent with the conclusion presented in a 2002 peer review report. Glenn L. Smith, D.O. and Gary R. Clark, Minnesota Board of Medical Practice Peer Review, August 16, 2002. The board contracted with Dr. Smith, a physician practicing in Oklahoma, and Mr. Clark, Executive Director of the Oklahoma Board of Osteopathic Examiners, to conduct the peer review.

⁷ A “public member” is defined in *Minnesota Statutes* 2011, 214.02, as follows: “Public member means a person who is not, or never was, a member of the profession or occupation being licensed or regulated or the spouse of any such person, or a person who does not have or has never had, a material financial interest in either the providing of the professional service being licensed or regulated or an activity directly related to the profession or occupation being licensed or regulated.” *Minnesota Statutes* 2011, chapter 214, contains various other provisions that define terms and set procedural requirements for all of Minnesota’s licenses and examining boards.

may serve longer than eight consecutive years. Physician members must come from each of Minnesota's eight congressional districts and must, as a whole, reflect the broad mix of expertise of physicians practicing in Minnesota.⁸

According to state law, the "primary responsibility and obligation of the Board of Medical Practice is to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine...."⁹ The board currently has a staff of 23 full-time employees (supplemented by attorneys from the Minnesota Office of the Attorney General and physicians and other medical experts working on contract).

Grounds for Disciplinary Action. In addition to granting the board authority to license individuals who are qualified to practice medicine in Minnesota, state law defines 27 grounds the board may use to take disciplinary action against a professional under its jurisdiction.¹⁰ They include, for example:

- Inability to practice medicine with reasonable skill and safety to patients.
- Unethical or unprofessional conduct.
- Improper management of medical records.
- False or misleading advertising.
- Unlawfully revealing privileged communications from or about a patient.
- Aiding in a suicide or attempted suicide.
- Sexual conduct or seductive communications with a patient.

According to data the Medical Practice Board submitted to the Sunset Advisory Commission, most of the complaints the board has received over the past ten years alleged some form of unprofessional or unethical conduct. For example, in 2010, the board's data showed that 60 percent of all complaints fell into those categories.

Forms of Disciplinary Action. As it responds to complaints, state law provides the board with seven forms of disciplinary action it may take.¹¹ They include the following:

- Revoke a license.

⁸ The required characteristics of board members are stated in *Minnesota Statutes* 2011, 147.01, subd. 1. While the board's primary jurisdiction is medical doctors, state law also gives the board certain regulatory responsibilities over other professionals from what are often referred to as "allied health professions," including acupuncturists, athletic trainers, naturopathic doctors, physician assistants, and respiratory therapists. Because state law does not mandate the appointment of representatives from these allied health professions to the board, the board has established an advisory council for each of the allied health professions to assist the board on matters related to those professions. Each advisory council is composed of representatives from the professional field on which they advise the board.

⁹ *Minnesota Statutes* 2011, 147.001.

¹⁰ *Minnesota Statutes* 2011, 147.091.

¹¹ *Minnesota Statutes* 2011, 147.141.

- Suspend a license.
- Revoke or suspend registration to perform interstate telemedicine.
- Impose limitations or conditions on the scope and use of a license.
- Impose a civil penalty.
- Order the physician to provide unremunerated professional service.
- Censure or reprimand the licensed physician.

State law also provides that, as an alternative to disciplinary action, the board (and other health-regulatory boards) “may attempt to correct improper activities and redress grievances through education, conferences, conciliation and persuasion...”¹² Consistent with this provision, the Board of Medical Practice has communicated its approach to discipline as follows:

While the Medical [Practice] Board has the authority to suspend or revoke licenses, it is believed that requiring education and putting restrictions on a physician’s license can solve many problems so the public is protected while maintaining valuable community resources.¹³

Complaint Resolution Process. Over the past ten years, the Board of Medical Practice has received an average of 840 complaints each year (ranging from a low of 770 in 2008 and a high of 941 in 2004). Most complaints come from patients and patients’ family members. State law obligates medical institutions, medical societies, licensed professionals, insurers, and others to report information to the board that might indicate a basis for disciplinary action against a licensed physician, and it obligates physicians to “self report” information about events that they themselves were involved in that could lead to disciplinary action.¹⁴

In the early 1990s, the board restructured its approach to processing complaints to accommodate an increase in complaints and a growing backlog of unresolved cases.¹⁵ The board’s goal was to establish a “triage system” that would allow the board to assess and sort complaints as to their severity and urgency. It is essentially the same system the board currently uses, and it is the one we examined.

In summary, the board’s complaint resolution process includes the following steps:

¹² *Minnesota Statutes* 2011, 214.10, subd. 2.

¹³ Contained in a brief information brochure published by the Board of Medical Practice, called “What you need to know about the Minnesota Board of Medical Practice.”

¹⁴ *Minnesota Statutes* 2011, 147.111.

¹⁵ For a contemporaneous assessment of the board’s restructuring, see Kent G. Harbison, “The Board of Medical Practice Improves Its Complaint Handling System,” *Minnesota Medicine*, (January 1995), 43-47.

- Information is received by board staff from mandated reporters, patients, family of patients, etc., which results in a complaint being logged into the board's complaint file management system. The system checks for other complaints against the same physician and adds them to the complaint file.
 - Complaint is reviewed by board's Complaint Review Unit supervisor and assigned to a medical regulations analyst, who contacts individuals (including the physician(s) named in the complaint), institutions, and others for additional information and documentation.
 - Complaint file is reviewed by a medical coordinator (physician working on contract for the board) who summarizes the medical aspects of a case and makes recommendations or requests additional information. Medical coordinators may also request that the board contract with a medical specialist to review the case. They may also recommend that a physician named in a complaint be brought in for what is referred to as a "medical coordinator conference," which can be a combination of education for the physician on an issue and evaluation of the physician's state of mind or acceptance of the complaint and need for corrective action. Medical coordinators may also request an investigation or legal counsel from an attorney at the Minnesota Office of the Attorney General.
 - Complaint file is assigned for review and action by one of the board's two complaint review committees (composed of two board members who are physicians and one public member). Each review committee meets once a month for most of the day. The committees may dismiss a complaint and close the case, request more information, and/or require a physician named in a complaint to meet with the committee at a future date. The committee may also propose a "corrective action agreement" with a physician or recommend disciplinary action against a physician. If a physician agrees to a proposed corrective action agreement, it does not go to the full board for ratification; however, proposed disciplinary actions do require ratification by the board.
 - In addition to taking action on proposed disciplinary actions, the full board hears oral arguments after an administrative hearing when a physician does not accept a complaint review committee's proposed corrective action agreement or disciplinary action. If the board and physician cannot agree on a resolution, either the board or the physician may request a "contested case" hearing under the state's Administrative Procedures Act. Contested case hearings are conducted by an administrative law judge from the Office of Administrative Hearings. The position of the complaint review committee is presented by an attorney from the Office of the Attorney General. The physician's position may be presented either by the physician or the physician's legal counsel. The board receives a report and
-

recommendation(s) from the presiding administrative law judge, but the final decision on how to resolve a complaint remains with the board.

There are additional details about the complaint review process on the board's Web site at:

<http://mn.gov/health-licensing-boards/medical-practice/public/complaints/complaint-review.jsp>

More detailed data about the nature and disposition of complaints is available in the report the board submitted to the Sunset Advisory Commission as part of the sunset review process. That report is available on the commission's Web site at:

http://www.commissions.leg.state.mn.us/sunset/reports/BoardofMedicalPractice_2012.pdf

Appendix E: Minnesota Department of Health Physician Workforce Survey

Physician Workforce Survey 2013



The Minnesota Department of Health collects this information as required by Minnesota Statutes, sections 144.051-144.052 and Minnesota Rules 4695.0100-4695.0300. This survey supports health workforce planning efforts in Minnesota. Your responses to the survey will not affect your license or registration renewal. This information is classified as public. Per Minnesota Statutes, section 144.1485, you may request your practice addresses be classified as private if this classification is required for your safety. If you need assistance filling out this form, please call (651) 201-3838 or Toll Free (800) 366-5424.

Section A: Training and Professional Information	
1. Did you receive your medical degree from a medical school in Minnesota?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Please check the appropriate box if you are a:	<input type="checkbox"/> Resident <input type="checkbox"/> Clinical Fellow <input type="checkbox"/> Locum Tenens
3. How many years of clinical experience (excluding medical school or graduate medical education residency) do you have? _____	
4. If you are currently practicing as a physician in Minnesota, how many more years do you plan to practice in Minnesota? <input type="checkbox"/> 5 years or less <input checked="" type="checkbox"/> 6-10 years <input type="checkbox"/> More than 10 years <input type="checkbox"/> Not practicing as a physician in MN	<i>If you answered #4 as "5 years or less," what is the main reason you plan to practice less than 6 years in Minnesota?</i> <input type="checkbox"/> Retirement <input type="checkbox"/> Work in another state <input type="checkbox"/> Change of professions <input type="checkbox"/> Other (specify) _____
5. In the past 12 months, did you volunteer your time to provide physician services? <input type="checkbox"/> Yes, estimated hours in past 12 months: _____ <input type="checkbox"/> No	
6. Which of the following choices best describes your current employment status? (Select only ONE).	<input type="checkbox"/> Employed in a paid position requiring a physician license (including residency or fellowship). <input type="checkbox"/> Employed in another field, but seeking work as a physician. <input type="checkbox"/> Employed in another field and not seeking work as a physician. <input type="checkbox"/> Unemployed, but seeking work as a physician. <input type="checkbox"/> Unemployed and not seeking work as a physician. <input type="checkbox"/> Not currently working due to family or medical reasons. <input type="checkbox"/> Retired. <input type="checkbox"/> Student (indicate field of study): _____ <input type="checkbox"/> None of the above.
Section B: Employment Information	
<i>Please provide the following information for all sites (except where otherwise indicated) where you work in a position that requires a physician's or surgeon's license. If you are not working in a position that requires a physician's or surgeon's license, please skip to question 23.</i>	
7. How many weeks did you work during the past year? _____ weeks	
8. How many hours do you work as a physician in a typical week? _____ (On average)	
9. How many hours per week do you provide direct patient care? _____ hours	
10. How many of these hours are primary care? _____ hours	

Prepared by the Minnesota Department of Health, Office of Rural Health and Primary Care
(651) 201-3838 or Toll Free (800) 366-5424
www.health.state.mn.us/divs/orhpc/workforce

Please return this form with your license renewal.

11. How many hours do you work in an average week at the site where you work the most hours weekly? ___ hrs.			
12. How many hours (on average) do you spend in the following activities each week?		13. Which of the following categories best describes the worksite where you work the most hours each week?	
Ambulatory care	___ hrs.	Office/Clinic	<input type="checkbox"/>
Acute care	___ hrs.	Hospital - outpatient	<input type="checkbox"/>
Medical Teaching	___ hrs.	Hospital - inpatient	<input type="checkbox"/>
Medical/Clinical Research	___ hrs.	Hospital – Emergency department	<input type="checkbox"/>
Telemedicine	___ hrs.	Research laboratory/setting	<input type="checkbox"/>
Administration	___ hrs.	Medical school	<input type="checkbox"/>
Other (specify) _____	___ hrs.	Nursing home or extended care facility	<input type="checkbox"/>
TOTAL =	___ Hours	Hospice care	<input type="checkbox"/>
		Treatment facility	<input type="checkbox"/>
		Other (specify) _____	<input type="checkbox"/>
14. Are you working as a hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Do you supervise a physician assistant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Do any advanced practice nurses work with you under a collaborative agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Do any nurse practitioners, clinical nurse specialists or certified nurse anesthetists prescribe drugs under a written agreement with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Regardless of your specialty, what obstetrical services have you provided in the past year? (Select ALL that apply) <input type="checkbox"/> Prenatal <input type="checkbox"/> Delivery <input type="checkbox"/> None		19. If you provide obstetric services, what percentage of your work time do they account for? ___%	
20. Regardless of your specialty, do you provide pediatric services? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. If you provide pediatric services, what percentage of your work time do they account for? ___%	
22. In addition to English, in which languages do you communicate for clinical purposes? (Select ALL that apply or "None")			
<input type="checkbox"/> Amharic <input type="checkbox"/> Lao <input type="checkbox"/> Somali <input type="checkbox"/> Sign Language <input type="checkbox"/> Arabic <input type="checkbox"/> Oromo <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Hmong <input type="checkbox"/> Russian <input type="checkbox"/> Swahili <input type="checkbox"/> None (English Only) <input type="checkbox"/> Khmer <input type="checkbox"/> Serbo-Croatian <input type="checkbox"/> Vietnamese			
Section C: Race and Ethnicity Information			
23. Are you of Hispanic, Latino or Spanish origin? <input type="checkbox"/> Yes <input type="checkbox"/> No			
24. What is your race? (Select ALL that apply.) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other (specify) _____			

Please return this form with your license renewal.

Appendix F: A Bill for an Act Making Housekeeping Changes to the Medical Practices Act

1.1 A bill for an act
1.2 relating to health; making changes to the Medical Practice Act; amending
1.3 Minnesota Statutes 2012, sections 147.001; 147.01, subdivision 1; 147.02,
1.4 subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 147.

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

1.6 Section 1. Minnesota Statutes 2012, section 147.001, is amended to read:

1.7 **147.001 SCOPE AND PURPOSE.**

1.8 Subdivision 1. Scope. Sections 147.01 to 147.37 may be cited as the Minnesota
1.9 Medical Practice Act.

1.10 Subd. 2. Purpose. The primary responsibility and obligation of the Board of
1.11 Medical Practice is to protect the public.

1.12 In the interest of public health, safety, and welfare, and to protect the public from the
1.13 unprofessional, improper, incompetent, and unlawful practice of medicine, it is necessary
1.14 to provide laws and regulations to govern the granting and subsequent use of the license to
1.15 practice medicine.

1.16 Sec. 2. Minnesota Statutes 2012, section 147.01, subdivision 1, is amended to read:

1.17 Subdivision 1. **Creation; terms.** The Board of Medical Practice consists of 16
1.18 residents of the state of Minnesota appointed by the governor. Ten board members must
1.19 hold a degree of doctor of medicine and be licensed to practice medicine under this
1.20 chapter. Not less than one board member must hold a degree of doctor of osteopathy and
1.21 either be licensed to practice osteopathy under Minnesota Statutes 1961, sections 148.11 to
1.22 148.16; prior to May 1, 1963, or be licensed to practice medicine under this chapter. Five
1.23 board members must be public members as defined by section 214.02. The governor shall

2.1 make appointments to the board which reflect the geography of the state. In making these
2.2 appointments, the governor shall ensure that no more than one public member resides in
2.3 each United States congressional district, and that at least one member who is not a public
2.4 member resides in each United States congressional district. The board members holding
2.5 the degree of doctor of medicine must, as a whole, reflect the broad mix of expertise of
2.6 physicians practicing in Minnesota. A member may be reappointed but shall not serve more
2.7 than eight years consecutively. Membership terms, compensation of members, removal of
2.8 members, the filling of membership vacancies, and fiscal year and reporting requirements
2.9 are as provided in sections 214.07 to 214.09. The provision of staff, administrative
2.10 services and office space; the review and processing of complaints; the setting of board
2.11 fees; and other provisions relating to board operations are as provided in chapter 214.

2.12 Sec. 3. Minnesota Statutes 2012, section 147.02, subdivision 1, is amended to read:

2.13 Subdivision 1. **United States or Canadian medical school graduates.** The board
2.14 shall issue a license to practice medicine to a person not currently licensed in another state
2.15 or Canada and who meets the requirements in paragraphs (a) to (i).

2.16 (a) An applicant for a license shall file a written application on forms provided by
2.17 the board, showing to the board's satisfaction that the applicant is of good moral character
2.18 and satisfies the requirements of this section.

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

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

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

2.30 (2) The applicant taking the United States Medical Licensing Examination (USMLE)
2.31 must have passed steps one, two, and three. Step three must be passed within five years of
2.32 passing step two, or before the end of residency training. The applicant must pass each of
2.33 steps one, two, and three with passing scores as recommended by the USMLE program
2.34 within three attempts. The applicant taking combinations of Federation of State Medical
2.35 Boards, National Board of Medical Examiners, and USMLE may be accepted only if the

3.1 combination is approved by the board as comparable to existing comparable examination
3.2 sequences and all examinations are completed prior to the year 2000.

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

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

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

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

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

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

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

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

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

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

4.1 Sec. 4. [147.0911] DIVERSIONARY PROGRAM.

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

4.7 Sec. 5. [147.61] OVERSIGHT OF ALLIED HEALTH PROFESSIONS.

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