



## STATE OF WISCONSIN

Department of Safety and Professional Services  
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Madison WI 53703

**Governor Scott Walker**

**Secretary Dave Ross**

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**MEDICAL EXAMINING BOARD MEETING**  
**Room 121A, 1400 E. Washington Avenue, Madison**  
**DRL Contact: Tom Ryan (608) 261-2378**  
**January 18, 2012**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting items may be removed from the agenda. Please consult the meeting minutes for a summary of the actions and deliberations of the Board.*

**8:00 A.M.**

**OPEN SESSION**

- 1. Call to Order – Roll Call**
- 2. Declaration of Quorum**
- 3. Approval of the Agenda (insert) (1-6)**
- 4. Approval of Minutes of December 14, 2011 (insert) (7-14)**
- 5. Case Presentations**

**Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s) in the Matter of:**

- a. Blair L. Lewis, MD - 09 MED 392 **(149-154)**
  - Attorney Kim Kluck
  - Case Advisor – Sandra Osborn
- b. Roger Pinc, MD – 10 MED 307 **(155-162)**
  - Attorney Kim Kluck
  - Case Advisor – Suresh Misra

**Presentation of Petition(s) for Extension of Time**

- a. 09 MED 033 – Clifford T. Bowe, MD **(169-172)**
  - Attorney Kim Kluck
  - Case Advisor – Suresh Misra
- b. 10 MED 404 – S. Dalip Singh, MD **(173-176)**
  - Attorney Jeanette Lytle
  - Case Advisor – Sujatha Kailas

## **6. Items Received After Mailing of Agenda**

- a. Presentation of Proposed Stipulations and Final Decisions and Orders
- b. Presentation of Proposed Decisions
- c. Petitions for Re-hearing
- d. Petitions for Summary Suspension
- e. Petitions for Extension of Time
- f. Petitions for Assessments
- g. Petitions to Vacate Orders
- h. Requests for Disciplinary Proceeding Presentations
- i. Motions
- j. Appearances from Requests Received or Renewed
- k. Speaking Engagement, Travel and Public Relation Requests
- l. Application Issues
- m. Examination Issues
- n. Continuing Education Issues
- o. Practice Questions

## **7. Items for Board Discussion**

- a. Physician Workforce Survey Preliminary Results – **APPEARANCE – 8:15 A.M. – Nancy Sugden, UWSMPH (insert) (15-16)**
- b. ARRA Grant Update – **APPEARANCE – 8:20 A.M. – Ari Oliver, DSPS, ARRA Program Analyst (insert) (17-18)**
- c. ARRA Grant Declaration of Cooperation – Board Review and Approval (**insert**) (19-30)
- d. Update on RL 4.08 Relating to Criminal Background Checks - **APPEARANCE – 8:25 A.M. – Ari Oliver, DSPS, ARRA Program Analyst (insert) (31-38)**
- e. PDMP – Review Current Draft and Consider Appointing a Representative to Testify at the Pharmacy Board Public Hearing on the Rule – **APPEARANCE – 8:35 A.M. – Chad Zadrazil, DSPS, PDMP Program Analyst (insert) (39-46)**
- f. Maintenance of Licensure Pilot Projects (**insert**) (47-52)
- g. FSMB Matters
  - 1) FSMB Annual Meeting, April 26-28, 2012, Fort Worth, TX (**insert**) (53-62)
  - 2) Consideration of Sheldon Wasserman for the FSMB Nominating Committee (**insert**) (63-64)
  - 3) FSMB Request for Letter of Support for Grant Application (**insert**) (65-66)
  - 4) Report from FSMB Special Committee on Ethics and Professionalism (**insert**) (67-86)
  - 5) Report from FSMB Workgroup to Define a Minimal Data Set (**insert**) (87-104)
- h. Chapter 8 Update
- i. Chapter 10 Update
- j. Board Appointments (**insert**) (105-106)
- k. Medical Board Newsletter
- l. Upcoming Outreach Opportunities

**8. Executive Director Matters**

- a. Annual Policy Review and Board Member Guidebook (insert) (107-138)

**9. Legislative Report**

- a. Senate Bill 306 (insert) (139-148)

**10. Screening Panel Report**

**11. Informational Item(s)**

**12. Public Comment(s)**

**13. Other Business**

**CLOSED SESSION**

**CONVENE TO CLOSED SESSION** to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g))

**CS-1 Deliberation of Stipulation(s), Final Decision(s) and Order(s) in the Matter of:**

- a. Blair L. Lewis, MD - 09 MED 392 (insert) (149-154)  
○ Attorney Kim Kluck
- b. Roger Pinc, MD – 10 MED 307 (insert) (155-162)  
○ Attorney Kim Kluck

**CS-2 Deliberation of Proposed Administrative Warning(s)**

- a. 09 MED 349 (J.P.H., MD) (insert) (163-164)  
○ Attorney Kim Kluck  
○ Case Advisor – Raymond Mager
- b. 10 MED 212 and 10 MED 239 (J.J.Y., MD) (insert) (165-166)  
○ Attorney Pamela Stach  
○ Case Advisor – Sheldon Wasserman
- c. 11 MED 240 (R.T.K., MD) (insert) (167-168)  
○ Attorney Arthur Thexton  
○ Case Advisor – Jude Genereaux

**CS-3 Consideration of Petition(s) for Extension of Time**

- a. 09 MED 033 – Clifford T. Bowe, MD (insert) (169-172)  
○ Attorney Kim Kluck
- b. 10 MED 404 – S. Dalip Singh, MD (insert) (173-176)  
○ Attorney Jeanette Lytle

**CS-4 Request(s) for Waiver of CME Requirements**

- a. F.B., MD (insert) (177-180)

**CS-5 Request(s) for Equivalency of ACGME Approved Post-Graduate Training**

- a. Alexandra S. Bullough, MD (insert) (181-216)

**CS-6 Monitoring**

- a. Chandra S. Reddy, MD – Request for Full Licensure (insert) (217-230)

**CS-7 Case Closings (insert) (231-232)**

**CS-8 Consulting with Legal Counsel**

**Deliberation of Items Received in the Bureau after Preparation of Agenda**

- a. Proposed Stipulations
- b. Proposed Decisions and Orders
- c. Objections and Responses to Objections
- d. Complaints
- e. Petitions for Summary Suspension
- f. Remedial Education Cases
- g. Petitions for Extension of Time
- h. Petitions for Assessments
- i. Petitions to Vacate Orders
- j. Motions
- k. Administrative Warnings
- l. Matters Relating to Costs
- m. Appearances from Requests Received or Renewed
- n. Examination Issues
- o. Continuing Education Issues
- p. Application Issues
- q. Monitoring Cases
- r. Professional Assistance Procedure Cases

Division of Enforcement – Meeting with Individual Board Members

Division of Enforcement – Case Status Reports and Case Closings

Ratifying Licenses and Certificates

**RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

Voting on Items Considered or Deliberated on in Closed Session if Voting is Appropriate

Other Business

**ADJOURNMENT**

**12:30 PM**

**CLOSED SESSION**

Examination of 3 Candidates for Licensure – Drs. Magiera, Musser, Osborn, and Wasserman

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**MEDICAL EXAMINING BOARD  
MINUTES  
DECEMBER 14 2011**

**PRESENT:** Carolyn Bronston; James Conterato, MD; LaMarr Franklin; Jude Genereaux; Sujatha Kailas, MD; Raymond Mager, DO; Christopher Magiera MD; Gene Musser, MD; Sandra Osborn, MD; Kenneth Simons, MD; Sheldon Wasserman, MD

**EXCUSED:** Suresh Misra, MD

**STAFF:** Tom Ryan, Executive Director; Sandy Nowack, Legal Counsel; Karen Rude-Evans, Bureau Assistant; other DSPS staff

**GUESTS:** Mark Grapentine, Wisconsin Medical Society; Judy Warmuth, WHA; Eric Jensen and Clark Collins, WAPA; Anne Hletko, Council on Physician Assistants; Nancy Sugden, UWSMPH; Robert Phillips, Marshfield Clinic; Franklin LaDue, Walgreens; Tim Storm

**CALL TO ORDER**

Dr. Sujatha Kailas, Vice Chair, called the meeting to order at 8:01 a.m. A quorum of eleven (11) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments:**

- Under PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS, add:
  - e. Michael R. Major, MD – 10 MED 393
    - Attorney Pamela Stach
    - Case Advisor – Suresh Misra
  - f. Lyndon Steinhaus, MD – 10 MED 011
    - Attorney Pamela Stach
    - Case Advisor – Gene Musser
- Item 7a – WIS ADMIN CODE CHAPTER MED 8, insert additional materials after page 14
- Item 7b – WIS ADMIN CODE CHAPTER MED 10, insert additional materials after page 14
- Item CS-2 – DELIBERATION OF STIPULATIONS, FINAL DECISIONS AND ORDERS, add:
  - b. Michael V. Baich, MD – 10 MED 294 – page 74 is replaced with corrected page
  - e. Michael R. Major, MD – 09 MED 423 – Attorney Pamela Stach (after page 90)
  - f. Lyndon Steinhaus, MD – 10 MED 011 – Attorney Pamela Stach (after page 90)

- Item CS-3, DELIBERATION OF PROPOSED ADMINISTRATIVE WARNINGS,  
Insert after page 96:
  - c. 10 MED 188 (E.S.J., MD) – Attorney Pamela Stach, Case Advisor – Gene Musser
- Item CS-5 – MONITORING, insert after page 144:
  - c. Kathleen A. Oriel, MD, Et al. – Request for approval of CME proposal
- Case Status Report – insert after page 146

**MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to adopt the agenda as amended. Motion carried unanimously.

### APPROVAL OF MINUTES OF NOVEMBER 16, 2011

#### Corrections:

- On page 8, under REQUEST FOR CE WAIVER, in the motion, after “Sandra” insert “Osborn”

**MOTION:** Sandra Osborn moved, seconded by Sheldon Wasserman, to approve the minutes of November 16, 2011 as corrected. Motion carried unanimously.

### PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

DOE Attorneys presented Proposed Stipulations, Final Decisions and Orders in the following disciplinary proceedings:

<b>Enrique W. Luy, MD</b>	<b>09 MED 364</b>
<b>Michael V. Baich, MD</b>	<b>10 MED 294</b>
<b>Philip R. Tolentino, MD</b>	<b>10 MED 349</b>
<b>Katherine M. Kaplan, MD</b>	<b>10 MED 393</b>
<b>Michael R. Major, MD</b>	<b>09 MED 423</b>
<b>Lyndon Steinhaus, MD</b>	<b>10 MED 011</b>

These items will be deliberated in closed session.

### ITEMS FOR BOARD DISCUSSION

#### Wis. Admin. Code Chapter MED 8 regarding Physician Assistants

Sandra Nowack reviewed with the Board the most current draft proposal for revisions to Wis. Admin. Code Chapter MED 8. Several revisions were made.

**MOTION:** Sheldon Wasserman moved, seconded by Carolyn Bronston, to move forward with Chapter MED 8 pending additional input from the Committee members and to delegate final authority for the Clearinghouse draft to Gene Musser and James Conterato. Motion carried unanimously.

**Wis Admin. Code Chapter MED 10**

Sandy Nowack reviewed the current draft of proposed changes to Wis. Admin. Code Chapter MED 10. The Board will continue the review and make further changes at a future meeting. No action taken at this time.

**Prescription Drug Monitoring Program – Update**

Tom Ryan updated the Board on the PDMP project. The Pharmacy Examining Board is meeting today to discuss the PDMP. The Rules Hearing will be scheduled for early 2012.

**Wisconsin Health Workforce Data Collaborative Voluntary Survey – Updates on the Status of the Survey for the Physician Assistant Renewal**

Nancy Sugden, Workforce Data Collaborative, appeared before the Board to discuss the survey for the DO and physician assistant renewals. The PA survey should be ready for testing next week the preliminary results from the MD survey should be available by February.

**Maintenance of Licensure Update – Tom Ryan**

Tom Ryan updated the Board on the Maintenance of Licensure pilot programs. The FSMB has developed a list of suggested pilots in three categories, which are:

1. Licensing System Pilots
2. Continuous Professional Development Program Pilots
3. Maintenance of Licensure Pilots

Mr. Ryan will email more details to the Board members and this matter will be revisited at the next Board meeting.

**Regulatory Digest/Newsletter – Call for Articles**

Jude Genereaux noted the name of the publication has been changed to the Medical Examining Board Newsletter. The Board discussed proposed articles. The annual report will also be included. The projected publication date for the Newsletter is March 2012.

**Upcoming Outreach Opportunities**

Sandy Osborn has been asked to speak as part of the physician impairment lecture to first year medical students at the UW Medical School in March 2012.

Sheldon Wasserman will speak to the psychiatry residency program at the Medical College of Wisconsin on January 11, 2012, and will present at grand rounds at Columbia St. Mary's Hospital in Milwaukee on February 14, 2012.

Gene Musser has been invited to speak to the psychiatry residency program at the UW Madison and Sujatha Kailas will give a presentation at Waukesha Memorial Hospital in January 2012.

## **EXECUTIVE DIRECTOR MATTERS**

There were no matters to discuss.

## **LEGISLATIVE REPORT**

There was press release regarding the discipline on the doctors who wrote the medical excuses during the demonstrations in January 2011.

## **SCREENING PANEL REPORT**

Jude Genereaux reported thirty three (33) cases were screened. Ten (10) cases were opened and four (4) ten-day letters were sent.

## **INFORMATIONAL ITEMS**

The informational items were noted.

## **PUBLIC COMMENTS**

There were no public comments.

## **OTHER BUSINESS**

Sheldon Wasserman spoke to the Board in support of SB 317 relating to electronic prescriptions for Schedule II drugs.

**MOTION:** James Conterato moved, seconded by Sheldon Wasserman, to have the Medical Examining Board go on record in support of Senate Bill 317. Motion carried unanimously.

## **RECESS TO CLOSED SESSION**

**MOTION:** Sandra Osborn moved, seconded by Sujatha Kailas, to convene to closed session to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)). Roll call: Carolyn Bronston-yes; James Conterato-yes; LaMarr Franklin-yes; Jude Genereaux-yes; Sujatha Kailas-yes; Raymond Mager-yes; Christopher Magiera-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Sheldon Wasserman-yes. Motion carried unanimously.

Open session recessed at 10:16 a.m.

**RECONVENE IN OPEN SESSION**

**MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to reconvene in open session. Motion carried unanimously.

Open session reconvened at 12:16 p.m.

**VOTING ON ITEMS CONSIDERED/DELIBERATED IN CLOSED SESSION**

**MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to reaffirm all motions made in closed session. Motion carried unanimously.

**FULL BOARD ORAL EXAMINATION**

**SARIT HOVAV, MD**

**MOTION:** Kenneth Simons moved, seconded by James Conterato, to deny the application for licensure to Sarit Hovav, MD. Motion carried unanimously.

**PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS**

**ENRIQUE W LUY, MD  
09 MED 364**

**MOTION:** Raymond Mager moved, seconded by Sandra Osborn, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Enrique W. Luy, MD. Motion carried unanimously.

**MICHAEL V BAICH, MD  
10 MED 294**

**MOTION:** Raymond Mager moved, seconded by Sandra Osborn, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Michael V. Baich, MD. Motion carried unanimously.

**PHILLIP R TOLENTINO, MD  
10 MED 349**

**MOTION:** Carolyn Bronston moved, seconded by LaMarr Franklin, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Phillip R. Tolentino, MD. Motion carried unanimously.

**KATHERINE M KAPLAN, MD**  
**10 MED 394**

**MOTION:** Raymond Mager moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Katherine M. Kaplan, MD. Motion carried. James Conterato was excused during deliberation and abstained from voting.

**MICHAEL R MAJOR, MD**  
**09 MED 423**

**MOTION:** Gene Musser moved, seconded by LaMarr Franklin, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Michael R. Major, MD. Motion carried unanimously.

**LYNDON STEINHAUS, MD**  
**10 MED 011**

**MOTION:** Raymond Mager moved, seconded by Sandra Osborn, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Lyndon Steinhaus, MD. Motion carried unanimously.

**PROPOSED ADMINISTRATIVE WARNINGS**

**MOTION:** Carolyn Bronston moved, seconded by James Conterato, to issue the Administrative Warning in case **10 MED 328**. Motion carried unanimously.

**MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to issue the Administrative Warning in case **11 MED 318**. Motion carried unanimously.

**MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to issue the Administrative Warning in case **10 MED 188**. Motion carried. Christopher Magiera was excused during deliberation and abstained from voting.

## PROPOSED ORDER FIXING COSTS

### STEVEN B GREENMAN, MD

**MOTION:** Gene Musser moved, seconded by Sandra Osborn, to adopt the Order Fixing Costs in the disciplinary proceedings against Steven B. Greenman, MD. Motion carried unanimously.

## MONITORING

### RAYMOND S KOZIOL, MD

Dr. Raymond Koziol made a personal appearance before the Board.

**MOTION:** Sandra Osborn moved, seconded by LaMarr Franklin, to grant the request from Raymond S. Koziol, MD, for full licensure. Motion carried six (6) to three (3). Sheldon Wasserman was excused during deliberation and abstained from voting.

### MICHAEL SCOTT MOORE, MD

**MOTION:** LaMarr Franklin moved, seconded Kenneth Simons, to approve the request form Michael Scott Moore, MD, for a reduction in drug screens from fifty six (56) to twenty eight (28) times per year plus one (1) hair test. Motion carried unanimously.

### KATHLEEN A ORIEL, MD, ET AL

The Board reviewed the information provided for the CME proposal. The course is approved provided it is a public course.

## CASE CLOSINGS

**MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to close cases **10 MED 274 and 10 MED 377** for insufficient evidence. Motion carried unanimously.

**MOTION:** Sandra Osborn moved, seconded by Carolyn Bronston, to close case **11 MED 141** for no violation. Motion carried unanimously.

**MOTION:** Raymond Mager moved, seconded Kenneth Simons, to close case **11 MED 174** for no violation. Motion carried unanimously.

## OTHER BUSINESS

There was no other business.

**ADJOURNMENT**

**MOTION:** LaMarr Franklin moved, seconded by Sandra Osborn, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:18 p.m.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Report from Nancy Sugden, UWSMPH, Regarding Preliminary Physician Survey	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Nancy Sugden will appear before the Board and deliver a report regarding survey data.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

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**State of Wisconsin  
Department of Safety & Professional Services**

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<p align="center">Items will be considered late if submitted after 4:30 p.m. and less than:</p> <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>			
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? ARRA Grant - Update	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? Appearance by Ari Oliver, DSPS ARRA Program Analyst  (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Ms. Oliver will appear before the Board to provide an update as to progress on the ARRA grant.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

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**State of Wisconsin  
Department of Safety & Professional Services**

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? ARRA GRANT Declaration of Cooperation - Board approval	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Review and consider motion to approve Declaration of Cooperation.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

## Midwest Licensure Portability Task Force

### Declaration of Cooperation

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WHEREAS, the Parties to this Declaration have developed licensure standards and procedures to ensure public health and safety within their jurisdictions using their authority to interpret and implement laws, draft administrative rules and develop licensure procedures;

WHEREAS, the Parties recognize that most of their licensure standards and procedures are identical or substantially similar to the licensure standards and procedures of the other Parties;

WHEREAS, the licensure procedures that physicians must complete to obtain a license to practice medicine in multiple Parties' jurisdictions are redundant and may be onerous to physicians applying to multiple jurisdictions;

WHEREAS, the Parties have information about physicians currently licensed by them that is pertinent to the licensure decisions made by other Parties and other jurisdictions;

WHEREAS, there is no national or regional standard or process for Parties to share information pertinent to another jurisdiction's licensure decision with the other jurisdiction;

NOW, THEREFORE, the Parties, by a representative, freely and voluntarily sign onto this Declaration under the following terms and conditions:

#### 1. Definitions

When used in this Declaration, the following terms have the meanings ascribed below:

- a) **Confidential Information** is any information of a Disclosing Party that it is obligated by statute, rule or other law not to disclose, whether or not marked or designated as confidential. It may include, but is not limited to, filed complaints and information regarding a Pending Investigation.
- b) A **Disclosing Party** is a Party to this Declaration which discloses its Confidential Information to a Receiving Party.
- c) The **Expedited Endorsement Process** is a licensure process that reduces and eliminates redundancies associated with applying for licensure in multiple jurisdictions while allowing Parties to retain their current licensing discretion.
- d) **Licensure Portability** is the ability of a license holder to obtain and maintain licenses granted by multiple jurisdictions.
- e) A **Pending Investigation** is a public or confidential investigation that is ongoing within a medical or osteopathic board or other licensing authority.

- f) A **Party** is a state medical board, osteopathic board or other licensing authority that signs onto to this Declaration.
- g) A **Receiving Party** is a Party to this Declaration which accepts, receives, views, or otherwise obtains Confidential Information from a Disclosing Party.
- h) The **Steering Committee** is made up of two (2) members of the Task Force that represent two (2) different Parties. The Steering Committee is responsible for planning and leading Task Force meetings and ensuring the Task Force makes progress.
- i) The **Task Force** is the Midwest Licensure Portability Task Force. It is made up of one (1) or two (2) representatives of each Party to this Declaration.

## 2. Purposes

The purposes of this Declaration are for the Parties to cooperate to:

- a) Improve the Parties' licensure procedures, creating more efficient processes for sharing relevant information among Parties and ensuring that public health and safety are fully protected in each Party's jurisdiction;
- b) Improve the ability of physicians who meet the requirements delineated in Section 9 and Attachments to obtain licenses to practice medicine in multiple jurisdictions;
- c) Improve the quality and increase the quantity of relevant information Parties share among themselves during a Party's licensure decision-making procedures; and
- d) Identify the current and potential issues facing the Parties that may be best addressed through interstate cooperation and to develop and implement a plan to solve any such identified issues.

## 3. Scope & Authority

This Declaration is a voluntary and, unless otherwise noted, nonbinding agreement among the Parties. Unless expressly stated, nothing in this Declaration is intended to create a legal obligation or create any right in, or responsibilities to, third parties. However, with its signature on this Declaration, each Party declares its intent to:

- a) cooperate with the other Parties to pursue the legal, administrative, procedural and other changes or amendments required to become and remain compliant with the requirements and specifications delineated in Section 9 and Attachments;
- b) share information about physicians licensed by it with the other Parties that is necessary to other Parties' licensure and disciplinary decisions;
- c) abide by Sections 3 through 8; and
- d) be bound by the terms and conditions of Section 10.

This Declaration is not an exclusive agreement and shall not prevent or limit other agreements or declarations, unless inherently incompatible with this Declaration, among Parties to this Declaration or between Parties and other entities.

Nothing in this Declaration is to be construed as an encroachment on the full and free exercise of United States federal authority, as an interference with the just supremacy of the United States or its several states, as affecting the federal structure of the United States or as enhancing the political power of the Parties at the expense of each other or other United States jurisdictions.

Nothing in this Declaration is to be construed in any way as an encroachment on the Parties' or any states' authority to grant licenses to physicians, regulate the practice of medicine within its jurisdiction or issue discipline to physicians.

All Parties warrant that they have the authority to sign this Declaration under their own laws and any other applicable laws or rules.

#### **4. Effective Date**

This Declaration is effective on the date that it is executed by any two (2) Parties, and is effective as to any other Party on the date that it is executed thereby. Nothing in this Declaration precludes additional parties with jurisdiction over licensing physicians from becoming Parties, subject to approval of the Steering Committee and a majority of current Parties.

The Declaration may be executed in multiple counterparts or duplicate originals, each of which shall constitute and be deemed as one and the same document.

#### **5. Withdrawal**

Parties are free to withdraw from this Declaration by sending written notice of intent to withdraw to the Steering Committee and other Parties. A Party's withdrawal shall be effective thirty (30) days after written notice of intent to withdraw is sent to the Steering Committee and other Parties.

#### **6. Organization & Meetings**

One (1) or two (2) representatives designated by each Party shall constitute the Task Force. A Party only gets one vote on business before the Task Force, whether it is represented by one (1) or two (2) people.

The Task Force shall be governed by the Steering Committee made up of two (2) members of the Task Force that represent different Parties. The two (2) members of the Steering Committee will be Co-Chairs of the Steering Committee and have equal rights and responsibilities. The Co-Chairs of the Steering Committee shall be voted on by the Task Force, including the current Co-Chairs of the Steering Committee, at every other required annual meeting.

As needed, the Task Force shall have at least one (1) annual meeting per calendar year. Every meeting shall be scheduled and conducted by the Steering Committee. The purpose of each required annual meeting shall be:

- a) to discuss Parties' licensure laws, rules and procedures;
- b) to review the Declaration and propose new issues that may need to be addressed; and
- c) to discuss other relevant information as determined by the Steering Committee.

The Steering Committee may schedule additional meetings.

#### **7. Reports to Parties**

Parties' representatives on the Task Force shall report progress, results and recommendations to the Parties during the Parties' scheduled meetings.

#### **8. Amendments to this Declaration**

At any time, a Party may propose amendments to this Declaration. The Steering Committee shall either conduct a meeting in addition to the annual meeting for the Task Force to vote on the amendment or have the Task Force vote on the amendment at the subsequent annual meeting. Approval by a majority of Parties is required to amend this Declaration.

#### **9. Common Expedited Endorsement Process**

Parties agree to use the Expedited Endorsement Process described in Attachment 2 for physician applicants who meet the eligibility requirements described in Attachment 1, both of which are incorporated by reference herein as though fully set forth.

#### **10. Use of Confidential Information**

By signing this Declaration, Parties agree to be bound by the terms and conditions of this Section and related definitions. Therefore, this Section is intended to create a legal obligation on the Parties. Confidential Information shall be maintained and kept by a Receiving Party according to the law by which the Receiving Party is bound and for the reasons intended by the Disclosing Party. A Receiving Party will endeavor to protect Confidential Information received from the Disclosing Party to the fullest extent permissible under law. A Receiving Party shall at a minimum apply a reasonable standard of care to prevent the unauthorized disclosure, dissemination or use of Confidential Information.

Receiving Party shall permit access to Disclosing Party's Confidential Information only to its employees who must know such information for furthering the specific expedited licensure objectives of the Parties to this Declaration.

Receiving Party shall not disclose, permit access to or share Confidential Information with another medical board, osteopathic board or licensing authority that is not a Party to this Declaration.

No term of this Declaration is intended to compel the disclosure of Confidential Information that a Party is prohibited from sharing with other Parties by statute, rule or other state law. To the extent that Confidential Information may be disclosed to another Party or other agency with jurisdiction over acts or conduct, or medical licensure, any Confidential Information disclosed shall not be redisclosed by the receiving agency except as otherwise authorized by law.

### **11. Severability**

The provisions of this Declaration are severable. If any portion of this Declaration is determined by a court to be void, unconstitutional or otherwise unenforceable, the remainder of this Declaration will remain in full force and effect.

**12. Signatures**

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Party Name

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Authorized Person Name

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**ATTACHMENT 1:  
COMMON EXPEDITED ENDORSEMENT  
ELIGIBILITY REQUIREMENTS**

When a physician holds a verified full, unrestricted, current and active license to practice medicine issued by any U.S. jurisdiction, it is presumptive evidence that the physician possesses the basic requisite skills and qualifications that each of the Parties require. While Parties retain discretion in their issuance of licenses, Parties agree that a common expedited endorsement licensure process should be available to the most qualified physicians.

Therefore, Parties agree to deploy the Common Expedited Endorsement Process, which is described in Attachment 2 and incorporated by reference herein as though fully set forth, to increase licensure portability by allowing physicians meeting or exceeding the following requirements to apply using a less redundant licensure process.

To be eligible to apply using the Common Expedited Endorsement Process, a physician must:

- Hold at least one verified, full, unrestricted, current and active license that was issued by any U.S. jurisdiction
- Not have ever held or currently hold a license that is or has ever been the subject of any Disciplinary Action<sup>1</sup>
- Not currently hold a license that is the subject of any Pending Investigation<sup>2</sup>
- Not have ever withdrawn an application to practice medicine or ever had an application to practice medicine denied by any United States or Canadian jurisdiction's licensing authority
- Not be the subject of an unsatisfied Agreement for Corrective Action
- Have been engaged in the Active Practice of Medicine<sup>3</sup> for at least five (5) years immediately preceding the application date

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<sup>1</sup> A "Disciplinary Action" is a public or confidential restriction, sanction, condition, cancellation or other professional limitation issued by a medical or osteopathic board, licensing authority, hospital, clinic, federal agency or the United States military, surrendering a license for cause, an agreement to place a license in inactive status in lieu of any disciplinary action or an institution staff sanction in any United States or Canadian jurisdiction

Satisfied Agreements for Corrective Action, letters of warning and other expressly non-disciplinary measures used to resolve a complaint are not "Disciplinary Actions."

<sup>2</sup> A "Pending Investigation" is a public or confidential investigation that is ongoing within a medical or osteopathic board, licensing authority, hospital, clinic, federal agency or the United States military.

<sup>3</sup> The "Active Practice of Medicine" includes private practice, employment in a hospital or clinical setting, employment by any governmental entity in community or public health or practicing administrative, academic or research medicine. It does not include residency, fellowships or postgraduate training of any kind.

Education:

- Be a graduate of an accredited medical school or college of osteopathic medicine:
  - For United States and Canadian graduates, this means that the school was a medical school accredited by the Liaison Committee on Medical Education (LCME) or a college of osteopathic medicine accredited by the American Osteopathic Association- Commission on Osteopathic College Accreditation (AOA-COCA)
  - For international graduates, this means that the school was recognized and approved by the Party from whom a license is sought and the physician possesses an “indefinitely valid” Educational Commission for Foreign Medical Graduates (ECFMG) Certificate or possesses a valid Fifth Pathway Certificate

Postgraduate Training:

- Have completed a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

Examinations:

- Have passed an examination or combination of examinations approved by the Party from whom a license is sought

Specialty Board Certification:

- Possess a current specialty board certification from the American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)
  - Lifetime certificate holders that are not currently engaged in Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC) do not meet this requirement

Criminal Background Check:

- Have an acceptable criminal history as determined by the Party

State-Specific Requirements:

- Satisfy all licensure requirements of the Party from whom a license is sought

**ATTACHMENT 2:  
COMMON EXPEDITED ENDORSEMENT  
PROCESS**

When a physician holds a verified full, unrestricted, current and active license to practice medicine issued by any U.S. jurisdiction, it is presumptive evidence that the physician possesses the basic requisite skills and qualifications that each of the Parties require. The presumption is valid because each Party undertakes similar, if not the same, licensure review procedures. While Parties retain discretion in their issuance of licenses, Parties agree that a regional expedited endorsement licensure process would complement their current licensure processes and improve the portability of the most qualified physicians.

Therefore, Parties agree to work towards deploying the following licensure review procedures when reviewing an applicant who satisfies the Common Expedited Endorsement Eligibility Requirements, which are described in Attachment 1 and incorporated by reference herein as though fully set forth. In doing so, Parties agree to work towards adopting licensure review procedures that follow to increase licensure portability:

- Parties may require applicants to complete the Federation of State Medical Boards' Uniform Application
  - Applicants must:
    - Disclose all malpractice history and provide documentation when requested
    - List all jurisdictions where he or she is currently or was previously licensed
    - Cause submission of verifications of all licenses currently or previously held
    - List the chronology of all activities for the time since completing medical school
    - Submit an NPDB-HIPDB Self-Query Report
- Upon receipt of an expedited endorsement application, Parties shall:
  - Obtain Electronic AMA or AOA Profiles
    - Both of which primary source verify ABMS/AOA Specialty Board Certification
  - Obtain an FSMB Disciplinary Report
  - Determine whether the applicant has an acceptable criminal history
- When a physician licensed by a Party applies for a license in a different Party's jurisdiction, the Party that already licensed the physician shall indicate, disclose or otherwise make known to the other Party whether there are any Pending Investigations, as defined by the Declaration, against the physician.
- Each Party retains the discretion to grant licenses to physicians within its jurisdiction according to its specific laws, policies and regulations.

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STATE OF WISCONSIN  
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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IN THE MATTER OF RULE-MAKING : ORDER OF THE  
PROCEEDINGS BEFORE THE : DEPARTMENT OF SAFETY  
DEPARTMENT OF SAFETY AND : AND PROFESSIONAL SERVICES  
PROFESSIONAL SERVICE : (CLEARINGHOUSE RULE 11-027)

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ORDER

The Wisconsin Department of Safety and Professional Services (formerly the Department of Regulation and Licensing) proposes an order to renumber and amend s. RL 4.08 (intro), and to create RL 4.08 (2), relating to background checks and fingerprinting.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

Sections 440.03 (13) (a), (b) and (c), and 448.05 (1) (a), Stats.

**Statutory authority:**

Sections 15.08 (5) (b), 227.11 (2) (a), 440.03 (1), 440.03(13) (d), 448.40 (1), Stats.

**Explanation of agency authority:**

Section 448.05, Stats., is enforced and administered by the Department of Safety and Professional Services ("DSPS") and the Medical Examining Board. Specifically, s. 448.40 (1), Stats., authorizes the Medical Examining Board to promulgate rules to carry out the purposes of the Medical Examining Board subchapter. Section 448.05 (1), Stats., is in the Medical Examining Board subchapter.

Further, the Medical Examining Board is obligated under s. 15.08 (5) (b), Stats., to promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the law relating to the particular trade or profession.

DSPS is a department in state government, and is therefore an "agency" under s. 227.01 (1), Stats.. Under s. 227.11(2) (a), Stats., it may promulgate rules interpreting the provisions of any statute enforced or administered by it, if the agency considers it necessary to effectuate the purpose of the statute. Both ss. 440.03 (13) and 448.05 (1), Stats., are enforced and administered by DSPS.

Last, DSPS is authorized under s. 440.03 (1), Stats., to promulgate rules defining uniform procedures to be used by the department, the attached boards, the examining boards, and the affiliated credentialing boards.

**Related statute or rule:**

Section 440.03 (7) Stats., and Wis. Admin. Code § RL 4.07 (52)

**Plain language analysis:**

Subject to ss. 111.321, 111.322 and 111.355, Stats., s. 448.05 (1) (a), Stats., requires that an applicant must not have an arrest or conviction record to be qualified for the granting of any license by the Medical Examining Board. Section 448.03 (13) (a), Stats., authorizes DSPS to conduct investigations to determine whether applicants have arrest or conviction records and require applicants to provide any information that is necessary for the investigations. Under s. 448.03 (13) (b), Stats., DSPS may investigate whether applicants for licenses to practice medicine and surgery have arrest or conviction records pursuant to rules it promulgates.

DSPS promulgated Wis. Admin. Code ss. RL 4.07 and RL 4.08 to interpret s. 448.03 (13), Stats.. Under ss. RL 4.07 and RL 4.08, DSPS may require an applicant for physician licensure to submit fingerprints and undergo a criminal background check if “there exists reason to believe that the applicant has failed to accurately describe his or her conviction record.”

Currently, applicants for physician licenses may be required to submit fingerprints and undergo criminal background checks if “there exists reason to believe that the applicant has failed to accurately describe his or her conviction record.” The proposed changes to Wis. Admin. Code s. RL 4.08 enable DSPS to require an applicant for a physician license to submit fingerprints and undergo a criminal background check as part of the licensure process when there is no reason to believe that an applicant has failed to accurately describe his or her conviction record. Therefore, DSPS may require any applicant for a physician license to submit fingerprints and undergo a criminal background check prior to DSPS issuing a license to him or her.

Requiring fingerprints and criminal background checks as part of the physician licensure process involves two changes to Wis. Admin. Code s. RL 4.08. First, the language added to SECTION 1 creates a class of licensed credentials the applicants for which may be required to be photographed, submit fingerprints, and undergo criminal background checks in situations when there is not a reason to believe that an applicant has failed to accurately describe his or her conviction record.

Second, SECTION 2 defines the physician license as a member of the class of licensed credentials created by the changes to SECTION 1. Together, the changes to SECTION 1 and SECTION 2 require all applicants for a physician license to practice medicine and surgery to submit a full set of fingerprints along with their application for licensure. The

fingerprints will be used to verify the applicant's identity and conduct searches for criminal arrests and convictions in accordance with s. 440.03 (13), Stats.

**Summary of, and comparison with, existing or proposed federal legislation:**

While there are numerous federal laws that empower the FBI to conduct criminal background checks and provide criminal history reports to state agencies for non-criminal purposes, two are most relevant in this case. They are: Public Law 92-544 (1972), 86 Stat. 1115, and the National Child Protection Act of 1993, 42 U.S.C. § 5119a, as amended by the Volunteers for Children Act, Public Law 105-251 (1998).

The most relevant federal law, and the basis of the proposed rule, is Public Law 92-544 (1972). Public Law 92-544 empowers the FBI to conduct criminal background checks and provide the resulting information to state agencies for non-criminal purposes, such as licensing. However, under Pub. L 92-544, the FBI will only conduct background checks and provide criminal history reports to state agencies for non-criminal purposes based on a federal law or state statute that explicitly authorizes background checks and the sharing of criminal history reports for non-criminal purposes.

Under the law, both the U.S. Attorney General and the Director of the FBI have the authority to determine whether a federal law or state statute explicitly authorize criminal background checks and the sharing of criminal history reports with state agencies for non-criminal purposes. *See* Pub. L 92-544 and 28 C.F.R. § 0.85(j). With its authority, the FBI delineated standards to determine whether a law authorizes background checks and the sharing of criminal history reports for non-criminal purposes. The standards are:

- The authorization must exist as the result of legislative enactment or its functional equivalent;
- The authorization must require fingerprinting of the applicant;
- The authorization must, expressly or by implication, authorize use of FBI records for screening of the applicant;
- The authorization must not be against public policy; and
- The authorization must not be overly broad in its scope, it must identify the specific category of applicants/licensees.

On January 7, 2011, Phillip Collins, Deputy Director of the Crime Information Bureau of the Wisconsin Department of Justice confirmed that the FBI approves s. 440.03 (13), Stats., as meeting the FBI standards listed above to enable DSPS to obtain fingerprints and criminal history reports as part of the physician licensing process. Therefore, Pub. L 92-544 is the federal basis for the proposed changes to s. RL 4.08 that enable DSPS to obtain criminal history reports from the FBI.

The second relevant federal law is the National Child Protection Act of 1993, 42 U.S.C. § 5119a as amended by the Volunteers for Children Act ("VCA"), Public Law 105-251 (1998). The proposed rule does not rely on the amendments made to 42 U.S.C. § 5119a by VCA because the FBI has approved s. 440.03(13) as adequate statutory authority to

enable DSPS to obtain fingerprints and criminal history reports as part of the physician licensing process. However, the Iowa Medical Board utilizes 42 U.S.C. § 5119a to enable the Board to require applicants for physician licenses to submit fingerprints and the Board to obtain criminal history reports from the FBI as a part of the Board's licensure process. The Iowa Board relies on the amendments made to 42 U.S.C. § 5119a by VCA because the FBI has approved 42 U.S.C. § 5119a as meeting the standards listed above but has not approved any Iowa statute as meeting the standards.

The Volunteers for Children Act enables state agencies and businesses that are designated as "qualified entities" by an authorized state agency to require "providers" to submit fingerprints for non-criminal background checks. Under the law, a "qualified entity" is "a business or organization, whether public, private, for-profit, not-for-profit, or voluntary, that provides care or care placement services, including a business or organization that licenses or certifies others to provide care or care placement services." 42 U.S.C. § 5119c. A "provider" is a person who wants to own, be employed by, be licensed by or volunteer at a "qualified entity." *Id.* The authorized state agency in Iowa has designated the Iowa Medical Board as a "qualified entity" and applicants as "providers." Therefore, the Iowa Medical Board is able to require background checks and obtain criminal history reports for the non-criminal purpose of reviewing applicants for physician licenses.

#### **Comparison with rules in adjacent states:**

**Illinois:** Illinois statute requires applicants for medical licensure to provide fingerprints for a criminal background check. 225 ILCS 60/9.7. The statute further requires the Illinois Department of Professional Regulation to promulgate rules to implement the requirement. *Id.* However, a review of Illinois' application and online instructions indicates that Illinois currently does not require applicants for physician licenses to submit fingerprints or undergo background checks. *See* <http://www.idfpr.com/dpr/WHO/med.asp>, accessed on Jan. 3, 2011.

**Iowa:** Iowa administrative rules require applicants for medical licensure to pay for and provide a full set of fingerprints for state and federal criminal background checks. IAC 653-9.4(2)p., 9.5(3)p., 9.6(2)j. and 8.4(7). Iowa promulgated the administrative rules based on the federal National Child Protection Act of 1993, 42 U.S.C. § 5119a as amended by the Volunteers for Children Act, Public Law 105-251 (1998). As mentioned above, the Volunteers for Children Act is approved by the FBI as a basis to enable "qualified entities" to require "providers" to submit fingerprints for non-law enforcement criminal background checks.

**Michigan:** Michigan statute requires applicants for medical licenses to provide fingerprints for state and federal criminal background checks. MCL 333.16174(3).

**Minnesota:** Minnesota currently does not require applicants for medical licenses to undergo criminal background checks.

### **Summary of factual data and analytical methodologies:**

In February 2010, DSPS was awarded an American Recovery and Reinvestment Act grant to lead a group of ten state medical and osteopathic boards to reduce barriers to the portability of physician licenses. Since the award, DSPS has worked with the boards in Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri and South Dakota to develop best practices to improve the licensing process of physicians. In November, the states identified requiring applicants to submit fingerprints and undergo criminal background as a best practice.

The background check requirement conforms to longstanding recommendations by the Federation of State Medical Boards ("FSMB"). Since April 2001, FSMB has affirmed its position that it is a best practice for state medical boards to "conduct criminal background checks as part of the licensure application process." See Federation of State Medical Boards, *Public Policy Compendium*, April 2010. The FSMB reaffirmed its position in April 2010. *Id.*

Further, as of September 2010, 35 out of 68 U.S. medical and osteopathic boards require applicants to submit fingerprints and undergo criminal background checks as part of the application process. FSMB, *Criminal Background Checks Overview by State*, Last Updated September 6, 2010, at [http://www.fsmb.org/pdf/GRPOL\\_Criminal\\_Background\\_Checks.pdf](http://www.fsmb.org/pdf/GRPOL_Criminal_Background_Checks.pdf).

### **Analysis and supporting documents used to determine effect on small business or in preparation of economic report:**

Section 227.137, Stats., requires an "agency" to prepare an economic impact report before submitting the proposed rule-making order to the Wisconsin Legislative Council. DSPS is not included as an "agency" in this section. Nonetheless, the department's Small Business Review Advisory Committee was consulted to determine whether the proposed rule would have any impact on small business in Wisconsin. The Committee concluded that the proposed rule will not have any significant economic impact on a substantial number of small businesses, as defined in s. 227.114 (1), Stats.

### **Anticipated costs incurred by the private sector:**

Every person seeking initial licensure to practice medicine and surgery in Wisconsin will incur the cost of conducting the criminal background check. The cost to the applicant of conducting a criminal background check is approximately \$56.25. The cost is the price the department charges applicants for the professions for which it currently requires the same criminal background check process.

### **Fiscal estimate:**

The department estimates that the proposed rule will have no significant fiscal impact.

**Effect on small business:**

On May 19, 2011, the department's Small Business Review Advisory Committee determined that the proposed rule will not have any significant economic impact on a substantial number of small businesses, as defined in s. 227.114 (1), Stats.

**Agency contact person:**

Shawn Leatherwood, Paralegal, Department of Safety and Professional Services, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4438; email at [Shancethea.L Leatherwood@wisconsin.gov](mailto:Shancethea.L Leatherwood@wisconsin.gov).

**Place where comments are to be submitted and deadline for submission:**

Comments may be submitted to Shawn Leatherwood, Paralegal, Department of Safety and Professional Services, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708-8935, or by email to [Shancethea.L Leatherwood@wisconsin.gov](mailto:Shancethea.L Leatherwood@wisconsin.gov). Comments must be received on or before August 1, 2011, to be included in the record of rule-making proceedings.

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TEXT OF RULE

SECTION 1. RL 4.08 (intro) is renumbered RL 4.08(1) and amended to read:

**RL 4.08 Photographs and fingerprints.** (1) The department may require an applicant for any of the credentials set forth in s. RL 4.07 and not listed in sub. (2) to be photographed and fingerprinted as a part of the credentialing process, if there exists reason to believe that the applicant has failed to accurately describe his or her conviction record. The department may refer photographs and fingerprints so obtained to the department of justice for internal analysis or submission to the federal bureau of investigation for the purpose of verifying the identity of the persons applicant fingerprinted and obtaining records of their his or her criminal arrests and convictions.

SECTION 2. RL 4.08 (2) is created to read:

The department shall require an applicant for a physician license under s. 448.02 to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the applicant's fingerprints. The department of justice may submit the fingerprint cards to the federal bureau of investigation for the purpose of verifying the identity of the applicant fingerprinted and obtaining records of his or her criminal arrests and convictions. The department shall charge the applicant any fees, costs, or other expenses incurred in conducting any investigation under this rule.

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(END OF TEXT OF RULE)

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The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

Dated 12/13/11

Agency 

Secretary  
Department of Safety and  
Professional Services

Ch. RL 4 CR 11-027 (Background Check)

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Prescription Drug Monitoring Program	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input checked="" type="checkbox"/> Chad Zadrari <span style="font-size: x-small;">(name)</span> <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Review the current draft and consider appointing Board representative to testify at the Pharmacy Board hearing on the rule.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

## Chapter Phar 18 PRESCRIPTION DRUG MONITORING PROGRAM

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| Phar 18.01 Authority and scope.                                      | 18.07 Use of PDMP information by the board and department. |
| Phar 18.02 Definitions.  | Phar 18.08 Access to and disclosure of PDMP information.   |
| Phar 18.03 Dispensing data.  | Phar 18.09 Limiting access to PDMP information.            |
| Phar 18.04 Submission of dispensing data.                            | Phar 18.10 Confidentiality of PDMP information.            |
| Phar 18.05 Correction of dispensing data.                            | Phar 18.11 Exchange of PDMP information.                   |
| Phar 18.06 Exemptions from compiling and submitting dispensing data. |  |

### Phar 18.01 Authority and scope.

The rules in this chapter are adopted under authority in ss. 15.08 (5) (b), 227.11 (2) (a), 450.02 (3) (a) and 450.19, Stats., for the purpose of creating a prescription drug monitoring program to collect and maintain information relating to the prescribing and dispensing of prescription drugs.

### Phar 18.02 Definitions.

As used in ch. Phar 18:

- (1) "Access" means to have the ability to view PDMP information through an account established with the board.
- (2) "Administer" has the meaning given in s. 450.01 (1), Stats.  
*the direct application of a vaccine or a prescribed drug or device, whether by injection, ingestion or any other means, to the body of a patient or research subject by any of the following:*
  - A practitioner or his or her authorized agent.
  - A patient or research subject at the direction of a practitioner.
  - A pharmacist.
- (3) "Animal" has the meaning given in s. 453.02(1m), Stats.  
*any animal except a human being.*
- (4) "Board" has the meaning given in s. 450.01 (2), Stats.  
*the pharmacy examining board.*
- (5) "Business day" means a business day, as defined in s. 421.301 (6), Stats., that is not a legal holiday under s. 995.20, Stats. or a federal legal holiday.
- (6) "Controlled substance" means a drug, substance, analog or precursor that is included in:
  - (a) Schedule II, III, IV or V in the federal controlled substances act, 21 USC 812(b)(2), (b)(3), (b)(4), (b)(5) and (c); or
  - (b) Schedule II, III, IV or V in subch. II. of s. 961, Stats., as amended by ch. CSB 2.
- (7) "DEA registration number" means the registration number issued to a pharmacy or practitioner by the department of justice, drug enforcement administration.
- (8) "Department" means the department of safety and professional services.
- (9) "Dispense" has the meaning given in s. 450.01 (7), Stats.  
*to deliver a prescribed drug or device to an ultimate user or research subject by or pursuant to the prescription order of a practitioner, including the compounding, packaging or labeling necessary to prepare the prescribed drug or device for delivery.*
- (10) "Dispenser" means a person licensed in this state to dispense drugs or licensed in another state and recognized by this state as a person authorized to dispense drugs.
- (11) "Dispenser delegate" means an agent or employee of a dispenser to whom it has delegated the task of inputting or accessing PDMP information.

- (12) "Dispensing data" means data compiled pursuant to s. Phar 18.03.
- (13) "Drug" has the meaning given in s. 450.01 (10), Stats.  
*- any substance recognized as a drug in the official U.S. pharmacopoeia and national formulary or official homeopathic pharmacopoeia of the United States or any supplement to either of them*  
*- any substance intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or other conditions in persons or other animals*  
*- any substance other than a device or food intended to affect the structure or any function of the body of persons or other animals*  
*- any substance intended for use as a component of any article [specified above] but does not include gases or devices or articles intended for use or consumption in or for mechanical, industrial, manufacturing or scientific applications or purposes*
- (14) "NDC number" means the universal product identifier used in the U.S. to identify a specific human drug product.
- (15) "NPI number" means the registration number issued to a practitioner or pharmacy by the national provider identifier registry.
- (16) "Patient" has the meaning given in s. 450.01 (14), Stats.  
*the person or other animal for whom drug products or devices are prescribed or to whom drug products or devices are dispensed or administered.*
- (17) "Person authorized by the patient" means person authorized by the patient in s. 146.81(5), Stats. and includes persons with delegated authority under s. 48.979, Stats.  
*- the parent, guardian, or legal custodian of a minor patient, as defined in s. 48.02 (8) and (11)*  
*- the person vested with supervision of the child under s. 938.183 or 938.34 (4d), (4b), (4m), or (4n),*  
*- the guardian of a patient adjudicated incompetent in this state, the personal representative, spouse, or domestic partner under ch. 770 of a deceased patient*  
*- any person authorized in writing by the patient or a health care agent designated by the patient as a principal under ch. 155 if the patient has been found to be incapacitated under s. 155.05 (2), except as limited by the power of attorney for health care instrument*  
*- If no spouse or domestic partner survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family, as defined in s. 632.895 (1) (d).*  
*- A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.*
- (18) "PDMP information" means data compiled and stored by the board from dispensing data submitted to it by dispensers and other information pertaining to the program.
- (19) "Pharmacy" means any place of practice licensed by the board under s. 450.06, Stats.
- (20) "Practitioner" has the meaning given in s. 450.01 (17), Stats.  
*a person licensed in this state to prescribe and administer drugs or licensed in another state and recognized by this state as a person authorized to prescribe and administer drugs.*
- (21) "Practitioner delegate" means an agent or employee of a practitioner to whom it has delegated the task of accessing PDMP information.
- (22) "Prescription" has the meaning given in s. 450.01 (19), Stats.  
*a drug or device prescribed by a practitioner.*
- (23) "Prescription drug"  
(a) means the following:  
1. a controlled substance included in s. 450.19(1), Stats.;
2. a controlled substance as defined in s. Phar 18.02 (6); and
3. a drug identified by the board as having a substantial potential for abuse, including Tramadol.

- (b) It does not mean a controlled substance that by law may be dispensed without a prescription order.
- (24) "Prescription Order" has the meaning given in s. 450.01 (21), Stats.  
*an order submitted orally, electronically or in writing by a practitioner for a drug or device for a particular patient.*
- (25) "Program" means the prescription drug monitoring program established under this chapter.
- (26) "Submit" means the electronic delivery of dispensing data compiled pursuant to s. Phar 18.03 to the board.
- (27) "Zero report" means a report that indicates that a dispenser has not dispensed a prescription drug since the previous submission of dispensing data or a zero report.

Phar 18.03 Dispensing data.

- (1) Subject to s. 18.06, a dispenser shall compile dispensing data that contains information about each time he or she dispenses a prescription drug to a patient.
- (2) The dispensing data shall contain the following information:
- (a) dispenser's full name;
  - (b) dispenser's NPI number or DEA registration number;
  - (c) date dispensed;
  - (d) prescription number;
  - (e) name and strength of the prescription drug;
  - (f) NDC number;
  - (g) quantity dispensed;
  - (h) estimated number of days of drug therapy;
  - (i) practitioner's full name;
  - (j) practitioner's NPI number or DEA registration number, if applicable;
  - (k) date prescribed;
  - (l) quantity prescribed;
  - (m) patient's full name;
  - (n) patient's address, including street address, city, state and ZIP code;
  - (o) patient's date of birth; and
  - (p) patient's gender.
- (3) A dispenser who fails to compile dispensing data as required under this chapter is subject to disciplinary action by the appropriate licensing board.

Phar 18.04 Submission of dispensing data.

- (1) Subject to s. 18.06 and subs. (3) and (4), a dispenser shall submit dispensing data to the board electronically within 7 days of dispensing a prescription drug.
- (2) Subject to s. 18.06 and sub. (5), a dispenser shall submit dispensing data to the board electronically in the format identified in the American society for automation in pharmacy (ASAP) implementation guide for prescription monitoring programs.
- (3) The board may grant a waiver from the requirements of sub. (1) to a dispenser if the dispenser is not able to submit dispensing data within 7 days of dispensing a prescription drug if:
- (a) the dispenser is unable to submit dispensing data as required by sub. (1) because of circumstances beyond its control; and
  - (b) the dispenser files with the board a written application for an extension on a form provided by the board prior to the required submission of dispensing data under sub. (1).

- (4) The board may grant a waiver from the requirements of subs. (1) and (6) to a dispenser who solely dispenses a prescription drug to a patient that is an animal if the dispenser:
  - (a) agrees to submit dispensing data in accordance with the electronic reporting requirements of this section, unless waived by the board;
  - (b) agrees to submit dispensing data compiled under s. Phar 18.03 to the board every 90 days;
  - (c) agrees to submit a zero report to the board if he or she does not dispense a prescription drug for 90 days; and
  - (d) files with the board a written application for a waiver on a form provided by the board.
- (5) If a dispenser is not able to electronically submit dispensing data as required by sub. (2), the board may grant a waiver to a dispenser under the following conditions:
  - (a) The dispenser does not have an electronic recordkeeping system capable of compiling dispensing data as specified in s. Phar 18.03 and both of the following conditions are met:
    1. The dispenser agrees in writing to immediately begin filing paper dispensing data on a form provided by the board for each prescription drug dispensed.
    2. The dispenser files with the board a written application for a waiver on a form provided by the board.
  - (b) The dispenser has an electronic recordkeeping system capable of compiling dispensing data as specified in s. Phar 18.03 and both of the following conditions are met:
    1. A substantial hardship is created by circumstances beyond the dispenser's control.
    2. The dispenser files with the board a written application for a waiver on a form provided by the board.
- (6) If a dispenser does not dispense a prescription drug for 7 days, the dispenser shall submit a zero report to the board.
- (7) A dispenser who fails to submit dispensing data or submits false information to the board is subject to disciplinary action by the appropriate licensing board.

Phar 18.05 Correction of dispensing data.

If a dispenser discovers omissions or inaccuracies in previously submitted dispensing data or other PDMP information, the dispenser shall notify the board in writing within 3 business days and submit written documentation that identifies the erroneous information and includes the correct information.

Phar 18.06 Exemptions from compiling and submitting dispensing data.

- (1) A dispenser is not required to compile or submit dispensing data when the prescription drug is administered directly to a patient.
- (2) The board shall exempt a dispenser from compiling and submitting dispensing data and from submitting a zero report as required under this chapter until the dispenser is required to renew his or her license, or until the dispenser dispenses a prescription drug, if the dispenser:
  - (a) provides evidence sufficient to the board that he or she does not dispense a prescription drug; and
  - (b) files with the board a written request for exemption on a form provided by the board.

Phar 18.07 Use of PDMP information by the board and department.

- (1) The board shall develop and maintain a PDMP database to store PDMP information.
- (2) The PDMP database shall store PDMP information in an encrypted format.
- (3) The board shall maintain a log of persons to whom the board grants access to PDMP information.
- (4) The board shall maintain a log of information submitted and accessed by each dispenser, dispenser delegate, practitioner and practitioner delegate.

- (5) The board shall maintain a log of requests for PDMP information.
- (6) Board and department staff, vendors and other agents of the board shall only have access to the minimum amount of PDMP information necessary for the following purposes:
  - (a) the design, implementation, operation, and maintenance of the PDMP database, including the electronic reporting system, as part of the assigned duties and responsibilities of their employment;
  - (b) the collection of prescription drug information as part of the assigned duties and responsibilities under s. 450.19, Stats. and this chapter; and
  - (c) other legally authorized purposes.

Phar 18.08 Access to and disclosure of PDMP information.

- (1) The board shall provide access to and disclose PDMP information in accordance with ss. 146.82 and 450.19, Stats., this chapter and other state or federal laws and regulations relating to the privacy of health care information.
- (2) The board shall not grant access to or disclose PDMP information to a person unless the person provides evidence satisfactory to the board that the person requesting PDMP information is entitled to the information.
- (3) The board shall grant access to PDMP information to a dispenser or dispenser delegate and a practitioner or practitioner delegate. To obtain access to PDMP information, a dispenser or dispenser delegate or practitioner or practitioner delegate shall file with the board a written application for an account on a form provided by the board.
- (4) Subject to pars. (a) to (i), upon receiving evidence satisfactory to the board that the person requesting PDMP information is entitled to the information, the board shall disclose PDMP information to the following persons:
  - (a) Patient. To obtain PDMP information, a patient shall:
    1. file with the board a notarized request for PDMP information on a form provided by the board; or
    2. appear in person at the department with two forms of valid government-issued proof of identity, one of which is photographic, and a request for PDMP information on a form provided by the board.
  - (b) Person authorized by the patient. To obtain PDMP information, a person authorized by a patient shall file with the board a notarized request for PDMP information on a form provided by the board and in accordance with s. 146.82, Stats.
  - (c) Health care facility staff committee, or accreditation or health care services review organization. To obtain PDMP information, a health care facility staff committee, or accreditation or health care services review organization shall file with the board a written request for PDMP information on a form provided by the board and in accordance with s. 146.82, Stats.
  - (d) Public health official and other public and private entity. To obtain PDMP information, a public health official or other public or private entity shall file with the board a written request for PDMP information on a form provided by the board and in accordance with s. 146.82, Stats.
  - (e) Federal and state governmental agency. To obtain PDMP information, a federal or state governmental agency shall file with the board a written request for PDMP information on a form provided by the board and in accordance with s. 146.82, Stats.
  - (f) Law enforcement authority. To obtain PDMP information, a federal, state or local law enforcement authority shall file with the board:
    1. a written request for PDMP information on a form provided by the board; and

2. a lawful order of a court of record or evidence otherwise required by s. 146.82, Stats.
- (g) Coroner, deputy coroner, medical examiner or medical examiner's assistant. To obtain PDMP information following the death of a patient, a coroner, deputy coroner, medical examiner or medical examiner's assistant shall file with the board a written request for PDMP information on a form provided by the board and in accordance with s. 146.82, Stats.
- (h) Department staff. To obtain PDMP information, department staff or staff of another licensing board who have been delegated the authority to investigate a dispenser or practitioner shall file with the board a written application for an account on a form provided by the board and in accordance with s. 146.82, Stats.
- (i) Relevant agency in another state. To obtain PDMP information, staff of a relevant agency in another state with which the program is not currently exchanging PDMP information under s. 18.12 shall file with the board:
  1. a written application for an account on a form provided by the board; and
  2. a written request for PDMP information that specifically indicates the legally authorized purpose for the information.
- (5) A person in possession of PDMP information shall only use PDMP information for purposes authorized under ss. 146.82 and 450.19, Stats., this chapter and other state or federal laws and regulations relating to the privacy of health care information.

Phar 18.09 Limiting access to PDMP information.

The board may suspend, revoke or otherwise restrict or limit a dispenser's, dispenser delegate's, practitioner's or practitioner delegate's account to access PDMP information for any of the following reasons:

- (1) the dispenser, dispenser delegate, practitioner or practitioner delegate is no longer licensed in this state to prescribe or dispense prescription drugs;
- (2) the dispenser, dispenser delegate, practitioner or practitioner delegate is no longer licensed in another state and recognized by this state as a person authorized to prescribe or dispense prescription drugs;
- (3) the board disciplines the dispenser, dispenser delegate, practitioner or practitioner delegate;
- (4) another licensing board disciplines the dispenser, dispenser delegate, practitioner or practitioner delegate;
- (5) a licensing board or equivalent agency in another jurisdiction disciplines the dispenser, dispenser delegate, practitioner or practitioner delegate;
- (6) the dispenser, dispenser delegate, practitioner or practitioner delegate uses PDMP information in violation of ss. 146.82, 450.19, Stats., this chapter or other state or federal laws or regulations relating to the privacy of health care information; or
- (7) the dispenser delegate or practitioner delegate is no longer delegated the task of inputting or accessing PDMP information.

Phar 18.10 Confidentiality of PDMP information.

- (1) The PDMP information maintained by the board, department or a vendor contracting with the department which is submitted to, maintained, or stored as a part of the program is not subject to inspection or copying under s. 19.35, Stats.
- (2) A person who discloses PDMP information in violation of ss. 146.82, 450.19, Stats., this chapter or other state or federal laws or regulations relating to the privacy of health care information, shall be subject to disciplinary action by the appropriate licensing board and all appropriate civil penalties.

Phar 18.11 Exchange of PDMP information.

- (1) The board may exchange PDMP information with a relevant agency in another U.S. state subject to the following:
  - (a) The relevant agency's prescription drug monitoring program is compatible with the program.
  - (b) The relevant agency in the other jurisdiction agrees to exchange similar information with the program.
- (2) In determining the compatibility of the relevant agency's prescription drug monitoring program, the board may consider the following:
  - (a) the safeguards for privacy of patient records and the agency's success in protecting patient privacy;
  - (b) the persons authorized by the agency to access the information stored by its prescription drug monitoring program;
  - (c) the schedules of controlled substances monitored by the agency;
  - (d) the information required by the agency to be submitted regarding the dispensing of a prescription drug; and
  - (e) the costs and benefits to the board of mutually sharing information with the agency.
- (3) The board may assess the agency's prescription drug monitoring program's continued compatibility with the program at any time.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Maintenance of Licensure Pilot Project	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Review the information provided and discuss potential MEB pilot project.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

## Maintenance of Licensure Pilot Projects (Phase 1)

### Licensing-System Pilots

#### *Purpose:*

- To evaluate the process, structure and resource requirements necessary, from a State Board perspective, to develop an effective and comprehensive MOL system.

#### *Targeted Stakeholder(s):*

- State Boards
- State Board Staff

#### *Initial Pilots:*

- State Board Readiness Inventory
- Communication about Each Pilot
- State Board License Renewal Process Integration

### Continuous Professional Development (CPD)-System Pilots

#### *Purpose:*

- To evaluate various aspects of the CPD Model and how they impact the process, structure and resource requirements necessary to develop an effective and comprehensive MOL system.

#### *Targeted Stakeholder(s):*

- Physicians
- Assessment Providers
- Education Providers
- Patient

#### *Initial Pilots:*

- Describing / Detailing Physician Practices
- Patient Safety
- Combined Fixed-Form Assessment Providing Physician Feedback
- Engage CME Providers

### MOL-System Pilots

#### *Purpose:*

- To evaluate the overall effectiveness of the process, structure and resource requirements necessary to develop an effective and comprehensive MOL system.

#### *Targeted Stakeholder(s):*

- State Boards
- Physicians
- Medical Organizations
- Public

#### *Initial Pilots:*

- Physician Acceptability Survey to Assess MOL Activities
- Non-MOC/OCC Physician
- Reporting of MOC Data to State Boards

89 We asked the staff to put together 20-25 pilots that ultimately would be required to fully  
90 demonstrate how MOL could be fully implemented across the country. Obviously, you can't do  
91 20-25 pilots all at once, so staff was asked to identify a handful of pilot projects that made  
92 sense as a phase I group. Then a Phase II and Phase III could be eased in over a period of time,  
93 perhaps a 3 to 4 year period.

94

95 These initial pilots are being offered to you as a consideration. We do not have all the details  
96 yet and we would love your feedback. I will be going over ten potential pilots in Phase I. We do  
97 not expect the boards to adopt all ten.

98

99 Here are some examples of the pilots. The categories are licensing system, CPD system and  
100 MOL system. Under the licensing system is state board readiness inventory pilot. This would  
101 entail surveys, an assessment of what each state board has available in terms of staff or specific  
102 tools, to begin to look at its readiness to implement MOL. Another licensing system pilot is  
103 communication about each pilot. This is communication not just about MOL, it is about what  
104 each pilot entails. Each board implementing a pilot will need to explain to physicians and  
105 members of the public what it is that they are doing. This pilot would be focused on a  
106 communication plan and talking points.

107

108 Sandra Waters, FSMB – The reason for wanting to pilot this is to get feedback on how MOL is  
109 being communicated, primarily from the medical boards and the physicians and key  
110 stakeholder groups.

111

112 Hank Chaudhry, D.O., FSMB - The third pilot in this category is state board license renewal  
113 process integration. This is looking at the way in which a state board currently processes  
114 licensure renewal and how would it be integrated with MOL.

115

116 Sandra Waters, FSMB – This is a pilot where we would be looking for guidance from the state  
117 boards.

118

119 Stan Riley, M.D., MA – It seems like all three of these pilots are almost essential.

120

121 Jim Peck, M.D., OR – We did do a survey of the surgeons and plan to do a survey of the entire  
122 licensees after our renewal is completed on December 31. One of the things we did find out is  
123 about 50% of the respondents do not know what MOL is. The surveys on communication and  
124 renewal process are all essential in how to get this done.

125

126 Hank Chaudhry, D.O., FSMB - Now, let's go over the next category of pilots, the MOL System  
127 pilots. This is looking at MOL and how it links up MOC and OCC, and how you demonstrate  
128 compliance. One category we would like to look at is specifically the category of physicians that  
129 are either not specialty certified or are certified but aren't engaged in MOC or OCC, or are  
130 grandfathered, so they were specialty certified at one point, but because they are  
131 grandfathered they don't have to do MOC or OCC, and are choosing not to. What kinds of tools

132 could be made available to this cohort of physicians is what this pilot, non-MOC/OCC physician,  
133 refers to.

134  
135 Another pilot is physician acceptability survey to assess MOL activities. What this pilot does, is  
136 it looks at what physicians are currently engaged in outside of a licensure requirement to assess  
137 their skills and how can that be linked up to MOL. There are a wide range of assessment tools  
138 out there that many physicians already engage, in which case MOL could be as simple as  
139 recognizing some of those activities and identifying which of those would be acceptable for  
140 MOL.

141  
142 The third pilot in this category is reporting of MOC data to state boards. This pilot is looking at  
143 MOC/OCC data that already exists and how can that link up to what a state board ultimately  
144 requires for MOL. I will remind everyone of something that should be obvious and something  
145 that the state boards are please to know is that the MOC program of the AMBS and the OCC  
146 program of AOA-BOS have moved, and/or are moving towards a continuous model. Years ago,  
147 these specialty certification/recertification processes had a 7 to 10 year time limit when they  
148 would expire. Both MOC and OCC are moving toward a continuous model which is very  
149 supportive of MOL. MOL truly is a continuous model. This pilot looks at what do you do with a  
150 physician who is already engaged in MOC or OCC, how do you get them on a logistical basis,  
151 how do you capture that in terms of MOL? Do you have them obtain an attestation letter from  
152 the ABMS or AOA-BOS? So, this pilot looks at how do the majority of physicians that are  
153 engaged in MOC or OCC, how they can demonstrate to a state board that they are actively  
154 engaged in those recertification programs.

155  
156 Linda Mascheri, AOA-BOS – Yes, most assuredly OCC will be a continuous process. We are  
157 looking at mechanisms for reporting where the physician is in the process, what he has  
158 completed, that would be available to state licensing boards. We are looking at making it  
159 accessible online.

160  
161 Hank Chaudhry, D.O., FSMB – Is that across all the specialties?

162  
163 Linda Mascheri, AOA-BOS – Yes, because all the specialties have to conform to the BOS.

164  
165 Kevin Weiss, M.D., ABMS – Our board approved the principles upon which the MOC program  
166 will be developing to 2015. Many of our boards are already formally doing continuous activity.  
167 An example is the American Board of Obstetrics and Gynecology. If you aren't doing something  
168 every year toward their process you won't be meeting the requirements. We are moving  
169 quickly away from the idea that every 5, 7 or 10 years this is happening. Also, just a couple of  
170 months ago we put online the information of meeting requirements of MOC and we have seven  
171 boards, for our first reporting cycle, and by this time next year we anticipate all 24 boards will  
172 be having that. We currently make it available through our public website.

173  
174 Hank Chaudhry, D.O., FSMB – Let me open the conversation to  
175 questions/thoughts/observations for these three pilots under the MOL system pilot category.

176 Jim Peck, M.D., Oregon - I spoke at the American College of Surgeons conference with an  
177 attendance of 15,000 surgeons, and the meeting on MOL and MOC was packed. It was  
178 interesting that we didn't get a lot of push-back. Most people were trying to figure out how  
179 they could get up to speed with MOC. The fact that ABMS was going to have it online and that  
180 it would have to be continuous because the American Board of Surgery is one of the seven  
181 boards. I think we are hearing less negative feedback than when we did our survey here in  
182 Oregon. We got a lot of negative feedback from the survey.

183  
184 Hank Chaudhry, D.O., FSMB – Let's move on to describe the third category of pilots which are  
185 the CPD system pilots. We have four in this category. The first is looking at describing/detailing  
186 physician practices. This pilot recognizes that physicians don't necessarily practice in the area  
187 in which they trained, so, this could also be through a survey process where we try to  
188 determine a process by which a state that implements MOL could determine and ascertain  
189 what that physician is actually doing in practice. In MOL the focus is less on what specialty you  
190 trained in, it is also an attempt to try and make sure MOL recognizes the area in which a  
191 physician is practicing. We felt that this could be a pilot to figure out how best to capture that  
192 kind of data. Another pilot is related to looking at a combined fixed-form assessment providing  
193 physician feedback. Assessments are an important component of many of the elements within  
194 the MOL components. You have the reflective self assessment, which is part of the first  
195 component, then the assessment of knowledge and skills within an area of practice that the  
196 physician is engaged in. So, this pilot looks at how we can begin to look at assessments and  
197 provide a mechanism where physicians can provide feedback as well as go through an  
198 assessment to demonstrate their competence in the categories in which they are practicing.  
199 This would probably be a pilot that the NBME and NBOME may wish to collaborate on. The  
200 focus is more on assessment.

201  
202 Peter Katsufakis, M.D., NBME – I would just emphasize a couple of points. One interesting  
203 aspect of this pilot is that we are looking to combine content from different organizations,  
204 basically NBME, NBOME and ABMS member boards, to create an assessment that is more  
205 tailored to the practice of an individual physician. The other point I would highlight is unlike the  
206 assessment that the three organizations have traditionally done, we are looking to build into  
207 these assessments a meaningful feedback for the physician that would then be used to guide  
208 subsequent educational training activities.

209  
210 Hank Chaudhry, D.O., FSMB – The next pilot is patient safety. One of the purposes of MOL is to  
211 insure the ongoing clinical competence of a physician in the area in which they practice, but the  
212 hope is that through the processes of MOL that we can actually make a difference in patient  
213 outcomes. When all three components are implemented over time by a state board, that will  
214 be easier to accomplish, but there is a strong feeling among the staff of the three organizations  
215 that there could be value in trying to determine early-on whether or not we can collate some of  
216 the tools, like patient safety, which is something that all the state boards, specialty boards, and  
217 physicians are interested in.

218

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**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? FSMB Annual Meeting	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> <div style="text-align: center;">(name)</div> <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Consider representation at the FSMB's annual meeting.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

**TRAVEL REIMBURSEMENT GUIDELINES  
FOR BOARD EXECUTIVE DIRECTORS  
ATTENDING THE FSMB ANNUAL MEETING**

The Federation of State Medical Boards of the United States, Inc. (FSMB) will reimburse board executive directors up to \$1,800 for travel, lodging and meal expenses incurred to attend the FSMB's Annual Meeting according to the Travel Reimbursement Guidelines. In the event the board executive director cannot attend the meeting, another senior staff person may be selected by the board president/chair to attend in the executive director's place. Annual Meeting registration fee will be waived.

**AIR TRAVEL**

The FSMB will reimburse the cost of one coach class, round trip airline ticket for the board executive director attending the annual meeting. **Tickets must be booked 14 days prior to travel through the Federation's authorized travel agency and billed directly to the corporate account. Tickets booked less than 14 days prior to travel or booked elsewhere will not be reimbursed.** However, if the executive director has access to a lower fare (such as a government rate) through another source, the FSMB will reimburse that airfare provided he/she obtains a written quote from the FSMB's travel agency for comparison. **The FSMB's Director of Meetings & Travel must be notified prior to making these alternate reservations.**

**Airline Class of Service**

All air travel must be in coach class. Travelers are expected to use the lowest logical airfare available (see below for definition) regardless of personal participation in a frequent flyer program. **Tickets will be nonrefundable and nontransferable.**

**Upgrades for Domestic Air Travel**

Upgrade coupons may be used only if they do not disqualify the traveler from a cheaper fare and are only allowed at the traveler's personal expense.

**Personal Stopovers**

Travelers must pay for any personal stopovers which increase airfare.

**Changes to Tickets**

Changes to tickets must be pre-approved by FSMB's Director of Meetings and Travel. Any additional fare or fee resulting from the change (including for standby travel on an earlier flight) will be at the traveler's expense unless the FSMB is requesting the traveler to make the change.

**Lowest Airfare Definition**

Travelers are expected to book the lowest logical airfare as determined by the travel agency based on the following parameters.

Negotiated Airfares - This could include designated airlines for certain routes, with which the Federation has a negotiated rate.

Routing - Routing requires no more than one stop with one change of plane for each way of a round trip. Routing does not increase the one-way total elapsed trip time (origin to destination) by more than 2 hours.

Time Window - Departure/arrival must be no more than 1 ½ hours before or after requested time for flights of 4 or more hours and 1 hour for flights less than 4 hours.

Should the board executive director choose a flight itinerary at a higher fare than a comparable fare offered by the FSMB's travel agency, he/she will be responsible for the additional expense regardless of whether the \$1,800 expense cap is reached.

If using rail or personal automobile, the total expense for such travel may not exceed the cost of prevailing coach airfare.

### **GROUND TRANSPORTATION**

Reimbursement for use of personal autos will be at a rate of 55.5 cents per mile plus fees for parking and tolls. Other auto expenses (violation tickets, maintenance) are not reimbursable. Reasonable cab fares and transfers to and from the airport will be reimbursed. Rental car expenses are not reimbursable.

### **LODGING**

In order to take advantage of the FSMB's scholarship, the board executive director must stay at the host hotel. Hotel costs will be reimbursed at the host hotel's single convention rate for up to **four nights from Wednesday through Saturday nights.**

### **MEALS & INCIDENTALS**

Meals (**when not provided**) and incidentals (e.g., tips, phone calls) will be reimbursed up to \$100 per day from Wednesday through Sunday. Consumption of alcohol is at the traveler's personal risk and the FSMB expects the traveler to act responsibly and avoid intoxication. Receipts for all meals are required. The FSMB does not reimburse on a per diem basis.

Excessive phone calls, in terms of number or length, will not be reimbursed.

### **MISCELLANEOUS EXPENSES**

Miscellaneous personal and business expenses are not reimbursable. These include:

- a) expense charges for family members or guests;
- b) expenses incurred for business related to other organizations;
- c) movies, gift shop purchases, dry cleaning/laundry
- d) Continuing Medical Education fees

Any such charges should be deducted when completing your reimbursement form.

### **SPECIAL TRAVEL ACCOMMODATIONS**

Individuals with documented disabilities as defined under the Americans with Disabilities Act of 1990 (ADA) may request special travel accommodations. Individuals requesting special accommodations must provide appropriate documentation to support the request. Requests will be evaluated on an individual basis.

The ADA and accompanying regulations define a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities. The purpose of documentation is to validate that the individual is covered under the ADA as a disabled individual. The purpose of accommodations is to provide equal access for individuals traveling on behalf of FSMB.

### **REIMBURSEMENT FORMS**

The FSMB Request for Reimbursement of Travel Expenses should be completed and submitted to the Federation's Director of Meetings and Travel within **90 days** following completion of travel. Requests for extensions must be in writing. Reimbursement will not be granted for requests received after 90 days unless a request for an extension has been submitted. **Receipts for all individual expenses exceeding \$25 must be attached to the reimbursement request.**



## MEMORANDUM

DATE: December 12, 2011

TO: **Presidents/Chairs and Executive Directors  
Member Medical Boards**

FROM: Deanne Dooley  
Executive Administrative Assistant  
Meeting and Travel Planning

RE: **Scholarship Program for the  
FSMB 2012 House of Delegates and Annual Meeting**

---

Preparations are underway for FSMB's 100<sup>th</sup> Annual Meeting to be held April 26 – April 28, 2012, at the Omni Fort Worth Hotel in Fort Worth, TX.

Reimbursement up to \$1,800 in travel expenses will be provided for each member board's president/chair attending as the voting delegate at the FSMB's House of Delegates Meeting on Saturday, April 28, 2012. If the president/chair is unable to participate, an alternate member of the medical board may be selected by the president/chair to attend as the designated voting delegate. **Please see the attached letter from the FSMB's Chair and President/CEO stressing the importance of the role of the voting delegate.**

The FSMB will also reimburse the executive director of each member board up to \$1,800 for expenses incurred in relation to his/her attendance at the Annual Meeting. In the event the executive director cannot participate, the president/chair may select another senior staff person to attend in the executive director's place.

Reimbursement for the voting delegate and the executive director will be made in accordance with the attached guidelines. Please complete the attached Scholarship Response Form identifying your board's scholarship recipients. **The deadline for returning the response form is February 3, 2012.** Upon receipt of the form, scholarship information and travel policies will be sent to the recipients.

Annual membership dues for member boards must be paid in full in order for both voting delegates and executive directors to take advantage of this scholarship opportunity. A draft agenda for the 2012 Annual Meeting will be posted on the FSMB's website at [www.fsmb.org](http://www.fsmb.org). Should you have any questions, you may reach me at 817-868-4086 or [ddooley@fsmb.org](mailto:ddooley@fsmb.org).

**TRAVEL REIMBURSEMENT GUIDELINES  
FOR VOTING DELEGATES  
ATTENDING THE FSMB ANNUAL MEETING**

The Federation of State Medical Boards of the United States, Inc. (FSMB) will reimburse board presidents/chairs up to \$1,800 for travel, lodging and meal expenses incurred to attend the FSMB's Annual House of Delegates Meeting according to the Travel Reimbursement Guidelines. In the event the president/chair cannot attend the meeting, an alternate member of the medical board may be selected by the board president/chair to attend as the designated voting delegate. **Only board members or associate members who participate as the voting delegate at the House of Delegates meeting will be eligible for reimbursement of expenses under this policy.** Annual Meeting registration fee will be waived.

**AIR TRAVEL**

The FSMB will reimburse the cost of one coach class, round trip airline ticket for the voting delegate attending the annual meeting. **Tickets must be booked 14 days prior to travel through the FSMB's authorized travel agency and billed directly to the corporate account. Tickets booked less than 14 days prior to travel or booked elsewhere will not be reimbursed.** However, if the voting delegate has access to a lower fare (such as a government rate) through another source, the FSMB will reimburse that airfare provided he/she obtains a written quote from the FSMB's travel agency for comparison. **The FSMB's Director of Meetings & Travel must be notified prior to making these alternate reservations.**

**Airline Class of Service**

All air travel must be in coach class. Travelers are expected to use the lowest logical airfare available (see below for definition) regardless of personal participation in a frequent flyer program. **Tickets will be nonrefundable and nontransferable.**

**Upgrades for Domestic Air Travel**

Upgrade coupons may be used only if they do not disqualify the traveler from a cheaper fare and are only allowed at the traveler's personal expense.

**Personal Stopovers**

Travelers must pay for any personal stopovers which increase airfare.

**Changes to Tickets**

Changes to tickets must be pre-approved by FSMB's Director of Meetings & Travel. Any additional fare or fee resulting from the change (including for standby travel on an earlier flight) will be at the traveler's expense unless the FSMB is requesting the traveler to make the change.

**Lowest Airfare Definition**

Travelers are expected to book the lowest logical airfare as determined by the travel agency based on the following parameters.

**Negotiated Airfares** - This could include designated airlines for certain routes, with which the Federation has a negotiated rate.

**Routing** - Routing requires no more than one stop with one change of plane for each way of a round trip. Routing does not increase the one-way total elapsed trip time (origin to destination) by more than 2 hours.

**Time Window** - Departure/arrival must be no more than 1 ½ hours before or after requested time for flights of 4 or more hours and 1 hour for flights less than 4 hours.

Should the voting delegate choose a flight itinerary at a higher fare than a comparable fare offered by the FSMB's travel agency, he/she will be responsible for the additional expense regardless of whether the \$1,800 expense cap is reached.

If using rail or personal automobile, the total expense for such travel may not exceed the cost of prevailing coach airfare.

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#### **LODGING**

In order to take advantage of the FSMB's scholarship, the Voting Delegate must stay at the host hotel. Hotel costs will be reimbursed at the host hotel's single convention rate for up to **four nights from Wednesday through Saturday nights.**

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- c) movies, gift shop purchases, dry cleaning/laundry
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**FEDERATION OF STATE MEDICAL BOARDS  
 2012 HOUSE OF DELEGATES AND ANNUAL MEETING  
 SCHOLARSHIP RECIPIENTS  
 RESPONSE FORM**

Please indicate below the name of your voting delegate for the 2012 Annual House of Delegates Meeting, as well as the name of the executive director or senior staff person who will be attending the Annual Meeting.

Please forward your response no later than **February 3, 2012**.

Name of Medical or Osteopathic Board: \_\_\_\_\_

Voting Delegate:

Executive Staff Representative:

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Title*

**NOTE: Confirmation and meeting materials will be sent to scholarship recipients at the address listed below.**

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Fax*

\_\_\_\_\_  
*Fax*

\_\_\_\_\_  
*Email*

\_\_\_\_\_  
*Email*

\_\_\_\_\_  
 Signature of Board President/Chair *(required)*

**PLEASE RETURN TO:**

**FEDERATION OF STATE MEDICAL BOARDS  
 ATTENTION: DEANNE DOOLEY  
 400 FULLER WISER ROAD, SUITE 300  
 EULESS, TX 76039  
 DDOOLEY@FSMB.ORG  
 FAX: (817) 868-4183**

**NATIONAL OFFICE**  
 400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039  
 (817)868-4000 | FAX (817)868-4098 | WWW.FSMB.ORG

**ADVOCACY OFFICE**  
 1110 VERMONT AVE., NW | SUITE 1000 | WASHINGTON, DC 20005  
 (202)530-4872 | FAX (202)530-4800



December 13, 2011

Dear Colleagues:

Preparations are underway for FSMB's Centennial Annual Meeting scheduled for April 26-28, 2012 in Fort Worth, Texas. The FSMB's House of Delegates (HOD) business meeting is held on the last day of the Annual Meeting. FSMB member board participation at the HOD meeting is extremely important because it is the boards' unique opportunity to gain greater insight into the FSMB's work and to contribute to the organization's policymaking process. The role of the voting delegate in that process is especially important because the delegate represents his/her state medical/osteopathic board on matters of significance to the board and elects FSMB Fellows to assist in carrying out the FSMB's work.

In anticipation of the HOD business meeting, we ask that you consider which of your board members will be best suited to serve as your voting delegate.

In order for the voting delegate to serve in a truly representative capacity, he/she is asked to fulfill a number of responsibilities.

Before the HOD meeting, the voting delegate is asked to:

- Become familiar with the structure, purpose and history of the FSMB HOD as well as FSMB's policymaking and election processes
- Attend meetings of the state medical and osteopathic board he/she represents to gain early information on statewide and national issues to be addressed at the HOD meeting
- Review all pre-meeting materials
- **Participate in a Voting Delegate Webinar on March 15, 2012 at 5:30-6:30 pm CDT**
- **Attend the Candidates Forum and Reference Committee meeting at the Annual Meeting and provide Reference Committee testimony as necessary**
- Network with colleagues at the Annual Meeting for additional information and perspectives on issues

During the meeting, the voting delegate is asked to:

- Follow the meeting rules as outlined by the Rules Committee
- Represent the position of his/her board during discussions as necessary
- Vote at the time requested

Following the meeting, the voting delegate is asked to:

- Report the results of the HOD meeting to his/her board
- Remain current on statewide and national issues affecting medical regulation in preparation for the next HOD meeting

**NATIONAL OFFICE**

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039  
(817)868-4000 | FAX (817)868-4098 | WWW.FSMB.ORG

**ADVOCACY OFFICE**

1110 VERMONT AVE., NW | SUITE 1000 | WASHINGTON, DC 20005  
(202)530-4872 | FAX (202)530-4800

As you can see, the role of the voting delegate should not be taken lightly. We therefore encourage you to give careful consideration in the selection of the individual who will be your representative at our Centennial meeting.

Sincerely,



Janelle A. Rhyne, MD, MA, MACP  
Chair



Humayun J. Chaudhry, DO, FACP  
President and CEO

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**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Consider Sheldon Wasserman Request for Board Approval to Apply for FSMB Nominating Committee Appointment	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> <div style="text-align: center; font-size: small;">(name)</div> <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Dr. Wasserman is interested in serving on the FSMB Nominating Committee. The Board should review this request and decide if it approves. If it does approve, a motion to that effect is necessary.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

## Nominating Committee

### COMMITTEE CHARGE

The charge of the Nominating Committee as currently set forth in the FSMB Bylaws is to submit a slate of one or more nominees for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates. The Committee will mail its slate of candidates to Member Boards not fewer than 60 days prior to the meeting of the House of Delegates.

Tasks of the Committee include:

1. Soliciting recommendations for candidates for elected positions from Member Boards and Fellows of the FSMB.
2. Assertively recruiting individuals who have the core competencies set forth on page 2 and who represent diversified backgrounds, experiences and cultures.
3. Educating potential candidates on core competencies for FSMB leadership roles and the responsibilities associated with respective leadership positions.
4. Reviewing letters of recommendation and supporting material of each individual nominated or recruited as a candidate for election.
5. Verifying that candidates have the core competencies for FSMB leadership positions.
6. Verifying that queries of FSMB Board Action Data Bank have been completed on physician candidates and that no actions have been reported which could call into question an individual's fitness for FSMB leadership.
7. Affirming that all candidates for elected leadership have disclosed any potential conflicts of interests.
8. Considering the importance of public representation on the FSMB Board of Directors and assuring the slate of candidates provides for election of adequate/qualified public representation.
9. Selecting and narrowing the slate of candidates to those who best demonstrate the core competencies; have the necessary qualifications and eligibility for a position; and bring valuable talents and perspectives to the FSMB.
10. Preparing a report to the House of Delegates that includes a slate of nominees for positions to be filled by election at the House of Delegates annual business meeting.
11. Determining process for notifying candidates of the Nominating Committee's decisions as soon as possible following the Committee meeting and providing the Nominating Committee report to the FSMB Board of Directors.

### TIME COMMITMENT

Members of the Nominating Committee serve two-year terms. The Committee will have its kick-off session in Fort Worth, Texas on the morning of Sunday, April 29, 2012 directly after the FSMB's Annual Meeting. The Committee will meet again via teleconference in July or August 2012 (date to be determined) and in Euless, Texas in January 2013.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? FSMB Request for Letter of Support for Grant Application	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <small>(name)</small> <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Decide if letter of support will be sent.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

LETTER OF SUPPORT

Date

Humayun J. Chaudhry, D.O.  
Chief Executive Officer  
Federation of State Medical Boards  
400 Fuller Wiser Road, Suite 300  
Eules, TX 76039-3855

Dear Dr. Chaudhry:

On behalf of the <BOARD NAME>, I am writing to express our support and commitment toward the further development and expansion of a multi-state cooperation between state licensing boards to create and implement policies that will reduce statutory and regulatory barriers to Telemedicine. The Board is particularly interested in overcoming unnecessary licensure barriers to cross-state practice, increasing mobility of health professionals, improving the efficiency of licensing and credential verification services and reducing redundancies in the licensing processes. We are in support of these initiatives, authorized under the Public Health Service Act, coordinated through the Health Resources and Services Administration (HRSA), and administered by the Federation of State Medical Boards (FSMB).

We are pleased by the opportunity the new grant presents to build on the important successes achieved pursuant to the 2006 License Portability Grant Program (LP1), which have continued under the 2009 License Portability Grant Program (LP2). The initial and subsequent funding provided a strong foundation and framework for the advancements made possible through this additional grant cycle. During the coming years, we believe that by continuing to leverage the experience of state medical boards from across the country, statutory and regulatory barriers will be reduced, greater efficiency will be achieved and public protection will remain paramount.

The <BOARD NAME> is committed to the success of this critical initiative and convinced that through our collaboration we will positively impact many aspects of health care delivery, including the promotion of telemedicine, improving access to health care, and the mobilization of physicians during public health and other emergencies. The <BOARD NAME> currently has <# of licensed and active physicians> that would benefit greatly of the initiative.

Thank you again for the opportunity to participate in this important initiative. We look forward to working with you, our state colleagues, the FSMB and AIM.

Sincerely,

< BOARD EXECUTIVE DIRECTOR >

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

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		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Report from FSMB Special Committee on Ethics and Professionalism	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Discuss the report and decide if any comments should be made to the Committee.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

## Ryan, Thomas - DSPS

---

**From:** Patricia McCarty (FSMB) [pmccarty@fsmb.org] on behalf of Humayun Chaudhry [hchaudhry@fsmb.org]  
**Sent:** Tuesday, December 20, 2011 10:09 AM  
**To:** Patricia McCarty (FSMB)  
**Subject:** For Comment - FSMB Report of the Special Committee on Ethics and Professionalism  
**Attachments:** Social Media Guidelines DRAFT.pdf

### MEMORANDUM

**To:** FSMB Member Board Executive Directors and Presidents/Chairs

**From:** Janelle Rhyne, M.D., MACP, Chair, Federation of State Medical Boards  
Humayun Chaudhry, D.O., FACP, President and CEO, Federation of State Medical Boards

**Date:** December 19, 2011

**Subject:** FSMB Report of the Special Committee on Ethics and Professionalism

In May 2011, FSMB Chair Dr. Janelle Rhyne appointed a Special Committee on Ethics and Professionalism to develop, as one of its first activities, guidelines for state medical and osteopathic boards to consider for their use in educating their licensees on the proper use of social media and social networking websites. The Committee was charged with providing ethical and professional guidance to the FSMB membership with regard to the use of electronic and digital media by physicians (and physician assistants, where appropriate) that may be used to facilitate patient care and nonprofessional interactions. Such electronic and digital media include, but are not limited to, email texting, blogs and social networks.

We are pleased to provide you with the Special Committee's draft report, which has been approved by the FSMB Board of Directors for distribution for solicitation of feedback from you. **We ask that you transmit your comments to Pat McCarty, FSMB Director of Leadership Services, at [pmccarty@fsmb.org](mailto:pmccarty@fsmb.org) or at 817-868-4067, no later than January 16, 2012** so that we have ample time to consider your comments before the report is reviewed by the FSMB's Board of Directors at our February 2012 meeting. The report will then be presented to the FSMB House of Delegates for adoption in April.

Should you have any questions, please feel free to contact either of us or Ms. McCarty. We look forward to hearing from you.

Thank you.

**Model Policy Guidelines for the Appropriate Use of Social Media and  
Social Networking in Medical Practice**

**A Policy Document of the Federation of State Medical Boards of the United States, Inc.**

# Report of the Special Committee on Ethics and Professionalism

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1 **Introduction and Charge**

2  
3 In recent years the medical profession has become aware of the opportunities and challenges that social  
4 media and social networking websites present for physicians. As technology has advanced, many  
5 hospitals and health care organizations have found it necessary to create their own policies in order to  
6 protect physicians and patients alike. In 2011, FSMB Chair Janelle A. Rhyne, M.D., MACP, asked the  
7 members of the Special Committee on Ethics and Professionalism to develop guidelines for state  
8 medical and osteopathic boards to consider for their use in educating their licensees on the proper use  
9 of social media and social networking websites.

10  
11 The Special Committee on Ethics and Professionalism was charged with providing ethical and  
12 professional guidance to the FSMB membership with regard to the use of electronic and digital media by  
13 physicians (and physician assistants, where appropriate) that may be used to facilitate patient care and  
14 nonprofessional interactions. Such electronic and digital media include, but are not limited to, email,  
15 texting, blogs and social networks. The Committee's proposed model guidelines contained in this report  
16 also focus on ways that physicians can protect the privacy and confidentiality of their patients as well as  
17 maintain a standard of professionalism in all social media and social networking interactions.

18  
19 The FSMB is grateful for the efforts of the members of the Special Committee on Ethics and  
20 Professionalism who provided input and direction for this project:

21		
22	Janelle A. Rhyne M.D., MACP, Chair	John P. Kopetski
23	FSMB Chair	Board Member
24	North Carolina Medical Board, Past President	Oregon Medical Board
25		
26	Lance A. Talmage, M.D., FACS, Ex Officio	M. Myron Leinwetter, D.O.
27	FSMB Chair-elect	President
28	State Medical Board of Ohio	Kansas State Board of Healing Arts
29		
30	Radheshyam M. Agrawal, M.D.	Bruce D. White, D.O., JD
31	Vice Chair	Director
32	Pennsylvania State Board of Medicine	Alden March Bioethics Institute
33		
34	Constance G. Diamond, DA	
35	Board Member	
36	New York State Office of Professional Medical Conduct	
37		
38	Robert P. Fedor, D.O.	
39	Board Member	
40	Florida Board of Osteopathic Medicine	

## Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

### Section One

#### Preamble

The use of social media has become increasingly important across all industries – including health care. *QuantiaMD* surveyed more than 4,000 physicians and reported in September 2011 that 87 percent use a social media website for personal use and 67 percent use social media for professional purposes.<sup>1</sup> In addition, there is some evidence that physicians may connect with patients through social media websites. A survey by the Markle Foundation showed that 6 percent of physicians would be willing to connect with their patients on social networking sites and another 9 percent were neutral on whether they would.<sup>2</sup>

Social media use presents several challenging questions for administrators and physicians, such as where the boundary of professionalism lies, and whether work experiences can be shared without violating the privacy and confidentiality of patients. Many physicians and medical students have been disciplined for unprofessional online conduct.<sup>3,4</sup> Many hospitals and health care organizations, including the Mayo Clinic, the Cleveland Clinic and the American Medical Association, have developed social media policies for their employees. Most physician licensing authorities in the United States have reported incidents of physicians engaging in online professionalism violations, many of which have resulted in serious disciplinary actions. In a 2010 survey of Executive Directors at state medical boards in the United States, 92 percent indicated that violations of online professionalism were reported in their jurisdiction. These violations included Internet use for inappropriate contact with patients (69 percent), inappropriate prescribing (63 percent), and misrepresentation of credentials or clinical outcomes (60 percent). In response to these violations, 71 percent of boards held formal disciplinary proceedings and 40 percent issued informal warnings. Outcomes from the disciplinary proceedings included serious actions such as license limitation (44 percent), suspension (29 percent), or revocation (21 percent) of licensure.

These growing concerns about physician use of social media demonstrates the need for a standardized social media policy. Social media has enormous potential for both physicians and their patients. It can be used to disseminate information and to forge meaningful professional relationships. However, these benefits must occur within the proper framework of professional ethics.

<sup>1</sup> [www.quantiamd.com/q-qcp/DoctorsPatientSocialMedia.pdf](http://www.quantiamd.com/q-qcp/DoctorsPatientSocialMedia.pdf)

<sup>2</sup> [www.ncmedboard.org/articles/detail/practicing\\_medicine\\_in\\_the\\_facebook\\_age\\_maintaining\\_professionalism\\_online/](http://www.ncmedboard.org/articles/detail/practicing_medicine_in_the_facebook_age_maintaining_professionalism_online/)

<sup>3</sup> [www.boston.com/lifestyle/health/articles/2011/04/20/for\\_doctors\\_social\\_media\\_a\\_tricky\\_case/?page=full](http://www.boston.com/lifestyle/health/articles/2011/04/20/for_doctors_social_media_a_tricky_case/?page=full)

<sup>4</sup> [www.ncbi.nlm.nih.gov/pubmed/19773566](http://www.ncbi.nlm.nih.gov/pubmed/19773566)

77 The use of social media and social networking in medical practice is a relatively new development, and  
78 physicians need education on the importance of maintaining the same professional and ethical  
79 standards in their online activity. The FSMB has developed this policy to encourage physicians who use  
80 social media and social networking to protect themselves from unintended consequences of such  
81 practices by:

- 82 • Protecting the privacy and confidentiality of their patients
- 83 • Avoiding requests for online medical advice
- 84 • Acting with professionalism
- 85 • Being forthcoming about their employment, credentials and conflicts of interest
- 86 • Being aware that information they post online may be available to anyone, and could be  
87 misconstrued

88 **Section Two**

89 **An Appropriate Physician-Patient Relationship**

90

91 The health and well-being of a patient depends upon a collaborative effort between the physician and  
92 patient. According to FSMB policy, the relationship between a physician and patient begins when an  
93 individual seeks assistance from a physician for a health-related matter, and the physician agrees to  
94 undertake diagnosis and treatment of the patient. The physician-patient relationship can even begin  
95 without a personal encounter, which allows for online interactions to constitute the beginning of the  
96 relationship. The physician-patient relationship is fundamental to the provision of acceptable medical  
97 care, and physicians are expected to recognize the obligations, responsibilities and patient rights  
98 associated with establishing and maintaining an appropriate physician-patient relationship, whether the  
99 interaction occurs in person or online.

100

101 The following narratives demonstrate how unintended consequences of physicians' use of social media  
102 and social networking can undermine a proper physician-patient relationship.

103

104 1. A urologist who is an astute clinician and well respected by his colleagues recently began posting  
105 his comments, views and observations on Twitter. The same day that the United States  
106 Preventive Services Task Force came out with a recommendation, in October 2011, against  
107 routine Prostate-Specific Antigen (PSA) screening in healthy men for prostate cancer, he posted  
108 a tweet with writing that used some disrespectful language to disagree with the  
109 recommendation. The tweet has now gone viral and has been read by many of his patients,  
110 colleagues, fellow researchers, family and friends.

111

112 2. A patient reports disrespectful language on a physician's blog. The physician expressed  
113 frustration towards another patient who had to visit the ER multiple times for failing to monitor  
114 their sugar levels. The physician referred to the patient as "lazy" and "ignorant" on their blog.

115

116 3. Approximately two years after a physician left their private practice, a former patient asked to  
117 "friend" them on Facebook. The physician set up a Facebook account to participate in a review  
118 course for Maintenance of Certification (MOC), but remained on Facebook to stay in touch with  
119 family. The physician felt conflicted about the request because they were no longer the patient's  
120 physician, and had no intention of returning to private practice. The patient was also very  
121 emotionally fragile, and cried at most office visits. The physician wrestled with whether or not to  
122 accept the request, but eventually did for fear that rejecting the request would damage the  
123 former patient's self-esteem. The former patient never posted anything inappropriate, and only  
124 contacted the physician to wish them happy birthday. The physician still feels uncomfortable  
125 maintaining this online "friendship", and has considered closing their Facebook account.

126

127 4. A psychiatrist in her 30s used Facebook to befriend a former female patient of similar age who  
128 she took care of when she was a psychiatry resident in another state. They had "hit it off"  
129 because they had similar tastes in music and art and developed a level of trust that the patient  
130 said she had not had with anyone else. They now periodically exchange pleasantries on

131 Facebook, but lately the patient's affect online appears different and the psychiatrist is worried.  
132 The psychiatrist is planning to spend the holidays with her family in the same state as her former  
133 patient, and is considering 'catching up' with her former patient, but is unsure how to properly  
134 initiate contact with her former patient. Should the psychiatrist just meet her for coffee? Is it  
135 appropriate for them to meet at all? She knows she probably shouldn't use Facebook because it  
136 may not be private, but she also doesn't want to give the patient her personal e-mail address.

137

138 5. A concerned patient reports her physician frequently describes "partying" on his Facebook page,  
139 which is accompanied by images of himself intoxicated. The patient begins to question whether  
140 her physician is in a proper state and prepared to treat her when she has early morning doctor's  
141 appointments.

142

143 6. A physician comes across the profile of one of his patients on an online dating website, and  
144 invites her to go on a date with him. The patient feels pressured to go on the date because if she  
145 doesn't, her next appointment with her physician would be awkward.

146

147 These examples highlight the importance of proper boundaries within the physician-patient relationship.  
148 Even seemingly innocuous online interactions with patients and former patients may violate the  
149 boundaries of a proper physician-patient relationship. Physicians should not use their professional  
150 position, whether online or in person, to develop personal relationships with patients. The appearance  
151 of unprofessionalism may lead patients to question a physician's competency. Physicians should refrain  
152 from portraying any unprofessional depictions of themselves on social media and social networking  
153 websites.

154

155

156 **Section Three**

157 **Parity of Professional and Ethical Standards**

158

159 To ensure a proper physician-patient relationship, there should be parity of ethical and professional  
160 standards applied to all aspects of a physician's practice, including online interactions through social  
161 media and social networking sites. Borrowing from the FSMB House of Delegate's *Model Guidelines for*  
162 *the Appropriate Use of the Internet in Medical Practice*, adopted in 2002, physicians using social media  
163 and social networking sites are expected to observe the following ethical standards:

164

165 Candor

166 Physicians have an obligation to disclose clearly any information (e.g., financial, professional or personal)  
167 that could influence patients' understanding or use of the information, products or services offered on  
168 any website offering health care services or information.

169

170 Privacy

171 Physicians have an obligation to prevent unauthorized access to, or use of, patient and personal data  
172 and to assure that "de-identified" data cannot be linked back to the user or patient.

173

174 Integrity

175 Information contained on websites should be truthful and not misleading or deceptive. It should be  
176 accurate and concise, up-to-date, and easy for patients to understand. Physicians associated with  
177 medical websites should strive to ensure that information provided is supported by current medical  
178 peer review literature (wherever possible), emanates from a recognized body of scientific and clinical  
179 knowledge and conforms to minimal standards of care. It should clearly indicate whether it is based  
180 upon scientific studies, expert consensus, professional experience or personal opinion.

181

182 How these ethical standards relate to the proper use of social media by physicians is explored further in  
183 the next section.

184 **Section Four**

185 **Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice**

186

187 The following guidelines have been developed for physicians who use social media and social  
188 networking in their personal and professional lives.

189

190 **Interacting with Patients**

191 Physicians are discouraged from interacting with patients on social media and social networking sites  
192 such as Facebook. Physicians should only have online interaction with patients when discussing the  
193 patient's medical treatment within the physician-patient relationship, and these interactions should  
194 never occur on social networking or social media websites.

195

196 **Discussion of Medicine Online**

197 Social networking websites may be useful places for physicians to gather to discuss their experiences, as  
198 well as to discuss areas of medicine and particular treatments. These types of professional interactions  
199 with other physicians represent an ancillary and convenient means for peer-to-peer education and  
200 discussion, but it is the responsibility of the physician, to the best of the physician's ability, to ensure  
201 that non-physicians do not have access to the information that is being shared. These websites should  
202 also be private and password protected to ensure that non-physicians do not gain access, because non-  
203 physicians who view these discussions may view them as medical advice, against the physicians' intent.  
204 Physicians should also check to ensure that any medical information from an online discussion that they  
205 plan to incorporate into their medical practice is corroborated and supported by current medical  
206 research.

207

208 **Privacy/Confidentiality**

209 Just as in the hospital or ambulatory setting, patient privacy and confidentiality must be protected at all  
210 times, especially on social media and social networking websites. These sites have the potential to be  
211 viewed by many people and any breaches in confidentiality could be harmful to the patient and in  
212 violation of federal privacy laws, such as HIPAA. While physicians may discuss their experiences in  
213 certain settings, they should never provide any information that could be used to identify patients.  
214 Physicians should never mention patients' room numbers, refer to them by code names, or even take  
215 their picture. If pictures of patients were to be viewed by others, it would constitute a serious HIPPA  
216 violation.

217

218 **Disclosure**

219 At times, physicians may be asked to write online about their experiences as a health professional, or  
220 they may post on a website under their capacity as a physician. When doing so, physicians must reveal  
221 any existing conflicts of interest, and they should be honest about their credentials as a physician.

222

223

224

225 **Posting Content**

226 Physicians should be aware that any information they post on a social networking site may be  
227 disseminated (whether intended or not) to a larger audience, and that what they say may be taken out  
228 of context or remain publicly available online in perpetuity. When posting content online, they should  
229 always remember that they are representing the medical community. Physicians should always act  
230 professionally and take caution not to post information that is ambiguous or that could be misconstrued  
231 or taken out of context. Physician employees of health care institutions should be aware that their  
232 employers may reserve the right to edit, modify or delete posts on their social media sites. Physician  
233 writers assume all risks related to the security, privacy and confidentiality of their posts. When  
234 moderating any website, physicians should delete inaccurate information or other's posts that violate  
235 the privacy and confidentiality of patients or that are of an unprofessional nature.

236

237 **General Professionalism**

238 In order to use social media and social networking sites professionally, physicians should also strive to  
239 adhere to the follow general suggestions:

- 240 • Use a personal rather than professional email address as the login for social media and social  
241 networking websites. Others who view a professional email attached to an online profile may  
242 misinterpret the physician's actions as representing the medical profession.
- 243 • Report any unprofessional behavior that is witnessed and always uphold principles of  
244 professionalism and refrain from unprofessional behavior.
- 245 • Cyber-bullying by a physician towards any individual is inappropriate and unprofessional.
- 246 • Refer, as appropriate, to an employer's social media or social networking policy for direction on  
247 the proper use of social media and social networking in relation to their employment.

248

249 **Medical and Osteopathic Board Sanctions and Disciplinary Findings**

250 State medical and osteopathic boards have the authority to discipline physicians for unprofessional  
251 behavior relating to the inappropriate use of social networking media such as:

- 252 • Inappropriate patient communication online
- 253 • Use of the Internet for inappropriate practice
- 254 • Online misrepresentation of credentials
- 255 • Online violations of patient confidentiality
- 256 • Failure to reveal conflicts of interest online
- 257 • Online derogatory remarks regarding a patient
- 258 • Online depiction of intoxication
- 259 • Discriminatory language or practices online

260 State medical and osteopathic boards have the option to discipline physicians for inappropriate or  
261 unprofessional conduct while using social media or social networking websites with actions that range  
262 from a letter of reprimand to the revocation of a license.

263

264 **Future Changes**

265 The Federation of State Medical Boards recognizes that emerging technology and societal trends will  
266 continue to change the landscape of social media and social networking, and how these websites are  
267 used by patients and physicians alike may likewise change. These guidelines are meant to be a starting  
268 point for the discussion of how physicians should properly communicate with their patients using social  
269 media, and these guidelines will need to be modified and adapted in future years as technology  
270 advances, best practices emerge, and opportunities for policy guidance are identified.

271 **Section Five**

272 **Key Definitions and Glossary**

273

274 For the purpose of this document and the guidelines presented, the following definitions apply:

275 **Social Media:** A way of broadcasting and discussing information to others.

276 **Social Networking:** Using a website for 2-way communication and for connecting with others.

277

278 **Glossary of Social Media and Social Networking Terms**<sup>5</sup>

279

280 **Avatar** - An Avatar is an image or username that represents a person online within forums and social  
281 networks.

282 **Blog** - Blog is a word that was created from two words: "web log". Blogs are usually maintained by an  
283 individual with regular entries of commentary, descriptions of events, or other material such as graphics  
284 or video. Entries are commonly displayed in reverse-chronological order. "Blog" can also be used as a  
285 verb, meaning *to maintain or add content to a blog*.

286 **Blogger** - Blogger is a free blogging platform owned by Google that allows individuals and companies to  
287 host and publish a blog typically on a subdomain. Example: yourblogname.blogspot.com

288 **Bridging** – Bridging can refer to the function patient networking sites serve for people living with chronic  
289 disease. Social networking for the chronically ill bridges the gap between the restrictive conditions in  
290 which they live and access to support groups and other resources that are important for coping and  
291 recovery.

292 **Chat** - Chat can refer to any kind of communication over the Internet, but traditionally refers to one-to-  
293 one communication through a text-based chat application commonly referred to as instant messaging  
294 applications.

295 **Comment** - A comment is a response that is often provided as an answer of reaction to a blog post or  
296 message on a social network. Comments are a primary form of two-way communication on the social  
297 web.

298 **Craigslist** - Craigslist is a popular online commerce site in which users sell a variety of goods and services  
299 to other users. The service has been credited for causing the reduction of classified advertising in  
300 newspapers across the United States.

301 **Delicious** - Delicious is a free online bookmarking service that lets users save website addresses publicly  
302 and privately online so that they can be accessed from any device connected to the Internet and shared  
303 with friends.

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<sup>5</sup> <http://blog.hubspot.com/blog/tabid/6307/bid/6126/The-Ultimate-Glossary-101-Social-Media-Marketing-Terms-Explained.aspx>

304 **Digg** - Digg is a social news website that allows members to submit and vote for articles. Articles with  
305 the most votes appear on the homepage of the site and subsequently are seen by the largest portion of  
306 the site's membership as well as other visitors.

307 **Email** - Electronic mail, commonly called e-mail or email, is a method of exchanging digital messages  
308 from an author to one or more recipients. Modern email operates across the Internet or other computer  
309 networks.

310 **Email Address** - An email address identifies an email box to which email messages are delivered.  
311 Individuals can separate their personal and professional identities online by managing personal and  
312 professional email addresses that are used for different purposes and require different styles of  
313 communication.

314 **Facebook** - Facebook is a social utility that connects people with friends and others who work, study and  
315 live around them. Facebook is the largest social network in the world with more than 500 million users.

316 **Firefox** - Firefox is an open-source web browser. It has emerged as one of the most popular web  
317 browsers on the Internet and allows users to customize their browser through the use of third-party  
318 extensions.

319 **Flash Mob** - A flash mob is a large group of people who assemble suddenly in a public place, perform an  
320 unusual and pointless act for a brief time, then quickly disperse. The term *flash mob* is generally applied  
321 only to gatherings organized via telecommunications, social media, or viral emails.

322 **Flickr** - Flickr is a social network based around online picture sharing. The service allows users to store  
323 photos online and then share them with others through profiles, groups, sets and other methods.

324 **Forums** - Also known as a message board, a forum is an online discussion site. It originated as the  
325 modern equivalent of a traditional bulletin board, and a technological evolution of the dialup bulletin  
326 board system.

327 **Foursquare** - Foursquare is a social network in which friends share their locations and connect with  
328 others in close physical proximity to each other. The service uses a system of digital badges to reward  
329 players who "check in" to different types of locations.

330 **Google Buzz** - Google Buzz is a social networking and messaging tool from Google, designed to integrate  
331 into the company's web-based email program, Gmail. Users can share links, photos, videos, status  
332 messages and comments organized in "conversations" and visible in the user's inbox.

333 **Google Chrome** - Google Chrome is a free web browser produced by Google that fully integrates into its  
334 online search system as well as other applications.

335 **Google Documents** - Google Documents is a group of web-based office applications that includes tools  
336 for word processing, presentations and spreadsheet analysis. All documents are stored and edited  
337 online and allow multiple people to collaborate on a document in real-time.

338 **Google Wave** - Google Wave is a collaboration tool developed by Google as a next-generation solution  
339 to e-mail communication. A *wave* is a live, shared space on the web where people can discuss and work  
340 together using richly formatted text, photos, videos, maps, and more.

341 **Hashtag** - A hashtag is a tag used on the social network Twitter as a way to annotate a message. A  
342 hashtag is a word or phrase preceded by a "#". Example: #yourhashtag. Hashtags are commonly used to  
343 show that a tweet, a Twitter message, is related to an event or conference.

344 **HTML** - HyperText Markup Language (HTML) is a programming language for web pages. Think of HTML as  
345 the brick-and-mortar of pages on the web -- it provides content and structure while CSS supplies style.

346 **Instant Messaging** - Instant messaging (IM) is a form of real-time direct text-based communication  
347 between two or more people. More advanced instant messaging software clients also allow enhanced  
348 modes of communication, such as live voice or video calling.

349 **Lifecasting** - Lifecasting is a continual broadcast of events in a person's life through digital media.  
350 Typically, lifecasting is transmitted through the Internet and can involve wearable technology.

351 **Like** - A "Like" is an action that can be made by a Facebook user. Instead of writing a comment for a  
352 message or a status update, a Facebook user can click the "Like" button as a quick way to show approval  
353 and share the message.

354 **Link Building** - Link building is an aspect of search engine optimization in which website owners develop  
355 strategies to generate links to their site from other websites with the hopes of improving their search  
356 engine ranking. Blogging has emerged as a popular method of link building.

357 **LinkedIn** - LinkedIn is a business-oriented social networking site. Founded in December 2002 and  
358 launched in May 2003, it is mainly used for professional networking. As of June 2010, LinkedIn had more  
359 than 70 million registered users, spanning more than 200 countries and territories worldwide

360 **Lurker** - A lurker online is a person who reads discussions on a message board, newsgroup, social  
361 network, or other interactive system, but rarely or never participates in the discussion.

362 **Mashup** - A content mashup contains multiple types of media drawn from pre-existing sources to create  
363 a new work. Digital mashups allow individuals or businesses to create new pieces of content by  
364 combining multiple online content sources.

365 **Moderation System** - A moderation system is the method a webmaster chooses to sort contributions  
366 which are irrelevant, obscene, illegal or insulting with regards to useful or informative contributions.

367 **MyLife** - MyLife is a Microsoft application that helps mobile phone users log their own blood pressure  
368 and weight and also monitor their meals and daily exercise.

369 **MySpace** - MySpace is a social networking website owned by News Corporation. MySpace became the  
370 most popular social networking site in the United States in June 2006 and was overtaken internationally  
371 by its main competitor, Facebook, in April 2008.

372 **New Media** - New Media is a generic term for the many different forms of electronic communications  
373 that are made possible through the use of computer technology. The term is in relation to "old" media  
374 forms such as print newspapers and magazines that are static representations of text and graphics.

375 **News Reader** - A news reader allows users to aggregate articles from multiple websites into one place  
376 using RSS feeds. The purpose of these aggregators is to allow for a faster and more efficient  
377 consumption of information.

378 **Newsvine** - Newsvine is a social news site similar to Digg in which users submit and vote for stories to be  
379 shared and read by other members of the community.

380 **Opera** - Opera is an open-source web browser. While not as popular as Firefox, Opera is used as the  
381 default browser on some gaming systems and mobile devices.

382 **Orkut** - Orkut is a social networking website that is owned and operated by Google. The website is  
383 named after its creator, Google employee Orkut Büyükkökten. Although Orkut is less popular in the  
384 United States than competitors Facebook and MySpace, it is one of the most visited websites in India  
385 and Brazil.

386 **Pandora** - Pandora is a social online radio station that allows users to create stations based on their  
387 favorite artists and types of music.

388 **Permalink** - A permalink is an address or URL of a particular post within a blog or website.

389 **Podcast** - A podcast, or non-streamed webcast, is a series of digital media files, either audio or video,  
390 that are released episodically and often downloaded through an RSS feed..

391 **Real-Time Search** - Real-time search is the method of indexing content being published online into  
392 search engine results with virtually no delay.

393 **Reddit** - Reddit is similar to Digg and Newsvine. It is a social news site that is built upon a community of  
394 users who share and comment on stories.

395 **Search Engine Optimization** - Search Engine Optimization is the process of improving the volume or  
396 quality of traffic to a website from search engines via unpaid or organic search traffic.

397 **Second Life** - Second Life is an online virtual world developed by Linden Lab. Users are called "residents"  
398 and they interact with each other through avatars. Residents can explore, meet other residents,  
399 socialize, participate in individual and group activities, create and trade virtual property and services  
400 with one another, and travel throughout the world.

401 **Skype** - Skype is a free program that allows for text, audio and video chats between users. Additionally,  
402 users can purchase plans to receive phone calls through their Skype account.

403 **Social Media** - Social media is media designed to be disseminated through social interaction, created  
404 using highly accessible and scalable publishing techniques.

405 **Social Media Monitoring** - Social media monitoring is a process of monitoring and responding to  
406 mentions related to a business that occur in social media.

407 **StumbleUpon** - Free web-browser extension which acts as an intelligent browsing tool for discovering  
408 and sharing web sites.

409 **Tag Cloud** - A tag cloud is a visual depiction of user-generated tags, or simply the word content of a site,  
410 typically used to describe the content of web sites.

411 **Texting** - Text messaging, or texting, refers to the exchange of brief written text messages between  
412 fixed-line phone or mobile phone and fixed or portable devices over a network.

413 **Tweet** - A message or update that one posts on Twitter.

414 **Twitter** - Twitter is a platform that allows users to share 140-character-long messages publicly. User can  
415 "follow" each other as a way of subscribing to each others' messages. Additionally, users can use the  
416 @username command to direct a message towards another Twitter user.

417 **Tumblr** - Tumblr lets users share content in the form of a blog. Users can post text, photos, quotes, links,  
418 music, and videos from your browser, phone, desktop, or email.

419 **USTREAM** - USTREAM is a live interactive broadcast platform that enables anyone with an Internet  
420 connection and a camera to engage to stream video online.

421 **URL** - A URL is most popularly known as the "address" of a web page on the World Wide Web, e.g.  
422 <http://www.example.com>

423 **Video Blog** - A video blog is a blog the produces regular video content often around the same theme on  
424 a daily or weekly basis. An example of a successful video blog is Wine Library TV.

425 **Vimeo** - Vimeo is a popular video sharing service in which users can upload videos to be hosted online  
426 and shared and watched by others. Vimeo user videos are often more artistic and the service does not  
427 allow commercial video content.

428 **Viral Marketing** - Viral marketing refers to marketing techniques that use pre-existing social networks to  
429 produce increases in brand awareness or to achieve other marketing objectives through self-replicating  
430 viral processes.

431 **Webinar** - A webinar is used to conduct live meetings, training, or presentations via the Internet.

432 **Widget** - A widget is an element of a graphical user interface that displays an information arrangement  
433 changeable by the user, such as a window or text box.

434 **Wiki** - A wiki is a website that allows the easy creation and editing of any number of interlinked web  
435 pages via a web browser, allowing for collaboration between users.

436 **Wikipedia** - Wikipedia is a free, web-based, collaborative, multilingual encyclopedia project supported  
437 by the non-profit Wikimedia Foundation. Its 15 million articles (over 3.3 million in English) have been  
438 written collaboratively by volunteers around the world, and almost all of its articles can be edited by  
439 anyone with access to the site.

440 **WordPress** - WordPress is a content management system and contains blog publishing tools that allow  
441 users to host and publish blogs.

442 **Yelp** - Yelp is a social network and local search website that provides users with a platform to review,  
443 rate and discuss local businesses.

444 **YouTube** - YouTube is a video-sharing website on which users can upload, share, and view videos.

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**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Report from FSMB Workgroup to Define a Minimal Data Set	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Discuss the report and decide if any comments should be made to the Workgroup by the 1/25 deadline.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

**Ryan, Thomas - DSPS**

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**From:** Humayun Chaudhry [hchaudhry@fsmb.org]  
**Sent:** Tuesday, December 20, 2011 1:45 PM  
**To:** Humayun Chaudhry  
**Attachments:** MDS Framework 12-19-2011.doc

**MEMORANDUM**

**To:** FSMB Member Board Executive Directors and Presidents/Chairs  
Representatives of Selected Organizations

**From:** Janelle Rhyne, M.D., MACP, Chair, Federation of State Medical Boards  
Humayun Chaudhry, D.O., FACP, President and CEO, Federation of State Medical Boards

**Date:** December 20, 2011

**Subject:** Report of the FSMB Workgroup to Define a Minimal Data Set

In May 2011, FSMB Chair Dr. Janelle Rhyne appointed a Working Group to Define a Minimal Data Set to recommend a framework by which state medical boards may begin to better define their physician workforce. The FSMB's Minimal Data Set (MDS) Workgroup, chaired by FSMB Associate Board Member Richard Whitehouse, Esq., convened in the summer of 2011 and was charged with consulting with national workforce groups such as the National Center for Health Workforce Analysis (NCHWA) to facilitate development of a minimal physician demographic data set as well as to develop a minimum physician demographic data collection tool and a physician demographic data repository.

In carrying out its charge, the MDS Workgroup was asked to build and recommend a framework for state boards, or their designated affiliate organizations, to collect and share with the FSMB additional demographic and practice data for physicians licensed in their jurisdictions.

We are pleased to provide you with the Workgroup's recommendations and report, which is also being provided to the FSMB Board of Directors. We ask that you transmit your comments to Aaron Young, Ph.D., FSMB's Senior Director of Research, at [ayoung@fsmb.org](mailto:ayoung@fsmb.org) or at 817-868-5179, no later than January 25, 2012 so that we have ample time to consider your comments before the report is formally presented to FSMB's Board of Directors at our February 2012 meeting. Following approval by the FSMB board, the report will then be presented to the FSMB House of Delegates for adoption in April in Fort Worth.

Should you have any questions, please feel free to contact either of us or Dr. Young. We look forward to hearing from you.

Thank you.

**Humayun J. Chaudhry, D.O., M.S., FACP, FACOI**  
President and Chief Executive Officer

**Federation of State Medical Boards**  
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**WORKGROUP TO DEFINE A MINIMAL DATA SET**

**Report on a Recommended Framework for a Minimal Physician Data Set**

**Approved for dissemination by FSMB Board of Directors**

**December 2011**

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## **PARTICIPANTS ON THE WORKGROUP TO DEFINE A MINIMAL DATA SET**

### **WORKGROUP MEMBERS**

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Executive Director, State Medical Board of Ohio

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### **EX OFFICIO**

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Chair-elect, Federation of State Medical Boards  
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President and CEO  
Federation of State Medical Boards

Sheila R. Still  
Admin Asst, Education and Library  
Federation of State Medical Boards

**FEDERATION OF STATE MEDICAL BOARDS  
WORKGROUP TO DEFINE A MINIMAL DATA SET**

**Report to the Federation of State Medical Boards, Inc**

**INTRODUCTION AND CHARGE**

The passage of the Patient Protection and Affordable Care Act (PPACA), the aging of the population and the growth of the population have been described as three of the most important factors influencing why accurate assessments of the supply and demand for physicians are critical to understanding the health care needs of citizens throughout the United States and its territories. Under the PPACA, it is estimated that by 2019 an additional 32 million Americans may be insured.<sup>i</sup> In terms of demographics, the total population of the United States is projected to grow by 60 million to a total of 373 million by 2030.<sup>ii</sup> Additionally, baby boomers started turning 65 in 2011 and each day for the next 19 years an estimated 10,000 boomers will reach age 65.<sup>iii</sup> By 2030, all boomers will be 65 years of age or older and represent nearly 20% of the total population.<sup>iv</sup> Health-care reform, a growing and aging population combined with a projected physician shortage as high as 130,000 by 2025,<sup>v</sup> underscore the importance of knowing as much as possible about the physician workforce. How this challenge is addressed will impact many areas of the physician education and qualification process, including initial certification and licensure (e.g., number of test administrations), specialty certification and maintenance of certification (MOC), and maintenance of licensure (MOL).

As part of their ongoing effort to protect the public, the nation's state medical and osteopathic boards regularly collect and disseminate information about actively licensed physicians in their jurisdictions to the Federation of State Medical Board's (FSMB) Physician Data Center. In 2010, the FSMB systematically collated and analyzed all of this data to determine an accurate count of the number, age, specialty certification, and location by region of actively licensed physicians in the United States and the District of Columbia.<sup>vi</sup> The inaugural 2010 FSMB Census was successful and highlighted the need for additional research. A limitation of the 2010 FSMB Census data was that it did not contain information about a physician's professional activity. Physicians engage in patient care and/or other non-patient care activities, including teaching, administration, research or other professional activities. Although non-patient care includes important activities that contribute to quality health care delivery, many physicians involved in such re activities may have an active license, which may contribute to an overestimation of the current physician workforce. Furthermore, a licensed physician may be retired or work only part time, which could also contribute to an overestimation of the current physician workforce.

It was clear from the census that opportunities exist for future analyses that could be maximized with an expanded data-collection-collaboration between the FSMB, its member boards, and other organizations within the house of medicine. In 2011, the FSMB House of Delegates adopted a resolution that called for the FSMB, in cooperation with its state medical and osteopathic boards, to develop a minimum physician demographic and practice data set, as well as a data collection tool and physician data repository. The FSMB Board of Directors, led by Board Chair Janelle Rhyne, MD, MA, MACP, created the FSMB Workgroup to Define a Minimal Data Set.

The FSMB's Minimal Data Set (MDS) Workgroup convened in the summer of 2011 and was charged with consulting with national workforce groups such as the National Center for Health Workforce Analysis (NCHWA) to facilitate development of a minimal physician demographic data set as well as develop a minimum physician demographic data collection tool and a physician demographic data repository. In carrying out its charge, the MDS Workgroup was asked to build and recommend a framework for state boards, or their designated affiliate organizations, to collect and share with the FSMB additional demographic and practice data for physicians licensed in their jurisdictions.

#### **IMPORTANCE OF A MINIMAL PHYSICIAN DATA SET**

The MDS Workgroup identified five key reasons why establishing a minimal data set is important to the health care system:

1. Physician workforce participation (entry, retention, exit and re-entry) is subject to unpredictable economic factors, licensure and certification requirements, skills portability, as well as structural workforce issues such as participation levels, workforce aging, lifestyle factors, and gender.
2. It provides accurate and consistent information about physicians to state boards which could be used in planning for the future needs.
3. Accurate projections of physician supply inform policymakers about the number and specialty composition of physicians, as well as help determine the need for other health care practitioners.
4. Some individuals hold licenses in more than one jurisdiction; uniform physician workforce data would lead to a better understanding of geographic participation and migratory patterns.
5. Physician supply and composition impact areas of the education and qualification process, including initial licensure, Maintenance of Licensure (MOL), specialty certification and Maintenance of Certification (MOC).

## METHODOLOGY

The MDS Workgroup held teleconference meetings on July 12, 2011 and September 19, 2011. The workgroup also had one face-to-face meeting with representatives from the National Center for Health Workforce Analysis (NCHWA) in Washington D.C., on November 22, 2011.

The MDS Workgroup agreed that a recommended framework for a minimal physician data set should be ready to be presented to the FSMB House of Delegates for a vote during the April 2012 FSMB Annual Meeting. However, if additional time was needed, an extension would be granted.

The MDS Workgroup used a knowledge-based approach to its deliberations. The workgroup reviewed pertinent health workforce literature, considered research conducted by other organizations, and studied standardized questions suggested by the NCHWA. To compare the current process being used and the physician workforce data elements being collected, the MDS Workgroup also gathered information available from 59 of the 69 FSMB member boards involved in licensing decisions. The information collected showed that 63 percent of responding boards collect at least some physician workforce data. As demonstrated by the findings, the procedures for collecting the data and the types of data elements collected vary noticeably for the 37 boards that indicated they collect information. Of the 37 boards that collect at least some physician workforce data the research indicates:

- 68 percent include workforce questions in their license renewal application
- 54 percent ask workforce questions that are voluntary
- 19 percent ask workforce questions that are mandatory
- 16 percent have a combination of voluntary and mandatory questions

In terms of demographic data sought by the boards, highlights from the 37 boards that collect data show similar variability:

- 49 percent ask for gender
- 46 percent ask for race
- 38 percent ask for ethnic background

The information collected also provided a range of other data points regarding physician characteristics and patient care. Generally, the research showed a fairly wide range of practices in terms of what kinds of questions are asked and what kind of information is being compiled by the boards.

Among the categories are questions about full-time vs. part-time practice, average hours per week per specialty area, hours per week spent in various practice settings, practice location and a variety of others.

- 78 percent ask if the physician works full time or part time
- 65 percent ask for practicing specialty(s)
- 49 percent ask average hours per week per specialty(s)
- 62 percent ask for average hours per week per practice setting

### **FRAMEWORK FOR A MINIMAL PHYSICIAN DATA SET**

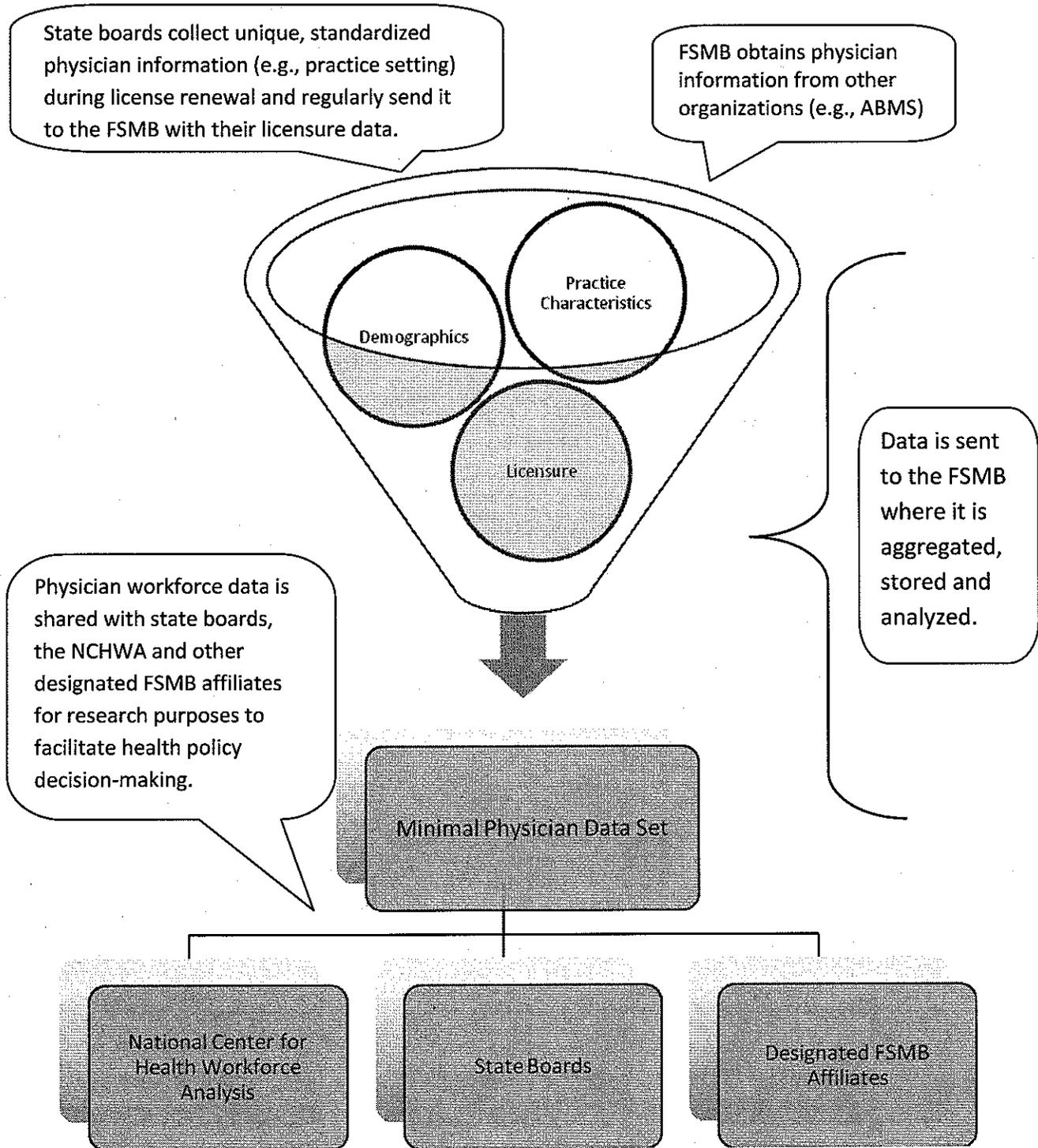
After reviewing applicable health workforce literature and analyzing information from state boards and the National Center for Health Workforce Analysis (NCHWA), the MDS Workgroup agreed that **a state board's license renewal process is a unique opportunity for collecting additional, up-to-date workforce information from physicians.** Twenty-six percent of state boards require physicians to renew their license every year, 66 percent require renewal once every two years and the remaining boards require renewal every three years or more. In addition, information gathered on the 37 boards that collect at least some physician workforce data indicated that the procedures for collecting data and the types of data elements collected vary considerably.

Based on this information, the MDS Workgroup developed and recommended a framework for a uniform minimal physician data set to be presented to the FSMB Board of Directors, state boards, and finally the FSMB House of Delegates at the 2012 FSMB Annual Meeting with the intent of future implementation by state medical and osteopathic boards. **The recommended principles of the framework for a minimal physician data set are:**

- **Workforce questions for a minimal physician data set should be added to a renewal application or be a separate questionnaire tied directly to the renewal process.** The collection process should be determined by each board, but the workgroup strongly recommends that the questions be a mandatory component to the renewal process to stress the importance of the data and maximize the quantity and quality of data collected.
- **Workforce questions for a minimal physician data set should be standardized across all state boards and not found in other sources.** Questions should be straightforward for licensees, take about 10 minutes or less to answer, and be in an easy-to-use electronic format that follows best practices for user-friendly, survey interface design (e.g., drop-down menus).

- State boards may choose to collect data using various methods. To further enhance the value of their data, state boards may also choose to expand their data by adding other questions not recommended for the minimal physician data set. **State boards should share their methods for collecting physician data and the additional information they collect with the FSMB and other state boards to help establish best practices for collecting physician workforce data.**
- **Data for the minimal physician data set should be aggregated and stored in the FSMB's Federation Physician Data Center (FPDC).** The FPDC is a comprehensive central repository of state-based data that contains some biographical, educational and disciplinary information about physicians licensed in jurisdictions throughout the United States and its territories. The complete database contains more than 1.6 million physician records, including information about physicians who are currently licensed, no longer licensed, or deceased. The FPDC is continuously updated and the majority of state boards provide medical licensure information to the FPDC on a monthly or quarterly basis. The workgroup strongly recommends that the boards include physician data from standardized workforce questions with their regular transmissions of licensure data to the FPDC.
- **The FSMB should maintain the repository of physician workforce data and create a confidential database for use by state boards, the NCHWA and other designated FSMB affiliates for research purposes.**
- **The FSMB should continue to collaborate with state boards and affiliate health care organizations to improve the collection and accuracy of physician workforce data in the United States.**

# GRAPHIC REPRESENTATION OF A MINIMAL PHYSICIAN DATA SET



## RECOMMENDED DATA ELEMENTS FOR A MINIMAL PHYSICIAN DATA SET

The MDS Workgroup identified the data elements listed below to be included in a uniform, minimal physician data set. The workgroup believes that many of the elements identified fall into one of three categories: (1) data currently provided by state boards as part of their regular transmissions of licensure data; (2) data that is or may be obtained by the FSMB through data sharing agreements with other organizations; or (3) unique and standardized data that state boards can obtain by adding questions to their renewal application or by asking questions as part of a separate questionnaire tied directly to the renewal process.

Data Element	Source and Rationale (when applicable)
Licensure status (active or inactive)	Currently provided by state boards.
Date of birth (mm/dd/yy)	Currently provided by state boards. FSMB has the date of birth for more than 96% of physicians with an active license.
Medical school graduated	Currently provided by state boards. FSMB has medical school matriculation data for more than 99% of physicians with an active license.
Medical school graduation year	Currently provided by state boards. FSMB has the medical school graduation year for more than 98% of physicians with an active license.
Specialty and subspecialty board certification	Obtained by FSMB. Specialty and subspecialty certification data is currently provided to FSMB by ABMS on a daily basis. FSMB is working with AOA to obtain access to their specialty and subspecialty certification data.
Maintenance of Certification and Osteopathic Continuous Certification	Obtained by FSMB from the ABMS and the AOA as the information becomes available.
Maintenance of Licensure	Provided by state boards as MOL programs are adopted and implemented.
Employment status	State board question. Physicians may hold an active license but be retired.
Provide clinical or patient care.	State board question. Physician may hold a position in a field of medicine, but do not provide direct patient care (important for reentry decisions by state boards).
If <u>no</u> , number of years since provided clinical or patient care	State board question. Provides important input for physician entry.
Areas of practice	State board question. This question provides input on the true areas of practice for a physician (primary care, dermatology, surgery).
Practice settings	State board question. Physician can practice in different settings (e.g., clinic or hospital).
Number of weeks worked during the past year	State board question. This information will help state boards better understand the level of participation among licensed physicians in their jurisdictions.
Average number of hours worked per week by activity	State board question. Some physicians are involved in direct patient care and work as an administrator and conduct research during the same week.
Clinical locations	State board question. Some physicians may work in more than one location.
Hours per week providing patient care by location	State board question. Some physicians may work varying amounts in more than one location.
Gender	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Race (optional)	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Ethnicity (optional)	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Languages spoken (optional)	State board question.

**RECOMMENDED QUESTIONS FOR A MINIMAL PHYSICIAN DATA SET**

The MDS Workgroup strongly recommends that the physician workforce questions presented in this section be added to state boards' renewal applications or be a separate questionnaire tied directly to the renewal process. The questions serve as a guide for standardizing a minimal set of data for physicians across all state boards.

1. What is your current employment status?
  - Actively working in a position that requires a medical license
  - Actively working in a field other than medicine
  - Not currently working
  - Retired
  
2. Are you currently providing clinical or patient care?
  - Yes
  - No
    - a. If no, how many years has it been since you provided clinical or patient care?
      - Less than 2 years
      - 2 to 5 years
      - 5 to 10 years
      - More than 10 years
  
3. Which of the following best describes the area(s) of practice in which you spend most of your professional time:

Area of Practice	Primary	Secondary	Completed Accredited Residency Program or Fellowship
Primary Care Specialties (General IM, Family Medicine/GP, General Peds, Geriatrics)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Internal Medicine Subspecialties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obstetrics and Gynecology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
General Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Surgical Specialties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatry (Adult and Child)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anesthesiology, Pathology, Radiology and Emergency Medicine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Specialty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Which of the following categories best describes your primary and secondary practice setting(s) where you work the most hours each week?

Practice Setting	Primary	Secondary
Office/Clinic	<input type="radio"/>	<input type="radio"/>
Hospital—Inpatient	<input type="radio"/>	<input type="radio"/>
Hospital—Outpatient	<input type="radio"/>	<input type="radio"/>
Hospital—Emergency Department	<input type="radio"/>	<input type="radio"/>
Federal Government Hospital	<input type="radio"/>	<input type="radio"/>
Research Laboratory	<input type="radio"/>	<input type="radio"/>
Medical School	<input type="radio"/>	<input type="radio"/>
Nursing Home or Extended Care Facility	<input type="radio"/>	<input type="radio"/>
Home Health Setting	<input type="radio"/>	<input type="radio"/>
Hospice Care	<input type="radio"/>	<input type="radio"/>
Federal/State/Community Health Center(s)	<input type="radio"/>	<input type="radio"/>
Local Health Department	<input type="radio"/>	<input type="radio"/>
Telemedicine	<input type="radio"/>	<input type="radio"/>
Volunteer in a Free Clinic	<input type="radio"/>	<input type="radio"/>
Other (specify):		

5. How many weeks did you work in the past year?

6. For all medical related positions held in (insert state name), indicate the average number of hours per week spent on each major activity:

Clinical or patient care \_\_\_\_\_ hours/week

Research \_\_\_\_\_ hours/week

Teaching/Education \_\_\_\_\_ hours/week

Administration \_\_\_\_\_ hours/week

Volunteering (medical related only) \_\_\_\_\_ hours/week

Other (specify): \_\_\_\_\_ hours/week

7. What is the location of the site(s) where you spend most of your time providing direct patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

- Principal location address: \_\_\_\_\_
  - Direct patient care hours per week at site: \_\_\_\_\_
- Second location address: \_\_\_\_\_
  - Direct patient care hours per week at site: \_\_\_\_\_
- Third location address: \_\_\_\_\_
  - Direct patient care hours per week at site: \_\_\_\_\_

8. What is your gender?

- Male
- Female

9. What is your race? (1 or more categories may be selected)—Recommended as Optional

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Other (specify)

10. Ethnicity: Are you Hispanic, Latino/a, or of Spanish origin?

(1 or more categories may be selected)—Recommended as Optional

- No
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Another Hispanic, Latino/a, or of Spanish origin (Specify)

11. In addition to English, indicate other languages in which you are fluent: (optional)

## **CONCLUSION**

The MDS Workgroup believes that state medical and osteopathic boards can play a vital role in helping to accurately determine the size, distribution and demographic make-up of the physician workforce in the United States. The type of medicine physicians practice and how the services they provide impact patients in their areas is just as important and better data is needed on the geographic distribution of physician supply to target state and federal resources designed to help ensure access. The MDS Workgroup believes that state boards have a unique opportunity to contribute to accurate workforce planning by collecting physician demographic and practice information at the time of license renewal. Uniformity of a basic set of questions asked across multiple jurisdictions at the time of license renewal would yield a better understanding of whether the supply of physicians can meet the needs of a growing and aging population.

The MDS Workgroup recommends that the 2012 FSMB House of Delegates support and adopt the recommended framework for a uniform minimal physician data set. It is recognized that there may be challenges to implementation of a minimal physician data set. However, the MDS Workgroup believes that the framework is feasible, reasonable, consistent with the resolution adopted by FSMB's House of Delegates in May 2011, and suitable for use by state medical and osteopathic boards. Furthermore, the MDS Workgroup believes that the FSMB can and should commit to a leadership role by providing state boards resources to help them implement a minimal physician data set.

## REFERENCES

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- <sup>i</sup> *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)*. s.l. : Congressional Budget Office, 2010.
- <sup>ii</sup> *Projections of the Population and Components of Change for the United States: 2010 to 2050 (NP2008-T1)* . s.l. : Population Division, U.S. Census Bureau, 2008.
- <sup>iii</sup> Cohn, D'Vera and Taylor, Paul. *Baby Boomers Approach Age 65 -- Glumly: Survey Findings about America's Largest Generation*. s.l. : Pew Research Center, 2010.
- <sup>iv</sup> *Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050 (NP2008-T2)*. s.l.: Population Division, U.S. Census Bureau, 2008.
- <sup>v</sup> *Physician Shortages to Worsen Without Increases in Residency Training*. s.l. : AAMC Center for Workforce Studies, 2010.
- <sup>vi</sup> Young A, Chaudhry H, Rhyne J, Dugan M. A Census of Actively Licensed Physicians in the United States, 2010. *Journal of Medical Regulation*. 2010-11, Vol. 96 (4).

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Board Appointments	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> <input type="checkbox"/> No  (name)	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  The Chair will make appointments to the Board's Work Groups, Committees and Liaison positions.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

## **BOARD WORK GROUPS, COMMITTEES AND LIAISONS**

**Application Review Liaisons:** Raymond Mager, Sheldon Wasserman, Kenneth Simons (alternate)

**ARRA Grant Liaison:** Raymond Mager

**Division of Enforcement Liaisons:** Carolyn Bronston, Sandra Osborn

**Evaluation Work Group: (Ch. 10 revisions)** Lamarr Franklin, Gene Musser, Sheldon Wasserman

**Legislative Liaison(s):** Christopher Magiera, Suresh Misra, Gene Musser, Ken Simons, Sheldon Wasserman

**Maintenance of Licensure Work Group:** Sujatha Kailas, Raymond Mager, Ken Simons, with Gene Musser as advisor

**Monitoring Liaison:** James Conterato

**Outreach Committee:** Jude Genereaux, Sujatha Kailas, Gene Musser, Sandra Osborn

**Professional Assistance Program Liaison:** Sandra Osborn

**Regulatory Newsletter Liaison:** Jude Genereaux

**State of Wisconsin  
Department of Safety and Professional Services**

**AGENDA REQUEST FORM**

<b>Name and Title of Person Submitting the Request:</b>  Tom Ryan		<b>Date When Request Submitted:</b>  1/5/2012	
Items will be considered late if submitted after 5 p.m. and less than:			
<ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before meeting for all other boards</li> </ul>			
<b>Name of Board, Committee, Council:</b> Medical Examining board			
<b>Board Meeting Date:</b> Jan 18, 2012	<b>Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>How should the item be titled on the agenda page?</b> Annual Policy Review and Board Member Guidebook	
<b>Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>Is an appearance before the Board being scheduled? If yes, by whom?</b>  <input type="checkbox"/> Yes by _____ (name)  <input checked="" type="checkbox"/> No	<b>Name of Case Advisor(s), if required:</b>	
<b>Describe the issue and action the Board should address:</b> Board members should familiarize themselves with this document before the meeting and come to the Board meeting with the last page signed, and to deliver the signed copy to Tom Ryan or Karen Rude-Evans.			
If this is a "Late Add" provide a justification utilizing the Agenda Request Policy:			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Late Adds must be authorized by a Supervisor, DOE Division Administrator, and Bureau Director. 3. Provide original documents needing Board Chairperson signature to the Bureau Director or Program Assistant prior to the start of a meeting.			
<b>Authorization:</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Division Administrator (if required)			Date
Bureau Director signature (indicates approval to add late items to agenda)			Date

# **Department of Safety and Professional Services**



## **Division of Board Services Board Member Guidebook**

# **Division of Board Services**

## **Board Member**

### **Guidebook**

#### **Table of Contents**

- Department Information
- Division of Board Services
- Powers and Responsibilities
- Agenda and Meetings
- Expenses and Travel
- Forms and Memos

# Department Information

# The Department of Safety and Professional Services

## History:

The 2011-13 biennial budget, 2011 Wisconsin Act 32 created the Department of Safety and Professional Services (DSPS) by combining the Department of Regulation and Licensing (DRL) and the Divisions of Safety and Buildings and Environmental and Regulatory Services from the Department of Commerce.

Chapter 75, Laws of 1967, created DRL and attached to it 14 separate examining boards that had been independent agencies. The 1967 reorganization also transferred to the department some direct licensing and registration functions not handled by boards, including those for private detectives and detective agencies, charitable organizations, and professional fund-raisers and solicitors.

DRL's responsibilities changed significantly since its creation. Initially, it performed routine housekeeping functions for the examining boards, which continued to function as independent agencies. Subsequently, a series of laws required the department to assume various substantive administrative functions previously performed by the boards and to provide direct regulation of several professions.

The DSPS Division of Safety and Buildings traces its roots to 1911 when the Legislature created the Industrial Commission in Chapter 485 to set standards for a safe place of employment. This "safe place" statute was extended in Chapter 588, Laws of 1913, to include public buildings, defined as "any structure used in whole or in part as a place of resort, assemblage, lodging, trade, traffic, occupancy, or use by the public, or by three or more tenants." The commission adopted its first building code in 1914. Programs added over the years include plumbing, heating, ventilation, air conditioning, energy conservation, private on-site waste treatment systems, accessibility for people with disabilities, and electrical inspection and certification. These responsibilities and the job of administering various other laws relating to the promotion of safety in public and private buildings, including enforcing building codes, and the licensure of occupations such as electricians and plumbers, were ultimately assumed by the Department of Commerce.

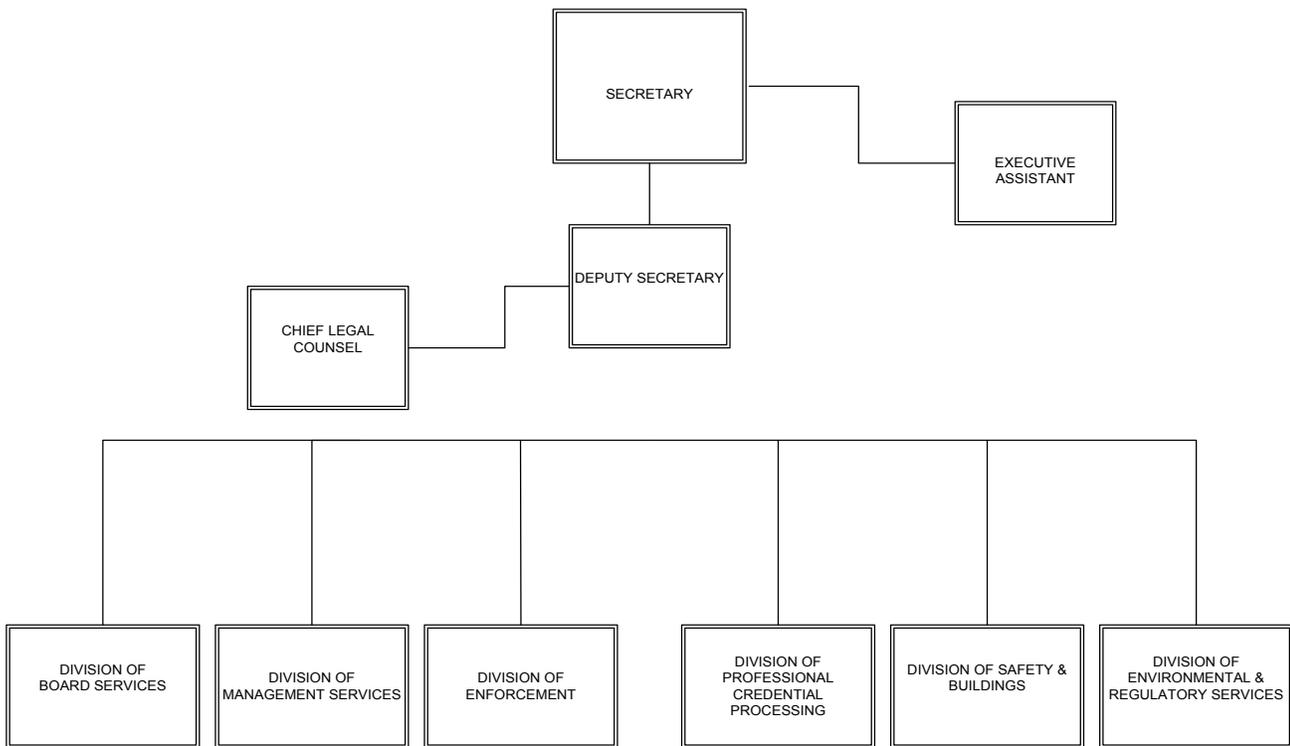
The DSPS Division of Environmental and Regulatory Services was created by 1995 Wisconsin Act 27 which transferred the PECFA program and the safety and buildings functions from the Department of Industry, Labor and Human Relations to the Department of Commerce.

# The Department of Safety and Professional Services

## Quick Facts

- Responsible for ensuring the safe and competent practice of licensed professionals in Wisconsin. The department also administers and enforces laws to assure safe and sanitary conditions in public and private buildings and regulates petroleum products and petroleum storage tank systems.
- Provides policy coordination and centralized administrative services for more than 70 boards, sections, councils, advisory committees, and direct licensing professions.
- Oversees the regulation of 200 types of credentials and specialty permits in more than 60 professional fields.
- Issues over 27,500 new credentials and renews more than 430,000 credential holders each biennium.
- Organized into six divisions and two offices:
  - Office of the Secretary
  - Division of Board Services
  - Division of Enforcement
  - Division of Environmental and Regulatory Services
  - Division of Management Services
  - Division of Professional Credential Processing
    - Office of Education and Examinations
  - Division of Safety and Buildings
- 379.6 full-time employees.
- Receives more than 2,500 consumer complaints per year.
- Verifies about 7,000 Wisconsin licenses per year to other states.

# The Department of Safety and Professional Services Organizational Structure



# **Division of Board Services**

## **Mission of DSPS and the Boards**

To protect the health, safety and well-being of the citizens of Wisconsin by ensuring the safe and competent practice of licensed professionals at the least cost to the state.

To ensure the availability of safe and competent professional services by:

- fairly administering education, experience and examination requirements;
- establishing professional practice standards;
- ensuring compliance by enforcing occupational licensing laws.

## **Division of Board Services-Board Staff**

17 staff in Board Services

1 Division Administrator

1 Program Assistant Supervisor

4 Executive Directors

4 Legal Counsel

4 Bureau Assistants

1 Adv-Paralegals

2 Paralegal

- There are approximately 300 board, council and committee members.
- A Bureau Director, Legal Counsel, and Bureau Assistant are assigned to each profession.
- The Division averages approximately 15 board, council and committee meetings each month.
- There are about 185 meetings scheduled each year.
- Provide the coordination and facilitation of a number of professional and administrative services to all of the regulatory boards, councils and committees.
- Provide administrative support.
- Coordinate and manage the business of each board, council or committee.
- Assist in facilitating the meetings.
- Provide professional services (analysis, evaluation and research).
- Coordinate drafting and implementation of laws, rules and policies.
- Coordinate board member travel and reimbursement processing.



**STATE OF WISCONSIN**  
 Department of Safety and Professional Services

1400 E Washington Ave  
 PO Box 8935  
 Madison WI 53708-8935

**Governor Scott Walker      Secretary Dave Ross**

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 Web: www.dsps.wi.gov

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**DIVISION OF BOARD SERVICES**  
**BOARD ASSIGNMENTS**

<b>Tom Ryan, Executive Director</b> <b>Sandy Nowack, Legal Counsel</b> <b>Karen Rude-Evans, Bureau Asst</b> <b>Shawn Leatherwood, Adv</b> <b>Paralegal</b>	<b>Denise Aviles, Executive Director</b> <b>Yolanda McGowan, Legal Counsel</b> <b>Michelle Solem, Bureau Asst</b> <b>Kris Anderson, Paralegal</b>	<b>Dan Williams, Executive Director</b> <b>Colleen Baird, Legal Counsel</b> <b>Kimberly Wood, Bureau Asst</b> <b>Sharon Henes, Paralegal</b>	<b>Berni Mattsson*, Executive Director</b> <b>Lydia Thompson, Legal Counsel</b> <b>David Carlson, Bureau Asst.</b> <b>Kris Anderson/Sharon Henes,</b> <b>Paralegal</b>
<ul style="list-style-type: none"> <li>▪ Medical Examining Board               <ul style="list-style-type: none"> <li>▫ Athletic Trainers Affiliated Credentialing Board</li> <li>▫ Council on Physician Assistants</li> <li>▫ Dietitians Affiliated Credentialing Board</li> <li>▫ Occupational Therapists Affiliated Credentialing Board</li> <li>▫ Perfusionists Examining Council</li> <li>▫ Podiatry Affiliated Credentialing Board</li> <li>▫ Respiratory Care Practitioners Examining Council</li> <li>▫ Massage Therapy &amp; Bodywork Therapy Affiliated Credentialing Board</li> </ul> </li> <li>▪ Nursing Home Ad. Ex Bd                (Colleen Baird – Legal Counsel)</li> <li>▪ Physical Therapy Ex. Bd</li> <li>▪ Radiography Ex. Bd</li> <li>▪ Veterinary Ex. Bd</li> </ul>	<ul style="list-style-type: none"> <li>▪ Accounting Examining Bd</li> <li>▪ Architects, Landscape Architects, Professional Engineers, Designers &amp; Land Surveyors Examining Board               <ul style="list-style-type: none"> <li>▫ Architects Section</li> <li>▫ Designers Section</li> <li>▫ Engineers Section</li> <li>▫ Landscape Architects Section</li> <li>▫ Land Surveyors Section</li> </ul> </li> <li>▪ Barbering &amp; Cosmetology Examining Board</li> <li>▪ Chiropractic Examining Bd</li> <li>▪ Crematory Authority Council</li> <li>▪ Funeral Directors Ex. Bd</li> <li>▪ Real Estate Board               <ul style="list-style-type: none"> <li>▫ RE Contractual Forms Advisory Committee</li> <li>▫ RE Curriculum &amp; Examination Council</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Controlled Substances Board</b></li> <li>▪ Geologists, Hydrologists &amp; Soil Scientists Examining Bd.               <ul style="list-style-type: none"> <li>▫ Geologists Section</li> <li>▫ Hydrologists Section</li> <li>▫ Soil Scientists Section</li> </ul> </li> <li>▪ Marriage &amp; Family Therapy, Professional Counseling, and Social Work Examining Bd.               <ul style="list-style-type: none"> <li>▫ Marriage &amp; Family Therapist Section</li> <li>▫ Professional Counselor Section</li> <li>▫ Social Worker Section</li> </ul> </li> <li>▪ Nursing, Board of               <ul style="list-style-type: none"> <li>▫ Examining Council on Licensed Practical Nurses</li> <li>▫ Examining Council on Registered Nurses</li> </ul> </li> <li>▪ Pharmacy Examining Board                (Lydia Thompson – Legal Counsel)</li> <li>▪ Psychology Examining Board</li> </ul>	<ul style="list-style-type: none"> <li>▪ Auctioneer Board</li> <li>▪ Cemetery Board</li> <li>▪ Dentistry Examining Board</li> <li>▪ Hearing &amp; Speech Examining Board               <ul style="list-style-type: none"> <li>▫ Council on Speech-Language Pathology &amp; Audiology                    (Colleen Baird – Legal Counsel)</li> </ul> </li> <li>▪ Optometry Ex. Board</li> <li>▪ Real Estate Appr. Board*               <ul style="list-style-type: none"> <li>▫ REA App Adv Com</li> </ul> </li> <li>▪ Sign Language Interp. Council</li> </ul>
<p><b>Direct Licensing:</b></p> <ul style="list-style-type: none"> <li>▪ Boxing</li> <li>▪ Home Inspectors</li> <li>▪ Interior Designers</li> <li>▪ Peddlers</li> <li>▪ Charitable Organizations</li> <li>▪ Professional Fund Raisers</li> </ul>	<p><b>Direct Licensing:</b></p> <ul style="list-style-type: none"> <li>▪ Athletic Agents Adv. Com.</li> <li>▪ Private Detectives</li> <li>▪ Private Security Persons               <ul style="list-style-type: none"> <li>▫ Firearms Permits</li> <li>▫ Firearms Certifiers</li> </ul> </li> </ul>	<p><b>Direct Licensing:</b></p> <ul style="list-style-type: none"> <li>▪ Behavioral Analysts</li> <li>▪ Sanitarians</li> <li>▪ Substance Abuse Counselors</li> </ul>	<p><b>Direct Licensing:</b></p> <ul style="list-style-type: none"> <li>▪ Acupuncture</li> <li>▪ Licensed Midwives Advisory Committee</li> <li>▪ Music, Art &amp; Dance Therapy</li> <li>▪ Professional Employer Organizations</li> </ul> <p><b>Where indicated by the following, the Bureau Assistants differ from the staff listing:</b></p> <ul style="list-style-type: none"> <li>• Lydia – Green</li> <li>• Sandy - Purple</li> <li>• Colleen - Orange</li> <li>• Karen – Red</li> <li>• Michelle - Yellow</li> <li>• Kim – Blue</li> </ul> <p>*Berni Mattsson also provides support to the Boards and Councils associated with the Division of Safety &amp; Buildings.</p>

# **Powers and Responsibilities**

## Powers of Regulatory Bodies

- **Examining Boards**

**Authority:**

- Set standards of professional competence and conduct for the professions.
- Prepare, conduct and administer examinations.
- Grant and deny credentials (licenses).
- Impose discipline.

**Appointed By:** Governor with Senate confirmation.

**Reimbursement:** Per Diem: \$25

Expenses: Actual and necessary expenses incurred in the performance of Examining Board duties.

- **Affiliated Credentialing Boards**

Bodies that are attached to an Examining Board to regulate professions that do not practice independently of the profession regulated by the Examining Board or that practice in collaboration with the profession regulated by the Examining Board.

**Authority:** With the advice of the examining board to which it is attached, sets standards of professional competence and conduct for the profession under the Affiliated Credentialing Board's supervision, reviews the qualifications of prospective new practitioners, grants credentials, and takes disciplinary action against credential holders.

**Appointed By:** Governor with Senate confirmation.

**Reimbursement:** Per Diem: \$25

Expenses: Actual and necessary expenses incurred in the performance of Board duties.

- **Examining Councils and Councils**

**Authority:** Serve an Examining Board in an advisory capacity to:

- Formulate rules to be promulgated by the Examining Board or department for the regulation of the specific profession.

**Appointed By:** Some Councils have members appointed by the Governor and others have members appointed by an Examining Board. Senate confirmation is not required. The Governor has the authority to appoint all public members.

**Reimbursement:** Per Diem: No compensation

Expenses: Actual and necessary expenses incurred in the performance of Council duties.

- **Auctioneer and Real Estate Appraisers Boards**

**Authority:** Advisory in all matters, except:

- Screening complaints.
- Imposing discipline.

**Appointed By:** Governor with Senate confirmation.

**Reimbursement:** Per Diem: \$25

Expenses: Actual and necessary expenses incurred in the performance of Examining Board duties.

- **Direct Licensing Advisory Committees and Screening Panel;**

- No examining board.
- The Secretary of the Department directly regulates the profession or occupation.
- The Secretary has authority to appoint committee and panel members.
- Committee and panel members serve at the discretion and pleasure of the Secretary.
- The Committee or panel members make recommendations and advise the Secretary on issues relating to the specific profession

**Appointed By:** Department Secretary

**Reimbursement:** Per Diem: No compensation

Expenses: Actual and necessary expenses incurred in the

### **Responsibilities of a Board Member**

- You are a public official who is dedicated to public service. You are willing to sacrifice your time and tolerate inconvenience, frustration, and scheduling conflicts to be available for board service.
- You have major responsibilities to the public and credential holders.
- You ARE NOT an advocate for private interest or professional groups.
- You must represent the highest standards of ethical and professional conduct.
- You must strive to avoid any relationship, activity or position that may influence, directly or indirectly, the performance of your official duties as a board member.
- You cannot serve as spokesperson for the board unless properly designated by the board.
- You must make public (and recuse yourself from) any conflict of interest that exists to ensure the integrity of the board and all of its decisions.
- You must comply with the rules of confidentiality, at all times, in dealings outside the board meeting.

### **Importance of Public Members**

- You are the voice of the public.
- You expand the range of perspectives available for higher quality and more creative board action.
- You balance decisions that might otherwise favor one faction of the regulated group over another.
- You make the governing board more responsive to the public it affects.
- You reduce the potential for board decisions to be professionally biased.
- You lend credibility to board accessibility and decisions.
- Public Member Concerns:
  - Being intimidated by professional members' experience in the field.
  - May impede board activity if technical issues are not understood.
  - Afraid to ask questions for fear of slowing down the meeting.
  - Professional members not treating public members as Board peers.

## **Responsibilities of the Board Chair**

- Recognize board members are entitled to speak or propose motions.
- Restate the motion after it has been seconded, then open for discussion.
- Close discussion and put motions to a vote. Restate the motion exactly as it was made or amended before calling for the question.
- Announce the result of the vote immediately. A tie vote defeats a motion requiring a majority of those voting. The chair may vote to make or break a tie.
- Avoid entering into any controversy or interfering with legitimate motions.
- Maintain order and proper procedure by making necessary rulings promptly and clearly.
- Expedite board business in every way compatible with the rights of the board members. You can allow brief remarks on motions, advise board members how to take action (proper motion or form of motion), or order proposed routing action without a formal vote (“If there is no objection, the minutes will stand approved as read. Hearing no objection, so ordered”).
- Protect the board from frivolous motions whose purpose is to obstruct the board’s business. You can refuse to entertain such motions. Never adopt such a course, however, merely to expedite business.
- Guard the board’s time by having board members vote to adopt an agenda at the beginning of the meeting. Follow the agenda faithfully. Do not permit unauthorized interruptions by spectators.

## **What Makes A Successful Board Member?**

- Recognition that the goal of the board is the protection of the public.
- Embracing role as a public servant.
- Common sense and a willingness to ask questions.
- Commitment to attendance.
- Willingness to devote time and effort to the work of the board.
- Open .
- Team player.
- Fairness.
- An orderly approach to decision making.
- Ability to set aside personal/business interests.

### **Board Members Should Avoid:**

- Obsession with a single issue.
- Self-serving by bringing own agenda to the table.
- Always taking the “contrarian” view—just for show.
- Expounding on strongly held opinions that are rarely backed by fact or research.
- Unpredictable participation or attendance.

### **Disappointments Experienced As Board Members:**

- Personal goals for improvement of the profession have not been realized.
- The public has not been served fairly.
- Lack of effort and dedication on the part of other board members.
- The “wheels” of government do not move fast enough.

### **Dealing With The Volatile World Of Meetings**

Some of the ideas are best undertaken by the Chair; however, you should feel free to help any meeting to progress. After all, why should you allow your time to be wasted?

- If a participant strays from the agenda item, call him/her back: “We should deal with that separately, but what do you feel about the issue X?”
- If there is confusion, you might ask: “Do I understand correctly that ...?”
- If you do not understand, say so: “I don’t understand that, would you explain it a little more; or, do you mean X or Y?”
- If a point is too vague ask for greater clarity: “What exactly do you have in mind?”
- If the speaker begins to ramble, wait until an inhalation of breath and jump in: “Yes, I understand that such and such, does anyone disagree?”
- If someone interrupts (someone other than the rambler), you should suggest that: “We can hear your contribution after Phoebe is finished.”
- If people chat, you might either simply state your difficulty in hearing/concentrating on the real speaker or ask them a direct question: “What do you think about that point?”
- If someone gestures disagreement with the speaker (e.g., by a grimace), then make sure they are brought into the discussion next: “What do you think Phoebe?”
- If there is an error, look for a good point first: “I see how that would work if X Y Z, but what would happen if A B C?”
- If you disagree, be *very* specific: “I disagree because .....

## Ethics For Board Members

Public officials must not engage in unethical or the appearance of unethical behavior. Board members should be cognizant of how their actions may be perceived by the public.

If you have questions about certain activities, you are encouraged to consult with the attorney from the Division of Board Services assigned to your Board.

### General Standards of Conduct For Board Members

- Board members must not act in an arbitrary or capricious manner in discharging any of their public duties. All Board member decisions whether the individual or collective ones must be based upon a reasoned consideration of facts applied to the correct law.

### Primary Duties of All Board Members

- Be knowledgeable about the statutes and rules governing the Board.
- Review and make decisions on all issues presented to the Board in compliance with the law and with the ultimate goal of protecting the public.
- Be aware that Board members are viewed as representatives of the Board when they appear at public meetings and professional gatherings. Board members should not speak for the Board unless specifically authorized to do so.
- Refer public inquiries about Board issues directly to the bureau director for your Board.
- Do not participate in discussion or vote on any matter in which the Board member has a personal or professional conflict of interest.
- Prepare for Board meetings by careful review of materials. Board members shall come to the meetings with preliminary opinions of the issues to be discussed and questions for clarification.
- As a professional member of the Board, remain current in standards of practice through reviewing professional literature and attending educational programming and through actual practice or relationships with colleagues in practice.
- As a public member of the Board, become educated regarding the practice of the profession.
- Maintain absolute confidentiality regarding disciplinary matters, examinations, examination scores and other closed-session issues. The failure to maintain confidentiality could result in loss of immunity Board members enjoy for purposes of their actions as Board members.

### Discipline

- The objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter others from engaging in similar conduct.
- Punishment of the licensee is not an appropriate consideration.
- The statutory framework which creates the Board's authority will provide the options available for discipline.
- The goal of a regulatory board is to protect the public.

## Standards of Ethical Conduct

### ■ The Five Commandments

- Do not act in an official capacity in a matter in which you have a private interest.
- Do not use your public position for a private benefit.
- Do not solicit or accept rewards or items or services likely to influence you.
- Do not use confidential information.
- Do not use your public position to obtain unlawful benefits.

### ■ Bias/ Conflict – Watch for:

- Financial Interests (employer/ employee/ competitor)
- Professional business Interests (have you worked with them in the past)
- Other – friends, non-friends
- Personal knowledge of facts which may not be in the record

# Agendas and Meetings

## Agendas and Meetings

- New Technologies – Share Point & Live Meeting.
- Agenda packets are mailed, emailed, and/or posted on Share Point about 7 calendar days prior to meeting.
- Agendas include:
  - Approval of the Agenda and Minutes
  - Open Session Items
    - Administrative Report
    - Legislation and Administrative Rules Issues
    - Public Hearings
    - Education and Exam Issues
    - Practice Questions
    - Current Issues Affecting the Profession
  - Closed Session items
    - Stipulations
    - Administrative Warnings
    - Deliberations on Proposed Disciplinary Actions
    - Case Closings
    - Monitoring Issues
    - Credentialing Issues
    - Exam Issues
- Agendas are published for public notice every Wednesday prior to the meeting on the Department's web site
- Meetings must comply with the Open Meetings Law.
- "To-Do" lists are distributed to staff within three (3) days after a meeting.
- Minutes are prepared within five (5) days after the board meeting.
  - Once the board approves the minutes, they are published on the Department's web site.

# Expenses and Travel

## General Expense Reimbursement Guidelines

- State statutes and Code of Ethics strictly prohibit any board member, his or her family, or co-workers from benefiting personally from free flight plans, lodging, meals, or other promotions which result from travel incurred in connection with board official business and paid from state or federal funds.
- All travel-related expenses are reimbursable within the limitations established by the Department of Employment Relations and the Department of Administration.
- Any board member whose appointment has been confirmed by the Senate or who has been nominated to fill a vacant board position is eligible to receive a per diem. Council and Committee members are not eligible for a per diem.
- Any board, council or committee member whose appointment has been confirmed by the Senate or who has been nominated to fill a vacant position is eligible to receive travel expenses for each day on which he or she has actually and necessarily engaged in the performance of board duties. If you are employed by the State of Wisconsin these requirements do not apply.
- All per diem and travel expense reimbursement vouchers must be submitted to the Department **within a month of the activity** in which payment is being requested.
- Any board member who wishes to attend out-of-state regional or national meetings or conventions must have prior approval by the Board and the Department, if he or she wishes to receive reimbursement for expenses by the Department.
- Employees in travel status are expected to use good judgment when incurring travel costs. Only expenses incurred while conducting official State business will be reimbursed. Reimbursement claims must represent actual, reasonable and necessary expenses.
- Reimbursement for air travel is limited to the lowest appropriate airfare which is defined as coach fare, which provides for not more than a 2-hour window from the traveler's preferred departure or arrival time and may require one plane transfer.
- Benefits from any airline promotion program, such as frequent flier points or credit vouchers, belong to the State and should be turned over to the Department.

## Lodging Accommodations

- Hotel arrangements for board meetings are scheduled by the department for all board meetings at the beginning of each year.
- Lodging the night before a board meeting will be reimbursed provided the board member would have to leave home before 6:00 a.m. in order to be at the meeting site by the set meeting time.
- Maximum reimbursement rate for in-state lodging is \$70, except in Milwaukee, Waukesha and Racine counties where the rate is \$80.
- Maximum reimbursement rates for out-of-state lodging are determined by the Office of State Employment Relations. In cases where a board member stays at the conference site, the conference room rate is allowable.

## Per Diem Guidelines

### **\$25 per day**

*(Only one per diem may be claimed per calendar day.)*

Examples:

- Attend board meeting or participate in a board meeting by telephone.
- Attend a Screening Panel Session when held on a day other than a board meeting date, in person or by telephone.
- Senate confirmation hearing.
- Exam administration or test development
- Attend a legislative or other public hearing as an authorized representative of the board on matters directly related to the work of the board. Prior approval from the secretary is required for per diem payments for more than one board-authorized representative at a public hearing.
- Represents the board at a meeting of a governmental body or other organization where attendance is necessary to the performance of the board's official duties.

### **5-Hour Rule**

- \$25 for performing a cumulative minimum of 5 hours engaged in:
  - Duties as a disciplinary case screener or board advisor including reviewing cases, consulting with investigators, etc. (NOTE: You will need to document the exact times performing these duties on your per diem form.
  - Preparation of board correspondence or articles
- Hours can only be claimed in the month the duties were performed. Hours cannot carry over to other months.

### **Insufficient Basis For Approval of a Per Diem**

- Travel days to or from board meetings, conferences, and other events when there is no event business conducted.
- Reading board agendas, meeting packets, minutes or transcripts.
- Attendance at professional association meetings, conferences, seminars, exam administrator or test development if there has not been prior board authorization and approval of the Secretary's office.

## Travel and Meal Guidelines

- **Mileage rate --** 48.5 cents per mile
- **Private Airplane--** 48.5 cents per mile
- **Meals** (*Maximum amounts*)

	<u>In-State Travel</u>	<u>Out-of-State Travel</u>
Breakfast	\$8	\$10
You must leave home before 6:00 a.m.		
Lunch	\$9	\$10
You must depart before 10:30 a.m. & return after 2:30 p.m.		
Dinner	\$17	\$20
You must return home after 7:00 p.m.		

*NOTE: Alcoholic beverages may not be claimed for any meal.*

- **Telephone:** One personal call home is reimbursable up to \$5 for each night in travel status.
- **Hotel Gratuities:** Gratuities to hotel employees are reimbursable up to \$2 on dates of departure and arrival, and up to \$2 per night for a stay at a hotel/motel.
- **Porterage:** Porterage costs at airports or bus terminals will be reimbursed. The claim should not exceed \$1 per piece of luggage.
- **Taxi/Shuttle:** Receipts are required for one-way fares exceeding \$25.

### Examples of Non-reimbursable Items

This list is not all-inclusive

- Traffic citations, parking tickets and other fines
- Mileage charges incurred for personal reasons, e.g., sightseeing, side trips, etc.
- Additional charges for late checkout
- Taxi fares to and from restaurants
- Meals included in the cost of registration fees or airfare
- Flight insurance
- Cancellation charges (unless fully justified)
- Alcoholic beverages
- Spouse or family members' travel costs
- Lost/stolen cash or personal property
- Personal items, e.g., toiletries, luggage, clothing, etc.
- Repairs, towing service, etc., for personal vehicle
- Pay-for-view movies in hotel room; personal entertainment
- Child care costs and kennel costs

# Forms and Memos

# Department of Regulation & Licensing

## PER DIEM REPORT

Month January Year 2011

**INSTRUCTIONS:** Send original (white) and first copy (yellow) to Bureau Director authorized to approve. Approving Bureau Director forwards original and first copy to Deputy Secretary, Department of Regulation and Licensing. Second copy (green) to be retained by claimant. Attach travel voucher if applicable.

NAME OF EXAMINING BOARD OR COUNCIL Board				BOARD OR COUNCIL MEMBER'S NAME John Doe			
Day	Specify Number of Hours	Purpose Code	Where Performed	Day	Specify Number of Hours	Purpose Code	Where Performed
1				17			
2				18			
3				19			
4				20			
5	7	A	DRL- Madison	21			
6				22			
7				23	2	G	Home
8				24			
9				25			
10				26			
11	3	B	Teleconference - Home	27			
12				28			
13				29			
14				30			
15				31			
16							

TOTAL DAYS CLAIMED 2 @ \$ 25.00 = \$50.00

<b>CLAIMANT'S CERTIFICATION</b> The undersigned certifies, in accordance with Sec. 16.53, Wis. Stats., that this account for per diem, amounting to \$25.00, is just and correct; and that this claim is for service necessarily incurred in the performance of duties required by the State, as authorized by law.	APPROVED:
	Bureau Director <span style="float: right;">Date</span>
Claimant's Signature <span style="float: right;">Date</span>	Secretary, Department of Regulation & Licensing
Social Security Number	Date

### Purpose Codes:

- A. Attend **Board meetings** in person or via teleconference call.
- B. Attend **Screening Panel** meetings on days other than board meeting days (teleconference calls)
- C. Attend **Hearings**, i.e., legislative, disciplinary or informal settlement conference hearings, on days other than board meeting days.
- D. Attend **Examinations**
- E. Attend **Test Development Sessions**, i.e., test review or analysis sessions, national testing sessions, tour of test facilities, etc.)
- F. Attend Senate Confirmation Hearings
- G. Review DOE cases
- H. Review credentialing applications other than at board meeting.
- G. Other (describe in detail)



## **Department Policy**

### **Deadline For Submitting Travel Vouchers and Per Diems**

Effective: Immediately

**Board Members will only be reimbursed for travel upon a motion made by the Board, Council, or Committee designating them as a representative and upon prior approval of the department.**

#### **Policy for Submitting Board Meeting Travel Reimbursement**

All travel vouchers and per diems must be submitted to the Department after each meeting and no later than the month following the Board meeting.

#### **Policy for Submitting Out-of-State Travel Reimbursement**

All travel vouchers and per diem vouchers must be submitted no later than the month following the month in which the out-of-state travel occurred.

#### **Forms Submitted after the Deadline**

Due to the Department's budget being an annual appropriation, those vouchers that are not submitted in a timely manner become at risk of not being reimbursed.

#### **Annual Appropriation:**

The Department receives authority from the legislature to spend a set amount of money each fiscal year. None of the authorized set amount can be carried forward to the next fiscal year.

**Division of Board Services**  
**HOTEL RESERVATIONS POLICY & PROCEDURE**

Effective January 1, 2010, the Department has selected the Fairfield Inn & Suites for all future hotel reservations.

**Fairfield Inn**  
**2702 Crossroads Dr**  
**Madison, WI 53718**  
**608-661-2700**

- If the board member is not going to use the reserved hotel room, it is the responsibility of the board member to cancel the room by calling the hotel themselves.
- If the hotel room is not cancelled, the board member may be responsible to pay the bill.
- If a meeting is cancelled due to a lack of quorum or no business, it is the responsibility of the Department to cancel any room reservations.

**QUORUM CONFIRMATION POLICY**

- It is every board member's responsibility to ensure there is a quorum to conduct business at all board meetings.
- It is the responsibility of each board member to inform the executive director of any meeting dates in which they will not be able to attend.
- If Division staff does not hear from a board member, they will assume that the board member will be attending the scheduled meeting.
- A quorum check will not be conducted prior to each scheduled board meeting.
- The only time Division staff will conduct a quorum check will be if two or more board members contact the Division indicating they will not be able to attend an upcoming scheduled meeting.
- Every board member will receive a list of all approved meeting dates at the first board meeting of the New Year. Please use this as a reference to assist in planning for the year ahead.

**INCLEMENT WEATHER POLICY & PROCEDURE**

**Quorum Note:** For open session you need one more than half of the total board membership. If there is formal discipline you will need 2/3 of the total board membership.

- Teleconference and Live Meeting options should be offered in order to continue with the scheduled meeting.
- Hotel rooms for the night before should be provided for any Board member traveling more than 50 miles from Madison and the meeting starts before 10:00 a.m.
- If a Board member who has a hotel reservation already in place will not attend and/or the meeting is cancelled, the hotel room should be cancelled immediately.



## **Division of Board Services Board Member Guidebook**

This Board Member Guidebook has been prepared for your information and understanding of the policies, expectations, and practices of the Department of Safety & Professional Services and the Division of Board Services. Please read it carefully. Upon completion of your review of this guidebook, sign the statement below, and return it to the Executive Director of your Board, Committee, or Council by the due date. A copy of this acknowledgment appears at the back of the guidebook for your records.

I, \_\_\_\_\_, have received and read a copy of the Division of Board Services Board Member Guidebook which outlines the policies, expectations, and practices of the Department of Safety & Professional Services and the Division of Board Services, as well as my responsibilities as a member of an attached Board, Council, or Committee.

I have familiarized myself with the contents of this guidebook. By my signature below, I acknowledge, understand, accept and agree to comply with the information contained in the Board Member Guidebook provided to me by the Division of Board Services. I understand this guidebook is not intended to cover every situation which may arise during my term, but is simply a general guide to the goals, policies, practices, and expectations of the Department of Safety & Professional Services.

\_\_\_\_\_  
(Member signature)

Please return by: \_\_\_\_\_  
(put date here)

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\_\_\_\_\_  
(Member signature)

Please return by: \_\_\_\_\_  
(put date here)

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 18, 2011	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Senate Bill 306	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> <span style="margin-left: 100px;">(name)</span> <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Board Review			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

LRB-3305/2

TJD/FFK/PJH:nwn&amp;kjf:rs

2011 - 2012 LEGISLATURE

## 2011 SENATE BILL 306

November 25, 2011 - Introduced by Senators LAZICH, GALLOWAY, GROTHMAN and LEIBHAM, cosponsored by Representatives LITJENS, BROOKS, CRAIG, HONADEL, JACQUE, T. LARSON, LEMAHIEU, A. OTT, J. OTT, STRACHOTA, THIESFELDT, WYNN, ZIEGELBAUER, ENDSLEY and KLEEFISCH. Referred to Committee on Health.

1           **AN ACT** *to repeal* 940.04 (3) and (4); *to amend* 253.10 (3) (b),  
 2                           253.10 (3) (d) 1.,  
 3                           253.10 (5) and 253.10 (7); and *to create* 253.10 (2) (am),  
 4                           253.10 (3) (c) 1. hm.,  
 5                           253.10 (3) (c) 1. jm., 253.10 (3) (c) 2. fm., 253.10 (7m) and  
 6                           253.105 of the statutes;  
 7                           **relating to:** voluntary and informed consent to an abortion,  
                           information on  
                           domestic abuse services, giving a woman an abortion-  
                           inducing drug, repealing  
                           criminal sanctions against women who perform or obtain  
                           certain abortion  
                           procedures, and providing a penalty.

### *Analysis by the Legislative Reference Bureau*

#### VOLUNTARY AND INFORMED CONSENT AND INFORMATION ON DOMESTIC ABUSE SERVICES

Under current law, a woman upon whom an abortion is to be performed or induced must give voluntary and informed written consent to the abortion. Consent is voluntary only if it is given freely and without coercion. This bill requires that the physician who is to perform or induce the abortion determine whether or not the

woman's consent is, in fact, voluntary. The physician must determine if the woman's consent is voluntary by speaking to her in person, out of the presence of anyone other than a person working for or with the physician. If the physician has reason to suspect that the woman is in danger of being physically harmed by anyone who is coercing the woman to consent to an abortion against her will, the physician must

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inform the woman of services for victims or individuals at risk of domestic abuse and provide her with private access to a telephone.

Currently, a woman's consent to an abortion is considered informed only if, at least 24 hours before the abortion is performed or induced, the physician or an assistant has, in person, orally provided the woman with certain information and given the woman written materials prepared by the Department of Health Services (DHS). If the pregnancy is the result of sexual assault or incest, the 24-hour period, but not the provision of information, may be waived or reduced under certain circumstances. Any person who violates the informed consent requirements is required to forfeit not less than \$1,000 nor more than \$10,000 and is liable to the woman upon whom the abortion is performed or induced.

The bill requires that, at least 24 hours before the abortion is performed or induced, the physician or another qualified physician inform the woman that she has a right to refuse or consent to an abortion, that her consent is not voluntary if anyone is coercing her to consent to an abortion against her will, and that it is unlawful for the physician to perform or induce the abortion without her voluntary consent. The physician or another qualified physician must also inform the woman, at least 24 hours before the abortion is induced that, if the abortion is induced by an abortion-inducing drug, the woman must return to the abortion facility for a follow-up visit 12 to 18 days after use of the drug to confirm the termination of the pregnancy and evaluate the woman's medical condition. The bill requires that the

physician or assistant inform the woman that the materials prepared by DHS, which must be given to her, contain information on services available for victims or individuals at risk of domestic abuse. Additionally, the bill requires DHS to include in the printed materials information on services in the state that are available for victims or individuals at risk of domestic abuse. The bill specifies that none of the penalties for violating the informed consent requirements may be assessed against the woman upon whom the abortion is to be performed or induced or attempted to be performed or induced.

#### RESTRICTIONS ON THE USE OF ABORTION-INDUCING DRUGS

This bill prohibits a person from giving a woman an abortion-inducing drug unless the physician who provided the drug for the woman performs a physical exam on the woman and is physically present in the room when the drug is given to the woman. An abortion-inducing drug is a drug that is prescribed to terminate the pregnancy of a woman who is known to be pregnant. Under this bill, a person who gives a woman an abortion-inducing drug in a manner that violates the prohibition is guilty of a Class I felony and may be subject to a civil action. This bill specifies that a penalty may not be assessed against a woman who receives an abortion-inducing drug.

#### REPEAL OF CERTAIN ABORTION PROHIBITIONS

Under current law, a pregnant woman who intentionally destroys the life of her unborn child or who consents to such destruction by another may be fined not more than \$200, imprisoned not more than six months, or both. For the same action with respect to an unborn quick child the penalty is a fine not to exceed \$10,000, imprisonment for not more than three years and six month, or both. None of these

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penalties apply to a therapeutic abortion that is performed by a physician; is necessary, or advised by two other physicians as necessary, to save the life of the mother; and is performed, except on an emergency basis, in a licensed

maternity hospital. These provisions were cited, along with other provisions not affected by this bill that prohibit performing an abortion generally, in *Roe v. Wade*, 410 U.S. 113 (1973), as substantially similar to a Texas statute that was held to violate the due process clause of the 14th Amendment to the U.S. Constitution.

A separate provision in current law prohibits prosecution of and imposing or enforcing a fine or imprisonment against a woman who obtains an abortion or otherwise violates any abortion law with respect to her unborn child or fetus. Further, crimes of being a party to a crime, solicitation, and conspiracy do not apply to a woman who obtains an abortion or otherwise violates an abortion law with respect to her unborn child or fetus.

This bill repeals the provisions in current law under which a pregnant woman who intentionally destroys the life of her unborn child or who consents to such destruction by another may be fined, imprisoned, or both. The bill does not affect any other criminal prohibition or limitation on abortion in current law and does not affect the provision that prohibits the prosecution, fine, or imprisonment against a woman who obtains an abortion or otherwise violates any abortion law with regard to her unborn child or fetus.

For further information see the *state* fiscal estimate, which will be printed as an appendix to this bill.

*The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:*

- 1 SECTION 1. 253.10 (2) (am) of the statutes is created to read:  
 2 253.10 (2) (am) "Abortion-inducing drug" means a drug,  
 3 medicine, oral  
 4 hormonal compound, mixture, or preparation, when it is prescribed to  
 5 terminate the  
 6 pregnancy of a woman known to be pregnant.
- SECTION 2. 253.10 (3) (b) of the statutes is amended to read:  
 253.10 (3) (b) *Voluntary consent*. Consent under this section  
 to an abortion is

7 voluntary only if the consent is given freely and without coercion by  
 8 any person. The  
 9 physician who is to perform or induce the abortion shall determine  
 10 whether the  
 11 woman's consent is, in fact, voluntary. Notwithstanding par. (c) 3., the  
 12 physician  
 13 shall make the determination by speaking to the woman in person,  
 14 out of the

15 presence of anyone other than a person working for or with  
 16 the physician. If the  
 17 physician has reason to suspect that the woman is in danger of being  
 18 physically  
 19 harmed by anyone who is coercing the woman to consent to an  
 20 abortion against her  
 21 will, the physician shall inform the woman of services for victims or  
 22 individuals at  
 23 risk of domestic abuse and provide her with private access to a  
 24 telephone.

25 SECTION 3. 253.10 (3) (c) 1. hm. of the statutes is created to  
 26 read:

27 253.10 (3) (c) 1. hm. If the abortion is induced by an abortion-  
 28 inducing drug,  
 29 that the woman must return to the abortion facility for a follow-up  
 30 visit 12 to 18 days  
 31 after the use of an abortion-inducing drug to confirm the termination  
 32 of the  
 33 pregnancy and evaluate the woman's medical condition.

34 SECTION 4. 253.10 (3) (c) 1. jm. of the statutes is created to  
 35 read:

36 253.10 (3) (c) 1. jm. That the woman has a right to refuse to  
 37 consent to an  
 38 abortion, that her consent is not voluntary if anyone is coercing her to  
 39 consent to an  
 40 abortion against her will, and that it is unlawful for the physician to  
 41 perform or  
 42 induce the abortion without her voluntary consent.

43 SECTION 5. 253.10 (3) (c) 2. fm. of the statutes is created to  
 44 read:

45 253.10 (3) (c) 2. fm. That the printed materials described in  
 46 par. (d) contain  
 47 information on services available for victims or individuals at risk of  
 48 domestic abuse.

49 SECTION 6. 253.10 (3) (d) 1. of the statutes is amended to  
 50 read:

51 253.10 (3) (d) 1. Geographically indexed materials that are  
 52 designed to inform  
 53 a woman about public and private agencies, including adoption  
 54 agencies, and  
 55 services that are available to provide information on family planning,

23 as defined in  
24 s. 253.07 (1) (a), including natural family planning information, to  
25 provide  
ultrasound imaging services, to assist her if she has received a  
diagnosis that her  
unborn child has a disability or if her pregnancy is the result of sexual  
assault or

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1 incest and to assist her through pregnancy, upon childbirth  
2 and while the child is  
dependent. The materials shall include a comprehensive list of the  
3 agencies  
4 available, a description of the services that they offer and a  
description of the manner  
5 in which they may be contacted, including telephone numbers and  
addresses, or, at  
6 the option of the department, the materials shall include a toll-free, 24  
-hour  
7 telephone number that may be called to obtain an oral listing of  
available agencies  
8 and services in the locality of the caller and a description of the  
services that the  
9 agencies offer and the manner in which they may be contacted. The  
materials shall  
10 provide information on the availability of governmentally funded  
programs that  
11 serve pregnant women and children. Services identified for the  
woman shall include  
12 medical assistance for pregnant women and children under s. 49.47  
(4) (am) and  
13 49.471, the availability of family or medical leave under s. 103.10, the  
Wisconsin  
14 works program under ss. 49.141 to 49.161, child care services, child  
support laws and  
15 programs and the credit for expenses for household and dependent  
care and services  
16 necessary for gainful employment under section 21 of the ~~internal  
revenue code~~  
Internal Revenue Code. The materials shall state that it is unlawful  
17 to perform an  
abortion for which consent has been coerced, that any physician who  
18 performs or  
induces an abortion without obtaining the woman's voluntary and  
19 informed consent  
is liable to her for damages in a civil action and is subject to a civil  
20 penalty, that the  
father of a child is liable for assistance in the support of the child,  
even in instances  
21 in which the father has offered to pay for an abortion, and that  
adoptive parents may  
22 pay the costs of prenatal care, childbirth and neonatal care. The

23 materials shall  
 24 include information, for a woman whose pregnancy is the result of  
 25 sexual assault or  
 incest, on legal protections available to the woman and her child if she  
 wishes to  
 oppose establishment of paternity or to terminate the father's  
 parental rights. The

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1 materials shall state that fetal ultrasound imaging and  
 auscultation of fetal heart  
 2 tone services are obtainable by pregnant women who wish to use them  
 and shall  
 3 describe the services. The materials shall include information on  
services in the  
 4 state that are available for victims or individuals at risk of domestic  
abuse.

5 SECTION 7. 253.10 (5) of the statutes is amended to read:  
 6 253.10 (5) PENALTY. Any person who violates sub. (3) or (3m)  
 (a) 2. or (b) 2. shall  
 7 be required to forfeit not less than \$1,000 nor more than \$10,000. No  
penalty may  
 8 be assessed against the woman upon whom the abortion is performed  
or induced or  
 9 attempted to be performed or induced.

10 SECTION 8. 253.10 (7) of the statutes is amended to read:  
 11 253.10 (7) AFFIRMATIVE DEFENSE. No person is liable under  
 sub. (5) or (6) or  
 12 under s. 441.07 (1) (f), 448.02 (3) (a), or 457.26 (2) (gm) for failure  
 under sub. (3) (c)  
 13 2. d. to provide the printed materials described in sub. (3) (d) to a  
 woman or for failure  
 14 under sub. (3) (c) 2. d., e., f., fm., or g. to describe the contents of the  
 printed materials  
 15 if the person has made a reasonably diligent effort to obtain the  
 printed materials  
 16 under sub. (3) (e) and s. 46.245 and the department and the county  
 department under  
 17 s. 46.215, 46.22, or 46.23 have not made the printed materials  
 available at the time  
 18 that the person is required to give them to the woman.

19 SECTION 9. 253.10 (7m) of the statutes is created to read:  
 20 253.10 (7m) CONFIDENTIALITY IN COURT PROCEEDINGS. (a) In  
 every proceeding  
 21 brought under this section, the court, upon motion or sua sponte, shall  
 rule whether  
 22 the identity of any woman upon whom an abortion was performed or  
 induced or  
 23 attempted to be performed or induced shall be kept confidential unless  
 the woman  
 24 waives confidentiality. If the court determines that a woman's identity  
 should be

25 kept confidential, the court shall issue orders to the parties,  
witnesses, and counsel

1 and shall direct the sealing of the record and exclusion of  
2 individuals from  
3 courtrooms or hearing rooms to the extent necessary to safeguard the  
4 woman's  
5 identity from public disclosure. If the court issues an order to keep a  
6 woman's  
7 identity confidential, the court shall provide written findings  
8 explaining why the  
9 woman's identity should be kept confidential, why the order is  
10 essential to that end,  
11 how the order is narrowly tailored to its purpose, and why no  
12 reasonable less  
13 restrictive alternative exists.

14 (b) Any person, except for a public official, who brings an  
15 action under this  
16 section shall do so under a pseudonym unless the person obtains the  
17 written consent  
18 of the woman upon whom an abortion was performed or induced, or  
19 attempted to be  
20 performed or induced, in violation of this section.

21 (c) The section may not be construed to allow the identity of a  
22 plaintiff or a  
23 witness to be concealed from the defendant.

24 SECTION 10. 253.105 of the statutes is created to read:  
25 253.105 Prescription and use of abortion-inducing drugs. (1)

26 In this  
27 section:

28 (a) "Abortion" has the meaning given in s. 253.10 (2) (a).

29 (b) "Abortion-inducing drug" has the meaning given in s.  
30 253.10 (2) (am).

31 (c) "Physician" has the meaning given in s. 448.01 (5).

32 (2) No person may give an abortion-inducing drug to a woman  
33 unless the  
34 physician who prescribed, or otherwise provided, the abortion-  
35 inducing drug for the  
36 woman:

37 (a) Performs a physical exam of the woman before the  
38 information is provided  
39 under s. 253.10 (3) (c) 1.

40 (b) Is physically present in the room when the drug is given to  
41 the woman.

