



## 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**  
**March 21, 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 February 15, 2011 (insert) (7-16)**
- 5. Case Presentations**

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

- a. Warren A. Olson, MD - 11 MED 114 **(115-120)**
  - Attorney Susan Gu
  - Case Advisor – LaMarr Franklin
- b. William H. Shuler, MD – 11 MED 278 **(121-126)**
  - Attorney Susan Gu
  - Case Advisor – Carolyn Bronston
- c. William J. Washington, MD – 10 MED 423 **(127-134)**
  - Attorney Susan Gu
  - Case Advisor – LaMarr Franklin
- d. Raju Fatehchand, MD – 11 MED 276 **(135-140)**
  - Attorney Susan Gu
  - Case Advisor – Carolyn Bronston

- e. Gurcharan S. Randhawa, MD – 11 MED 126 **(141-148)**
  - Attorney Susan Gu
  - Case Advisor – Jude Genereaux
- f. Nicholas Caro, MD – 10 MED 124 **(149-154)**
  - Attorney Kim Kluck
  - Case Advisor – Raymond Mager
- g. Cindy L. Gile, MD – 10 MED 229 **(155-162)**
  - Attorney Kim Kluck
  - Case Advisor – LaMarr Franklin
- h. Mirian Organ, MD – 10 MED 368 **(163-170)**
  - Attorney Kim Kluck
  - Case Advisor – Sheldon Wasserman
- i. Karen Butler, MD – 11 MED 117 **(171-176)**
  - Attorney Kim Kluck
  - Case Advisor – LaMarr Franklin
- j. David Buchanan, MD – 10 MED 121 **(177-184)**
  - Attorney Pamela Stach
  - Case Advisor – Gene Musser
- k. Eugene C. Rigstad, MD – 10 MED 211 **(185-192)**
  - Attorney Pamela Stach
  - Case Advisor – Carolyn Bronston
- l. Kenneth E. Sparr, MD – 11 MED 172 **(193-202)**
  - Attorney Pamela Stach
  - Case Advisor – James Conterato
- m. Gregory Goetz, MD – 11 MED 308 **(203-216)**
  - Attorney Pamela Stach
  - Case Advisors – James Conterato and Raymond Mager

**6. Executive Director Matters**

- a. Resignation of Christopher Magiera, MD
- b. Other

**7. Items Received After Mailing of Agenda**

- a. Presentation of Proposed Stipulations and Final Decisions and Orders
- b. Presentation of Proposed Decisions
- c. Presentation of Interim Orders
- d. Petitions for Re-hearing

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

**8. Items for Board Discussion**

- a. Prescription Drug Monitoring Program Report – Gene Musser (**insert**) (17-24)
- b. Maintenance of Licensure – Report from MOL Workgroup (**insert**) (25-42)
- c. FSMB Matters
- d. Review of Wis. Admin. Code Med 8
- e. Chapter MED 10 Update
- f. DSPS Website – Report from Website Workgroup
- g. Medical Board Newsletter (**insert**) (43-44)
- h. WMS Annual Meeting and Resolutions – Sandra Osborn
- i. Upcoming Outreach Opportunities
- j. Guidelines for Meeting Procedures and Conflicts (**insert**) (45-48)

**9. Legislative Report**

- a. Legislative Report - AB 547, SB 383, SB 421 and SB 450 (**insert**) (49-82)
- b. Senate Bill 464/Assembly Bill 615 – Committee Testimony (**insert**) (83-92)

**10. Screening Panel Report**

**11. Informational Item(s) (insert) (93-114)**

**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. Warren A. Olson, MD - 11 MED 114 **(insert) (115-120)**
  - o Attorney Susan Gu
- b. William H. Shuler, MD – 11 MED 278 **(insert) (121-126)**
  - o Attorney Susan Gu
- c. William J. Washington, MD – 10 MED 423 **(insert) (127-134)**
  - o Attorney Susan Gu
- d. Raju Fatehchand, MD – 11 MED 276 **(insert) (135-140)**
  - o Attorney Susan Gu
- e. Gurcharan S. Randhawa, MD – 11 MED 126 **(insert) (141-148)**
  - o Attorney Susan Gu
- f. Nicholas Caro, MD – 10 MED 124 **(insert) (149-154)**
  - o Attorney Kim Kluck
- g. Cindy L. Gile, MD – 10 MED 229 **(insert) (155-162)**
  - o Attorney Kim Kluck
- h. Mirian Organ, MD – 10 MED 368 **(insert) (163-170)**
  - o Attorney Kim Kluck
- i. Karen Butler, MD – 11 MED 117 **(insert) (171-176)**
  - o Attorney Kim Kluck
- j. David Buchanan, MD – 10 MED 121 **(insert) (177-184)**
  - o Attorney Pamela Stach
- k. Eugene C. Rigstad, MD – 10 MED 211 **(insert) (185-192)**
  - o Attorney Pamela Stach
- l. Kenneth E. Sparr, MD – 11 MED 172 **(insert) (193-202)**
  - o Attorney Pamela Stach
- m. Gregory Goetz, MD – 11 MED 308 **(insert) (203-216)**
  - o Attorney Pamela Stach

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

- a. 10 MED 153 (J.C.H., MD) **(insert) (217-220)**
  - o Attorney Arthur Thexton
  - o Case Advisor – Gene Musser

**CS-3 Review of Administrative Warning - APPEARANCES – 10:20 A.M. - DOE Attorney Pamela Stach, Attorney Steven Sager and Respondent in the following matter:**

- a. 10 MED 188 (E.S.J., MD) (insert) (221-224)
  - o Attorney Pamela Stach

**CS-4 Consideration of Complaint(s)**

- a. 11 MED 325 (C.S.U., MD) (insert) (225-228)
- b. 10 MED 299 (A.G.P., PA) (insert) (229-232)
- c. 11 MED 340 (A.B., MD) (insert) (233-236)
- d. 11 MED 390 (D.E.R., MD) (insert) (237-252)

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

- a. Ahmed Mansour Elkenany, MD (insert) (253-282)
- b. Hari Korsapati, MD (insert) (283-338)
- c. Luis Antonio Sosa Lozano, MD (insert) (339-388)

**CS-6 Reconsideration of Request for Equivalency of ACGME Approved Post-Graduate Training**

- a. Denis M. Jones, MD (insert) (389-464)

**CS-7 Request(s) for Waiver/Extension of Time for CME Requirement**

- a. W.G.S., DO – Request for Waiver of CME Requirement (insert) (465-466)
- b. M.A.M., DO – Request for Extension of Time to Complete CME Requirement (insert) (467-468)
- c. T.C.R., DO - Request for Extension of Time to Complete CME Requirement (insert) (469-470)

**CS-8 Monitoring**

- a. Milan Jordan, MD – Request for Full Licensure (insert) (471-494)

**CS-9 Case Closings (insert) (495-496)**

**CS-10 Consulting with Legal Counsel**

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

- a. Proposed Stipulations
- b. Proposed Decisions and Orders
- c. Proposed Interim Orders

- d. Objections and Responses to Objections
- e. Complaints
- f. Petitions for Summary Suspension
- g. Remedial Education Cases
- h. Petitions for Extension of Time
- i. Petitions for Assessments
- j. Petitions to Vacate Orders
- k. Motions
- l. Administrative Warnings
- m. Matters Relating to Costs
- n. Appearances from Requests Received or Renewed
- o. Examination Issues
- p. Continuing Education Issues
- q. Application Issues
- r. Monitoring Cases
- s. 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 5 Candidates for Licensure – Drs. Kailas, Magiera, Osborn and Wasserman

**MEDICAL EXAMINING BOARD  
MINUTES  
FEBRUARY 15, 2012**

**PRESENT:** Carolyn Bronston; LaMarr Franklin (arrived 8:08 a.m.); Sujatha Kailas, MD; Raymond Mager, DO; Christopher Magiera MD; Suresh Misra, MD; Gene Musser, MD; Sandra Osborn, MD; Kenneth Simons, MD; Sheldon Wasserman, MD

**EXCUSED:** Jude Genereaux, Timothy Swan, MD, Sridhar Vasudevan, MD

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

**GUESTS:** Mark Grapentine, Wisconsin Medical Society; Eric Jensen, Lou Falligant, Clark Collins and David Wilson, WAPA; Anne Hletko, Council on Physician Assistants; Jeremy Levin, RWHC; Attorney Mary Lee Ratzel; Judy Warmuth, WHA; Tim Stumm, WHN; Scott Becher

**CALL TO ORDER**

Dr. Sheldon Wasserman, Chair, called the meeting to order at 8:00 a.m. A quorum of nine (9) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments:**

- Under PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS, add:
  - i. Naglaa Abdel-Al, MD – 11 MED 127
    - Attorney Pamela Stach
    - Case Advisor – Jude Genereaux
- Under APPEARANCES REGARDING PETITION FOR SUMMARY SUSPENSION, add:
  - Proposed Interim Stipulation and Interim Agreement and Order
  - Petition and Order for Designation of Hearing Official
- Item 7a - Under PUBLIC HEARING ON CH MED 8, insert:
  - Clearinghouse Report for Ch. MED 8
  - Axley Brynson Proposal for MED 8.08 with WAPA Edits
- Item 8c – BUDGET LAPSE REPORT, insert additional materials after page 124
- Item 8e – FSMB MATTERS, insert after page 124:
  - Public Member Scholarships
- Item 10a – LEGISLATIVE REPORT - Senate Bill 306, insert additional materials after page 144 (AB 371)

- Item CS-1 – DELIBERATION OF STIPULATIONS, FINAL DECISIONS AND ORDERS, add:
  - i. Naglaa Abdel-Al, MD – 11 MED 127 – Attorney Pamela Stach (after page 240)
- Item CS-2 - DELIBERATION OF PETITION FOR SUMMARY SUSPENSION, add:
  - Proposed Interim Stipulation and Interim Agreement and Order
  - Petition and Order for Designation of Hearing Official
- Case Status Report – insert at the end of the agenda in closed session

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

### APPROVAL OF MINUTES OF JANUARY 18, 2012

#### **Correction:**

- On page 1, under AMENDMENTS, correct the spelling of Sandra Olson to Sandra Osborn

**MOTION:** Suresh Misra moved, seconded by Kenneth Simons, to approve the minutes of January 18, 2012 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>Michael A. Dehner, MD</b>	<b>09 MED 028</b>
<b>Dale E. Bauwens, MD</b>	<b>09 MED 108</b>
<b>Clifford T. Bowe MD</b>	<b>09 MED 033</b>
<b>James A. Shapiro, MD</b>	<b>10 MED 303</b>
<b>Susan J. Frazier, MD</b>	<b>11 MED 249</b>
<b>Richard Banchs, MD</b>	<b>10 MED 304</b>
<b>Brian Fox, MD</b>	<b>10 MED 313</b>
<b>Ronald K. Meyer, MD</b>	<b>11 MED 058</b>
<b>Naglaa Abdel-Al, MD</b>	<b>11 MED 127</b>

These items will be deliberated in closed session.

**PRESENTATION OF PETITION FOR SUMMARY SUSPENSION AND  
PROPOSED INTERIM STIPULATION AND INTERIM AGREEMENT AND ORDER**

**VICTORIA MUNDLOCH, MD  
09 MED 258 AND 10 MED 363**

DOE Attorney Pamela Stach, Attorney Mary Lee Ratzel and Dr. Victoria Mondloch appeared before the Board in the matter of the Petition for Summary Suspension. This matter will be deliberated in closed session. Sheldon Wasserman was excused during the presentations.

**PUBLIC HEARING ON CH MED 8 RELATING TO THE PHYSICIAN TO  
PHYSICIAN ASSISTANT RATIO**

Sheldon Wasserman called the Public Hearing to order at 9:00 a.m. The Board held this hearing to receive testimony from the public on a proposed amendment to the administrative rules related to physician assistants in Chapter MED 8. This proposed rule change was prompted by a need to modernize existing regulations to reflect the national trend to increase the number of physician assistants a physician may simultaneously supervise. These proposed rules also address defining supervision between physicians and physician assistants; clarifying when a personal appearance or an oral examination is necessary, and the periodic review of physician assistant prescribing practices. Written and oral comments become a part of the formal record of the rule-making process.

The following people testified: Mark Grapentine, Lou Fallilgant, David Wilson, Clark Collins, Anne Hletko and Judy Warmuth.

Sheldon Wasserman adjourned the public hearing at 9:30 a.m.

**ITEMS FOR BOARD DISCUSSION**

**ARRA Grant – Demonstration of Online Verification System**

Ari Oliver gave a comprehensive demonstration of the online verification system. This system will be more efficient for the licensees.

**ARRA Grant Declaration of Cooperation**

The Board voted to adopt the Declaration of Cooperation at the last meeting.

**Budget Lapse Report – Karen Vanschoonhoven, DSPS Budget Director**

Karen Vanschoonhoven, DSPS Budget Director, discussed the Budget Lapse report with the Board. The Board has concerns with the amount of money that is lapsed from the Medical Examining Board appropriation.

### **Maintenance of Licensure**

Tom Ryan will reconvene the Maintenance of Licensure work group in the near future.

### **FSMB Matters**

- **Public Member Scholarships to the FSMB Annual Meeting, April 26-28, 2012, Fort Worth, Texas**

**MOTION:** Sandra Osborn moved, seconded by Kenneth Simons, to authorize LaMarr Franklin to apply for the FSMB scholarship to attend as the Board's public member at the FSMB Annual Meeting to be held April 26-28, 2012, in Fort Worth, Texas. Motion carried unanimously.

This travel must be fully funded by the FSMB. DSPS staff will not attend this meeting due to travel restrictions.

### **Wis Admin. Code Chapter MED 10**

Kenneth Simons reported on the recommendation made by the MED 10 work group during the teleconference held on February 14, 2012.

### **DSPS Website Improvement Opportunities**

Due to the merger with the former Commerce Department, the agency's website is being revised. Tom Ryan suggested the Board members review the website and send suggestions and comments on improving and updating the information on the Medical Examining Board. Kenneth Simons suggested a focus group to review the easy use of the website and Carolyn Bronston would like more information available when querying a physician.

**MOTION:** Sujatha Kailas moved, seconded by Kenneth Simons, to convene a work group on website improvements. Motion carried unanimously.

The work group members are Carolyn Bronston, LaMarr Franklin, Sujatha Kailas, Sheldon Wasserman and Tom Ryan.

### **Medical Examining Board Newsletter**

The Medical Examining Board Newsletter has been sent out, however not all members received a copy. Tom Ryan will follow up with the mailing lists.

### **Upcoming Outreach Opportunities**

Sheldon Wasserman presented at Grand Rounds at Columbia St. Mary's' Hospital in Milwaukee on February 14, 2012.

Sujatha Kailas will give a presentation on May 3, 2012 at St. Agnes Hospital in Fond du Lac.

## EXECUTIVE DIRECTOR MATTERS

Tom Ryan reviewed the newest appointees to the Board. Dr. Timothy Swan is a radiologist from Marshfield Clinic and replaces Dr. Azita Hamedani. Dr. Sridhar Vasudevan is an anesthesiologist/pain specialist from Belgium, WI and replaces Dr. James Conterato. Both the new members should be at the March meeting. Dr. Raymond Mager and Dr. Suresh Misra are still awaiting confirmation.

Sheldon Wasserman publicly thanked Dr. James Conterato and Dr. Azita Hamedani for their excellent work and service on the Medical Examining Board.

## LEGISLATIVE REPORT

### **Senate Bill 420**

Gene Musser reported this bill, relating to the make-up of the Medical Examining Board, has been introduced in the Senate and has been referred to the Health Committee.

### **Senate Bill 306/Assembly Bill 371**

Gene Musser reviewed this proposed legislation with the Board.

### **Assembly Bill 487**

This item was reviewed. Legal Counsel Sandy Nowack noted this bill does not allow for transitional licensing and this would be a hardship for both licensees and Department staff. No Board action was taken at this time.

## SCREENING PANEL REPORT

LaMarr Franklin reported twenty five (25) cases were screened. Ten (10) cases were opened and three (3) ten-day letters were sent.

## INFORMATIONAL ITEMS

The informational items were noted.

## PUBLIC COMMENTS

None.

## OTHER BUSINESS

Sandra Osborn and Sandy Nowack attended the CME for the physicians who were disciplined for writing the sick notes. The course was well designed and informative.

### **RECESS TO CLOSED SESSION**

**MOTION:** Sandra Osborn moved, seconded by Kenneth Simons, 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; LaMarr Franklin-yes; Sujatha Kailas-yes; Raymond Mager-yes; Christopher Magiera-yes; Suresh Misra-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Sheldon Wasserman-yes. Motion carried unanimously.

Open session recessed at 11:09 a.m.

### **RECONVENE IN OPEN SESSION**

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

Open session reconvened at 1:55 p.m.

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

**MOTION:** Gene Musser moved, seconded by Sandra Osborn, to reaffirm all motions made in closed session. Motion carried unanimously.

### **PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS**

#### **MICHAEL A DEHNER MD 09 MED 028**

**MOTION:** Carolyn Bronston moved, seconded by Sandra Osborn, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Michael A. Dehner, MD. Motion carried unanimously.

#### **DALE E BAUWENS, MD 09 MED 108**

**MOTION:** Sujatha Kailas moved, seconded by Carolyn Bronston, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Dale E. Bauwens, MD. Motion carried. Raymond Mager abstained.

**CLIFFORD T BOWE, MD**  
**09 MED 033**

**MOTION:** LaMarr Franklin moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Clifford T. Bowe, MD. Motion carried unanimously.

**JAMES A SHAPIRO, MD**  
**09 MED 367**

**MOTION:** Sandra Osborn moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against James A. Shapiro, MD. Motion carried unanimously.

**SUSAN J FRAZIER, MD**  
**11 MED 249**

**MOTION:** LaMarr Franklin moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Interim Order in the disciplinary proceedings against Susan J. Frazier, MD. Motion carried unanimously.

**RICHARD BANCHS, MD**  
**10 MED 304**

**MOTION:** Kenneth Simons moved, seconded by Carolyn Bronston, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Interim Order in the disciplinary proceedings against Richard Banchs, MD. Motion carried unanimously.

**BRIAN FOX, MD**  
**10 MED 313**

**MOTION:** Sujatha Kailas moved, seconded by Carolyn Bronston, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Interim Order in the disciplinary proceedings against Brian Fox, MD. Motion carried unanimously.

**RONALD K MEYER, MD  
11 MED 058**

**MOTION:** Sujatha Kailas moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Interim Order in the disciplinary proceedings against Ronald K. Meyer, MD. Motion carried unanimously.

**NAGLAA ABDEL-AL, MD  
11 MED 127**

**MOTION:** Carolyn Bronston moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Interim Order in the disciplinary proceedings against Naglaa Abdel-Al, MD. Motion carried unanimously.

**DELIBERATION OF PETITION FOR SUMMARY SUSPENSION**

**VICTORIA J MONDLOCH, MD  
09 MED 258 AND 10 MED 363**

**MOTION:** Carolyn Bronston moved, seconded by Sandra Osborn, to adopt the Proposed Interim Stipulation and Interim Agreement and Order in the disciplinary proceedings against Victoria J. Mondloch. Motion carried. Suresh Misra, Kenneth Simons and Sujatha Kailas opposed. Sheldon Wasserman was excused during deliberation and abstained from voting.

**PROPOSED ADMINISTRATIVE WARNINGS**

**MOTION:** Sujatha Kailas moved, seconded by LaMarr Franklin, to issue the Administrative Warning in case **09 MED 439 against respondent J.G., MD**. Motion carried unanimously.

**REVIEW OF ADMINISTRATIVE WARNING**

DOE Attorney Kim Kluck, Respondent's Attorney Randall Gold and Gary Bridgewater, MD, appeared before the Board.

**MOTION:** Raymond Mager moved, seconded by Sandra Osborn, to rescind the Administrative Warning in case **10 MED 176 against respondent Gary Bridgewater, MD**. Motion carried unanimously.

**REQUEST FOR EQUIVALENCY OF ACGME APPROVED POST-GRADUATE TRAINING**

**DENIS M JONES, MD**

**MOTION:** Sujatha Kailas moved, seconded by Carolyn Bronston, to deny the request from Denis M. Jones, MD, for equivalency of the ACGME approved post-graduate training. Motion carried. Kenneth Simons abstained.

**DELIBERATION OF CLEARINGHOUSE COMMENTS AND PUBLIC COMMENTS REGARDING CH MED 8**

**MOTION:** Kenneth Simons moved, seconded by Sujatha Kailas, to reject the proposal from the Wisconsin Hospital Association and to appoint Gene Musser as the liaison for Ch. Med 8. Motion carried unanimously.

**MONITORING**

**RUDY V BYRON, MD**

**MOTION:** Sujatha Kailas moved, seconded by Raymond Mager, to grant the request from Chandra S. Reddy, MD, for the extension of time to complete the education. Motion carried unanimously.

**STEVEN B GREENMAN, MD**

**MOTION:** Carolyn Bronston moved seconded by Sandra Osborn, to require Steven B. Greenman, MD, to pay 20% of his costs each year for the next five (5) years. Motion carried unanimously.

**MOTION:** Kenneth Simons moved, seconded by Sujatha Kailas, to deny the request of Steven B. Greenman, MD, for reinstatement of his license. Motion carried unanimously.

**KIRSTEN D PETERSON, MD**

**MOTION:** Sujatha Kailas moved, seconded by Carolyn Bronston, to approve the request from Kirsten D. Peterson, MD, for a reduction in screens to twenty eight (28) per year. Motion carried unanimously.

**CASE CLOSINGS**

**MOTION:** Carolyn Bronston moved, seconded by Raymond Mager, to close case **11 MED 004** for compliance gained. Motion carried unanimously.

- MOTION:** Raymond Mager moved, seconded by LaMarr Franklin, to close case **10 MED 371** for no violation. Motion carried unanimously.
- MOTION:** Kenneth Simons, moved, seconded Sandra Osborn, to close case **11 MED 158** for no violation. Motion carried unanimously.
- MOTION:** Raymond Mager, moved, seconded Kenneth Simons, to close case **11 MED 246** for prosecutorial discretion (P7). Motion carried unanimously.
- MOTION:** Sujatha Kailas moved, seconded by Raymond Mager, to close case **11 MED 229** for insufficient evidence. Motion carried unanimously.
- MOTION:** Raymond Mager moved, seconded by LaMarr Franklin, to close case **10 MED 052** for insufficient evidence. Motion carried unanimously.
- MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to close case **11 MED 188 against respondent W.S.N, MD,** for no violation and **against respondent C.S., MD,** for insufficient evidence, with a recommendation to have a photographic record of all colonoscopies. Motion carried unanimously.
- MOTION:** Raymond Mager moved, seconded by Carolyn Bronston, to close case **11 MED 233** for no violation. Motion carried unanimously.
- MOTION:** Carolyn Bronston moved, seconded by Sujatha Kailas, to close case **10 MED 308** for prosecutorial discretion (P7). Motion carried unanimously.

#### **RATIFY ALL LICENSES AND CERTIFICATES**

- MOTION:** Sujatha Kailas moved, seconded by LaMarr Franklin, to ratify all licenses and certificates as issued. Motion carried unanimously.

#### **OTHER BUSINESS**

- MOTION:** Sujatha Kailas moved, seconded by LaMarr Franklin, to authorize Sandra Nowack or other DSPS staff as appropriate to sign the Order regarding the request for equivalency of ACGME approved post-graduate training, on Dr. Wasserman's behalf. Motion carried unanimously.

#### **ADJOURNMENT**

- MOTION:** Gene Musser moved, seconded by Kenneth Simons to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 1:575 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: <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: March 21, 2012	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 Report – Gene Musser	
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:  The PEB met on 3/9 and to consider changes based on the comments noted on the document and those given at the hearing.			
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

- |  |  |
|--|--|
| 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.

**Comment [RT1]:** General Comments  
All: Funding of the PDMP

PSW: Recommends creation of advisory committee

WHA: Wants clarity regarding dispensing machines  
- Generally, based on a physician dispensing model

WMS/MEB: Recommends inclusion of methadone clinics

MEB: Recommends inclusion of pain clinics

WMS: Recommends adding requirement for practitioner to give notice at time of prescribing\*

\*All corrections since the 2/9 PEB meeting are blue and bolded.

**Comment [RT2]:** WMS: Recommends adding "...and making such information accessible to health care practitioners with prescribing authority so as to support clinical decision-making."

**Comment [RT3]:** WMS: Recommends adding "federal"

**Comment [RT4]:** GHC:SCW: Wants clarity regarding "delivery" v. "dispensing"

For Reference:  
450.01(5): "Deliver" or "delivery" means the actual, constructive or attempted transfer of a drug or device from one person to another.

**Comment [RT5]:** PSW/Walgreens/NAACDS/GHC:SCW: Does "dispenser" mean pharmacy or pharmacist?

Example from Washington:  
"Dispenser" means a *practitioner or pharmacy* that delivers to the ultimate user a schedule II, III, IV, or V controlled substance or other drugs identified by the board of pharmacy in WAC 246-470-020...

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- (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

Comment [RT6]: GHC-SCW: Recommends using a different term, such as:

- Monitored [prescription] drug
- Program [prescription] drug

Iowa uses the term "Program prescription [drug]"

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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

**Comment [RT7]:** NACDS/DOC: Notes that including non-controlled substances can be difficult to comply with

WMS: Recommends adding "Nubain"

**Comment [RT8]:** ASAP: Data fields are only available in 4.1 or 4.2

GHC-SCW: Recommends adding information regarding payment type

WVMS: Notes that some of the data fields are not applicable to veterinarians

**Comment [RT9]:** See Comment RT5

**Comment [RT10]:** PSW/Walgreens: Notes that ASAP may not support

**Comment [RT11]:** NACDS: Recommends changing to "may be"

**Comment [RT12]:** MEB: Wants clarity regarding whether the reporting period is fixed or rolling

DHS: Suggests a shorter reporting period, the shorter the better

**Comment [RT13]:** WVMS: Recommends using a format more suitable for veterinarian dispensers

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- (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 5 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.

**Comment [RT14]:** Walgreens: Recommends adding "knowingly"

**Comment [RT15]:** NACDS: Recommends changing to "may be"

**Comment [RT16]:** Marshfield: Recommends clarifying how 18.05 relates to 18.04(7)

GHC-SCW: Wants clarity regarding drugs "dispensed" but not "delivered" (see Comment RT4)

**Comment [RT17]:** PSW: Recommends changing to 7-days

**Comment [RT18]:** WVMs: Consider changing statute to include directly administered drugs

WVMs: Recommends exemption for 10-day post-operative drugs dispensed by veterinarians

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- (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 (f), 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.

**Comment [RT19]:** GHC-SCW/DHS:  
Recommends making it clearer who has accounts v.  
real-time access to PDMP information and the  
various methods to access PDMP information

**Examples:**

- Medicaid (would like real-time access)
- DURs
- AODA

DHS: Recommends clarity in how out-of-state  
pharmacies are affected and will interface with the  
PDMP

DHS: Wants clarity on how access will be granted to  
various entities

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- (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.

Comment [RT20]: Walgreens: Recommends adding "knowingly"

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.

Comment [RT21]: WMS: Recommends making it clearer how 18.09 relates to 18.08

DHS: Wants clarity regarding the Board's ability to limit access of non-practitioners and dispensers

WMS: Recommends adding "The board may also suspend a law enforcement authority's account to access PDMP information if personnel of the law enforcement authority have been determined to have improperly re-released to other parties personally identifiable health information about a patient that had been obtained from the program's databases."

WMS: Recommends clarifying "state" v. "jurisdiction" language

Comment [RT22]: WMS: Recommends adding "the practitioner is no longer licensed in another jurisdiction when such licensure had been recognized by this state as the basis for the practitioner having the authority to prescribe or dispense prescription drugs in this state."

Phar 18.10 Confidentiality of PDMP information.

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- (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.

**Comment [RT23]:** WMS: Recommends clarifying "state" v. "jurisdiction" language

**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: March 21, 2012	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 – Report from MOL Workgroup	
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 materials and discuss next steps. Note that the FSMB has indicated that the workforce survey the Board sent with the 2011 MD renewal and will send with the 2012 DO renewal may be used as a pilot project under "State Board License Renewal Process Integration."			
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

## ATTACHMENT 1 – BACKGROUND INFORMATION ON MOL

### History of the Federation of State Medical Boards' Maintenance of Licensure (MOL) Initiative February 8, 2012

The intent of this document is to provide an overview of the history and current focus of work of the Federation of State Medical Boards' (FSMB) Maintenance of Licensure (MOL) initiative.

Maintenance of Licensure is envisioned as a system of continuous professional development for physicians that supports, as a condition for license renewal, a physician's commitment to lifelong learning that is objective, relevant to their area of practice and contributes to improved health care. The FSMB, which represents the nation's state medical and osteopathic boards, is the lead proponent of the MOL system. The MOL concept was formally adopted by FSMB's House of Delegates in 2010.

#### **What is driving the need for MOL?**

The ultimate goal of MOL is to improve patient care and safety. As health care consumers have become more empowered and informed in recent years, a new emphasis on medical quality and safety has grown in the United States. State medical and osteopathic boards and the medical profession as a whole are facing increasing demand for greater accountability and transparency. At the same time, health care organizations throughout the system – from hospitals to medical specialty societies – have committed themselves to new systems of quality measurement and improvement. As medicine has become more complex and fast-evolving, the need for lifelong learning and skills maintenance has increased.

#### **FSMB Policy on MOL**

In 2004, the FSMB House of Delegates adopted the following policy statement: "*State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking re-licensure.*"

Since that time, a multi-year analysis of MOL policy and implementation has proceeded with the consideration of and input from multiple stakeholders. Numerous workgroups, comprising representatives from the FSMB member boards, the public and other key stakeholder organizations within the medical community, have been convened to support this work. As a result of this work and analysis, in 2010 the FSMB House of Delegates adopted a framework for MOL that consists of three major components reflecting what is known about effective lifelong learning in medicine:

1. **Reflective Self-Assessment** (*What improvements can I make?*): Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.
2. **Assessment of Knowledge and Skills** (*What do I need to know and be able to do?*): Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. **Performance in Practice** (*How am I doing?*): Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

#### **Addressing Physicians' Concerns**

As it has throughout its development of the MOL concept, the FSMB continues to work closely with national medical organizations to ensure the needs and concerns of busy physicians are taken into account as the MOL concept evolves. Examples of features that are being considered for MOL in order to create a well-integrated system include:

- The framework and recommendations proposed by FSMB would not require physicians to take exams in order to comply with MOL.
- The proposed system would eliminate redundancy by allowing Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), as well as other defined educational activities physicians already engage in, to count toward fulfillment of MOL.
- For physicians who are not specialty certified – or are, but don't engage in MOC or OCC because they are "grandfathered" or otherwise don't need to or want to – other activities by which MOL requirements may be met will need to be identified. In its work developing an MOL system, the FSMB has begun to identify such activities and is working with physicians, state boards and a number of organizations now to further evaluate them.
- The FSMB's MOL recommendations emphasize physicians' privacy. Work to date has recommended that physicians would use their own practice data as a way to compare their performance with peers locally and nationally as a way to identify opportunities for improvement (or as a demonstration of improvement). Comparison of data is something that physicians would do on their own; each individual physician's practice data would not be used by the state board to compare his/her performance with other physicians.

#### **Pilot Projects**

Currently, a variety of pilot projects that will advance our understanding of the process, structure and resources necessary to develop an effective and comprehensive MOL system are in development. Current discussions are focused on ten potential pilot projects, which will be presented to interested state boards in early 2012, with implementation anticipated to start in early to mid-2012.

The involvement of the state medical and osteopathic boards is essential to the further development and implementation of the pilot programs. To date there are eleven state boards that have expressed interest in participating in the pilots: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, State Medical Board of Ohio, Oklahoma State Board of Osteopathic Examiners, Oregon Medical Board, Virginia Board of Medicine and Wisconsin Medical Examining Board.

#### **Other MOL Work**

In addition to the participating pilot boards, numerous other groups are working with the FSMB to guide and develop MOL policy and pilot processes and to ensure that the concerns and input of the broad spectrum of physician education, training and practice, as well as the public, are considered as the implementation of MOL progresses. In 2011, FSMB chair Janelle Rhyne, M.D., established a MOL Workgroup on Non-Clinical Physicians to define the non-clinical physician and develop

pathway(s) that non-clinical physicians may follow to successfully participate in a state member board's MOL program. The workgroup's report is expected to be available for comment in late 2012. The FSMB has also established a CEO Advisory Council on MOL, comprising CEOs or other executive staff from 14 key stakeholder organizations, to act as an advisory body to FSMB on MOL.

**For more information**

The Winter 2011-2012 edition of the FSMB's *Journal of Medical Regulation* will feature an article about Maintenance of Licensure titled "Maintenance of Licensure: Evolving from Framework to Implementation". This edition of the *Journal* will be available in February 2012.

Additional information about MOL is available at: [www.fsmb.org/mol.html](http://www.fsmb.org/mol.html). Specific inquiries about MOL can be directed to Frances Cain, FSMB Director, Post-Licensure Assessment System, at [fcain@fsmb.org](mailto:fcain@fsmb.org) or (817) 868-4022.

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# Maintenance of Licensure: Evolving from Framework to Implementation

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**IN BRIEF** The authors provide a report summarizing progress to date in the Federation of State Medical Boards' long-term Maintenance of Licensure (MOL) initiative.

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## Introduction

Shortly after April 2010, following the adoption by its House of Delegates of a framework for Maintenance of Licensure (MOL), the Federation of State Medical Boards (FSMB) began earnest deliberations and discussions to facilitate MOL process design and implementation by interested state medical and osteopathic boards. An MOL Implementation Group established by the FSMB has since developed a series of practical recommendations addressing such issues as the optimum timing and periodicity of a state board's MOL requirements and the role of specialty board recertification and continuing medical education (CME).<sup>1</sup>

The FSMB has also had preliminary discussions with a wide range of organizations with experience and expertise in the areas of physician assessment and specialty certification, and organizations that already offer a variety of tools and activities that could meet one or more MOL requirements. Last summer, 11 state medical and osteopathic boards reported to the FSMB that they were interested in collaborating to consider participation in specific MOL pilot projects.

This article—a follow-up to “Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care,” a monograph approved by the FSMB's Board of Directors and published in the *Journal of Medical Regulation* in 2010<sup>2</sup>—summarizes and reports on the progress that has been made in moving MOL from framework to implementation. Though MOL is a few years away from implementation by any state board, the FSMB has pledged to continue to lead, coordinate and proceed in a logical fashion to provide the necessary support to state boards so that progress with its implementation remains methodical and evolutionary, not revolutionary, as physicians with active medical licenses

are asked to periodically demonstrate their ongoing clinical competence in their area of practice as a condition for licensure renewal.

## MOL Implementation Group and Its Deliberations

The MOL Implementation Group (IG) was charged by the FSMB's Board of Directors in 2010 to act in support of FSMB policy. Its report, presented to the FSMB's House of Delegates last year as a follow-up to the 2010 report of the FSMB's Advisory Group on Continued Competence of Licensed Physicians (AG), was “intended to provide more detailed guidance to FSMB's state member boards ... as they consider

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implementation of MOL programs.” The IG said that it sought to offer recommendations for MOL as “a rational and well-considered proposal to facilitate the engagement of physicians in a culture of continuous improvement and to assure the public, through a verifiable and reproducible system, that physicians are actively participating in such an effort.”

First and foremost, the IG noted, “nearly half of U.S. physicians already fulfill the intent of MOL” through their participation in the continuous specialty certification programs of the American Board of Medical Specialties (ABMS) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS). Both of these recertification programs were listed in the AG report among the tools that practicing physicians have available to them to fulfill the requirements of each of the three components of MOL (reflective self-assessment, assessment of knowledge and skills, and performance in practice). While the report of the AG had acknowledged that physicians actively engaged in the ABMS Maintenance of Certification (MOC) or soon to be engaged in AOA BOS Osteopathic Continuous Certification (OCC) programs “could substantially meet” MOL

requirements, the IG report in 2011 definitively supported the concept. It noted also that both MOC and OCC programs were themselves evolving—like MOL—into fully continuous quality improvement programs.

In a census of actively licensed physicians in the United States conducted two years ago, the FSMB found that 74.5 percent of the nation's 850,085 physicians were certified by at least one ABMS specialty board. Among doctors of medicine (M.D.), 77 percent were specialty certified by the ABMS; among doctors of osteopathic medicine (D.O.), 38 percent were ABMS-certified and 40 percent certified by an AOA BOS specialty board. The IG's conservative assessment that "nearly half of U.S. physicians already fulfill the intent of MOL" reflects a reality noted in the census, that 216,352 physicians (both M.D. and D.O.) are not specialty-certified, that a large plurality of physicians are either grandfathered for MOC or OCC (that is, they are not required to recertify) and that another plurality are not participating in MOC or OCC for whatever reason. An additional group of physicians that is not specialty-certified includes those who are in graduate medical education training but have not yet taken their specialty board examinations. Because state licensing boards have never provided a specialty medical license—instead providing a license for the

general undifferentiated practice of medicine—the IG made clear that neither MOC nor OCC are intended to become mandatory requirements for medical licensure but should be recognized as substantially meeting any state's MOL requirements. The majority of MOL pilot projects, in fact, will likely be designed to determine and identify multiple options and pathways by which physicians who are not specialty-certified or are not engaged in MOC or OCC may fulfill a state board's MOL requirements.

Alluding to the fact that many physicians serve as leaders in emerging team-based models of health care delivery, such as the patient-centered medical home, the IG said it hoped that its recommendations "can serve as a model for other health care professions as they look at developing their own continuous improvement processes." In fact, the National Council of State Boards of Nursing, the National Association of Boards of Pharmacy, the National Commission for Certification of Physician Assistants and the American Association of Physician Assistants have all embarked on such programs for their health professionals.

#### **MOL Implementation Group's 2011 Recommendations**

The 2011 recommendations of the IG (see Figure 1) were calibrated to adhere to the guiding principles

**Figure 1**  
**MOL Implementation Group's 2011 Recommendations to State Boards<sup>1</sup>**

- ① Consider pursuing a "phased approach" for MOL implementation.
- ② Require each licensee to complete certified and/or accredited CME, a majority of which (at least half) should be practice-relevant.
- ③ Require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.
- ④ Require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide and then apply best evidence or consensus recommendations to improve and subsequently reassess their care.
- ⑤ Require each licensee to complete a minimum Component One activity on an annualized basis, a majority of which is devoted to practice-relevant CME that supports practice improvement, and to document completion of one Component Two and one Component Three activity every five to six years.
- ⑥ Consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA BOS Osteopathic Continuous Certification (OCC) programs to have fulfilled all three components of MOL.
- ⑦ Regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.
- ⑧ Strive for consistency in the creation and execution of MOL programs.

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for MOL adopted by the FSMB's House of Delegates in 2010 as part of the AG report (see Figure 2). Recognizing that the adoption of MOL represents a "substantial paradigm shift" for state medical and osteopathic boards, the IG advised state boards to consider pursuing a "phased approach" for MOL implementation, though it said it would encourage state boards that were interested in a more expedited process. It recommended that once a state

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THE MAJORITY OF MOL PILOT PROJECTS WILL LIKELY BE DESIGNED TO IDENTIFY MULTIPLE OPTIONS BY WHICH PHYSICIANS WHO ARE NOT SPECIALTY-CERTIFIED MAY FULFILL A STATE BOARD'S MOL REQUIREMENTS.

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board has decided to implement MOL, a year or two should be spent in preparing for MOL, including a "readiness assessment, preparatory steps, initial communication to licensed physicians (and) involvement of stakeholders." Such preparation, the IG said, should address program implementation activities, including communication with training programs and medical schools; a review of the board's medical practice act, policies, rules and regulations; an inventory of staff and financial resources; review and use of an FSMB "MOL Toolbox" that will consist of practical guidance, assistance and resources; an evaluation of data needs; concrete decisions on program design and physician activities deemed acceptable for MOL compliance; and revisions to the medical license renewal application as needed. (Many of these items will likely be incorporated in the first phase of MOL pilot projects.) The IG also recommended that state boards hold informational meetings about MOL with legislators, state medical

and osteopathic societies, physicians, the public and other key stakeholders.

After this preparatory time, the IG suggested that each of the three components of MOL (i.e., reflective self-assessment, assessment of knowledge and skills, and performance in practice) be sequentially implemented in a phased approach (up to two to three years for each component), noting that once MOL is fully implemented by a state board, all licensed physicians in that jurisdiction will be "expected to comply with the entire MOL program as designed." In calling for the adoption of the first component of MOL first, rather than all three components at once, the IG said it hoped to demonstrate early success in MOL implementation to build momentum for subsequent components, to "build on the known and familiar" to ease the transition from license renewal to MOL and to "develop buy-in over time" for more elaborate continuous professional development activities. In the area of CME, a critical element of the first component of MOL, the IG advised state boards to require each licensee to complete certified and/or accredited CME, a majority of which (that is, at least half) should be practice-relevant.

Regarding the assessment of knowledge and skills, the second component of MOL, the IG advised state boards to require licensees to participate in knowledge and skills assessments to identify learning opportunities that guide their improvement activities. The IG suggested such activities should be developed by an objective third party with demonstrated expertise in these areas; be structured, validated and consistently reproducible; be credible with the public and the profession; provide meaningful assessment feedback; and provide formal documentation that describes the nature of the activity and its successful completion. In reiterating a point made by the AG a

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**Figure 2**  
**The Guiding Principles of Maintenance of Licensure<sup>4</sup>**

- ① MOL should be administratively feasible and developed in collaboration with other stakeholders.
  - ② The authority for establishing MOL requirements should remain within the purview of state medical boards.
  - ③ MOL should not compromise patient care or create barriers to physician practice.
  - ④ The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
  - ⑤ MOL should balance transparency with privacy protections.
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year earlier, the IG said high-stakes examinations may be an option by which a physician may choose to meet this requirement (as with MOC or OCC) but such an examination should not be mandated for MOL for physicians not engaged in MOC or OCC activities. Recognizing the limited resources of most state boards, particularly in challenging economic times, the IG said it "would not expect" state boards to develop external assessments unless they chose to do so but could see state boards accepting external, objective assessments that met their licensing requirements.

For the third MOL component, performance in practice, the IG advised state boards to require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide in their area of practice and then apply best evidence or consensus recommendations to improve and subsequently reassess their care. In essence, the IG suggested that physicians should be asked to use their available practice data to evaluate patient outcome variation, both within their own practices as well as in comparison to local and national peers "when such data is available." Recognizing that component three of MOL "will evolve over time," the IG recommended that state boards consider the "full range of ongoing high-quality practice improvement activities that are now being implemented by specialty and professional societies, certifying boards, hospitals, physician groups and quality improvement organizations" that it listed in its report as examples.

Although the term of license renewal currently varies between one and three years among state boards, the IG advised state boards to require each licensee to annually complete a minimum MOL Component One activity, a majority of which is devoted to practice-relevant CME that supports practice improvement, and to document completion of one Component Two and one Component Three activity every five to six years. Until physicians and state boards are able to demonstrate continuous engagement in MOL activities in a "rolling and uninterrupted manner through automated data reporting," the IG said, most state boards will have to rely upon periodic documentation and verification as evidence of participation in required MOL activities. Explaining its rationale for different periodicities for the three components, the IG said "requiring completion of some Components less frequently than every license re-registration cycle will make implementation of MOL more administratively feasible for SMBs [state medical

boards] and strikes a balance between ensuring sufficient rigor in the MOL process and ensuring that compliance with MOL is not overly burdensome for licensees."

The IG noted that MOL, MOC and OCC are similar but not identical in purpose or design. While they each require a physician's commitment to lifelong learning and self-assessment through a variety of approaches, MOL does not require specialty board certification. However, the IG advised state boards to consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA BOS Osteopathic Continuous Certification (OCC) to have substantially fulfilled all three components of MOL. Since MOL—unlike MOC or OCC—is expected to be mandatory for all physicians as a requirement of medical licensure renewal, the IG said it should be reasonably adaptable for a more heterogeneous physician population that includes those that are and are not specialty-certified, and those that are and are not engaged in MOC or OCC activities.

The IG also advised state boards to regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work, an effort currently being addressed in part by an FSMB working group looking at a minimal data set of questions that all state boards could require of physicians

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AS MOL ADVANCES, THE FSMB HAS AN INTEREST ON BEHALF OF STATE MEDICAL BOARDS TO COLLABORATE WITH ORGANIZATIONS THAT HAVE EXPERTISE IN ACTIVITIES THAT COULD SATISFY MOL REQUIREMENTS.

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when they renew their license. There is also an FSMB working group looking at ways in which non-clinical physicians may meet a state's MOL requirements. Finally, recognizing that 22.7 percent of the nation's physicians have more than one state medical license, the IG advised state boards to strive for consistency in the creation and execution of state-based MOL programs across the country.

#### **Preparing for MOL Pilot Project Implementation**

Several months before the IG presented its report to the House of Delegates, in 2011, a meeting was held in Chicago of the FSMB, the National Board of Medical Examiners (NBME), the National Board

of Osteopathic Medical Examiners (NBOME), the ABMS and the AOA BOS to begin to explore ways in which discussions could be pursued to develop and design pilot projects for state medical boards to consider as they implement MOL.

As MOL advances, the FSMB has an interest on behalf of state boards to collaborate with organizations that have expertise in physician assessment, specialty certification and practice-specific tools and activities that could satisfy MOL requirements. The five organizations have met on a regular basis, rotating between Dallas and Philadelphia and Chicago, and have exchanged information and explored opportunities for bilateral (e.g., NBME-NBOME) or multilateral work on specific MOL pilot implementation projects. The members of the group have also acknowledged the need to engage with organizations like the Council of Medical Specialty Societies (CMSS), the Accreditation Council for Continuing Medical Education (ACCME) and the American Medical Association (AMA), to name just three, to better identify existing CPD tools, activities and processes. The FSMB has taken the lead in most of these communications and is still in the early phases of these discussions.

On March 18, 2011, then-FSMB Chair Freda Bush, M.D., sent a letter to the executive directors of all 70 state medical boards in the United States, updating them on the progress being made with the advancement of MOL and noting that the FSMB and several collaborating organizations were now "ready to explore specific methodologies by which a state may wish to pilot MOL implementation." She asked them to formally respond by June 1 if they were interested in participating with the FSMB in MOL pilot implementation projects. The June 1 deadline was selected in part to enable further discussions with state boards at the FSMB's annual meeting that April in Seattle.

Between March and June, FSMB board members and staff fielded queries and comments from several state boards, both at the annual meeting and at selected site visits to specific boards at their request to talk about MOL. While there was widespread interest among many states to be among the first to consider implementing MOL, there was also concern about the resources that may be required to do so. Many respondents expressed a desire to move forward, however, with several state boards openly sharing some of the steps they were already considering in order to implement MOL in their jurisdictions. The Massachusetts Board of Registration in Medicine,

for instance, expressed a desire to implement MOL in that state by 2015, the same year that its rules requiring physicians to demonstrate familiarity with electronic health records as a condition for license renewal are expected to go into effect. The Vermont Board of Medical Practice announced that it would require, for the first time, completion of CME credits for licensure renewal, an important precursor to MOL implementation. The Colorado Medical Board reported that the Colorado Medical Society had created an MOL committee and would be collaborating with them on possible implementation strategies. Some state boards, such as the Pennsylvania State Board of Medicine, have created their own MOL Committee to further examine the issue. The Minnesota Board of Medical Practice reported that it had adopted a rule change to recognize physicians engaged in MOC and OCC programs as having satisfied that state's CME requirements for licensure renewal. Other state boards expressed an interest in MOL but said there were more pressing agenda items at the moment, while others expressed an interest in allowing best practices to emerge as they continued to follow developments.

By June, 11 state boards replied that they were interested in considering participation in MOL pilot implementation projects with the FSMB: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, Medical Board of Ohio, Oklahoma State Board of Osteopathic Examiners, Oregon Medical Board, Virginia Board of Medicine and the Wisconsin Medical Examining Board.

#### **The Evolution of MOL Pilot Implementation Projects**

During a conference call on September 7, 2011, the FSMB led a discussion with those state boards that had expressed an interest in participating in MOL pilot projects. During this call, FSMB staff members shared the results of discussions they have had with a wide range of organizations, and concluded by the end of the call that there was wide interest among the state boards in the ultimate implementation of as many as 20 to 30 pilot projects, with perhaps a third of that number developed for implementation by early 2012.

The state boards were given an opportunity to share their thoughts on three broad, hypothetical approaches to MOL implementation: an open system, a closed system and a hybrid system. In an open MOL system, a wide variety of tools and options

could be seen as acceptable to support the needs of state boards and licensees such that content for each of the three MOL components could be provided by multiple users with distributed data repositories; the onus would be on physicians and state boards, however, to determine on a continuous basis which activities could meet MOL requirements. In a closed system, by contrast, a specified system to support a state's MOL needs could link with a centralized data repository with defined schedules and designated registration for MOL compliance; the onus in this case would be on the system. In a hybrid system, there could be both open and closed elements but standards for each MOL component would need to be identified in advance and the system centralized. Similar discussions were held with the MOL IG—shortly after Janelle Rhyne, M.D., began her term as FSMB Chair—and a council of chief executive officers from a wide range of stakeholder organizations across the continuum of medical education and practice.

Partly as a result of those discussions, 10 possible pilot projects were identified and presented for feedback in a conference call in November to interested state boards. The proposed projects include processes to determine a state board's readiness to implement MOL, to integrate a state board's existing license renewal process with what will be needed for MOL and to demonstrate how physicians engaged in MOC and OCC may be able to report compliance with MOL to state boards.

In meetings in December and January, additional discussions have continued with the hope of ultimately offering interested state boards the opportunity to initiate pilot projects by early 2012. As MOL advances with more granularity and progress, the FSMB is preparing a formal communications plan that goes beyond educational and informational presentations, including the FSMB's publications and website, to educate a larger population of physicians about MOL and its implementation. Internally, the FSMB has created an MOL Team to coordinate its messages, activities, meetings, discussions, communications, media queries and leadership of MOL. Additional information about planned MOL activities will also be provided to state boards and interested stakeholders at the FSMB's annual meeting in April 2012 in Fort Worth, Texas. ■

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*(This report was formally approved by the FSMB Board of Directors.)*

## References

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## ATTACHMENT 2 – DETAILED INFORMATION ON PILOT PROJECTS

### Start Date: Spring 2012

#### 1. State Board Readiness Inventory

*Purpose:*

- To identify issues state medical boards need to consider and possibly resolve to ensure successful implementation of MOL

*Objective:*

- Develop and test a survey for use by boards to gauge readiness and challenges in implementing MOL (i.e., personnel, costs, structure, infrastructure, etc.)

#### 2. State Board License Renewal Process Integration:

*Purpose:*

- To assess the means by which MOL integrates with the various licensure renewal policies and procedures

*Objective:*

- Assess the impact of MOL on state board structure, policies and procedures
- Determine the impact on the MOL system caused by varied renewal periodicities
- Outline how physicians can demonstrate compliance with MOL

#### 3. Engage CME Providers:

*Purpose:*

- To develop data about CME providers' needs, expectations and current state of infrastructure that will inform future activities and decisions about how to integrate CME offerings into the MOL system

*Objective:*

- Assess the extent to which CME providers currently use structured physician needs assessment activities as the basis for designing educational interventions
- Gather data regarding ways in which CME providers currently link CME to external assessment activities

### Start Date: Summer 2012

#### 1. Communication about Each Pilot

*Purpose:*

- To create a common understanding and uniform approach to language and messages used to communicate about MOL and each pilot

*Objective:*

- Develop communication materials and identify spokespersons to address the needs of the core audiences (state medical boards, physicians, medical organizations, legislators, and the public)

2. Describing/Detailing Physician Practices:

*Purpose:*

- To develop methods for describing and representing individual physicians' practice that can be used to identify assessment, learning, and practice improvement needs

*Objective:*

- Develop practice models and data sets
- Provide tools to elicit learning and practice needs
- Link learning and improvement to identified needs

3. Combined Fixed-Form Assessment Providing Physician Feedback:

*Purpose:*

- To determine the feasibility and value of combining test content from multiple organizations into a practice-relevant assessment that will identify feedback to guide self-directed study

*Objective:*

- Identify major content domains / blueprint
- Develop models for providing meaningful feedback
- Determine the cost-benefit of this tool

4. Physician Acceptability Survey to Assess MOL Activities:

*Purpose:*

- To collect input from licensed physicians about the potential features of a comprehensive MOL system

*Objective:*

- Assess the extent to which physicians support different models for continuous learning and practice improvement
- Evaluate physicians' preferences for various elements for a comprehensive MOL system

5. Patient Safety:

*Purpose:*

- To assess the value of the ABMS patient safety improvement program in meeting MOL components

*Objective:*

- To evaluate the use of the ABMS patient safety program as part of a suite of MOL services

6. Reporting of MOC Data to State Boards:

*Purpose:*

- To evaluate one or more processes for reporting information to state medical boards regarding ABMS Member Board Diplomates meeting MOC program requirements

*Objective:*

- Determine state board requirements for communication of MOC reporting
- Facilitate the sharing of data to the state boards

**Start Date: TBD**

1. Non-MOC/OCC Physician

*Purpose:*

- To evaluate how physicians not engaged in MOC or OCC will engage in and meet the requirements for MOL

*Objective:*

- Define the non-MOC/OCC physician
- Identify the activities the non-MOC/OCC physician will engage in
- Outline potential reporting mechanisms to state medical boards

## **L1 State Readiness Inventory Survey Questions**

### Introduction

Incorporate a purpose statement for the survey, number of questions and approximate time to complete. The survey will be used to outline specific board needs related to the pilots.

1. Select your state medical board
2. Which of the following best describes your current position with the board?  
(select one from a list of options)
3. Indicate your level of agreement or disagreement with each of the following statements:  
(cross-tab – select one from a rating scale for a list of statements regarding state board's expectations around MOL and pilots...)

### Motivation for Participating in MOL

4. Which of the following describes your reasons for participating in MOL?  
(check all that apply)
5. How would you describe the value of MOL? (or another way to ask – Why is MOL of benefit to your board/licensees?)  
(select all that apply)
6. Rank order choices selected for the previous question.
7. How important is it for MOL to...  
(cross-tab – select one from a rating scale for elements regarding...)

### MOL Understanding

8. How well do you understand MOL in general?  
(rating scale)
9. What is your perception of the level of familiarity with MOL for the following groups (Board, Staff)  
(rating scale with cross-tabs)
10. MOL purpose statement: "Maintenance of Licensure is a system of continuous professional development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves care."

Please indicate your level of agreement or disagreement with this statement.  
(select one from a rating scale)

11. How well do you understand the 3 components of MOL?  
(cross-tab - select one from a rating scale for each component)
12. About how much time did it take to gain a comfort level with understanding MOL?  
(select one option)
13. Rate how well you think MOL has communicated about...  
(cross-tab – select one from a rating scale for elements regarding...)
14. What would have improved your understanding of MOL?  
(free text)
15. How would you like to learn more about MOL?  
(select all that apply from a list of options or free text)

#### Pilot Understanding, Selection and Preparation

16. What is your (your board's?) level of familiarity (or comfort?) with the MOL pilot projects?  
(rating scale)
17. About how much time did it take to gain a comfort level with understanding the pilots?  
(select one option)
18. Based upon your understanding of the 10 pilots being proposed, select the pilots you are most interested in participating in.
19. Force rank the pilots identified above.
20. How much lead time do you think your board will need to prepare for participating in a pilot?  
(select one option)

#### Pilot Execution

##### License Renewal Process and Integration with the Pilot

21. How frequently do you renew physician licenses?  
(select one from list of options)
22. How many license renewals did your board process last year?  
(select one from a range of options)

23. What mechanisms does your board have in place/available to evaluate/validate a licensee's participation in continuous professional development activities?  
(select from range of options and/or free text)
24. What mechanisms would you like your board to have in place/available to evaluate/validate a licensee's participation in continuous professional development activities?  
(select from range of options and/or free text)
25. Would your board prefer to tie pilot activities with your board's license renewal process/cycle or have physicians engage in pilots as a stand-alone activity?  
(select one)
26. What mechanisms do you have in place to track activities and outcomes throughout the pilot?

#### Selection of Participants

27. How will questions from physician participants be directed and answered?  
(select one from a list of options) (or would free text work better?)
28. How will your board identify and solicit licensees to participate in the pilots?  
(free text)
29. How will you look at licensees to determine the appropriate population to participate in the pilots?  
(free text)
30. How many physicians would your board feel comfortable have participate in the pilots?  
(select one from a range of values)
31. Do you anticipate needing to develop a means to incentivize physicians to participate?  
(yes/no)
32. If so, how could this be accomplished?

#### Pilot Resources

33. What tools does your board have available to facilitate communicate between board staff, the pilot organizations (FSMB, NBME, NBOME, ABMS, AOA BOS), and physicians participating in the pilot?  
(select all that apply from a list of options)
34. How many staff would you be able to devote to pilot work?

(select one from a range of values)

35. How often would you prefer to have staff representatives from the pilot organizations meet with your board?  
(select one from a range of values)
36. How would you prefer to have staff representatives from the pilot organizations meet with your board?  
(rank order from a list of options)
37. How many hours per week, on average, would your staff (individually or as a collective??) be able to work on the pilots?  
(select one from a range of values)
38. What is your current level of engagement with the following? (CME, state medical associations/societies, etc.)  
(cross-tab – select one option from a range of values for each entity)
39. Which organizations would you want to engage in the pilots?  
(select all that apply from a list of options)
40. What additional tools will you need to execute the pilot effectively? (forced selection plus free text)

#### Timing

41. What would your board consider to be acceptable amount of time to conduct and complete a pilot?  
(select one option)
42. When would you prefer to begin the pilot?

#### Cost

43. What is the anticipated cost to conduct a pilot?  
(select one option)
44. Does your board have funds available (sufficient funds) to participate in a pilot?  
(yes/no)  
If yes, select one option from a range of values
45. (Or could ask #8 this way) Do you think your board will need to secure any funding to participate in a pilot(s)?  
(yes/no)

If yes, how much money do you think your board would need?  
(select from a range of values)

#### Pilot Communication and Reporting

46. Which method do you prefer to communicate with the pilot organizations (FSMB, NBME, NBOME, ABMS, AOA BOS), and physicians participating in the pilot?  
(cross-tab – select one from list of options or rank order options for 1) pilot organizations and 2) physicians)
47. How would you rate the following communication vehicles  
(cross-tab – select one from a rating scale for list of communication vehicles)
48. Would you be willing to share the outcomes of your pilots with other state medical boards?  
(yes/no)
49. What barriers are there to participating in MOL and MOL Pilots?  
(selection of items, plus “other” and please explain)

#### Closing

50. How likely would you be to recommend participation in a pilot to another state medical board?  
(rating scale)
51. How beneficial (or positive?) do you think the pilot process will be to your board?  
(select one from a rating scale)
52. Rate how well you think MOL will perform on each of the following:  
(cross-tab – select one from a rating scale for each of the following: 1) promote high standards for physician license, 2) promote high standards for physician regulation, etc.)
53. Rate how well you think FSMB has performed on each of the following  
(cross-tab – select one from a rating scale for elements regarding MOL communication, such as creating a network for the regular exchange of information about MOL, communicating with boards about the purpose, components, implementation of MOL)
54. Who will be your board’s MOL representative?  
(Name)
55. What are your additional thoughts (free text)

**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: March 21, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MEB Newsletter Discussion	
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 possible inclusions in the Summer/Fall Board Newsletter.			
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 AND PROFESSIONAL SERVICES**  
**CORRESPONDENCE / MEMORANDUM**

**DATE:** February 28, 2012

**TO:** Wisconsin Medical Examining Board

**FROM:** Sandy Nowack  
Legal Counsel

**SUBJECT: GUIDELINES FOR MEETING PROCEDURES AND CONFLICTS**

At the request of Drs. Kailas and Wasserman, the following are current procedural guidelines for the Medical Examining Board.

**Voting on quasi-judicial matters occurs in closed session, without straw votes. Final results of the votes will be recorded in the open record of the proceeding.**

- Quasi-judicial matters include: licensing, discipline of any person licensed by the board, consideration of motions or requests for legal action, issuing orders, and the taking of formal action on any such matter.
- Board members will vote in closed session on quasi-judicial matters with no additional vote in open session. Instead, the results of closed session votes will be recorded in the public record. Because the closed session vote is the actual vote, there is no need to “re-do” the vote in open session.
- Before the Board moves from closed to open session, individual board members MAY move to change their votes. Votes MAY NOT be changed after the Board moves into open session for two reasons: a) doing so eliminates the board’s opportunity for full and fair deliberation; b) votes in closed session will now be the actual vote and not a straw vote.
- Open session votes to adopt all votes made in closed session are impermissible.

**Any member, by request, may require a roll call vote, in open session, on matters not requiring confidentiality (e.g. board elections).**

**Matters which require an exercise of the Board’s lawful authority will be addressed through motion and recorded.**

- Motions help insure legal sufficiency of the meeting record.
- All matters in which the Board takes official action shall be heard by motion.
- Any delegation, or partial delegation, of the Board’s authority to act shall be heard by motion.
- All matters of legal significance shall be heard by motion.
- All official statements of policy or position shall be heard by motion.
- Legal staff will assist with formulation of motions as requested or as necessary for legal sufficiency, for clarity and to insure that motions are within the Board’s authority.
- The Board chair may offer motions.

**Board members refrain from discussion on substantive matters until a motion has been made and seconded.** Doing so helps keep the deliberation focused.

**Board members must abstain or leave the room or both, when faced with conflicts of interest. Conflicts of interest include: individuals with whom the members work or have worked; situations in which the board member knows information about a case that was not obtained through the investigation; the investigation involves any person with whom the board member has a personal relationship—whether it be positive or negative. Conflicts of interest include but are not limited to:**

- The board member determines he or she cannot act without personal bias, whether the bias is positive or negative.
- The conflict of interest is such that the mere appearance of impropriety would call into question the objectivity of the board’s vote. Example: If a board member’s business partner were the subject of a disciplinary proceeding, the board member may not participate even if the board member honestly believes the board member could hear the matter without bias.
- The board member serves as case advisor, the Board is considering whether or not to take disciplinary action, and there is no stipulation permitting the case advisor to participate in deliberations. *The parties to stipulated resolutions typically agree that the case advisor may participate in closed session deliberations to address questions and to speak in favor of the stipulated agreement.*
- The board member serves as the case advisor and the Board is considering whether or not to issue a formal complaint.

- In considering proposed legislation, Board members who have--in their capacity as private citizens--had a role in the legislation should disclose their involvement to the Board. Generally, the member may participate in the deliberation and vote unless the Board member believes the Board member cannot act in the Board's best interest, without consideration of personal gain or benefit.
- These are guidelines and in some instances legal counsel may determine that the appearance of impropriety is such that even if there is no actual conflict, a Board member must abstain.

**If you have a potential conflict of interest, please contact legal counsel as soon as you become aware of the possible conflict.** Please avoid discussing the nature of the conflict with the full board before discussion with counsel; doing so may influence other board members. For example: if a board member abstains because the board member has been personal friends with the respondent and holds a very high opinion of the respondent, the mere act of explaining the conflict could appear to influence board decisions.

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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: <b>Medical Examining Board</b>			
4) Meeting Date: <b>March 21, 2012</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>Legislative Report</b>	
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:  Other bills: <ul style="list-style-type: none"> <li>• 2011 AB 547</li> <li>• 2011 SB 383</li> <li>• 2011 SB 421</li> <li>• 2011 SB 450</li> </ul>			
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-4043/1

MGG/MG/PH/RK/RN/TK:all:jf

2011 - 2012 LEGISLATURE

**2011 ASSEMBLY BILL 547**

February 8, 2012 - Introduced by Representative RIVARD, cosponsored  
by Senator  
LEIBHAM. Referred to Committee on Homeland Security and  
State Affairs.

1           **AN ACT** *to repeal* 15.407 (2) (a), 101.07, 101.177, 101.563,  
2           145.08 (1m), 145.135  
3           (title), 145.135 (1) (title), 145.19 (1) (title), 145.19 (5), 157.12  
4           (1) and 457.02 (5);  
5           *to renumber and amend* 15.407 (10), 101.01 (11), 101.01 (12),  
6           101.985 (2) (a)  
7           (intro.), 101.985 (2) (a) 2., 101.985 (2) (a) 3., 145.135 (1),  
8           145.135 (2) (intro.),  
9           145.135 (2) (a) to (f), 145.19 (1), 443.015, 443.03 (1) (b) 1.,  
10           443.08 (1), 443.08 (2),  
11           443.08 (3) (a), 443.08 (4) (a), 443.08 (4) (b), 443.08 (5), 443.13,  
12           443.14 (1) and  
13           443.14 (4); *to amend* 15.407 (1m), 15.407 (2) (b), 15.407 (2) (c),  
14           20.165 (2) (de),  
              20.165 (2) (j), 20.165 (2) (L), 20.320 (3) (title), 20.320 (3) (q),  
              59.70 (1), 59.70 (5)  
              (title), 59.70 (5) (a), 59.70 (5) (b), 60.70 (5), 60.72 (4), 60.726  
              (title), 60.726 (2),  
              60.77 (5) (b), 60.77 (5) (bm), 60.77 (5) (bs), 60.77 (5) (j), 101.02  
              (20) (a), 101.02  
              (21) (a), 101.145 (2), 101.745 (2), 101.952 (3), 101.985 (2)  
              (title), 101.985 (2) (am),  
              101.985 (2) (b), 101.985 (2) (c), 101.985 (2) (d), 101.985 (4),  
              101.985 (5) (b) 1.,  
              101.985 (7) (a) (intro.), 145.01 (4m), 145.01 (5), 145.01 (10) (a)  
              2., 145.01 (12),  
              145.045 (1), 145.045 (3), 145.07 (3) (a), 145.07 (5), 145.14 (2)  
              (a), 145.19 (2),

1 145.19 (3), 145.19 (4), 145.19 (6), 145.195 (1), 145.195 (2), 145.20  
(title), 145.20  
2 (1) (a), 145.20 (1) (am), 145.20 (1) (b), 145.20 (2) (intro.),  
145.20 (2) (a), 145.20  
3 (2) (d), 145.20 (2) (e), 145.20 (2) (f), 145.20 (2) (g), 145.20 (2)  
(h), 145.20 (3) (a)  
4 1., 145.20 (3) (a) 2., 145.20 (3) (b), 145.20 (3) (c), 145.20 (3) (d),  
145.20 (4), 145.20  
5 (5) (a), 145.20 (5) (am), 145.20 (5) (b), 145.20 (6) (a) 2., 145.24  
(1), 145.24 (2),  
6 145.24 (3), 145.245 (title), 145.245 (1) (a) 1., 145.245 (1) (ae),  
145.245 (4) (intro.),  
7 145.245 (4) (b), 145.245 (4) (e), 145.245 (4m) (intro.), 145.245  
(4m) (a), 145.245  
8 (4m) (b), 145.245 (4m) (c), 145.245 (5) (a) 1., 145.245 (5) (a) 2.,  
145.245 (5) (a) 3.,  
9 145.245 (5m) (a), 145.245 (6) (a), 145.245 (6) (b), 145.245 (7)  
(a), 145.245 (7) (b),  
10 145.245 (7) (c), 145.245 (7) (d), 145.245 (7) (e), 145.245 (8) (a),  
145.245 (9) (b),  
11 145.245 (9) (c), 145.245 (9) (e), 145.245 (11) (e), 145.245 (11m)  
(b), 145.245 (11m)  
12 (c), 145.245 (11m) (d), 145.245 (13), 145.245 (14) (d), 160.255  
(title), 160.255 (1),  
13 160.255 (2), 160.255 (3), 160.255 (4), 160.255 (5), 168.11 (1)  
(b) 1., 200.21 (11),  
14 200.29 (1) (c) 3. a., 236.13 (2m), 281.41 (3) (a), 281.41 (3) (b)  
3., 281.41 (3) (b) 4.,  
15 281.48 (2) (bm), 281.48 (2) (d), 281.48 (2) (f), 281.48 (2) (g),  
281.48 (2m), 281.48  
16 (3) (e), 281.48 (4g), 281.59 (1m) (c), 281.68 (3) (a) 2. f., 440.21  
(4) (a), 440.21 (4)  
17 (b), 440.26 (4), 440.91 (2) (intro.), 440.91 (2) (a), 440.91 (8),  
443.01 (2), 443.015  
18 (title), 443.03 (1) (intro.), 443.03 (1) (a), 443.03 (1) (b) 2.,  
443.03 (2), 443.035  
19 (intro.), 443.035 (1), 443.04, 443.05 (1) (intro.), (a) and (b) and  
(2), 443.06 (1) (a),  
20 443.06 (2) (intro.), 443.06 (3), 443.07 (1) (intro.), 443.07 (1) (a),  
443.07 (3), 443.07  
21 (5), 443.09 (4m), 443.09 (5), 443.10 (1) (a) to (d), 443.10 (2) (c),  
443.10 (2) (d),  
22 443.10 (2) (f), 443.10 (2) (h), 443.10 (3), 443.10 (4) (a) and (b),  
443.11 (1) (intro.),  
23 443.11 (1) (e), 443.11 (2), 443.11 (3), 443.11 (4), 443.11 (5),  
443.11 (6), 443.18 (1)  
24 (a), 443.18 (2) (a) and (b), 445.06, 448.63 (1) (d) 2., 450.02  
(3m) (a) (intro.),  
25 450.071 (1), 454.01 (5) (b), 454.08 (2) (a), 459.12 (1), 961.23 (5)  
and 961.23 (7);



This bill specifies, similarly, that DSPS authority to regulate public buildings does not include the authority to regulate buildings used for farming.

Under current law, the Dwelling Code Council (council) reviews the standards and rules for the construction of one-family and two-family dwellings (dwellings) and for modular homes and recommends a uniform dwelling code and a statewide modular home code for adoption by DSPS.

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Current law requires that the council have 18 members and that each member serve a three-year term. Of those members, current law requires a specified number of members to represent certain interest groups, including building trade labor organizations, certified building inspectors, building contractors, and members of the public. This bill reduces the membership of the council from 18 to seven members. The bill provides that each member must represent at least one of the interest groups for which representation on the council is required under current law, but does not require that each interest group be represented on the council. The bill also reduces the terms of the members from three-year terms to two-year terms.

Under current law, DSPS regulates elevators, escalators, and similar conveyances that move people or things. Under current law, contractors and mechanics constructing, altering, replacing, repairing, or otherwise working with these conveyances, and inspectors of these conveyances, must be licensed by DSPS. With certain exceptions, to be licensed as an elevator mechanic, an individual must apply to DSPS and either must complete an apprenticeship program approved by the U.S. Department of Labor or by the Department of Workforce Development or must have sufficient work history during the three years preceding the application in working with these conveyances and have passed an elevator mechanic's examination that is administered by DSPS or that is administered by a nationally recognized training program that is approved by DSPS.

This bill creates alternative requirements that may be met in order to be issued an elevator mechanic's license. Under the bill, an individual is eligible for a license if he or she verifies to DSPS that he or she has successfully completed a four-year training program established by the National Elevator Industry Educational Program or an equivalent four-year training program that is approved by DSPS and that he or she has had a certain level of experience working with elevators and other conveyances. This experience requirement may be met by being employed during each of the five years immediately preceding the date of the license application for at least 1,000 hours as an elevator mechanic, or in another capacity that has allowed him or her to remain familiar with elevator equipment, technology, and industry practices. The experience requirement may alternatively be met by meeting the 1,000-hour requirement in any five years preceding the date of the license application if the applicant verifies that this alternative is due to the applicant's work being disrupted by high unemployment in the elevator industry, military service, illness, disability, or another factor beyond the applicant's control.

Current law requires every person who is licensed by DSPS to sell manufactured homes to consumers to carry his or her license when engaged in his or her business and to display the license upon request. Current law also requires the licensee's employer to be named on the license. Current law specifies that if the licensee changes employers, then the licensee must immediately mail the license to DSPS so that DSPS can endorse the change on the license. This bill eliminates the requirement that the licensee mail his or her license to DSPS when the licensee changes employers and the requirement that DSPS endorse that change on the license.

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Under current law, DSPS makes payments to eligible cities, villages, and towns (political subdivisions) for local fire prevention and protection from

payments collected from insurers who insure against fire damage in this state. These payments from insurers are often referred to as "fire department dues." A political subdivision must meet certain eligibility criteria in order to receive these payments such as having a fire chief and being able to immediately dispatch fire fighters and equipment. The use of the payment to the political subdivision is limited to activities such as fire inspection, the purchase of equipment, and training of fire fighters.

Beginning with calendar year 2000 and ending with calendar year 2004, the state was required to make these payments to each political subdivision without regard to eligibility of the political subdivision for the payments. This bill repeals this requirement.

Current law imposes requirements for smoke detectors that must be installed in public residential buildings, one-family and two-family dwellings, and in manufactured homes. One of those requirements is that the smoke detectors be approved by Underwriters Laboratories, Inc. This bill provides, instead, that the smoke detectors must bear an Underwriters Laboratories, Inc., listing mark or similar mark from an independent product safety certification organization.

Current law requires a device that dispenses a gasoline-ethanol fuel blend for sale at retail to be marked or labeled with the percentage of ethanol at all times when the product is offered for sale. Current law requires the marking or labeling to use one-half inch high letters with a stroke of not less than one-eighth inch in width.

This bill eliminates the requirements with regard to the lettering used on the marking or labeling.

Under current law, DSPS regulates persons who install or service a piece of refrigeration equipment (refrigeration equipment) that contains ozone-depleting refrigerant (refrigerant). Among other requirements, current law requires a person who installs or services a piece of refrigeration equipment that contains refrigerant

to certify that the person does not use the refrigerant for cleaning purposes, transfers the refrigerant to storage containers using approved equipment, and does not knowingly or negligently release the refrigerant to the environment. DSPS also regulates persons who sell used, new, or reclaimed refrigerant. Refrigerants are also regulated under federal law.

This bill repeals current state law with regard to the regulation of persons who install or service most types of refrigeration equipment that contain refrigerant and with regard to the regulation of most sales of used, new, and reclaimed refrigerant. The bill does not repeal current state law that applies to the regulation of refrigerant in mobile air conditioners and in trailer refrigeration equipment.

Under current law, a sewage treatment and disposal system serving a single structure is defined as, or referred to, as a "private sewage system." This bill changes the phrase "private sewage system" to "private on-site wastewater treatment system" throughout the statutes.

Under current law, no person may install a private sewage system on the person's property without a valid sanitary permit issued by the applicable local governmental unit that issues sanitary permits. Current law requires the

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governmental unit to send a copy of each permit that it issues to DSPS. This bill eliminates this requirement and requires that the governmental unit submit to DSPS a period summary of the permits it issues at intervals to be determined by DSPS.

Current law specifies a minimum fee for the issuance of a sanitary permit for private sewage system. It also specifies the amount that a governmental unit must send with a permit when it forwards a copy of the permit to DSPS. However, under current law, DSPS may adjust these fees by rule. This bill eliminates the statutorily specified fees and maintains DSPS' authority to promulgate these fees by rule.

Current law requires DSPS to prescribe the information to be included in the

sanitary permit and to furnish sanitary permit forms to local governmental units.

This bill eliminates the requirement that DSPS supply sanitary permit forms to local governmental units.

Under current law, to be eligible to take an examination for a master plumber license, the applicant for the license must have had no less than 1,000 hours per year experience in three or more consecutive years or must be an engineering graduate from a school or college approved by DSPS. This bill eliminates the requirement that the three or more years be consecutive.

DSPS may classify master and journeyman plumbers as being restricted as to the type of work they do. A state resident who has a restricted journeyman plumber license may take the examination for a restrictive master plumber license if he or she has been engaged in a restricted type of plumbing work for a period of not less than 1,000 hours per year for two or more consecutive years. This bill eliminates the requirement that the two or more years be consecutive.

Current law authorizes DSPS to administer license examinations to persons applying to DSPS for master and journeymen plumber licenses and licenses that relate to the design, installation, and maintenance or repair of automatic fire sprinkler systems. DSPS charges fees for these examinations and licenses. Under current law, if an applicant for a license fails to pay a license fee within 30 days after receiving notice that the applicant has passed the examination for the license, DSPS may not issue the license and the applicant again has to take the examination and pay the examination fee. This bill repeals this provision.

Under current law, DSPS may not promulgate any rule that prohibits the use of manual flushing devices for urinals. This bill repeals this provision.

#### OCCUPATIONAL REGULATION

Under current law, DSPS issues occupational and professional licenses, registrations, and similar approvals (licenses). Some of these licenses are referred to in specific statutes and others are issued pursuant to DSPS's rule-making

authority. Under current law, DSPS may not issue or renew certain licenses that are specifically referred to in the statutes to applicants who are delinquent in family or child support payments or in payment of state taxes. This bill expands the scope of the types of licenses for which issuance or renewal must be denied due to support or tax delinquency to include all of the occupational and professional licenses issued by DSPS.

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Under current law, DSPS may conduct investigations, hold hearings, and make findings to determine whether a person has engaged in a practice or used a professional title without a required credential. If, after holding a hearing, DSPS determines that the person does not have the appropriate credential, DSPS may issue a special order prohibiting the person from continuing the practice or using the title. DSPS may issue a temporary restraining order in lieu of holding a hearing if DSPS has reason to believe that the person has engaged in a practice or used a title without a required credential. If a person against whom a special order has been issued violates that order, the person is subject to forfeitures. If a person against whom a temporary restraining order has been issued violates that order, the person is subject to fines or imprisonment or both.

Current law also authorizes certain boards, affiliated credentialing boards, and examining boards attached to DSPS, including the Board of Nursing, the Podiatry Affiliated Credentialing Board, and the Medical Examining Board, to fine or imprison, or both, persons who violate laws or regulations applicable to the professions regulated by those boards.

This bill clarifies that the authority granted to DSPS to impose fines or forfeitures against or imprison a person who has engaged in a practice or used a title without holding the appropriate credential is separate from and in addition to the authority granted to the various boards to enforce the laws and regulations applicable to the professions regulated by those boards.

Currently, DSPS requires by rule that a person who holds a credential issued by DSPS send a notice to DSPS within 48 hours of his or her conviction of a crime.

This bill places that requirement in the statutes.

Under current law, the Medical Examining Board may refuse to accept a person's voluntary surrender of his or her license if the board has received allegations of unprofessional conduct by the person.

This bill allows a person to voluntarily surrender his or her occupational license, permit, or certificate of certification or registration, but allows the licensing agency to refuse to accept that surrender if the agency has received a complaint against the person or has commenced disciplinary proceedings against the person.

Under current law, the Pharmacy Examining Board may grant a variance from a law or rule applicable to pharmacists or the practice of pharmacy if each of the following conditions is satisfied: 1) the Pharmacy Examining Board determines that a natural or man-made disaster or emergency exists or has occurred; 2) a pharmacist has requested the variance; and 3) the Pharmacy Examining Board determines that the variance is necessary to protect the public health, safety, or welfare. This bill adds as another condition that the law or rule either permits a variance or requires approval from the Pharmacy Examining Board prior to obtaining a variance.

Current law requires every wholesale distributor of a prescription drug to obtain a license from the Pharmacy Examining Board. This law applies to wholesale distributors of oxygen. This bill exempts wholesale distributors of oxygen from the requirement to obtain a license from the Pharmacy Examining Board.

Under current law, the Hearing and Speech Examining Board may promulgate rules governing hearing instrument specialists, but not speech-language

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pathologists or audiologists. This bill permits the Hearing and Speech Examining Board to promulgate rules governing speech-language pathologists and audiologists.

Current law, as affected by 2005 Wisconsin Act 334, requires an applicant to complete two years of postgraduate podiatrist training to be eligible for licensure as a podiatrist. Prior to that act, one year of postgraduate podiatrist training was required. The act first applied to persons submitting applications on June 1, 2010, but did not specify the treatment of those who had completed the one-year training requirement before that date.

This bill clarifies that an applicant who completed one year of postgraduate training in a program approved by the Podiatrist Affiliated Credentialing Board by June 1, 2010, is eligible for licensure as a podiatrist.

Under current law, members of the Respiratory Care Practitioners Examining Council, which serves the Medical Examining Board in an advisory capacity, may serve no more than two consecutive three-year terms. This bill eliminates the two-term limit.



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**WISCONSIN LEGISLATIVE COUNCIL  
AMENDMENT MEMO**

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<b>2011 Assembly Bill 547</b>	<b>Assembly Amendments 1 to 9</b>
<i>Memo published: March 1, 2012</i>	
<i>Contact: Don Salm, Senior Staff Attorney (266-8540)</i>	

Assembly Amendments 1 to 9 to 2011 Assembly Bill 547 contain technical and, in a few instances, substantive changes to the bill requested by the Department of Safety and Professional Services (DSPS).

**ASSEMBLY AMENDMENT 1**

This amendment deletes SECTION 235 in the bill which would have repealed current s. 457.02 (5), Stats. That provision specifies that ch. 457, Stats., does not authorize any individual who is certified or licensed under that chapter to use the title “alcohol and drug counselor” or “chemical dependency counselor” unless the individual is certified as an alcohol and drug counselor or as a chemical dependency counselor through a process recognized by DSPS.

**ASSEMBLY AMENDMENT 2**

This amendment repeals current s. 440.91 (8), Stats., which provides that certain specified real estate salesperson statutory provisions also apply to cemetery salespersons. According to DSPS, this provision is outdated and unnecessary.

**ASSEMBLY AMENDMENT 3**

This amendment repeals current s. 457.25 (5), Stats., which requires the appropriate section of the Marriage and Family Therapy, Professional Counseling and Social Work Examining Board to send a letter to a credential holder if a complaint is received. According to DSPS, this statutory requirement is unique to this board and is duplicative of the normal investigative process used in the DSPS’s Division of Enforcement and, as such, is unnecessary.

#### ASSEMBLY AMENDMENT 4

This amendment is a technical correction requested by DSPS to make the bill accord with the revision DSPS intended to make. The original bill's SECTION 70 resulted in a change in s. 145.19 (3), Stats., that was contrary to the change that DSPS had requested.

#### ASSEMBLY AMENDMENT 5

This amendment is a technical correction requested by DSPS. The bill provision goes further than DSPS intended in its request to exclude farm buildings from the definition of "place of employment" in s. 101.05 (5), Stats., created in the bill. The amendment applies the exclusion to certain specified provisions of subch. I of ch. 101, Stats., instead of the entire subchapter.

#### ASSEMBLY AMENDMENT 6

This amendment revises various provisions in the bill that relate to the Uniform Dwelling Code Council. The amendment:

- Increases the council size from 7 to 11.
- Adds "fire prevention professional" as a category of persons that may be placed on the council.
- Clarifies that the "designer" referred to in the possible membership categories of the council is a designer credentialed by DSPS by the same examining board that credentials architects and engineers.
- Clarifies that the non-voting secretary to the council is not to be counted as one of the 11 members of the 11-member council.
- Increases the quorum size for the council from five to seven.
- Adds "modular housing" to the manufactured home category of representatives that may be placed on the council, and adds "retailers" to that same category. Under the amendment, a person may be eligible for membership on the council from this category if he or she is a representative of "manufacturers, retailers, or installers of manufactured or modular one- and 2-family housing."

#### ASSEMBLY AMENDMENT 7

This amendment changes the credential issued to dietitians from a certificate to a license. To do so, it makes changes in numerous statutory provisions that currently refer to the "certification" of dietitians or the "certificate" issued to dietitians, to instead refer to the "licensure" of dietitians or the "license" issued to dietitians. For example, s. 448.70 (1m), Stats., defines the term "certified dietitian." The amendment changes the defined term to "licensed dietitian." Also, s. 448.78, Stats., is currently titled "Certification of dietitians." The amendment changes the title to "Licensure as a dietitian."

The amendment does not change the definition of "dietitian" or "dietetics" and therefore, does not change the scope of practice of a dietitian, as currently set forth in Wisconsin law. In addition, the amendment does not change the current requirements for obtaining a credential to be a dietitian and practice dietetics. The amendment contains a transition clause that would treat a person who holds a dietitian certificate when the legislation takes effect as having a dietitian license.

Since the scope of dietetic practice and the requirements for obtaining credentialing as a dietitian are unchanged by Assembly Amendment 7, the current effect of the amendment may be viewed as technical and not substantive.

#### **ASSEMBLY AMENDMENT 8**

This amendment defines the requirements applicable to a funeral director who is in charge of a funeral establishment by specifying that the director has full charge, control, and supervision of all funeral directing and embalming services at the funeral establishment, and that the director must ensure that the funeral establishment operates in compliance with ch. 445, Stats., and rules promulgated by the examining board.

#### **ASSEMBLY AMENDMENT 9**

This amendment deletes an unnecessary sentence in s. 145.17 (1), Stats., because DSPS has never used any of the organizations listed in that sentence for certification of inspection.

#### **LEGISLATIVE HISTORY**

At an executive session on 2011 Assembly Bill 547 on February 22, 2011, the Assembly Committee on Homeland Security and State Affairs voted to adopt Assembly Amendments 1 to 6, 8, and 9 to the bill, all on votes of Ayes, 8; Noes, 0. The committee voted to adopt Assembly Amendment 7 on a vote of Ayes, 6; Noes, 2. The committee then voted for passage of the bill, as amended, on a vote of Ayes, 8; Noes, 0.

DLS:jb;ksm

LRB-3804/1

RPN;jld:rs

2011 - 2012 LEGISLATURE

## 2011 SENATE BILL 383

January 18, 2012 - Introduced by Senators DARLING, SHILLING, KEDZIE and TAYLOR, cosponsored by Representatives SEVERSON, VAN ROY, VOS, SPANBAUER, BILLINGS, PASCH and ZEPNICK. Referred to Committee on Health.

1           **AN ACT** *to renumber* 448.015 (1); *to amend* 448.02 (1), 448.03  
 2                   (2) (c), 448.03 (2)  
 3                   (e), 448.03 (2) (k), 448.05 (1) (d) and 448.05 (6) (a); and *to*  
 4                   *create* 15.407 (7),  
 5                   448.015 (1b), 448.015 (1c), 448.03 (1) (d), 448.03 (3) (g), 448.03  
 6                   (7), 448.04 (1) (g),  
                   448.05 (5w), 448.05 (6) (ar), 448.13 (3), 448.22 and 448.23 of  
                   the statutes;  
                   *relating to:* licensing anesthesiologist assistants and creating  
                   the Council on  
                   Anesthesiologist Assistants and granting rule-making  
                   authority.

### *Analysis by the Legislative Reference Bureau*

This bill creates licensure requirements and practice standards for anesthesiologist assistants.

The bill prohibits a person from practicing as an anesthesiologist assistant or representing or implying that the person is an anesthesiologist assistant unless the person holds a license to practice as an anesthesiologist assistant granted by the Medical Examining Board (board). The bill requires the board to issue a license to a person who has: 1) obtained a bachelor's degree; 2) completed an accredited

anesthesiologist assistant program; and 3) passed a certifying examination. The board may also issue a license to a person who is licensed as an anesthesiologist assistant in another state, if that state authorizes a licensed anesthesiologist assistant to practice in the same manner and to the same extent as this state.

Under the bill, an anesthesiologist assistant may assist an anesthesiologist in the delivery of medical care only under the supervision of an anesthesiologist who

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is immediately available and able to intervene if needed. The scope of an anesthesiologist assistant's practice is limited to assisting only the supervising anesthesiologist and performing only certain medical care tasks assigned by the supervising anesthesiologist. The medical care tasks are specified in the bill and include the following: 1) developing and implementing an anesthesia care plan; 2) implementing monitoring techniques; 3) pretesting and calibrating anesthesia delivery systems; 4) administering vasoactive drugs and starting and adjusting vasoactive infusions; 5) administering intermittent anesthetic, adjuvant, and accessory drugs; 6) implementing spinal, epidural, and regional anesthetic procedures; and 7) administering blood, blood products, and supportive fluids.

The bill requires an anesthesiologist assistant to be employed by one of certain health care providers specified in the bill and to enter into a supervision agreement with an anesthesiologist who represents the anesthesiologist assistant's employer. The supervision agreement must identify the anesthesiologist assistant's supervising anesthesiologist and define the scope of the anesthesiologist assistant's practice, and may limit the anesthesiologist assistant's practice to less than the full scope of anesthesiologist assistant practice authorized by the bill.

The bill authorizes a student anesthesiologist assistant to perform only medical care tasks assigned by an anesthesiologist, who may delegate the supervision of a student to a qualified anesthesiology provider. The bill also creates a

five-member  
 Council on Anesthesiologist Assistants to advise and make  
 recommendations to the  
 board.

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. 15.407 (7) of the statutes is created to read:  
 2                   15.407 (7) COUNCIL ON ANESTHESIOLOGIST ASSISTANTS;  
 3 DUTIES. There is created  
 4 a council on anesthesiologist assistants in the department of safety  
 5 and professional  
 6 services and serving the medical examining board in an advisory  
 7 capacity. The  
 8 council's membership shall consist of the following members, who  
 shall be selected  
 from a list of recommended appointees submitted by the president of  
 the Wisconsin  
 Society of Anesthesiologists, Inc., after the president of the Wisconsin  
 Society of  
 Anesthesiologists, Inc., has considered the recommendation of the  
 Wisconsin

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1                   Academy of Anesthesiologist Assistants for the appointee  
 2 under par. (b), and who  
 3 shall be appointed by the medical examining board for 3-year terms:  
 4                   (a) One member of the medical examining board.  
 5                   (b) One anesthesiologist assistant licensed under s. 448.04 (1)  
 6 (g).  
 7                   (c) Two anesthesiologists.  
 8                   (d) One lay member.

9                   SECTION 2. 448.015 (1) of the statutes is renumbered 448.015  
 10 (1d).

11                   SECTION 3. 448.015 (1b) of the statutes is created to read:  
 12 448.015 (1b) "Anesthesiologist" means a physician who has  
 13 completed a  
 14 residency in anesthesiology approved by the American Board of  
 Anesthesiology or  
 the American Osteopathic Board of Anesthesiology, holds an  
 unrestricted license,  
 and is actively engaged in clinical practice.

15                   SECTION 4. 448.015 (1c) of the statutes is created to read:  
 16 448.015 (1c) "Anesthesiologist assistant" means an individual  
 licensed by the

15 board to assist an anesthesiologist in the delivery of certain medical  
16 care with  
17 anesthesiologist supervision.

18 SECTION 5. 448.02 (1) of the statutes is amended to read:  
19 448.02 (1) LICENSE. The board may grant licenses, including  
20 various classes  
21 of temporary licenses, to practice medicine and surgery, to practice  
22 perfusion, to  
23 practice as an anesthesiologist assistant, and to practice as a  
24 physician assistant.

25 SECTION 6. 448.03 (1) (d) of the statutes is created to read:  
26 448.03 (1) (d) No person may practice as an anesthesiologist  
27 assistant unless  
28 he or she is licensed by the board as an anesthesiologist assistant.

29 SECTION 7. 448.03 (2) (c) of the statutes is amended to read:

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30 448.03 (2) (c) The activities of a medical student, respiratory  
31 care student,  
32 perfusion student, anesthesiologist assistant student, or physician  
33 assistant student  
34 required for such student's education and training, or the activities of  
35 a medical  
36 school graduate required for training as required in s. 448.05 (2).

37 SECTION 8. 448.03 (2) (e) of the statutes is amended to read:

38 448.03 (2) (e) Any person other than a physician assistant or  
39 an  
40 anesthesiologist assistant who is providing patient services as  
41 directed, supervised  
42 and inspected by a physician who has the power to direct, decide and  
43 oversee the  
44 implementation of the patient services rendered.

45 SECTION 9. 448.03 (2) (k) of the statutes is amended to read:

46 448.03 (2) (k) Any persons, other than physician assistants,  
47 anesthesiologist  
48 assistants, or perfusionists, who assist physicians.

49 SECTION 10. 448.03 (3) (g) of the statutes is created to read:

50 448.03 (3) (g) No person may designate himself or herself as  
51 an  
52 "anesthesiologist assistant" or use or assume the title  
53 "anesthesiologist assistant" or  
54 append to the person's name the words or letters "anesthesiologist  
55 assistant" or  
56 "A.A." or any other titles, letters, or designation that represents or  
57 may tend to  
58 represent the person as an anesthesiologist assistant unless he or she  
59 is licensed as  
60 an anesthesiologist assistant by the board. An anesthesiologist  
61 assistant shall be  
62 clearly identified as an anesthesiologist assistant.

63 SECTION 11. 448.03 (7) of the statutes is created to read:

22                   448.03 (7) SUPERVISION OF ANESTHESIOLOGIST ASSISTANTS.  
23                   An anesthesiologist  
24                   may not supervise more than the number of anesthesiologist  
25                   assistants permitted  
                    by reimbursement standards for Part A or Part B of the federal  
                    Medicare program  
                    under Title XVIII of the federal Social Security Act, 42 USC 1395 to  
                    1395hhh.

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1                   SECTION 12. 448.04 (1) (g) of the statutes is created to read:  
2                   448.04 (1) (g) *Anesthesiologist assistant license*. The board  
3                   shall license as an  
4                   anesthesiologist assistant an individual who meets the requirements  
5                   for licensure  
6                   under s. 448.05 (5w). The board may, by rule, provide for a temporary  
7                   license to  
8                   practice as an anesthesiologist assistant. The board may issue a  
9                   temporary license  
10                  to a person who meets the requirements under s. 448.05 (5w) and who  
11                  is eligible to  
12                  take, but has not passed, the examination under s. 448.05 (6). A  
13                  temporary license  
14                  expires on the date on which the board grants or denies an applicant  
15                  permanent  
16                  licensure or on the date of the next regularly scheduled examination  
17                  required under  
18                  s. 448.05 (6) if the applicant is required to take, but has failed to apply  
19                  for, the  
20                  examination. An applicant who continues to meet the requirements  
21                  for a temporary  
22                  license may request that the board renew the temporary license, but  
23                  an  
                    anesthesiologist assistant may not practice under a temporary license  
                    for a period  
                    of more than 18 months.

15                  SECTION 13. 448.05 (1) (d) of the statutes is amended to read:  
16                  448.05 (1) (d) Be found qualified by three-fourths of the  
17                  members of the board,  
18                  except that an applicant for a temporary license under s. 448.04 (1) (b)  
19                  1. and 3. ~~and~~  
20                  (e), ~~and~~ (g) must be found qualified by 2 members of the board.

19                  SECTION 14. 448.05 (5w) of the statutes is created to read:  
20                  448.05 (5w) ANESTHESIOLOGIST ASSISTANT LICENSE. An  
21                  applicant for a license  
22                  to practice as an anesthesiologist assistant shall submit evidence  
23                  satisfactory to  
                    board that the applicant has done all of the following:  
                    (a) Obtained a bachelor's degree.

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1                   (b) Satisfactorily completed an anesthesiologist assistant  
2                   program that is  
3                   accredited by the Commission on Accreditation of Allied Health  
4                   Education  
5                   Programs, or by a predecessor or successor entity.

6                   (c) Passed the certifying examination administered by, and  
7                   obtained active  
8                   certification from, the National Commission on Certification of  
9                   Anesthesiologist  
10                   Assistants or a successor entity.

LRB-3909/1

MPG:wlj:ph

## 2011 - 2012 LEGISLATURE

**2011 SENATE BILL 421**

February 2, 2012 - Introduced by Senators VUKMIR, S. FITZGERALD, OLSEN, SCHULTZ and SHILLING, cosponsored by Representatives PETRYK, RINGHAND, T. LARSON, NYGREN, PASCH, RADCLIFFE, RIVARD, SEVERSON, STEINEKE, THIESFELDT, TRANEL, BROOKS and SPANBAUER. Referred to Committee on Health.

1 **AN ACT** to amend 50.09 (1) (a) (intro.), 50.09 (1) (f) 1., 50.09 (1)  
 2 (h), 50.09 (1) (k),  
 3 50.49 (1) (b) (intro.), 70.47 (8) (intro.), 146.82 (3) (a), 252.07  
 4 (8) (a) 2., 252.07 (9)  
 5 (c), 252.11 (2), 252.11 (4), 252.11 (5), 252.11 (7), 252.11 (10),  
 6 252.14 (1) (ar) 14.,  
 7 252.16 (3) (c) (intro.), 252.17 (3) (c) (intro.), 252.18, 343.16 (5)  
 8 (a), 448.03 (5) (b),  
 448.56 (1), 448.56 (1m) (b), 448.67 (2), 450.11 (7) (b) and  
 450.11 (8) (b); and to  
 create 50.01 (4p), 252.01 (5), 450.01 (15r), 450.01 (16) (h) 3.  
 and 450.13 (5) (c)  
 of the statutes; relating to: authorizing medically related  
 actions by physician  
 assistants.

*Analysis by the Legislative Reference Bureau*

Under current law, the Medical Examining Board grants physician assistant licenses to individuals who meet training and examination requirements and any other requirements established in rules promulgated by the Medical Examining Board.

The following provisions under current law authorize physicians or other

health care professionals to act under specified circumstances and to affect individuals by these authorized actions:

1. Unless medically contraindicated as documented by a nursing home or community-based residential facility resident's physician in the resident's medical

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record, the resident has the right to private and unrestricted communications with his or her family, physician, attorney, and others; to share a room with his or her spouse or domestic partner if the spouse or domestic partner is also a resident; to participate in activities of social, religious, and community groups; and to be free from chemical and physical restraints.

2. Home health services that are provided to an individual by a home health agency must be those specified under a plan for furnishing the services that is established and periodically reviewed by a physician.

3. For hearings before the local board of review concerning assessments of property taxes, an ill or disabled person who presents to the board a letter from a physician or osteopath confirming the illness or disability may present testimony by telephone.

4. Under laws relating to confidentiality of patient health care records, a physician who treats a patient whose physical or mental condition, in the physician's judgment, affects his or her ability to exercise reasonable and ordinary control over a motor vehicle may, without the patient's informed consent, report the patient's name and other information to the Department of Transportation. Physicians are exempted from civil liability for reporting, or not reporting, this information in good faith.

5. Under laws relating to communicable diseases:

a. The Department of Health Services (DHS) may order an individual who has a confirmed diagnosis of infectious tuberculosis or symptoms indicative of tuberculosis confined to a facility if several conditions are met, including notifying a court of the confinement and providing to the court a physician's

written statement  
affirming the tuberculosis or symptoms.

b. If a court orders confinement of an individual with infectious tuberculosis or symptoms indicative of tuberculosis, the individual must remain confined until DHS or a local health officer, with the concurrence of a treating physician, determines that treatment is complete or that the individual is no longer a public health threat.

c. If, following a request by an officer of DHS or a local health officer, a person reasonably suspected of being infected with a sexually transmitted disease refuses or neglects examination by a physician or treatment, the DHS officer or local health officer may have the person committed to an institution for examination, treatment, or observation.

d. If a person with a sexually transmitted disease ceases or refuses treatment before reaching what is in a physician's opinion the noncommunicable stage, the physician must notify DHS and the person may be committed by a court for examination or treatment.

e. If a physician has reported to DHS a case of sexually transmitted disease, information regarding the disease and its treatment is not privileged before a court.

f. The State Laboratory of Hygiene must examine specimens for the diagnosis of sexually transmitted disease for any physician or local health officer and must report positive results to the local health officer and DHS.

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g. If a local health officer or DHS officer requires it, a person who is employed in the handling of food products or is suspected of having a disease in a form that is communicable by food handling must submit to an examination by the officer or by a physician.

6. Under occupational regulation laws relating to physical therapists, a physical therapist may practice only on the written referral of a physician, chiropractor, dentist, or podiatrist, except under certain conditions, including providing services to an individual for a previously diagnosed medical

condition after  
informing the individual's physician, chiropractor, dentist, or  
podiatrist.

7. Under occupational regulation laws relating to podiatrists,  
a podiatrist who  
renders chargeable services to, among others, a patient or physician,  
must render a  
statement of the charge directly to the person served.

8. Under laws relating to the practice of pharmacy, current  
law does the  
following:

a. Defines the term "practice of pharmacy" to include making  
therapeutic  
alternate drug selections in accordance with written guidelines or  
procedures  
approved by a hospital and by a physician for his or her patients for a  
hospital stay.

b. Provides that information communicated to a physician in  
an effort  
unlawfully to procure a prescription drug is not privileged  
communication.

c. Requires the enforcement of prescription drug laws that  
apply to physicians  
to be the responsibility of the Department of Regulation and Licensing  
and the  
Medical Examining Board.

d. Exempts pharmacists from requirements that they provide  
certain  
information when dispensing a drug product equivalent, if the patient  
is in a hospital  
and the drug product equivalent is dispensed in accordance with  
guidelines  
approved by, among others, the patient's physician.

Currently, an advanced practice nurse prescriber may act in  
the same manner  
physicians may act in the instances specified above.

This bill expands the current laws described above that  
authorize physicians  
to act under specified circumstances and to affect individuals by these  
authorized  
actions, by similarly authorizing individuals licensed as physician  
assistants.

For further information see the *state and local* 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. 50.01 (4p) of the statutes is created to read:  
 2                   50.01 (4p) "Physician assistant" has the meaning given in s.  
 3                   448.01 (6).

3                   SECTION 2. 50.09 (1) (a) (intro.) of the statutes is amended to  
 read:

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1                   50.09 (1) (a) (intro.) Private and unrestricted communications  
 2                   with the  
 3                   resident's family, physician, physician assistant, advanced practice  
 4                   nurse prescriber,  
 5                   attorney, and any other person, unless medically contraindicated as  
 6                   documented by  
 7                   the resident's physician, physician assistant, or advanced practice  
 8                   nurse prescriber  
 9                   in the resident's medical record, except that communications with  
 10                  public officials or  
 11                  with the resident's attorney shall not be restricted in any event. The  
 12                  right to private  
 13                  and unrestricted communications shall include, but is not limited to,  
 14                  the right to:

8                   SECTION 3. 50.09 (1) (f) 1. of the statutes is amended to read:

9                   50.09 (1) (f) 1. Privacy for visits by spouse or domestic  
 10                  partner. If both spouses  
 11                  or both domestic partners under ch.770 are residents of the same  
 12                  facility, the spouses  
 13                  or domestic partners shall be permitted to share a room unless  
 14                  medically  
 15                  contraindicated as documented by the resident's physician, physician  
 16                  assistant, or  
 17                  advanced practice nurse prescriber in the resident's medical record.

14                  SECTION 4. 50.09 (1) (h) of the statutes is amended to read:

15                  50.09 (1) (h) Meet with, and participate in activities of social,  
 16                  religious, and  
 17                  community groups at the resident's discretion, unless medically  
 18                  contraindicated as  
 19                  documented by the resident's physician, physician assistant, or  
 20                  advanced practice  
 21                  nurse prescriber in the resident's medical record.

19                  SECTION 5. 50.09 (1) (k) of the statutes is amended to read:

20                  50.09 (1) (k) Be free from mental and physical abuse, and be  
 21                  free from chemical  
 22                  and physical restraints except as authorized in writing by a  
 23                  physician, physician  
 24                  assistant, or advanced practice nurse prescriber for a specified and  
 limited period of  
 time and documented in the resident's medical record. Physical  
 restraints may be  
 used in an emergency when necessary to protect the resident from  
 injury to himself

25 or herself or others or to property. However, authorization for  
continuing use of the

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1 physical restraints shall be secured from a physician,  
2 physician assistant, or  
3 advanced practice nurse prescriber within 12 hours. Any use of  
4 physical restraints  
5 shall be noted in the resident's medical records. "Physical restraints"  
6 includes, but  
7 is not limited to, any article, device, or garment that interferes with  
8 the free  
9 movement of the resident and that the resident is unable to remove  
10 easily, and  
11 confinement in a locked room.

12 SECTION 6. 50.49 (1) (b) (intro.) of the statutes is amended to  
13 read:

14 50.49 (1) (b) (intro.) "Home health services" means the  
15 following items and  
16 services that are furnished to an individual, who is under the care of a  
17 physician,  
18 physician assistant, or advanced practice nurse prescriber, by a home  
19 health agency,  
20 or by others under arrangements made by the home health agency,  
21 that are under  
22 a plan for furnishing those items and services to the individual that is  
23 established  
24 and periodically reviewed by a physician, physician assistant, or  
25 advanced practice  
nurse prescriber and that are, except as provided in subd. 6., provided  
on a visiting  
basis in a place of residence used as the individual's home:

SECTION 7. 70.47 (8) (intro.) of the statutes is amended to  
read:

70.47 (8) HEARING. (intro.) The board shall hear upon oath all  
persons who  
appear before it in relation to the assessment. The board shall hear  
upon oath, by  
telephone, all ill or disabled persons who present to the board a letter  
from a  
physician, osteopath, physician assistant, as defined in s. 448.01 (6),  
or advanced  
practice nurse prescriber certified under s. 441.16 (2) that confirms  
their illness or  
disability. The board at such hearing shall proceed as follows:

SECTION 8. 146.82 (3) (a) of the statutes is amended to read:

146.82 (3) (a) Notwithstanding sub. (1), a physician,  
physician assistant, as  
defined in s. 448.01 (6), or advanced practice nurse prescriber certified  
under s.

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1                   441.16 (2) who treats a patient whose physical or mental  
2                   condition in the physician's,  
3                   physician assistant's, or advanced practice nurse prescriber's  
4                   judgment affects the  
5                   patient's ability to exercise reasonable and ordinary control over a  
6                   motor vehicle may  
7                   report the patient's name and other information relevant to the  
8                   condition to the  
9                   department of transportation without the informed consent of the  
10                   patient.

SECTION 9. 252.01 (5) of the statutes is created to read:

LRBa2238/1

MPG:cjs:ph

## 2011 - 2012 LEGISLATURE

**SENATE AMENDMENT 1,  
TO 2011 SENATE BILL 421**

February 13, 2012 - Offered by Senator VUKMIR.

1 At the locations indicated, amend the bill as follows:

2 1. Page 5, line 22: after that line insert:

3 " SECTION 7M. 118.15 (3) (a) of the statutes is amended to  
4 read:

5 118.15 (3) (a) Any child who is excused by the school board  
6 because the child

7 is temporarily not in proper physical or mental condition to attend a  
8 school program

9 but who can be expected to return to a school program upon  
10 termination or

11 abatement of the illness or condition. The school attendance officer  
12 may request the

parent or guardian of the child to obtain a written statement from a  
licensed

physician, dentist, chiropractor, optometrist or psychologist,

physician assistant, or

nurse practitioner, as defined in s. 255.06 (1) (d), or certified advanced  
practice nurse

prescriber or Christian Science practitioner living and residing in this  
state, who is

listed in the Christian Science Journal, as sufficient proof of the  
physical or mental

1 condition of the child. An excuse under this paragraph shall  
2 be in writing and shall

3 state the time period for which it is valid, not to exceed 30 days."

(END)

LRB-3952/1

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2011 - 2012 LEGISLATURE

# 2011 SENATE BILL 450

February 9, 2012 - Introduced by JOINT LEGISLATIVE COUNCIL.  
Referred to  
Committee on Workforce Development, Small Business, and  
Tourism.

1  
2  
3  
4

**AN ACT** to renumber 447.05 and 455.06; and to create 440.033,  
447.05 (2),  
448.07 (1m), 448.55 (4), 450.08 (3), 455.06 (2) and 457.20 (5)  
of the statutes;  
relating to: collecting workforce survey information from  
health care  
providers.

*Analysis by the Legislative Reference Bureau*

This bill is explained in the NOTES provided by the Joint  
Legislative Council in  
the bill.

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:*

JOINT LEGISLATIVE COUNCIL PREFATORY NOTE: This  
bill was prepared for the Joint  
Legislative Council's Special Committee on Health Care  
Access.

Current law requires the board of nursing to  
require each applicant for renewal of  
a credential to complete a workforce survey developed by  
the department of workforce

development. The board may not renew a credential unless the renewal applicant has completed the nursing workforce survey to the satisfaction of the board. In addition, current law requires each applicant for renewal to pay a nursing workforce survey fee of \$4.

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This bill creates similar statutes with respect to workforce surveys of persons seeking renewal of a license as a dentist, dental hygienist, physician, psychologist, physical therapist, physician assistant, pharmacist, or clinical social worker. The survey is to be developed jointly by the department of safety and professional services, the department of health services, and the department of workforce development. However, the bill does not include a workforce survey fee.

SECTION 1. 440.033 of the statutes is created to read:

**440.033 Health care provider workforce survey. (1)**

DEFINITION. In this section, "health care provider" means a dentist or dental hygienist licensed under s. 447.04, a physician or physician assistant licensed under s. 448.04, a physical therapist licensed under s. 448.51, a pharmacist licensed under s. 450.03, a psychologist licensed under s. 455.04 (1), and a clinical social worker licensed under s. 457.08 (4).

(2) SURVEY FORM. The department, the department of health services, and the department of workforce development jointly shall develop, and revise as those agencies deem appropriate, one or more survey forms to gather data under ss. 447.05 (2), 448.07 (1m), 448.55 (4), 450.08 (3), 455.06 (2), and 457.20 (5). The data gathered shall be used to assist the department of workforce development in evaluating the supply of, demand for, and turnover among health care providers in this state and whether there are regional shortages of health care providers, shortages of health care providers in any specialty areas, or impediments to entering a health care provider profession in this state, and shall be used to assist the department of health services in identifying health professional shortage areas in this state.

18                   (3) SURVEY RESULTS. (a) The department, the dentistry  
19                   examining board, the  
20                   medical examining board, the physical therapy examining board, the  
21                   pharmacy  
                  examining board, the psychology examining board, and the marriage  
                  and family  
                  therapy, professional counseling, and social work examining board  
                  shall share the

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1                   results of the survey with the department of health services  
2                   and the department of  
3                   workforce development.

4                   (b) Every 2 years, the department shall compile, process, and  
5                   evaluate the  
6                   survey results and submit a report of its findings to the speaker of the  
7                   assembly and  
8                   the president of the senate under s. 13.172 (3) and to the governor.

9                   SECTION 2. 447.05 of the statutes is renumbered 447.05 (1).

10                  SECTION 3. 447.05 (2) of the statutes is created to read:

11                  447.05 (2) (a) The examining board shall require each  
12                  applicant for the renewal  
13                  of a license as a dentist or dental hygienist, as a condition for  
14                  renewing the license,  
15                  to complete and submit to the department with the application for  
16                  renewal of the  
17                  license a workforce survey developed under s. 440.033 (2).

18                  (b) The examining board may not renew a license of a dentist  
19                  or dental  
20                  hygienist unless the renewal applicant has completed the workforce  
21                  survey to the  
22                  satisfaction of the examining board. The examining board shall  
23                  establish standards  
24                  to determine whether the survey has been completed.

25                  SECTION 4. 448.07 (1m) of the statutes is created to read:

                  448.07 (1m) WORKFORCE SURVEY. (a) The board shall require  
                  each applicant for  
                  the renewal of a license as a physician or physician assistant, as a  
                  condition for  
                  renewing the license, to complete and submit to the department with  
                  the application  
                  for renewal of the license a workforce survey developed under s.  
                  440.033 (2).

                  (b) The board may not renew a license of a physician or  
                  physician assistant  
                  unless the renewal applicant has completed the workforce survey to  
                  the satisfaction  
                  of the board. The board shall establish standards to determine  
                  whether the survey  
                  has been completed.

                  SECTION 5. 448.55 (4) of the statutes is created to read:

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1                   448.55 (4) (a) The examining board shall require each  
2 applicant for the renewal  
3 of a license as a physical therapist, as a condition for renewing the  
4 license, to  
5 complete and submit to the department with the application for  
6 renewal of the  
7 license a workforce survey developed under s. 440.033 (2).

8                   (b) The examining board may not renew a license of a  
9 physical therapist unless  
10 the renewal applicant has completed the workforce survey to the  
11 satisfaction of the  
12 examining board. The examining board shall establish standards to  
13 determine  
14 whether the survey has been completed.

15                   SECTION 6. 450.08 (3) of the statutes is created to read:

16                   450.08 (3) (a) The board shall require each applicant for the  
17 renewal of a license  
18 as a pharmacist, as a condition for renewing the license, to complete  
19 and submit to  
20 the department with the application for renewal of the license a  
21 workforce survey  
22 developed under s. 440.033 (2).

23                   (b) The board may not renew a license of a pharmacist unless  
24 the renewal  
25 applicant has completed the workforce survey to the satisfaction of the  
26 board. The  
27 board shall establish standards to determine whether the survey has  
28 been  
29 completed.

30                   SECTION 7. 455.06 of the statutes is renumbered 455.06 (1).

31                   SECTION 8. 455.06 (2) of the statutes is created to read:

32                   455.06 (2) (a) The examining board shall require each  
33 applicant for the renewal  
34 of a license as a psychologist, as a condition for renewing the license,  
35 to complete and  
36 submit to the department with the application for renewal of the  
37 license a workforce  
38 survey developed under s. 440.033 (2).

39                   (b) The examining board may not renew a license of a  
40 psychologist unless the  
41 renewal applicant has completed the workforce survey to the  
42 satisfaction of the

---

43                   examining board. The examining board shall establish  
44 standards to determine  
45 whether the survey has been completed.

46                   SECTION 9. 457.20 (5) of the statutes is created to read:

47                   457.20 (5) (a) The examining board shall require each  
48 applicant for the renewal  
49 of a license as a clinical social worker, as a condition for renewing the

6 license, to  
complete and submit to the department with the application for  
renewal of the  
7 license a workforce survey developed under s. 440.033 (2).  
8 (b) The examining board may not renew a license of a clinical  
social worker  
9 unless the renewal applicant has completed the workforce survey to  
the satisfaction  
10 of the examining board. The examining board shall establish  
standards to determine  
11 whether the survey has been completed.  
12 (END)

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Gene Musser		<b>2) Date When Request Submitted:</b>  _____	
		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>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b> March 21, 2012	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> 2011 Senate Bill 464 and Assembly Bill 615 and Committee Testimony	
<b>7) Place item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b> (name)  <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  _____	
<b>10) Describe the issue and action that should be addressed:</b>  Review the attached documents as part of the legislative report.			
<b>11) Authorization</b>			
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-4031/1

MPG:med:jf

2011 - 2012 LEGISLATURE

## 2011 SENATE BILL 464

February 13, 2012 - Introduced by Senator GALLOWAY, cosponsored by Representatives SEVERSON, LITJENS, STEINEKE, SPANBAUER and WEININGER. Referred to Committee on Labor, Public Safety, and Urban Affairs.

1 **AN ACT** *to amend* 440.03 (13) (b) (intro.); and *to create* 440.15  
 2 of the statutes;  
 3 **relating to:** prohibiting fingerprinting in connection with  
 4 professional  
 5 credentials issued by the Department of Safety and  
 Professional Services or an  
 examining board or affiliated credentialing board, except as  
 provided in the  
 statutes, and requiring the exercise of rule-making authority.

### *Analysis by the Legislative Reference Bureau*

Under current law, the Department of Safety and Professional Services (DPS) and examining boards and affiliated credentialing boards under DPS administer Wisconsin's professional credentialing laws. Current law requires DPS to obtain fingerprints from the following persons:

1. An applicant for a private detective license or private security permit.
2. An applicant for a juvenile martial arts instructor permit.
3. An applicant for or a holder of numerous other professional credentials in connection with an investigation by DPS concerning whether an applicant or credential holder has been charged with or convicted of a crime.

Those fingerprints may be submitted by the department of justice to the federal bureau of investigation to verify the identity of the person fingerprinted and obtain records of the person's criminal history, if any.

This bill prohibits DSPS or an examining board or affiliated credentialing board from requiring that an applicant for or a holder of a professional credential issued by DSPS or a board submit fingerprints in connection with that credential,

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except as described above with respect to DSPS. The bill also requires that DSPS promulgate rules that establish the criteria DSPS will use to determine whether an investigation concerning a credential applicant's or credential holder's arrest or conviction record is necessary.

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

1           SECTION 1. 440.03 (13) (b) (intro.) of the statutes is amended to read:

2           440.03 (13) (b) (intro.) The department may investigate  
3 whether an applicant  
4 for or holder of any of the following credentials has been charged with  
5 or convicted  
6 of a crime only pursuant to rules promulgated by the department  
7 under this  
8 paragraph, including rules that establish the criteria that the  
9 department will use  
10 to determine whether an investigation under this paragraph is  
11 necessary, except as  
12 provided in par. (c):

SECTION 2. 440.15 of the statutes is created to read:

440.15 No fingerprinting. Except as provided under s. 440.03 (13) (c), the department or a credentialing board may not require that an applicant for a credential or a credential holder be fingerprinted or submit fingerprints in connection with the department's or the credentialing board's credentialing.

LRB-2975/3

MPG:med:jm

2011 - 2012 LEGISLATURE

## 2011 ASSEMBLY BILL 615

February 22, 2012 - Introduced by Representatives SEVERSON,  
LITJENS, STEINEKE,  
SPANBAUER and WEININGER, cosponsored by Senator  
GALLOWAY. Referred to  
Committee on Homeland Security and State Affairs.

1 **AN ACT** *to amend* 440.03 (13) (b) (intro.); and *to create* 440.15  
2 of the statutes;  
3 **relating to:** prohibiting fingerprinting in connection with  
4 professional  
5 credentials issued by the Department of Safety and  
Professional Services or an  
examining board or affiliated credentialing board, except as  
provided in the  
statutes, and requiring the exercise of rule-making authority.

### *Analysis by the Legislative Reference Bureau*

Under current law, the Department of Safety and  
Professional Services (DSPS)  
and examining boards and affiliated credentialing boards under DSPS  
administer  
Wisconsin's professional credentialing laws. Current law requires  
DSPS to obtain  
fingerprints from the following persons:

1. An applicant for a private detective license or private security permit.
2. An applicant for a juvenile martial arts instructor permit.
3. An applicant for or a holder of numerous other professional credentials in connection with an investigation by DSPS concerning whether an applicant or credential holder has been charged with or convicted of a crime.

Those fingerprints may be submitted by the department of justice to the federal

bureau of investigation to verify the identity of the person fingerprinted and obtain records of the person's criminal history, if any.

This bill prohibits DSPS or an examining board or affiliated credentialing board from requiring that an applicant for or a holder of a professional credential issued by DSPS or a board submit fingerprints in connection with that credential,

---

except as described above with respect to DSPS. The bill also requires that DSPS promulgate rules that establish the criteria DSPS will use to determine whether an investigation concerning a credential applicant's or credential holder's arrest or conviction record is necessary.

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2 440.03 (13) (b) (intro.) The department may investigate  
3 whether an applicant  
4 for or holder of any of the following credentials has been charged with  
5 or convicted  
6 of a crime only pursuant to rules promulgated by the department  
7 under this  
8 paragraph, including rules that establish the criteria that the  
9 department will use  
10 to determine whether an investigation under this paragraph is  
11 necessary, except as  
12 provided in par. (c):

SECTION 2. 440.15 of the statutes is created to read:

9 440.15 No fingerprinting. Except as provided under s. 440.03  
10 (13) (c), the  
11 department or a credentialing board may not require that an  
12 applicant for a  
13 credential or a credential holder be fingerprinted or submit  
fingerprints in  
connection with the department's or the credentialing board's  
credentialing.

(END)

Chair van Wanggaard, and members of the Committee, I'd like to thank you for the opportunity to appear before you today. My name is Gene Musser. I'm a clinical cardiologist, and for purpose of identification I would note that I am employed by the University of Wisconsin Medical Foundation and Medical School and work at Meriter Hospital. I'm here on a scheduled day off of work, thus on my own time, and don't appear as a representative of any of those organizations. I am in addition a member of the Wisconsin Medical Examining Board, to which I was appointed in January of 2004. I served as Chair for the years 2007-2009 and am currently Vice Chair. I'm appearing here today in opposition to SB 464. I'm doing so as an MEB member with some knowledge of the issues involved, but I would state explicitly that I am not here at the direction of nor representing an official position of the MEB as it is currently constituted. Though I reported on the existence of this bill and the companion AB615 at the February MEB meeting, the Board didn't consider the question of taking a position on the bills but will do so at its March meeting. If the Board elects to take a position it will at that time communicate to the relevant people and entities.

CR 11-027, effective February 1, 2012, authorizes the Department of Safety and Professional Services to require fingerprints and criminal background checks as a part of all applications for physician licensure. These bills seek to overturn that general authority, limiting it to specific situations outlined in rules to be created.

I think it's important for the Committee to be aware that CR 11-027 was initiated by and developed at the request of the members of the MEB rather than by DSPS. The MEB consists of nine physicians with MD degrees, one with a DO degree, and three public members. This requirement was first the subject of a motion in June, 2006, by Leif Erickson, a surgeon with

Aurora in Burlington, appointed to the MEB by then Governor Scott McCallum, and seconded by Sandra Osborn, a retired pediatrician with the Dean Clinic in Madison and former president of the Wisconsin Medical Society. At a later meeting it was the subject of a motion made by Jack Lockhardt, a rheumatologist with the Gunderson Clinic in LaCrosse and also a former president of the WMS. The scope statement for the rule was approved unanimously by the MEB at its meeting in January, 2011. The rule was a longtime project of Virginia Heinemann, a public Board member from Wausau, appointed by then Governor Thompson, and who served from 1999-2007 and is now 83. In a phone call yesterday she affirmed her opposition to this bill, and absent some current infirmity would likely be here testifying against it. Public and professional Medical Board members from all across the state, appointed by Governors Thompson, McAllum, Doyle and/or Walker have over the years advocated and voted for this rule.

As a part of the rule-making process the MEB held a public hearing on July 20. No one appeared nor submitted written testimony in opposition to the rule. The Wisconsin Board of Nursing submitted testimony strongly supporting the rule, citing criminal background checks as "... a necessary and modern component of a regulatory board's authority."

The rule was submitted to the Assembly and Senate Committees on Health. The Assembly committee held a hearing on September 21 and took no action in opposition to the rule. Nor did the Joint Committee for Review of Administrative Rules after its hearing November 10. The Senate committee didn't hold a hearing.

Representative Severson in circulating his bill for co-sponsorship cited concerns about the burden of cost and time to applicants and slowing the review and application process. I

think it's worthwhile quantitating these concerns. The Department has estimated the cost to applicants as approximately \$51. Digital fingerprinting can be done through the vendor specified by the Department, but prints can be taken at any police station. Processing time is estimated at a week or a little longer at worst and Department personnel do not believe this requirement will delay granting of licenses.

The performance of criminal background checks at licensure is not just our idea. Doing so is recommended by the Federation of State Medical Boards in its Essentials of a Modern Medical and Osteopathic Practice Act. In a side-bar to an article about the MEB, written by Gina Barton in the Milwaukee Journal-Sentinel in January, 2008, among the recommendations for improvement in Wisconsin's system of doctor regulation was "Pass legislation that allows the board to conduct national criminal background checks on new doctors who want to be licensed in the state." The National Governors Association Center for Best Practices State Alliance for E-Health has recommended that "Governors and state legislatures should direct their state boards to require that applicants seeking initial professional state licensure and licensure renewals undergo state and federal criminal background checks ..."

Criminal background checks will eventually be necessary to promote what's called the portability of medical licenses between states. The Wisconsin MEB has led an effort to allow expedited licensure among a group of midwestern states. A background check has been identified as a best practice and important component of the expedited licensure process.

Wisconsin is not alone in requiring fingerprinting and a formal criminal background check. As of December, 2011, the FSMB reports that approximately 35 Boards around the country require fingerprints, including Illinois, Indiana, Iowa, and

Michigan. For the internationalists among you, background checks are required in British Columbia, Manitoba, Ontario, Quebec and Nova Scotia, as well as Great Britain and Australia.

The purpose of the rule is to further the Board's mandate of protection of the public. Performance of the background check allows independent assessment of the truthfulness of answers on the application and is in the best tradition of President Ronald Reagan's oft-stated policy: "Trust but verify". The National Practitioner Databank allows the MEB to know the disciplinary and malpractice histories of physicians wishing to relocate to Wisconsin. Performing criminal background checks provides potentially critical analogous information.

There is no recent national survey of the results of requiring criminal background checks. A few points consistently are made by those who do so: (1) knowing a background check will occur probably increases the honesty of application completion, (2) it's impossible to know how many potential applicants decide not to apply when they find that a background check will be done, and (3) almost all involved Boards are of the opinion that the checks are valuable in their application process, including Iowa, Michigan, Idaho, Mississippi, Nevada (checks ". . . absolutely identify meaningful events."), North Carolina, California, and several others. As the number of states requiring checks has increased, those who fail to do so could theoretically become magnets for applicants with something to hide.

The Iowa Board reports that between 2008 and 2011 five to eleven applicants per year have received letters of warning because of non-disclosure of a criminal past. Nationally, the FSMB in 2006 estimated that 2-5% (though up to 10%) of applicants have some sort of criminal past and that 1-3% (and up to 10%) fail to report it. They state that the most commonly

unreported crimes include DUI and theft, though others have included everything from sex crimes, forgery, domestic violence, drug use, child abuse and murder.

We don't and really can't know what our rule will yield. The Department doesn't keep records of positive responses to questions about criminal past and it's of course impossible to know how many have failed to disclose past problems. Wisconsin receives approximately 2000 new applications for licensure per year. If our applicants are on the low end of the national estimate we won't find much. If we resemble Iowa there will be several per year. What I do know is: (1) over the last five years the MEB has consistently been on record as favoring checks the use of which is widespread nationally, (2) nearly all who are knowledgeable about checks believe they are valuable, and (3) through the very recent rule-making process there was no opposition at our public hearing and that three legislative committees as recently as December 11, 2011 declined to take action against the rule.

I would respectfully request and recommend that the committee take no action on this bill. I thank you very much for your attention.

Gene Musser, MD

February 28, 2012

**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: March 21, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Item	
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:  For informational purposes only.			
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

## REPORT OF THE BOARD OF DIRECTORS

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

Referred to: Reference Committee

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In 2011, the FSMB House of Delegates adopted a resolution that called for the FSMB, in cooperation with state medical 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 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.

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 state board's license renewal process is a unique opportunity for collecting additional, up-to-date workforce information from physicians. The Workgroup developed a recommended framework for a uniform minimal physician data set. The recommended principles of the framework 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. If a state board does not have authority to collect the majority of data suggested as part of license renewal, the board should consult with the FSMB and other state boards about establishing a survey to obtain workforce information from their licensees.

- 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.
- The minimal physician data set is a shared responsibility, and the FSMB will assist state boards in building the database.
- 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 a central 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.

A full report on a Recommended Framework for a Minimal Physician Data Set is provided as **Attachment 1**.

The board of directors recommends that the House of Delegates adopt the recommendations contained in the Workgroup's report.

**ITEM FOR ACTION:**

**The board of directors recommends that the recommendations contained in the Report on a Recommended Framework for a Minimal Physician Data Set be adopted and the remainder of the report be filed.**

# **Attachment 1**



**WORKGROUP TO DEFINE A MINIMAL DATA SET**

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

**February 2012**

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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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Minnesota Board of Medical Practice

William L. Gant, MEd  
Chair, Washington Board of Osteopathic Medicine and Surgery

Margaret (Meg) B. Hansen, PA-C, MPAS  
Executive Director, South Dakota Board of Medical and Osteopathic Examiners

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Partners Healthcare, Massachusetts

Linda K. Whitney, MA  
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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 of the United States, Inc.**

**INTRODUCTION AND CHARGE**

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the aging of the population and the overall 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 residents throughout the United States and its territories. Under the ACA, it is estimated that by 2019 an additional 32 million Americans may become 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 medical licensure (e.g., number of test administrations) and Maintenance of Licensure (MOL), specialty certification and Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC).

As part of their ongoing effort to protect the public, the nation's state medical boards regularly collect and disseminate information about actively licensed physicians in their jurisdictions to the Federation of State Medical Boards (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 activities may have an active license, which may contribute to an overestimation of the current physician workforce of physicians able to directly deliver health care. 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

43 resolution that called for the FSMB, in cooperation with state medical boards, to develop a minimum  
44 physician demographic and practice data set, as well as a data collection tool and physician data  
45 repository. The FSMB Board of Directors, led by Board Chair Janelle Rhyne, MD, MA, MACP, created  
46 the FSMB Workgroup to Define a Minimal Data Set.

47  
48 The FSMB's Minimal Data Set (MDS) Workgroup convened in the summer of 2011 and was charged  
49 with consulting with national workforce groups such as the National Center for Health Workforce  
50 Analysis (NCHWA) to facilitate development of a minimal physician demographic data set as well as to  
51 develop a minimum physician demographic data collection tool and a physician demographic data  
52 repository. In carrying out its charge, the MDS Workgroup was asked to build and recommend a  
53 framework for state boards, or their designated affiliate organizations, to collect and share with the  
54 FSMB additional demographic and practice data for physicians licensed in their jurisdictions.

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

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

61

- 62 1. Physician workforce participation (entry, retention, exit and reentry) is subject to unpredictable  
63 economic factors, licensure and certification requirements, skills portability, as well as structural  
64 workforce issues such as participation levels, workforce aging, lifestyle factors, and gender.
- 65 2. Because physicians renew their license on a regular basis, working with state medical boards on a  
66 minimal data set is a cost-effective approach for collecting basic physician data.
- 67 3. It provides accurate and consistent information about physicians to state and federal policy  
68 makers which could be used in planning and resource allocation. Accurate projections of  
69 physician supply inform policymakers about the number and specialty composition of physicians,  
70 as well as help determine the need for other health care practitioners.
- 71 4. Some individuals hold licenses in more than one jurisdiction; uniform physician workforce data  
72 would lead to a better understanding of geographic participation and migratory patterns.
- 73 5. Physician supply and composition impact areas of the education and qualification process,  
74 including initial licensure, Maintenance of Licensure (MOL), specialty certification and  
75 Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC).

76

77 **METHODOLOGY**

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

82  
83 The MDS Workgroup agreed that a recommended framework for a minimal physician data set should  
84 be ready to be presented to the FSMB House of Delegates for a vote during the April 2012 FSMB  
85 Annual Meeting. However, if additional time was needed, an extension would be granted.

86  
87 The MDS Workgroup used a knowledge-based approach to its deliberations. The workgroup reviewed  
88 pertinent health workforce literature, considered research conducted by other organizations, and  
89 studied standardized questions suggested by the NCHWA. To compare the current process being used  
90 and the physician workforce data elements being collected, the MDS Workgroup also gathered  
91 information available from 59 of the 69 FSMB member boards involved in licensing decisions. The  
92 information collected showed that 63 percent of responding boards collect at least some physician  
93 workforce data. As demonstrated by the findings, the procedures for collecting the data and the types  
94 of data elements collected vary noticeably for the 37 boards that indicated they collect information. Of  
95 the 37 boards that collect at least some physician workforce data the research indicates:

- 96  
97       • 68 percent include workforce questions in their license renewal application  
98       • 54 percent ask workforce questions that are voluntary  
99       • 19 percent ask workforce questions that are mandatory  
100       • 16 percent have a combination of voluntary and mandatory questions

101  
102 In terms of demographic data sought by the boards, highlights from the 37 boards that collect data  
103 show similar variability:

- 104  
105       • 49 percent ask for gender  
106       • 46 percent ask for race  
107       • 38 percent ask for ethnic background

108  
109 The information collected also provided a range of other data points regarding physician characteristics  
110 and patient care. Generally, the research showed a fairly wide range of practices in terms of what kinds  
111 of questions are asked and what kind of information is being compiled by the boards.

112  
113

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

- 117
- 118 • 78 percent ask if the physician works full time or part time
  - 119 • 65 percent ask for practicing specialty(s)
  - 120 • 49 percent ask average hours per week per specialty(s)
  - 121 • 62 percent ask for average hours per week per practice setting
- 122
- 123

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

125

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

134

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

140

- 141 • **Workforce questions for a minimal physician data set should be added to a renewal**  
142 **application or be a separate questionnaire tied directly to the renewal process.** The collection  
143 process should be determined by each board, but the workgroup strongly recommends that the  
144 questions be a mandatory component to the renewal process to stress the importance of the  
145 data and maximize the quantity and quality of data collected. If a state board does not have  
146 authority to collect the majority of data suggested as part of license renewal, the board should  
147 consult with the FSMB and other state boards about establishing a survey to obtain workforce  
148 information from their licensees.
- 149
- 150 • **Workforce questions for a minimal physician data set should be standardized across all state**  
151 **boards and not found in other sources.** Questions should be straightforward for licensees, take  
152 about 10 minutes or less to answer, and be in an easy-to-use electronic format that follows best  
153 practices for user-friendly, survey interface design (e.g., drop-down menus).

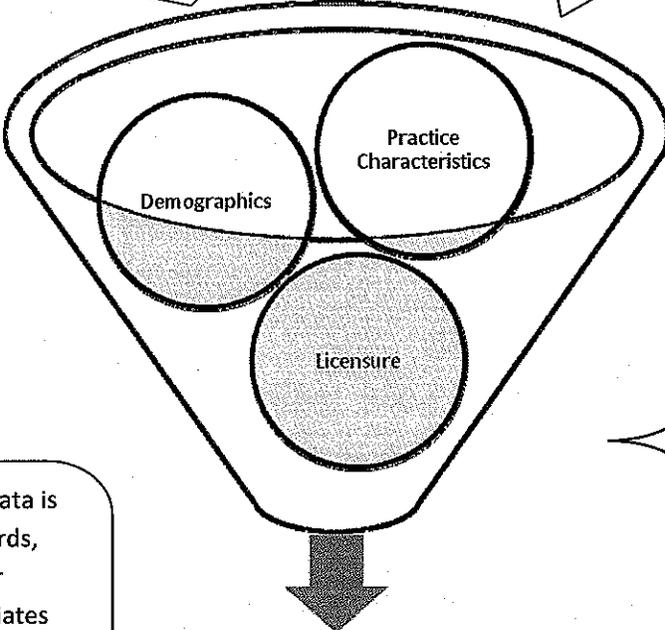
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- State boards may choose to collect data using various methods. To further enhance the value of their data, state boards may also choose to expand their data by adding other questions not recommended for the minimal physician data set. **State boards 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.**
  - **The minimal physician data set is a shared responsibility, and the FSMB will assist state boards in building the database.**
  - **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 a central 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.**

GRAPHIC REPRESENTATION OF A MINIMAL PHYSICIAN DATA SET

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State boards collect unique, standardized physician information (e.g., practice setting) during license renewal and regularly send it to the FSMB with their licensure data.

FSMB obtains physician information from other organizations (e.g., ABMS)



Data is sent to the FSMB where it is aggregated, stored and analyzed.

Physician workforce data is shared with state boards, the NCHWA and other designated FSMB affiliates for research purposes to facilitate health policy decision-making.

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Minimal Physician Data Set

National Center for Health Workforce Analysis

State Boards

Designated FSMB Affiliates

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193  
194

195 **RECOMMENDED DATA ELEMENTS FOR A MINIMAL PHYSICIAN DATA SET**

196  
 197 The MDS Workgroup identified the data elements listed below to be included in a uniform, minimal  
 198 physician data set. The workgroup believes that many of the elements identified fall into one of three  
 199 categories: (1) data currently provided by state boards as part of their regular transmissions of  
 200 licensure data; (2) data that is or may be obtained by the FSMB through data sharing agreements with  
 201 other organizations; or (3) unique and standardized data that state boards can obtain by adding  
 202 questions to their renewal application or by asking questions as part of a separate questionnaire tied  
 203 directly to the renewal process.

204

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 re-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.

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

207  
208 The MDS Workgroup strongly recommends that the physician workforce questions presented in this  
209 section be added to state boards' renewal applications or be a separate questionnaire tied directly to  
210 the renewal process. The questions serve as a guide for standardizing a minimal set of data for  
211 physicians across all state boards.

- 212  
213 1. What is your current employment status?  
214     ○ Actively working in a position that requires a medical license  
215     ○ Actively working in a field other than medicine  
216     ○ Not currently working  
217     ○ Retired  
218  
219 2. Are you currently providing direct clinical or patient care on a regular basis?  
220     ○ Yes  
221     ○ No  
222  
223     a. If no, how many years has it been since you provided clinical or patient care?  
224         ○ Less than 2 years  
225         ○ 2 to 5 years  
226         ○ 5 to 10 years  
227         ○ More than 10 years

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3. Which of the following best describes the area(s) of practice in which you spend most of your professional time:

Area of Practice	Principal	Secondary	Completed Accredited Residency Program or Fellowship
Adolescent Medicine	0	0	0
Anesthesiology	0	0	0
Allergy and Immunology	0	0	0
Cardiology	0	0	0
Child Psychiatry	0	0	0
Colon and Rectal Surgery	0	0	0
Critical Care Medicine	0	0	0
Dermatology	0	0	0
Endocrinology	0	0	0
Emergency Medicine	0	0	0
Family Medicine/General Practice	0	0	0
Gastroenterology	0	0	0
Geriatric Medicine	0	0	0
Gynecology Only	0	0	0
Hematology & Oncology	0	0	0
Infectious Diseases	0	0	0
Internal Medicine (General)	0	0	0
Nephrology	0	0	0
Neurological Surgery	0	0	0
Neurology	0	0	0
Obstetrics and Gynecology	0	0	0
Occupational Medicine	0	0	0
Ophthalmology	0	0	0
Orthopedic Surgery	0	0	0
Other Surgical Specialties	0	0	0
Otolaryngology	0	0	0
Pathology	0	0	0
Pediatrics (General)	0	0	0
Pediatrics Subspecialties	0	0	0
Physical Med. & Rehab.	0	0	0
Plastic Surgery	0	0	0
Preventive Medicine/Public Health	0	0	0
Psychiatry	0	0	0
Pulmonology	0	0	0
Radiation Oncology	0	0	0
Radiology	0	0	0
Rheumatology	0	0	0
Surgery (General)	0	0	0
Thoracic Surgery	0	0	0
Urology	0	0	0
Vascular Surgery	0	0	0
Other Specialties	0	0	0

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

Practice Setting	Principal	Secondary
Office/Clinic—Solo Practice	<input type="radio"/>	<input type="radio"/>
Office/Clinic—Partnership	<input type="radio"/>	<input type="radio"/>
Office/Clinic—Single Specialty Group	<input type="radio"/>	<input type="radio"/>
Office/Clinic—Multi Specialty Group	<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"/>
Hospital—Ambulatory Care Center	<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):	<input type="radio"/>	<input type="radio"/>

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5. How many weeks did you work in medical related positions in the past 12 months?

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

- 242  
 243 Clinical or patient care \_\_\_\_\_ hours/week  
 244 Research \_\_\_\_\_ hours/week  
 245 Teaching/Education \_\_\_\_\_ hours/week  
 246 Administration \_\_\_\_\_ hours/week  
 247 Volunteering (medical related only) \_\_\_\_\_ hours/week  
 248 Other (specify): \_\_\_\_\_ hours/week

249 *Another approach to obtaining this information would be to ask licensees: (1) number of weeks worked*  
 250 *in the past 12 months, (2) average number of hours worked per week, and (3) the percentage of time per*  
 251 *week spent on each major activity (e.g., clinical or patient care, research etc.).*

252  
 253 7. What is the location of the site(s) where you spend most of your time providing direct clinical or  
 254 patient care? Please enter the complete address for up to three locations and your direct  
 255 patient care hours per week at each site.

256 *(The workgroup strongly recommends collecting full addresses if all possible, but zip codes only would be*  
 257 *acceptable for a minimal data set.)*

258 Principal Location Address

259 \_\_\_\_\_  
 260 Number Street  
 261 \_\_\_\_\_  
 262 City/Town State Zip Code: □□□□□

263 Direct patient care hours per week at site: \_\_\_\_\_

264  
 265 Second Location Address

266 \_\_\_\_\_  
 267 Number Street  
 268 \_\_\_\_\_  
 269 City/Town State Zip Code: □□□□□

270 Direct patient care hours per week at site: \_\_\_\_\_

271  
 272 Third Location Address

273 \_\_\_\_\_  
 274 Number Street  
 275 \_\_\_\_\_  
 276 City/Town State Zip Code: □□□□□

277 Direct patient care hours per week at site: \_\_\_\_\_

278 8. What is your sex?

- 279  Male
- 280  Female

281  
282

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

- 284  White
- 285  Black or African American
- 286  American Indian or Alaska Native
- 287  Asian
- 288  Native Hawaiian/Other Pacific Islander
- 289  Other (specify)

290 *The workgroup acknowledges that this is a condensed list and state boards may choose to use more*  
291 *detailed response sets (e.g., HHS Data Standards for Race and US Census Bureau Race Categories).*

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293

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

295 (1 or more categories may be selected)—Recommended as Optional

- 296  No
- 297  Yes, Mexican, Mexican American, Chicano/a
- 298  Yes, Puerto Rican
- 299  Yes, Cuban
- 300  Yes, Another Hispanic, Latino/a, or of Spanish origin (specify)

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302

303 11. Do you speak a language other than English at home? (optional)

- 304 a. Yes
- 305 b. No

306  
307

308 12. What is this language? (if you answered Yes to #11)

- 309 a. Spanish
- 310 b. Other Language (identify)

311

312 **CONCLUSION**

313  
314 The MDS Workgroup believes that state medical boards can play a vital role in helping to accurately  
315 determine the size, distribution and demographic make-up of the physician workforce in the United  
316 States. The type of medicine physicians practice and how the services they provide impact patients in  
317 their areas is just as important and better data is needed on the geographic distribution of physician  
318 supply to target state and federal resources designed to help ensure access. The MDS Workgroup  
319 believes that state boards have a unique opportunity to contribute to accurate workforce planning by  
320 collecting physician demographic and practice information at the time of license renewal. Uniformity  
321 of a basic set of questions asked across multiple jurisdictions at the time of license renewal would yield  
322 a better understanding of whether the supply of physicians can meet the needs of a growing and aging  
323 population.

324  
325 The MDS Workgroup recommends that the 2012 FSMB House of Delegates support and adopt the  
326 recommended framework for a uniform minimal physician data set. It is recognized that there may be  
327 challenges to implementation of a minimal physician data set. However, the MDS Workgroup believes  
328 that the framework is feasible, reasonable, consistent with the resolution adopted by FSMB's House of  
329 Delegates in May 2011, and suitable for use by state medical boards. Furthermore, the MDS  
330 Workgroup believes that the FSMB can and should commit to a leadership role by providing state  
331 boards resources to help them implement a minimal physician data set.

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- 
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