Upcoming Meetings:

December 19, 2024

January 16, 2025

February 21, 2025

ALASKA STATE MEDICAL BOARD

QUARTERLY MEETING

FRIDAY, NOVEMBER 15, 2024

DRAFT - AGENDA

Discussion of the following topics may require executive session. Only authorized members will be permitted to remain in the Board/Zoom room during executive session.

Location: By Zoom
Register in advance for this meeting:
https://us02web.zoom.us/meeting/register/tZAqd-2tqzguHdxgedfJqlQUnaAEKfSUe4F2

Agenda

9:00 a.m. 1. Call to Order / Roll Call

9:02 a.m. 2. Review / Approval of Agenda

9:05 a.m. 3. Review / Approval of Minutes

- August 9, 2024
- September 19, 2024
- October 10, 2024

9:10 a.m. 4. Ethics Disclosure

9:15 a.m. 5. Physicians Health Committee Update – Dr. Foland

9:30 a.m. 6. Board Interviews

K.P

D.T

10:30 a.m. 7. Old Business:

- Telehealth regulations

10:45 a.m. 8. Break

11:00 a.m. 9. New Business:

- Legal Consultation - Executive Session
- PDMP Delegation
- Medical Spa Guidance

12:00 p.m. 10. Lunch Break

1:00 p.m. 11. Public Comments

1:10 p.m. 12. Investigations – Executive Session

- Case #: 2023-000401 (L.A.)
- Case #: 2021-000336 (B.B)
- Case #: 2023-000070 (V.D)
- Case #: 2023-000065 (L.D.)
- Case #: 2023-000026 (D.E.)
- Case #: 2022-000233 (N.P.)
- Case #: 2020-000208, 2020-000491, 2023-000533 (R.T.)
- Case #: 2022-000247-Probation
- Case#: 2022-000268, 2023-000262 (R.T.)

3:00 p.m. 13. Break

3:15 p.m. 14. Applicant Review

- Full Board Review (Executive Session)
- Ratification of Full Licenses

4:00 p.m. 15. Malpractice Case Reviews (Executive Session)

5:00 p.m. 16. Wrap Up / Adjourn

Tentative date for next meeting: December 19 at 4:00 p.m.

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STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD
MINUTES OF MEETING
Friday, August 9, 2024

These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional Licensing. They have not been reviewed or approved by the Board.

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a quarterly meeting of the Alaska State Medical Board was held Friday, August 9, 2024.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Nimmo at 9:01 a.m.

Roll Call
Board members present:
David Barnes, DO
Sarah Bigelow Hood, PA-C (Vice-Chair)
Lydia Mielke, Public Member (Secretary)
Eric Nimmo, MD (Chair)
David Paulson, MD
Brent Taylor, MD
David Wilson, Public Member
Absent: Matt Heilala, DPM

Board staff present: Natalie Norberg, Executive Administrator; Jason Kaeser, Licensing Supervisor; Sonia Lipker, Senior Investigator; Shelley Irons, Investigator; Kendra Wardlaw, Investigator; Charley Larson, Investigator; Carmen Pora, Investigator; Billy Homestead, Senior Investigator

2. **Review / Approval of Agenda**

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

3. **Review/Approval of Minutes**
On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board accepted the minutes for May 3, 2024; May 30, 2024; June 13, 2024; and July 18, 2024 meetings as presented.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

4. Ethics Disclosures

Ethics reporting by board members is done on a quarterly basis and is a standing item on the quarterly meeting agenda. The Chair requested Ms. Norberg query each board member.

There were no ethical disclosures made by board members.

5. Division Update

Chair Nimmo invited Melissa Dumas, CBPL Admin. Operations Manager, to address the Board. Ms. Dumas provided a brief overview of the Board's FY24 3rd Quarter budget, highlighting a budget surplus, which is the rationale for the division's recent regulatory change proposal to decrease license fees. Physician biennial license fees will be reduced by $75.00, making the total cost for the fee $350 from $425.00; Physician Assistant biennial license fees will be reduced by $100, making the total cost for the license fee $150.00 from $250.00. Additionally, the $125,00 fee for Physician Assistant Collaborative Plans is eliminated. The new fee changes will go into effect on September 12, 2024.

6. Investigation Unit Updates:

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Case# 2022-001182 with Board and Investigative staff remaining during session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 9:14 a.m. The Board returned on the record at 9:19 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board imposed a civil fine as proposed for Matthew Cannava in Case No. 2022-001182.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Case# 2023-000386 with the reviewing board member abstaining from the session and board and Investigative staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 9:21 a.m. The Board returned on the record at 9:24 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the consent agreement as proposed for Tyson Bubnar in Case# 2023-000386.

Roll Call: Yeas, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Case #2023-000302 with the reviewing board member abstaining from the session and board and Investigative staff remaining during the session

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 9:27 a.m. The Board returned on the record at 9:31 a.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Board imposed a civil fine as proposed for Lucy Peterson in Case #2023-000302.

Roll Call: Yeas, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing #2023-000019 with Board and Investigative staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 9:33 a.m. The Board returned on the record at 9:35 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board imposed a civil fine as proposed for Pravina Sheth in #2023-000019.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Case# 2023-000016 with the reviewing board member abstaining from the session and Board and Investigative staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 9:36 a.m. The Board returned on the record at 9:39 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board imposed a civil fine as proposed for Stanley Smith in Case# 2023-000016.

Roll Call: Yeas, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Case# 2019-000664 with Board and Investigative staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 9:42 a.m. The Board returned on the record at 10:03 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board ordered a summary suspension for Claribel Tan in Case# 2019-00664.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2) & (c)(4) and the Alaska Constitutional Right to Privacy Provisions, for the purpose of Prescription Drug Monitoring Program Registration Violations in Case Numbers: 2022-000637, 2021-000613, 2022-000725, 2023-000496 and changes to the disciplinary matrix for such violations, with the reviewing board member abstaining during the case discussions and Investigative and Board staff remaining during session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 10:06 a.m. The Board returned on the record at 10:19 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board imposed a civil fine as proposed for Jeanne Haberer in Case# 2022-00637, Mary Huff in Case# 2021-000613, Mitali Mehta in Case# 2022-000725, and Matthew Williamson in Case#2023-000496.

Roll Call: Yeas, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board decided to accept changes to its disciplinary sanctions guidelines as proposed pertaining to prescription drug monitoring program registration violations.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

Break – The Board went off the record at 10:22 a.m. and returned on the record at 10:33 a.m.

7. Deliberative Sessions

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into a deliberative session under AS 44.62.310(d) solely to make a decision concerning the Office of Administrative Hearing's decision related to sanctions,

In the Matter of Raymond Andreassen, D.O.
Board Case Number 2018-000439/843/502
Office of Administrative Hearings Case Number 22-0897-MED

all others were excluded during the deliberative session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

Absent: Dr. Heilala

The Board entered the deliberative session at 10: 37 a.m. The Board returned on the record at 10:48 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board decided in accordance with AS 44.64.060(e)(3) to adopt the decision of the Administrative Law Judge but modified the sanction to include a three-year suspension followed by probation for three years and the imposition of a civil fine of $25,000 with $10,000 suspended and all other conditions proposed by the Administrative Law Judge to be imposed.

In the Matter of Raymond Andreassen, D.O.
Board Case Number 2018-000439/843/502
Office of Administrative Hearings Case Number 22-0897-MED

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered into a deliberative session under AS 44.62.310(d) solely to make a decision,

In the Matter of Mahmood Ahmad, M.D
Board Case Number: 2022-00787
Office of Administrative Hearings Case Number 22-0726-MED
all others were excluded during the deliberative session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered the deliberative session at 10:51 a.m. The Board returned on the record at 10:57 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board adopted the Administrative Law Judge's decision in accordance with AS 44.64.060(e)(1)

In the Matter of Mahmood Ahmad, M.D
Board Case Number: 2022-00787
Office of Administrative Hearings Case Number 22-0726-MED

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

Malpractice case reviews

Due to being ahead of schedule, it was decided to address agenda item #14 at this time in the meeting.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board enter into executive session in accordance with AS 44.62.310 (c)(3), and Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing malpractice cases involving the following practitioners:

1. **Christpoher Hager, MD**
2. **Kamran Janua, MD**
3. **Avery Knapp, MD**
4. **William McIntyre, MD**
5. **Gregory Strohmeyer, MD**
6. **Matthew Williamson, DO**
7. **Yuming Yin, MD**

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 11:00 a.m. The Board returned on the record at 11:44 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board decided to take no further action with respect to malpractice cases related to the following physicians:

1. **Christpoher Hager, MD**
2. **Kamran Janua, MD**
3. **Avery Knapp, MD**
4. **William McIntyre, MD**
5. **Yuming Yin, MD**

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board decided to issue non-disciplinary advisory letters for the malpractice cases to the following physicians:

1. **Gregory Strohmeyer, MD**
2. **Matthew Williamson, DO**

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board decided to issue a Letter of Inquiry to the Surgery Center of Wasilla.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

8. Lunch Break – The Board went off the record at 11:48 a.m. and returned on the record at 1:01 a.m.

9. Public Comments / Board Correspondence

There were no members of the public present who requested to address the Board. Chair Nimmo and Ms. Norberg highlighted written communication received including an invitation from the FSMB to participate in training for new board members and an inquiry about the Board's telemedicine regulations. It was noted that recent changes in federal and state legislation will require updates to these regulations.

10. Board Interview

Dr. Brian Hinnebusch elected to have his interview conducted in executive session.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Dr. Brian Hinnebusch's application for licensure, with Board staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

The Board entered executive session at 1:17 p.m. The Board returned on the record at 1:49 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board approved a temporary permit for Dr. Hinnebusch and instructed the Executive Administrator to provide follow up information to Dr. Hinnebusch.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

11. Old Business

Physician-Pharmacy Agreements

Chair Nimmo provided background information. Agreements are allowed between physicians and pharmacists when criteria outlined in regulation are met. There are two such agreements for the Board's consideration. The first agreement is between Whale's Tail pharmacy and Dr. Sealander. This agreement proposes to grant the pharmacist authority to dispense a one-time refill for a medication

previously prescribed by the physician so long as other criteria are met, and if the doctor's office is closed, and the physician is not reachable. Chair Nimmo stated this sounded like an appropriate and reasonable agreement, other board members concurred. It was noted that the agreement is missing a provision (required in regulation) that allows the physician to override the agreement if the physician considers it medically necessary or appropriate. It was suggested the Executive Administrator follow-up with the parties and request the agreement be updated to include all of the medical board's regulatory requirements. The second agreement before the Board is one of seven identical agreements between one physician, Dr. Weir and the Walmart pharmacists that work in seven different Walmart pharmacies throughout the state. These agreements would authorize the pharmacists to prescribe hormonal contraception, after the pharmacist screens and assesses the patient. Chair Nimmo pointed out that according to the medical board's regulations, the physician or physician assistant must issue the prescription and conduct the physician examination. Chair Nimmo and three other board members voiced concerns about pharmacists being given the authority to prescribe hormonal contraception.

The Board discussed granting Dr. Nimmo the authority to approve future physician-pharmacy agreements independently, unless he has concerns, in which case he will bring them before the Board. Future agreements approved independently by Dr. Nimmo will be saved in a folder in Onboard for board members to review.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board denied the proposed Cooperative practice pharmacy Agreements between Dr. Weir and the Alaska Walmart facilities. If implemented as presented the agreements would grant prescriptive authority to pharmacists for hormonal contraceptive therapies, which is in violation of state medical board regulation 12 AAC 40.983 (d).

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board granted Chair Nimmo the authority to review and approve cooperative pharmacy agreements and to bring agreements to the board for review at his discretion.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala

12. New Business

Priority Action Items

The Board reviewed their prioritized list of action items and explored possible strategies for addressing the items, such as discussing an item all together during a board meeting or creating subcommittees. Chair Nimmo facilitated a discussion regarding the first item on the list, establishing new guidelines for the board's review of licensee's malpractice cases. Various metrics/filters to screen-out cases requiring a board review were identified, such as the number of dismissed cases, dollar amount of settlement,

number of suits, practice area and regional differences. Chair Nimmo suggested a board member could be assigned to screen all cases to decide which ones come to the Board. Board members generally agreed they want to continue with their current practice of reviewing all cases with a monetary settlement, and they would be willing to start reviewing a higher number of cases during board meetings in order to gain a sense of any trends or potential metrics that could be applied at a future date to screen-out cases for review. Several board members stated the pressure to review investigative cases is more burdensome at this time than the workload from reviewing malpractice cases. Pursuing statutory changes to add additional members to the board and to fix antiquated language that does not allow board members to respond to inquiries related to subpoenas by email was discussed. Dr. Nimmo observed that increasing board membership would concretely decrease workload while fixing the subpoena language would have less of a direct impact on workload. Some members expressed concerns about pursuing additional members for the board. Dr. Barnes stated he has a contact in the State Senate and would be willing to ask for the Senator's support in fixing the antiquated subpoena language. Several board members spoke in favor of this idea.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board authorized Dr. Barnes to speak with Senator Shower about statute updates with regards to communication efficiencies and modernizations.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson.
Absent: Dr. Heilala and Dr. Paulson

Mr. Wilson left the meeting at 2:48 p.m.

13. Break – The Board went off the record at 2:48 p.m., and returned on the record at 3:04 p.m.

14. Malpractice Case Reviews – see page #7, this item was addressed earlier in the agenda.

15. Applicant Review

Board members were queried about their individual applicant reviews, no concerns were identified.

Dr. Paulson left the meeting at 3:08 p.m.

Ratification of Full Licenses

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved the following list of physician assistants for full licensure.

	Lic Type	First Name	Last Name
1.	PA	Margaret	Holbrook
2.	PA	Paul	Jachimek
3.	PA	Jeremy	Krider
4.	PA	Marlina	Robinson

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor
Absent: Dr. Heilala, Dr. Paulson and Mr. Wilson

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board approved the following list of osteopathic physicians for full licensure.

	Lic Type	First Name	Last Name
1.	DO	Lien	Nguyen
2.	DO	Todd	Paxton
3.	DO	Genova	Stearns

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor
Absent: Dr. Heilala, Dr. Paulson and Mr. Wilson

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved the following list of allopathic physicians for full licensure.

	Lic Type	First Name	Last Name
1.	MD	Muna	Beeai
2.	MD	Ericka	Berger
3.	MD	Richard	Bruckner
4.	MD	Jessica	Clarke
5.	MD	Arvind	Durvasan
6.	MD	Christopher	Findley
7.	MD	Amy	Flick
8.	MD	Murray	Hamilton
9.	MD	Jeffrey	Hebert
10.	MD	Fatimah	Jah
11.	MD	Vishal	Jani
12.	MD	Peter	Kim
13.	MD	Sunil	Kurup
14.	MD	Kyle	Lapidus
15.	MD	Kerry	Latham
16.	MD	Yolanda	Lau
17.	MD	Howard	Leftin
18.	MD	Paul	Llobet
19.	MD	Michael	Mai
20.	MD	Murat	Mardirossian
21.	MD	Joseph	Martinez
22.	MD	Stephen	McElroy

	Lic Type	First Name	Last Name
26.	MD	Yosuke	Miyashita
27.	MD	Rushabh	Modi
28.	MD	Justin	Morgan
29.	MD	Andrea	Nelsen
30.	MD	Oleg	Odin
31.	MD	Miguel	Palos
32.	MD	Prabhjot	Pannu
33.	MD	Todd	Paxton
34.	MD	Mary	Peterson
35.	MD	Anthony	Rowe
36.	MD	Gerald	Rowland
37.	MD	David	Sanford
38.	MD	Michael	Sarkees
39.	MD	Laligam	Sekhar
40.	MD	Scott	Stoughton
41.	MD	Atilla	Uner
42.	MD	Cheryl	Villareal
43.	MD	David	Walker
44.	MD	Brad	Watkins
45.	MD	Barbara	Zimmerman
46	MD	Grald	Rowland
47.	MD		

23.	MD	Jennifer	McQuade		48.	MD		
24.	MD	Daniel	Miner		49.	MD		
25.	MD	Seema	Misra		50.	MD		

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor
Absent: Dr. Heilala, Dr. Paulson and Mr. Wilson

Full Board Review

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing license applications with board staff remaining during session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor
Absent: Dr. Heilala, Dr. Paulson and Mr. Wilson

The Board entered executive session at 3:11 p.m. The Board returned on the record at 3:39 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board decided to table a decision to grant Dr. James Black a license until a complete application is received.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor
Absent: Dr. Heilala, Dr. Paulson and Mr. Wilson

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board decided to postpone a decision to grant Dr. Dolf Ichtertz a license until further information is received.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor
Absent: Dr. Heilala, Dr. Paulson and Mr. Wilson

16. Wrap up/Adjourn

The next monthly meeting was tentatively scheduled for September 19, 2024.

The meeting was adjourned by unanimous consent at 3:42 p.m.

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD
MINUTES OF MEETING
Thursday Sept 19, 2024

These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional Licensing. They have not been reviewed or approved by the Board.

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a special meeting of the Alaska State Medical Board was held Thursday, September 19, 2024.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Nimmo at 4:00 p.m.

Roll Call
Board members present:
Eric Nimmo, MD, Chair
David Barnes, DO
Sarah Bigelow-Hood, Vice-Chair
Matt Heilala, DPM
Lydia Mielke, Public Member (Secretary)
Brent Taylor, MD
David Wilson, Public Member
Absent: David Paulson, MD

State employees present:
Glenn Saviers, CBPL Deputy Director; Rebecca Hattan, AAG; Natalie Norberg, Executive Administrator and Jason Kaeser, Licensing Supervisor

2. Review / Approval of Agenda

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board amended the agenda to change the order of the items addressed to allow for the legal debrief to be the first order of business.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Absent: Dr. Paulson

3. Legal Debrief

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board entered executive session for the purpose of discussing matters under AS 44.62.310 (C)(4), related to attorney-client privilege with State employees remaining in the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Absent: Dr. Paulson

The Board entered executive session at 4:04 p.m. The Board exited executive session at 4:54 p.m.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board directed the Executive Administrator to work with the Board Chair to draft a statement to surge and support the Attorney General to appeal the judge's preliminary decision in 3 AN-19-11710CI.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Nays: Ms. Bigelow-Hood
Absent: Dr. Paulson

4. Telemedicine Regulation

Dr. Nimmo invited Ms. Norberg to introduce and explain the reasons for needed revisions to 12 AAC 40.943. First, changes to federal and state legislation have rendered the existing language in sections 12. AAC 40.943 (b) obsolete. Second, the regulations currently cite old FSMB guidance from 2014. The FSMB adopted updated telemedicine guidance in 2022. Finally, clarity is needed for telemedicine prescribers regarding the definition of a physician-patient relationship. State law 08.64.364 (c)(2) specifies that a physician or physician assistant may not prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the physician or physician assistant does not have a prior physician-patient relationship. The medical board has not defined physician-patient relationship, however there is a definition under the medical marijuana statutes. The public has questioned whether this relationship can be established through a video conference visit. After a discussion, board members agreed that the changes to section 12. AAC 40.943 (b) to eliminate obsolete language are necessary, however they could not reach a consensus on whether to adopt the new FSMB guidelines by reference or the proposed definition for physician-patient relationship. It was agreed that that the initiation of a regulation project to fix the outdated language should be tabled until the Board can decide on how to address the other two matters.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood and denied by a roll call vote the Board decided against approving a regulation project to eliminate the outdated language in 12. AAC 40.943 (b) and requesting a regulation change project.

Roll Call: Nays, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Absent: Dr. Paulson

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood the Board approved by roll call vote a decision to table any decisions regarding regulation change to 12. AAC 40.943.

Roll Call: Yays, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Absent: Dr. Paulson

5. Applicant Review

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow-Hood, and approved by a roll call vote, the Alaska State Medical Board entered executive session under AS 44.62.310(c)(3), and the Alaska Constitutional Right to Privacy Provisions with Board staff remaining in the session for the purpose of discussion applications for licensure for the following physicians:

- James Black, MD
- Benjamin Makamson, DO
- Brent Meredith, MD
- Jon Miller, MD
- Daniel Taheri, MD

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood , Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Absent: Dr. Paulson

The Board entered executive session at 5:23 p.m. The Board exited executive session at 5:47 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board approved physicians Jon Miller and Benjamin Makamson for full licenses.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor and Mr. Wilson
Absent: Dr. Paulson

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board decided to issue Dr. James Black a temporary permit and requested the Executive Administrator to follow up with Dr. Black to provide additional information.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor and Mr. Wilson
Absent: Dr. Paulson

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board decided to table a decision on whether to grant Dr. Daniel Taheri a license until he is interviewed, and further information is obtained.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor and Mr. Wilson
Absent: Dr. Paulson

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board decided to deny a license to Dr. Brent Meredith. The board cited in its decision that Dr. Meredith does not meet the criteria for licensure in accordance with AS 08.64.225. Specifically, he has not completed three years of post-graduate education in a recognized hospital approved by the Accreditation Council for Graduate Medical Education; he currently does not hold a full license to practice in medicine in any

other US state or territory, nor is he board certified in a specialty area. The Board recognized Dr. Meredith for his wealth of experience as a physician assistant but did not find this experience as a sufficient substitute for post-graduate residency training.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor and Mr. Wilson
Absent: Dr. Paulson

6. Wrap up / Adjourn

The next meeting will be on October 10, 2024 at 5:00 PM. The primary agenda item at this meeting will be to review the Physician Assistant Work Group's proposed changes to regulations.

Dr. Barnes reported that in follow up to the discussion at the last meeting, he approached Mike Shower about sponsoring language in a bill to address outdated procedural processes for the Medical Board in statute; Senator Shower stated he would support this. Ms. Norberg will provide Dr. Barnes with draft language for the changes needed.

Dr. Barnes raised a concern related to Naturopathic physicians promoting high doses of Vitamin D for hypothyroidism when there is no evidence of hypothyroidism, which can cause life-threatening conditions for patients. Options for how to address this concern were discussed including filing a complaint against an individual naturopathic provider for patient harm, or the board might want to consider a resolution or issuing a statement of concern at a future meeting.

The meeting was adjourned by unanimous consent at 6:00 p.m.

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD
MINUTES OF MEETING
Thursday October 10, 2024

These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional Licensing. They have not been reviewed or approved by the Board.

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a special meeting of the Alaska State Medical Board was held Thursday, October 10, 2024.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Nimmo at 5:00 p.m.

Roll Call
Board members present:
Eric Nimmo, MD, Chair
David Barnes, DO
Sarah Bigelow-Hood, Vice-Chair
Matt Heilala, DPM
Lydia Mielke, Public Member (Secretary)
Brent Taylor, MD
David Wilson, Public Member
Note: David Paulson, MD was present but did not answer at roll call.

State employees present:
Natalie Norberg, Executive Administrator and Jason Kaeser, Licensing Supervisor

2. Review / Approval of Agenda

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson

3. Physician Assistant Regulation Project
Chair Nimmo invited Ms. Bigelow Hood to present the work group's changes to the physician assistant regulations. After the members of the work group were named, Ms. Bigelow Hood provided a section-by-section review and rationale for the recommended changes. Primary points of discussion were around the changes to eliminate the requirement for methods of assessment to be included in collaborative practice agreements; the fact that the change to permitting practice agreements to be maintained at the practice level will eliminate the ability for the public to view/search agreement participants from the licensing website; and the inclusion of advanced practitioners as having the ability to provide the requisite hours of onsite training for new physician assistants in remote settings. Board members generally acknowledged their understanding for and support for the changes.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, Alaska State Medical Board accepted the changes proposed to Article 5. Physician Assistants, in sections *12. AAC 40. 400 through 12. AAC. 40.490*, as presented requested the initiation of a regulation change project.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson

The members of the work group were heartily thanked by the Chair and other members of the board for their hard work.

4. Wrap up / Adjourn

Board members discussed the proposed date of the next quarterly board meeting and decided to change the date from November 8, 2024, to November 15, 2024.

The meeting was adjourned by Dr. Nimmo at 6:12 p.m.

Submitted by:

Natalie Norberg, Executive Administrator — Date: 10/11/2024

The issue:

Regulation 12. AAC 40.943 Standards of practice for telemedicine, under the State Medical Board is outdated and needs to be revised.

In 2022 new state and federal legislation was enacted, rendering much of the language in 12 AAC. 40.943 obsolete. Also in 2022, the FSMB issued new telemedicine guidelines.

Background:

Change in Federal law:

The requirement for the DATA waiver was eliminated at the federal level. Section 1262(a)(1) of the Consolidated Appropriations Act, 2023 (Pub. L. No: 117–328), which was enacted on December 29, 2022, amended the CSA (21 U.S.C. 823(h)) and eliminated the requirement that practitioners obtain a waiver to prescribe certain schedule III—V medications for the treatment of opioid use disorder (OUD). This immediately removed the requirement for practitioners to submit a notification of intent and to receive the Drug Addiction Treatment Act of 2000 (DATA)-Waiver before prescribing buprenorphine.

Change in State law:

HB 265 eliminated the requirement for a health care provider to conduct an in-person visit prior to providing telehealth services. This law also created the ability for providers to prescribe controlled substances for through telehealth so long as state and federal laws are followed.

Key issues for the Board's consideration:

1) Decide whether to eliminate outdated language in 12. AAC 40.943 to align with new state and federal laws.
2) Decide whether to adopt the 2022 FSMB telemedicine guidance by reference.

Separate but related issue

3) Decide whether to define "physician-patient relationship" in 12 AAC 40.990 Definitions.

State law 08.64.364 (c)(2) specifies that a physician or physician assistant may not prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with

whom the physician or physician assistant does not have a prior physician-patient relationship.

The medical board has not defined physician-patient relationship. The public has questioned whether this relationship can be established through a video conference visit.

Definition of physician-patient relationship under the medical marijuana statutes, AS 17.37.070 (2), a physician-patient relationship means that the physician obtained a patient history, performed an in-person physical examination of the patient, and documented written findings, diagnoses, recommendations, and prescriptions in written patient medical records maintained by the physician.

12. AAC 40.943 Standards of practice for telemedicine.

Proposed Edit:	Rationale/Citation:
(a) The guiding principles for telemedicine practice in the American Medical Association (AMA), Report 7 of the Council on Medical Service (A-14), Coverage of and Payment for Telemedicine, dated 2014, and the Federation of State Medical Boards (FSMB), ~~Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, dated April 2014~~ Appropriate Use of Telemedicine Technologies in in the Practice, dated 2022, are adopted by reference as the standards of practice when providing treatment, rendering a diagnosis, prescribing, dispensing, or administering a prescription or controlled substance without first conducting an in-person physical examination under AS 08.64.364.	The FSMB adopted new Telemedicine guidance in 2022. The board may want to consider adopting the new guidelines.
~~(b) During a public health emergency declared by the governor or commissioner of health and social services, an appropriate licensed health care provider need not be present with the patient to assist a physician or physician assistant with examination, diagnosis, and treatment if the physician or physician assistant is prescribing, dispensing, or administering buprenorphine to initiate or continue treatment for opioid use disorder and the physician or physician assistant~~	08.01.085 (e) renders this subsection obsolete. Prescribers must adhere to federal laws (including emergency waivers) and state laws related to prescribing controlled substances.
~~(1) is a waived practitioner under 21 U.S.C 823(g)(2) (Drug Addiction Treatment Act (DATA));~~	08.01.085 (e) renders this subsection obsolete. Prescribers must adhere to federal laws (including emergency waivers) and state laws related to prescribing controlled substances. The Consolidated Appropriations Act, 2023 (Pub. L. No: 117–328), which was enacted on December 29, 2022, eliminated the Data Waiver at the federal level.

~~2) documents all attempts to conduct a physical examination under AS 08.64.364(b), the reason why the examination cannot be performed, and the reason why another health care provider cannot be present with the patient; and~~	08.01.085 (h) prohibits this.
~~(3) requires urine or oral toxicology screening as part of the patient's medication adherence plan.~~	08.01.085 (e) renders this subsection obsolete
b) A practitioner who uses telemedicine must establish a valid practitioner-patient relationship with the person who receives telemedicine services. The relationship is established when the practitioner agrees to undertake diagnosis or treatment of the patient and the patient agrees that the practitioner will diagnose or treat the patient. A valid practitioner-patient relationship may be established through telemedicine if the standard of care does not require an initial in person encounter. 1) Prior to providing treatment, including issuing prescriptions, a practitioner who uses telemedicine should interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient.	Based on guidance from FSMB and the language from other states.

THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the FSMB Workgroup on Telemedicine
Adopted by the FSMB House of Delegates, April 2022

INTRODUCTION

In April 2014, the Federation of State Medical Boards (FSMB) adopted the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practices of Medicine,* superseding the *Model Guidelines for the Appropriate Use of the Internet in Medical Practice (2002).* At the time of its adoption, the *Model Policy (2014)* addressed current regulatory challenges associated with the provisions of telemedicine. Since then, the utilization of telemedicine has dramatically increased, resulting in not only advancements in telemedicine technologies, but also identification of newer or more pressing challenges to effective telemedicine utilization.

There are numerous factors contributing to the continual increase of telemedicine being used as a component of the practice of medicine. The greatest of these catalysts by far has been the global COVID-19 pandemic and resulting national public health emergency (PHE). Prior to the declaration of a PHE by the United States, telemedicine visits accounted for a small percentage of total care visits, but within the first six months of the PHE, total telemedicine visits increased by more than 2,000 percent. Certain specialties, such as psychiatry, endocrinology and neurology, saw greater increases in telemedicine utilization than others. The PHE increased familiarity with telemedicine for patients and providers alike and signals greater use in the future.[1][2] Telemedicine allows continued relationships between patients and providers after both office-based and telemedicine visits. Patients and physicians alike also now expect telemedicine to continue to be a component of healthcare delivery.

The rapid expansion of telemedicine has at the same time led to concerns regarding fraud and abuse, patient safety and access inequity. While the PHE led to rapid expansion of telemedicine, counties in the United States with lower median income, less broadband availability, and less pre-

[1] Cortex C, Mansour O, Qato DM, Stafford R, Alexander C. Changes in Short-term, Long-term, and Preventative Care Delivery in US Office-Based and Telemedicine Visits During the COVID-19 Pandemic. *Jama Health Forum.* 2021;2(7):e211529. Doi:10.1001/jamahealthforum.2021.1529
[2] Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider E. The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases. The Commonwealth Fund. 22 Feb 2021.

PHE telemedicine use continue to utilize telemedicine at a far lesser rate than other counties.[3] Additional patient groups have also experienced inequity of telemedicine access, including older adults, those with limited English proficiency, and people from certain racial and ethnic minority groups. In 2019, despite the ubiquitous appearance of smartphone and related devices availability, 25 million Americans lacked internet access, while 14 million people did not have equipment capable of sharing or playing video images, such as a laptop, pc computer, smartphone, tablet or other device. Specifically, 18 percent of adults aged 65 or older did not have internet access at home, 13 percent of people living in non-metropolitan areas lacked internet access, and seven percent living in metropolitan areas lacked internet access.[4] These marginalized and minoritized communities may be left behind despite advancements in telemedicine and improved access to care, unless such inequities are addressed.

Telemedicine is one component of the delivery of healthcare, and it can vary in quality, appropriateness and usefulness. It is important that as telemedicine continues to be utilized, regulatory agencies balance expanding regulatory opportunities for the adoption of telemedicine technologies with ensuring public health and safety. To address the challenges and evolving use of telemedicine, as well as apply lessons learned from the COVID-19 pandemic, Kenneth B. Simons, MD, the Chair of the Federation of State Medical Boards (FSMB), appointed the Workgroup on Telemedicine in May of 2021 to revise and expand the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)* to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards"), health care providers and patients. The Workgroup was charged with evaluating the impact of license waivers and modifications on the practice of medicine across state lines; evaluating the easing of geographic, site-specific and modality restrictions on the practice of telemedicine and the impact on patient access and care; reviewing current state and federal legislative, policy and regulatory trends; and evaluating the appropriate use of telemedicine during a public health emergency versus nonemergent/nonurgent times.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine, while raising awareness for licensees and patients alike as to the appropriate standards of care in the delivery of medical services via telemedicine technologies. The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation. It is the intent of the workgroup to offer a model policy for use by state medical boards and lawmakers to expand regulatory opportunities and enable wider, appropriate adoption of telemedicine technologies for delivering care while ensuring the public's health and safety.

In developing the guidelines that follow, the workgroup took into account lessons learned from the PHE and conducted a comprehensive review of extant state and federal statutes and regulations,

[3] Patel S, Rose S, Barnett M, Huskamp H, Uscher-Pines L, Mehrotra A. Community Factors Associated with Telemedicine Use During the COVID-19 Pandemic. *Jama Netw Open.* 2021;4(5):e2110330. Doi:10.1001/jamanetopen.2021.10330.

[4] Amin K, Rae M, Ramirez G, Cox C. How Might Internet Connectivity Affect Health Care Access? Peterson-KFF Health System Tracker. December 14, 2020. https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/#item-start

telemedicine technologies currently in use and proposed/recommended standards of care, and identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

SECTION 1. Model Guidelines for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine in the United States and offer opportunities for improving the delivery and accessibility of health care, particularly through telemedicine. Telemedicine continues to be best defined as the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. State medical boards, in fulfilling their statutory duty to protect the public, often face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient consistent with the same standard of care; and 4) limiting the inappropriate prescribing and dispensing of certain medications.

The [Name of Board] recognizes the potential benefits of the use of telemedicine technologies to deliver medical care. When utilized appropriately, telemedicine technologies can enhance connection between patients and physicians, and reduce inequities in the delivery of care. Telemedicine technology can facilitate patient examinations and permit diagnosis, if acceptable under the standard of care. Telemedicine technologies also enable remote patient monitoring and permit physicians to obtain medical histories, give medical advice and counseling, and prescribe medication and other treatments.

These guidelines do not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method of enabling physician-to-patient communications. Telemedicine is one component of the practice of medicine. A physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history taking of the patient consistent with established, evidence-based standards of care for the particular patient presentation. When the standard of care that is ordinarily applied to an in-person encounter cannot be met by virtual means, the use of telemedicine technologies is not appropriate.

The Board has developed these guidelines to educate licensees and the public as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies,

while promoting the responsible and safe practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Physicians are encouraged to comply with nationally recognized health standards and codes of ethics. There should be consistent ethical and professional standards applied to all aspects of a physician's practice. A physician's professional discretion as to the diagnoses, scope of care, or treatments should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e., a prescription or referral) or the utilization of telemedicine technologies.

Section Two. Licensure

A physician must be licensed, or appropriately authorized, by the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time that telemedicine technologies are used. Physicians who diagnose, treat, or prescribe using online service sites are engaging in the practice medicine and must possess appropriate licensure in all jurisdictions where their patients receive care.[5]

There are a few instances, however, where certain exceptions may permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located. These exceptions to licensure are only permissible for established medical problems or ongoing workups and care plans, or in cases of prospective patient screening for complex referrals. Should medical care be sought by the patient for a different medical diagnosis or condition, the physician must refer the patient to a physician licensed in the state where the patient is located or obtain a license to practice medicine in the state where the patient is located. Specifically, these exceptions are:

<u>Consultations and Screenings</u>

Physician-to-Physician Consultations
The physician-to-physician consultation exception permits a consulting physician licensed in another state in which they are located to use telemedicine or other means to consult with a licensed

[5] To avoid confusion about when a physician does or does not require a license to practice across state lines, states are encouraged to consider various means of license portability. States may promote license portability by joining national compacts, such as the Interstate Medical Licensure Compact, as one mechanism to help physicians achieve necessary multi-state licensure to legally provide care to patients in other states.

practitioner who remains responsible for diagnosing and treating the patient in the state where the patient is located.

Prospective Patient Screening for Complex Referrals
Physicians providing specialty assessments or consultations, such as at Centers for Excellence, are not required to obtain a license in the state where the patient is located in order to screen a patient for acceptance of a referral. The out-of-state physician may then provide care via telemedicine utilizing the physician-to-physician consultation exception above. If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located.

Episodic and Follow-Up Care for Established Patients

Episodic Follow-Up Care
A patient that is temporarily located outside the jurisdiction of a physician with which the patient has an established relationship may receive care via telemedicine technologies provided it is possible for the physician to gather sufficient clinical information during the evaluation to provide care that meets the accepted standard of care. If the patient is presenting with new medical conditions, the physician may consider directing the patient to obtain local care.

If the physician becomes aware that the patient's out of state location is no longer temporary, the physician should similarly develop a plan to transition care to a physician licensed in the state where the patient is located. Physicians providing care under this exception should also be prepared to make referrals to a hospital or to a local specialist who can step in and assist, especially in cases of devolving medical or mental status.

Follow-up After Travel for Surgical/Medical Treatment
Due to the unavailability, rarity or severity of a diagnosis or necessary treatment, a patient may choose to travel specifically to obtain specialty care at a medical center located in another state. In this situation, a significant portion of the diagnosis and treatment of the patient should occur in the physician's state of licensure, to include but not limited to, a surgical or procedural intervention. After the workup, procedure, or treatment is performed, the patient may return to their own state of residence and require additional follow-up care. When this follow-up can be effectively provided virtually, physicians should be allowed to utilize telemedicine without obtaining a license to practice in the state where the patient resides. Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary.

Clinical Trials

Physicians who work on clinical trials recruit patients based off certain criteria in hopes of increasing the likelihood of a successful and diverse clinical trial. When working on clinical trials that are enabled by telemedicine technologies, physicians should be not be precluded from including patients that reside in a state where the physician does not have a license to practice medicine. Physicians providing out-of-state care under this exception should ensure that their

patients have backup plans to receive care locally if changes in their medical condition make that necessary.

Section Three. Standard of Care

A practitioner who uses telemedicine must meet the same standard of care and professional ethics as a practitioner using a traditional in-person encounter with a patient. The failure to follow the appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the medical board.

Scope of Practice

A practitioner who uses telemedicine should ensure that the services provided are consistent with the practitioner's scope of practice, including the practitioner's education, training, experience and ability. Physicians may supervise and delegate tasks via telemedicine technologies so long as doing so is consistent with applicable laws.

Establishment of a Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks care from a physician. The relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an in-person encounter between the physician (or other appropriately supervised health care practitioner) and patient. A physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity, location, and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. If available, a patient should be able to select an identified physician for telemedicine services, not be assigned to a physician at random, and have access to follow-up care.

[6] American Medical Association, Council on Ethical and Judicial Affairs, *Fundamental Elements of the Patient-Physician Relationship (1990)*, available at http://www.ama- assn.org/resources/doc/code-medical-ethics/1001a.pdf.

Evaluation and Treatment of the Patient

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Gathering clinical history to make a diagnosis is often an iterative process and physicians need to have the opportunity and ability to ask iterative follow-up questions. If an evaluation requires additional ancillary diagnostic testing under the standard of care, the physician must complete such diagnostics, arrange for the patient to obtain the needed testing, or refer the patient to another provider. Additionally, as part of meeting the standard of care, physicians must use digital images, live video, or other modalities as needed to make a diagnosis if the standard of care in-person would have required physical examination. Treatment and consultation recommendations made in a virtual setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in in-person settings. Diagnosis, prescribing, or other treatment based solely on static online questionnaires, or those that do not obtain all of the information necessary to meet applicable standards of care, are not acceptable. Physicians practicing telemedicine utilizing adaptive questionnaires must have the ability to ask follow-up questions or obtain further history, especially when doing so is required to collect adequate information to appropriately diagnosis or treat.

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of a traditional physical examination. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are recommended. To further assure patient safety in the absence of a physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe.

Prescribing medications via telemedicine, as is the case during in-person care, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each prescription issued during a telemedicine encounter must be evaluated by the physician in accordance with state and federal laws, as well as current standards of practice, and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Informed Consent, Disclosure, and Functionality of Online Services Making Available Telemedicine Technologies

Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient and the patient's location
- Identification of the physician, the physician's credentials, and the physician's state or territory of practice;
- Identification of the patient's primary care physician, if available;

- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, patient education, etc.);
- The patient agrees that the physician determines, in conjunction with applicable laws, whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, enabling password protection of data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party, if consistent with state and federal law.

Physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated healthcare providers;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the online platform and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the online platform owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Physicians may choose to make health-related and non-health-related goods or products available to patients to meet a legitimate patient need in instances where the goods are medically necessary for patients and not immediately or reliably available to patients by other means. Physicians who choose to make goods available to patients should be cautioned that they must be mindful of the

inherent power differential that characterizes the physician-patient relationship and therefore the significant potential for exploitation of patients. The principle of non-exploitation of patients also applies to scenarios involving physician-owned pharmacies located in practice offices. In such instances, physicians should offer patients freedom of choice in filling any prescriptions and must therefore allow prescriptions to be filled elsewhere.[7]

Continuity of Care and Referral for Emergent Situations

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient and, subject to the patient's consent, any identified care provider of the patient immediately after the encounter. Physicians have the responsibility to refer patients for in-person follow-up care when a patient's medical issue requires an additional in-person physical exam, diagnostic procedure, ancillary lab, or radiologic test.

If a patient is inappropriate for care via telemedicine technologies or experiences an emergent situation, complication, or side effects after an encounter using telemedicine technologies, physicians should have a standing plan in place and have the responsibility to refer the patient to appropriate care (e.g. acute care, emergency room, or another provider) to ensure patient safety. It is insufficient for physicians to simply refer all patients to the emergency department; each situation should be evaluated on an individual basis and referred based on its severity and urgency.

Physicians have an obligation to support continuity of care for their patients. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient may be considered patient abandonment or result in discipline from the Board. A physician may not delegate responsibility for a patient's care to another person if the physician knows, or has reason to know, that the person is not qualified to undertake responsibility for the patient's care.

Medical Records

The medical record should include, if not required by law, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records. Records should be in a format that is easily transferable to the patient. If requested by the patient, physicians must share the medical record with the patient's primary care physician and other relevant members of the patient's existing care team.

[7] FSMB. *Position Statement on Sale of Goods by Physicians and Physician Advertising*. April 2016, available at: https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-sale-of-goods-by-physicians-and-physician-advertising.pdf

Privacy and Security of Patient Records & Exchange of Information

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information" and "Confidentiality of Substance Use Disorder Patient Records," issued by the Department of Health and Human Services (HHS).[89] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional in-person encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) healthcare personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory results must be secure within existing technology (i.e., password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Section 4. Definitions

For the purposes of these guidelines, the following definitions apply:

"Consulting Physician" means a physician who evaluates a patient and relevant medical data or images, or other information, through telemedicine technologies upon recommendation of a referring physician.

"Patient Abandonment" means the termination of a health care physician-patient relationship without the assurance that an equal or higher level of care meeting the assessed needs of the patient's condition is present and available.

"Remote Patient Monitoring" means the use of synchronous or asynchronous electronic information and communication technology to collect personal health information and medical data from a patient in one location that is transmitted to a licensee in another location for use in the treatment and management of medical conditions that require frequent monitoring.

[8] *45 C.F.R. § 160, 164 (2000).*
[9] *42 C.F.R. Part 2 (2017).*

"Static Online Questionnaire" means an internet questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast with an adaptive, interactive, and responsive online interview.

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. Telemedicine is not an e-mail/instant messaging conversation or fax-based interaction. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, in-person encounter between a provider and a patient. Telemedicine may include audio-only communications, but audio-only communications should only be used as a substitute when a patient is unable or unwilling to access live-interactive modalities or when audio-only interactions are considered the standard of care for the corresponding healthcare service being delivered.

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location, with or without an intervening healthcare provider.

SECTION 2. Equity of Healthcare Access

When utilized and deployed effectively as a seamlessly integrated part of healthcare delivery, telemedicine can improve access and reduce inequities in the delivery of healthcare. To be effective, certain barriers must be eliminated or reduced, such as literacy gaps, access to broadband internet, and coverage and payment of telemedicine services.

Education

Physicians, health systems, and other telemedicine providers should develop educational and training information for patient groups with known limited digital literacy and access.

Broadband Internet

State governments should pursue policies to expand broadband access to all geographic regions, including low-cost options to those communities that are unable to afford it.

Coverage and Payment

Limiting coverage may lead to additional inequities in the delivery of healthcare via telemedicine. Health plans should provide coverage for the cost of healthcare services provided through telemedicine on the same basis and to the same extent that the carrier is responsible for coverage through in-person treatment or consultation. Health plans should not have separate networks for telehealth or select telehealth providers.

ADDITIONAL REFERENCES

12 Va. Admin. Code § 5-31-10

45 C.F.R. § 160, 164 (2000)

Alaska Admin. Code tit. 7, § 110.639

AMA. Council on Ethical and Judicial Affairs. *Code of Medical Ethics*.

AMA. *Report of the Council on Medical Service.* Addressing Equity in Telehealth. 7-CMS-21. (June 2021).

AMA. *Report of the Council on Medical Service*. Licensure and Telehealth. 8-CMS-21. (June 2021).

AOA. Policy Statement – Telemedicine. H601-A/17. (July 2017)

Ark. Code Ann. § 17-80-402(5)

Cal. Bus. & Prof. Code § 2290.5(d).

Center for Connected Health Policy. Impact of Audio-only Telephone in Delivering Health Services During COVID-19 and Prospects for Future Payment Policies & Medical Board Regulations. August 25, 2021.

Center for Connected Health Policy. *State Telehealth Laws and Reimbursement Polices Report, Fall 2021*. October 2021.

The Department of Health and Human Services, HIPAA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. *Model Guidelines for the Appropriate Use of the Internet in Medical Practice.* April 2002.

FSMB. *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.* April 2014.

Iowa Admin. Code r. 653-13.11(8)

Miss. Code R. § 30-2635-5

North Carolina Medical Board. Position Statement. Telemedicine. May 2021.

Nev. Rev. Stat. § 630.304 – 630.305

Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-payment Medical Review Requirements., 86 FR 64996 (Nov. 19, 2021)(revising 42 C.F.R. § 403, 405, 410, 411, 414, 415, 423, and 425).

Wash. Admin. Code § 246-919-668

Washington Medical Commission. Policy Statement. Telemedicine. November 2021.

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[10] State Medical Board or organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report.

Introduction:

The Medical Board currently has several Policies/Guidance documents posted on its website that contain guidance that conflict with existing statutes and regulations. These policies include:

1) MED_Guide_Dermatological (Attachment I)
2) Med_Guide_Delegating_to_Unlicensed_Assistants (Attachment II)
3) MED_Guide_Lasers_Laser_Surgery (Attachment III)

Examples of the conflicting/outdated guidance:

1) ***Guidelines for Physicians in Delegating Procedures to Non-physician Personnel When Performing Certain Dermatological Procedures (implemented in 2004 and updated in 2014 and 2017);*** advises that "the supervising physician shall be physically present on-site, immediately available, and able to respond promptly to any question or problem that may occur while the procedure is being performed."
   However:
   Regulation 12 AAC 40.920 Standards for delegation of routine duties (implemented in 2019) states that: "Either the original or substitute delegating physician, podiatrist, osteopath, or physician assistant shall remain readily available for consultation by the person to whom the duty is delegated, either in person or by telecommunication."

2) ***Guidelines for Physicians in Delegating Procedures to Non-physician Personnel When Performing Certain Dermatological Procedures (implemented in 2004 and updated in 2014 and 2017);*** also advises that "Estheticians are prohibited from providing services that are considered the practice of medicine such as injections, chemical peels…., or use of certain equipment (such as lasers, etc.)."
   However:
   the standards outlined in 12 AAC 40.920 are broad enough such that it is possible if an esthetician received the training needed to perform a delegated duty, and the medical duty was considered "routine" in the medical spa or the "health and wellness" clinic setting, they could perform a service considered the practice of medicine.

Statute and Regulation Citations:

Sec. 08.64.106. Delegation of routine medical duties. (Implemented in 2018)
The board shall adopt regulations authorizing a physician, podiatrist, osteopath, or physician assistant licensed under this chapter to delegate routine medical duties to an agent of the physician, podiatrist, osteopath, or physician assistant. The regulations must

(1) require that an agent who is not licensed under this chapter may perform duties delegated under this section only if the agent meets applicable standards established by the board;

(2) require that a physician, podiatrist, osteopath, or physician assistant may not delegate duties related to pain management and opioid use and addiction; and

(3) define the phrase "routine medical duties."

12 AAC 40.920 Standards for delegation of routine duties (Implemented in 2019)

(a) A physician, podiatrist, osteopath, or physician assistant licensed under AS 08.64 may delegate the performance of routine medical duties to an agent of the physician, podiatrist, osteopath, or physician assistant, if the following conditions are met:

(1) the duty to be delegated must be within the scope of practice of the delegating physician, podiatrist, osteopath, or physician assistant;

(2) a licensed physician, podiatrist, osteopath, or physician assistant must assess the patient's medical condition and needs to determine if a duty for that patient may be safely delegated;

(3) the patient's medical condition must be stable and predictable;

(4) the person to whom the duty is to be delegated has received the training needed to safely perform the delegated duty, and this training has been documented;

(5) the delegating physician, podiatrist, osteopath, or physician assistant determines that the person to whom a duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;

(6) performance of the delegated duty would not require the person to whom it is delegated to exercise professional medical judgment or have knowledge of complex medical skills;

(7) the delegating physician, podiatrist, osteopath, or physician assistant provides to the person, with a copy maintained on record, written instructions that include

(A) a clear description of the procedure to follow to perform each task in the delegated duty;

(B) the predicted outcomes of the delegated task;

(C) procedures for observing, reporting, and responding to side effects, complications, or unexpected outcomes in the patient; and

(D) the procedure to document the performance of the duty in the patient's record.

(b) A physician, podiatrist, osteopath, or physician assistant who has delegated a routine duty to another person shall provide appropriate direction and supervision of the person, including the evaluation of patient outcomes. Another physician, podiatrist, osteopath, or physician assistant may assume delegating responsibilities from the delegating physician, podiatrist, osteopath, or physician assistant if the substitute physician, podiatrist, osteopath, or physician assistant has assessed the patient, the skills of the person to whom the delegation was made, and the plan of care. Either the original or substitute delegating physician, podiatrist, osteopath, or physician assistant shall remain readily available for consultation by the person to whom the duty is delegated, either in person or by telecommunication.

(c) The delegation of a routine duty to another person under this section is specific to that person and for that patient, and does not authorize any other person to perform the delegated duty.

(d) The physician, podiatrist, osteopath, or physician assistant who delegated the routine duty to another person remains responsible for the quality of the medical care provided to the patient.

(e) Routine medical duties that may be delegated to another person under the standards set out in this section means duties that

(1) occur frequently in the daily care of a patient or group of patients;

(2) do not require the person to whom the duty is delegated to exercise professional medical knowledge or judgment;

(3) do not require the exercise of complex medical skills;

(4) have a standard procedure and predictable results; and

(5) present minimal potential risk to the patient.

(f) Duties that require the exercise of professional medical knowledge or judgment or complex medical skills may not be delegated. Duties that may not be delegated include

(1) the assessment of the patient's medical condition, and referral and follow-up;

(2) formulation of the plan of medical care and evaluation of the patient's response to the care provided;

(3) counseling of the patient and the patient's family or significant others regarding the patient's health;

(4) transmitting verbal prescription orders, without written documentation, from the patient's health care provider;

(5) duties related to pain management and opioid use and addiction;

(6) the initiation, administration, and monitoring of intravenous therapy, including blood or blood products;

(7) the initiation administration, and monitoring of procedural sedation;

(8) assessing sterile wound or decubitus ulcer care;

(9) managing and monitoring home dialysis therapy;

(10) oral tracheal suction;

(11) medication management for unstable medical conditions requiring ongoing assessment and adjustment of dosage or timing of administration;

(12) placement and administration of nasogastric tubes and fluids;

(13) initial assessment and management of newly-placed gastrostomy tubes and the patient's nutrition; and

(14) the administration of injectable medications, unless

(A) it is a single intramuscular, intradermal, or subcutaneous injection, not otherwise prohibited under 12 AAC 40.967(33); and

(B) all other provisions of this section are met; and

(C) the delegating physician, podiatrist, osteopath, or physician assistant is immediately available on site.

(g) The provisions of this section apply only to the delegation of routine medical duties by a physician, podiatrist, osteopath, or physician assistant licensed under AS 08.64; they do not apply when duties have not been delegated, including when a person is acting

(1) within the scope of the person's own license;

(2) under other legal authority; or

(3) under the supervision of another health care provider licensed under AS 08, who has authority to delegate routine duties.

Attachment I

Alaska State Medical Board

Policies and Procedures

Board Issued Guidelines	Section 6
Subject:	***Guidelines for Physicians in Delegating Procedures to Non-physician Personnel When Performing Certain Dermatological Procedures***
Implemented:	January 16, 2004
Revised:	March 7, 2014; August 3-4, 2017

The Alaska State Medical Board has adopted the following to be its guideline to physicians licensed to practice medicine in Alaska when considering the delegation of certain procedures to non-physician office personnel.

Non-Physician Practice of Medicine and the Use of Non-Physician Office Personnel

The guiding principle for all physicians is to practice ethical medicine with the highest possible standards. Physicians should be properly trained in all procedures performed to insure the highest level of patient care and safety. A physician should be fully qualified by residency training and preceptorship or appropriate course work. Training should include an extensive understanding of cutaneous medicine and surgery, the indications for each procedure, and the pre- and post-operative care involved in treatment. It is the position of the board that only active and properly licensed doctors of medicine and osteopathy shall engage in the practice of medicine. Unlicensed personnel are prohibited from providing services that are considered the practice of medicine.

Under the appropriate circumstances, a physician may delegate certain procedures to licensed non-physician health care practitioners (e.g., registered nurses, physician assistants, etc.). These procedures include administering a botulinum toxin or dermal filler, autotransplantation of biological materials, or treating with chemical peels below the dermal layer, or hot lasers. A physician may also delegate the performance of some non-invasive treatments to non-physician health practitioners (e.g., nurses, physician assistants, cosmetologists, estheticians, etc.) The physician must ensure that the non-physician health practitioners are appropriately trained and licensed, and are practicing within the scope of their own license.

Medical treatments require an initial consultation and supervision by a licensed physician. The treatments must be performed under direct supervision by the physician. T… physician shall be physically present on-site, immediately available, and a… promptly to any question or problem that may occur while the procedure is… is the physician's obligation to ~~insure~~ ensure that the non-physician health… the proper training in cutaneous medicine, the indications for the procedure, and the pre- and post-operative care involved, and are provided with written protocols.

Natalie Norberg
2024-11-04 23:10:02

This is in conflict with 12 AAC 40.920 (b) - the delegating practitioner does not have to be onsite.

There is a separate Board-issued guideline regarding the use of lasers. The Board adopted the AMA policy which defines laser usage and differentiates the appropriate use of ablative treatment (“hot laser”) and non-ablative treatment (“cold laser”).

Estheticians are prohibited from providing services that are considered the [illegible] such as injections, chemical peels, liposuction, autotransplantation, admin[illegible] dermal fillers, or use of certain equipment (such as lasers, etc.) Procedures [illegible] practice of medicine may only be performed by a licensed physician.

Under Alaska law, a licensee may be sanctioned for intentionally or negli[illegible] performance of patient care by persons under the licensee’s supervision tha[illegible] minimum professional standards even if the patient was not injured; in ad[illegible] unprofessional conduct to delegate professional practice responsibilities that require a license or permit to a person who does not possess the appropriate education, training, or licensure to perform the responsibilities.

Natalie Norberg
2024-11-04 23:19:32
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the standards outlined in 12 AAC 40.920 are broad enough such that it is possible if an esthetician received the training needed to perform a delegated duty, and the medical duty was considered "routine" in the medical spa or the "health and wellness" clinic setting, they could perform a service considered the practice of medicine.

Attachment II Alaska State Medical Board
Board Issued Guidelines

Subject:	***Delegating to Medical Assistants (Unlicensed Assistive Personnel)***
Implemented:	July 28-29, 2011
Revised:	January 26-27, 2012, November 3-4, 2016

Medical Assistants (MAs) are unlicensed assistive personnel that perform office and clinical functions. There is currently no licensing program for MAs. Unlicensed assistive personnel are prohibited from providing services that are considered the practice of medicine, such as patient assessment or evaluation of care, health counseling, IV therapy, procedural sedation, home dialysis therapy, oral tracheal suction, medication management, injections, chemical peels, liposuction, autotransplantation, administering Botox or dermal fillers, or use of certain equipment (such as lasers, etc.) Procedures considered to be the practice of medicine may only be performed by a licensed physician.

A physician who supervises MAs is the primary treating physician with ultimate responsibility for the patient and is responsible for the activities of the MA, including direct supervision when delegating routine duties. A physician may only delegate routine duties; there is no provision for a physician to delegate clinical duties that are under their own scope of practice. The scope of practice for physicians in Alaska is defined in statute; those physicians who employ MAs are advised to be familiar with the requirements and comply with them.

Note: Under Alaska law, a licensee may be sanctioned for intentionally or negligently permitting the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured; in addition, it is considered unprofessional conduct to delegate professional practice responsibilities that require a license or permit under to a person who does not possess the appropriate education, training, or licensure to perform the responsibilities.

Attachment III

Alaska State Medical Board
Board Issued Guidelines

Subject:	***Guidelines Regarding the Use of Lasers and Laser Surgery***
Implemented:	January 16, 2004
Revised:	October 25, 2007

The Alaska State Medical Board has adopted the policies of the American Medical Association, following, to be its guidelines to its licensees in Alaska with regard to who may perform laser surgery.

Performance of Laser Surgery

American Medical Association's Policy H-475.989, Laser Surgery, reads:

> "Laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services."

American Medical Association's Policy H-475.988, Laser Surgery, reads:

> "The board opines that revision, destruction, incision or other structural alteration of human tissue using laser is surgery."

The board has further adopted into its policy the American College of Surgeons' "*Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques*" adopted February 9, 2007 by the ACS Board of Regents attached hereto.

Attachment III

Alaska State Medical Board
Board Issued Guidelines

American College of Surgeons

[ST-11] Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques

Adopted February 9, 2007 by ACS Board of Regents

Recognizing the increased usage of laser surgery and to provide professional guidance to state and federal regulatory bodies addressing laser and other surgery issues, the American College of Surgeons wishes to make the following revised statement regarding these operative techniques. The original statement was published in the March 1991 issue of the ***Bulletin.***

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery is also the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery (this does not include administration by nursing personnel of some injections, such as subcutaneous, intramuscular and intravenous when ordered by a physician). **All of these surgical procedures are invasive**, including those that are performed with lasers, and the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel.

In recent years, technological advances have made it possible to perform cosmetic surgical procedures of the skin using a variety of devices and techniques. Lasers, pulsed light and radio frequency devices are often used for ablative and non-ablative treatments. An ablative treatment is expected to excise, burn or vaporize the skin below the dermo-epidermal junction. Non-ablative treatments are those that are not expected or intended to excise, burn or vaporize the epidermal surface of the skin. **Any procedures that can damage the eye (cornea to retina) are ablative and should only be performed by a licensed physician.**

The American College of Surgeons believes that surgery using lasers, pulsed light, radio frequency devices or other means is the practice of medicine and constitutes standard forms of surgical intervention. It is subject to the same regulations that govern the performance of all surgical procedures including those that are ablative or non-ablative, regardless of site of service (i.e., hospital, ambulatory surgery center, physician's office, or other locations). Patient safety and quality of care are paramount, and the College therefore believes that patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. This is evidenced by comprehensive surgical training and experience, including the management of complications, and the acquisition and maintenance of credentials in both the appropriate surgical specialties (i.e., board certification) and in the use of lasers, pulsed light and radio frequency devices of other similar techniques.

However, the College also recognizes that the use of ablative lasers may be delegated to non-physician advanced health care practitioners (defined as Nurse Practitioners or Physician Assistants) who are appropriately trained, and licensed by the state in which they practice. Ablative treatments or procedures performed by non-physician advanced health care practitioners should fall within the statutory and/or regulatory scope of the practitioner's profession. The physician may delegate the performance of ablative treatments through the use of written protocols to an advanced health care practitioner. Direct supervision should be provided by the physician whenever performance of ablative treatments has been delegated to an advanced health practitioner, unless specific state regulations allow for lesser amounts of supervision. The physician is responsible for doing the initial review of the patient and for authorizing the treatment plan. This should be appropriately noted in the patient's chart prior to any initial ablative treatment.

Physicians may also delegate the performance of non-ablative treatments to non-physician health practitioners (defined as registered nurses, cosmetologists, aestheticians, and medical assistants of other qualified personnel) provided the treatments are performed under direct supervision by the physician consistent with state laws and regulations in the state where they practice. The physician must also assure that these practitioners are: appropriately trained, licensed by the state in which they practice, practicing within the scope of their licensure, and provided with written protocols. Similar to ablative treatments, the physician is responsible for doing the initial review of the patient and for authorizing the treatment plan, and this should be appropriately noted in the patient's chart prior to any initial non-ablative treatment.

In those cases where the surgeon may utilize the services of a non-physician advanced health practitioner or non-physician health practitioner as an assistant during the performance of laser surgery (including ablative or non-ablative procedures), the assistant must:

- Be properly licensed, certified and/or credentialed to practice their profession;
- Have appropriate education and training for assisting the surgeon in laser surgery procedures; and
- Complete their assigned duties under the direct supervision of the surgeon performing the procedure.

Individuals who perform laser surgery utilizing lasers, pulsed light or radio frequency devices of other techniques should meet the principles of the College (http://www.facs.org/fellows_info/statements/stonprin.html) in all respects, to include the avoidance of any misrepresentations to the public regarding unfounded advantages of the laser compared with traditional operative techniques.

State Affairs • Division of Advocacy and Health Policy • American College of Surgeons
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Department of Commerce Community, and Economic Development
Corporations, Business and Professional Licensing

Summary of All Professional Licensing
Schedule of Revenues and Expenditures

Medical Board	FY 18	FY 19	Biennium	FY 20	FY 21	Biennium	FY 22	FY 23	Biennium	FY 24
Revenue										
Revenue from License Fees	$ 347,304	$ 2,380,618	$ 2,727,922	$ 578,308	$ 2,597,830	$ 3,176,138	$ 945,106	$ 2,876,309	$ 3,821,415	$ 852,030
General Fund Received					$ -	-	$ 272,744	$ 173,090	445,834	$ 40,368
Allowable Third Party Reimbursements	3,517	184	3,701	$ -	$ -	-	$ -	$ -	-	$ 1,071
TOTAL REVENUE	$ 350,821	$ 2,380,802	$ 2,731,623	$ 578,308	$ 2,597,830	$ 3,176,138	$ 1,217,850	$ 3,049,399	$ 4,267,249	$ 893,469
Expenditures										
Non Investigation Expenditures										
1000 - Personal Services	488,823	473,122	961,945	420,810	521,976	942,786	446,216	454,584	900,800	507,288
2000 - Travel	17,577	15,801	33,378	13,357	-	13,357	8,875	1,471	10,346	3,442
3000 - Services	44,741	31,730	76,471	23,009	46,044	69,053	69,997	97,210	167,207	93,406
4000 - Commodities	2,016	1,525	3,541	1,252	1,290	2,542	3,278	3,045	6,323	2,972
5000 - Capital Outlay	-		-	-	-	-	-	-	-	-
Total Non-Investigation Expenditures	553,157	522,178	1,075,335	458,428	569,310	1,027,738	528,366	556,310	1,084,676	607,108
Investigation Expenditures										
1000-Personal Services	210,010	226,965	436,975	264,001	272,106	536,107	289,348	336,511	625,859	411,332
2000 - Travel		2,104	2,104	2,032	-	2,032	2,655	-	2,655	-
3023 - Expert Witness	1,700	7,577	9,277	16,050	22,775	38,825	31,350	14,000	45,350	39,107
3088 - Inter-Agency Legal	60,885	34,329	95,214	56,267	33,435	89,702	42,629	208,613	251,242	484,830
3094 - Inter-Agency Hearing/Mediation	9,299	28,803	38,102	18,640	911	19,551	11,870	61,195	73,065	164,138
3000 - Services other		3,348	3,348	1,919	625	2,544	1,257	2,126	3,383	1,112
4000 - Commodities		-	-	-	-	-	-	-	-	126
Total Investigation Expenditures	281,894	303,126	585,020	358,909	329,852	688,761	379,109	622,445	1,001,554	1,100,645
Total Direct Expenditures	835,051	825,304	1,660,355	817,337	899,162	1,716,499	907,475	1,178,755	2,086,230	1,707,753
Indirect Expenditures										
Internal Administrative Costs	225,669	263,046	488,715	285,614	316,771	602,385	250,301	286,502	536,803	250,148
Departmental Costs	150,736	168,176	318,912	123,361	143,500	266,861	122,427	120,114	242,541	143,482
Statewide Costs	78,101	72,595	150,696	90,219	108,989	199,208	92,456	86,033	178,489	88,909
Total Indirect Expenditures	454,506	503,817	958,323	499,194	569,260	1,068,454	465,184	492,649	957,833	482,539
			-			-				
TOTAL EXPENDITURES	**$ 1,289,557**	**$ 1,329,121**	**$ 2,618,678**	**$ 1,316,531**	**$ 1,468,422**	**$ 2,784,953**	**$ 1,372,659**	**$ 1,671,404**	**$ 3,044,063**	**$ 2,190,292**
Cumulative Surplus (Deficit)										
Beginning Cumulative Surplus (Deficit)	$ 137,265	$ (801,471)		$ 250,210	$ (488,013)		$ 641,395	$ 486,586		$ 1,864,582
Annual Increase/(Decrease)	(938,736)	1,051,681		(738,223)	1,129,408		(154,809)	1,377,996		(1,296,823)
Ending Cumulative Surplus (Deficit)	$ (801,471)	250,210		$ (488,013)	$ 641,395		$ 486,586	$ 1,864,582		$ 567,759
Statistical Information										
Number of Licenses for Indirect calculation	7,138	8,421		9,801	12,808		8,259	9,221		7,676

Additional information:

- *General fund dollars were received in FY21-FY23 to offset increases in personal services and help prevent programs from going into deficit or increase fees.*
- *Most recent fee change: Fee reduction FY25*
- *Annual license fee analysis will include consideration of other factors such as board and licensee input, potential investigation load, court cases, multiple license and fee types under one program, and program changes per AS 08.01.065.*

Department of Commerce Community, and Economic Development
Corporations, Business and Professional Licensing

Summary of All Professional Licensing
Schedule of Revenues and Expenditures

Appropriation Name (Ex)	(Multiple Items)
Sub Unit	(All)
PL Task Code	MED1

Sum of Budgetary Expenditures	Object Type Name (Ex)				
Object Name (Ex)	1000 - Personal Services	2000 - Travel	3000 - Services	4000 - Commodities	Grand Total
1011 - Regular Compensation	482,822.31				482,822.31
1014 - Overtime	50.43				50.43
1021 - Allowances to Employees	432.00				432.00
1023 - Leave Taken	81,558.35				81,558.35
1028 - Alaska Supplemental Benefit	34,658.91				34,658.91
1029 - Public Employee's Retirement System Defined Benefits	28,582.45				28,582.45
1030 - Public Employee's Retirement System Defined Contribution	23,820.94				23,820.94
1034 - Public Employee's Retirement System Defined Cont Health Reim	15,347.21				15,347.21
1035 - Public Employee's Retiremnt Sys Defined Cont Retiree Medical	4,487.35				4,487.35
1037 - Public Employee's Retiremnt Sys Defined Benefit Unfnd Liab	68,231.89				68,231.89
1040 - Group Health Insurance	159,343.37				159,343.37
1041 - Basic Life and Travel	52.95				52.95
1042 - Worker's Compensation Insurance	3,169.42				3,169.42
1047 - Leave Cash In Employer Charge	13,038.09				13,038.09
1048 - Terminal Leave Employer Charge	9,030.61				9,030.61
1053 - Medicare Tax	7,863.82				7,863.82
1063 - GGU Business Leave Bank Usage	598.96				598.96
1069 - SU Business Leave Bank Contributions	365.61				365.61
1077 - ASEA Legal Trust	543.05				543.05
1079 - ASEA Injury Leave Usage	44.14				44.14
1080 - SU Legal Trst	189.85				189.85
1970 - Personal Services Transfer	(15,611.54)				(15,611.54)
2000 - In-State Employee Airfare		695.42			695.42
2001 - In-State Employee Surface Transportation		160.05			160.05
2002 - In-State Employee Lodging		229.00			229.00
2003 - In-State Employee Meals and Incidentals		90.00			90.00
2005 - In-State Non-Employee Airfare		474.79			474.79
2010 - In-State Non-Employee Non-Taxable Reimbursement		84.96			84.96
2013 - Out-State Employee Surface Transportation		100.66			100.66
2015 - Out-State Employee Meals and Incidentals		1,606.62			1,606.62
2970 - Travel Cost Transfer		-			-
3002 - Memberships			3,865.00		3,865.00
3023 - Expert Witness			39,107.00		39,107.00
3035 - Long Distance			96.14		96.14
3036 - Local/Equipment Charges			18.90		18.90
3044 - Courier			129.96		129.96
3045 - Postage			1,025.92		1,025.92
3046 - Advertising			1,443.84		1,443.84
3057 - Structure, Infrastructure and Land - Rentals/Leases			179.52		179.52
3085 - Inter-Agency Mail			1,294.09		1,294.09
3088 - Inter-Agency Legal			549,755.35		549,755.35
3094 - Inter-Agency Hearing/Mediation			185,677.69		185,677.69
3970 - Contractual Transfer			-		-
4000 - Books and Educational Supplies				57.00	57.00
4002 - Business Supplies				75.53	75.53
4005 - Subscriptions				2,955.00	2,955.00
4006 - I/A Commodity Purchases				10.00	10.00
Grand Total	**918,620.17**	**3,441.50**	**782,593.41**	**3,097.53**	**1,707,752.61**

FY 2024 CBPL COST ALLOCATIONS

Name	Task Code	Direct Revenues	General Fund Received	3rd Party Reimbursement	Total Revenues	Direct Expense	Percentage of board licenses/total licensees:	Department certified transactions % by Fiscal Revenue $	Indirect Expense (Total Non-PCN Allocated)	Percentage of program direct Personal Services:	Total Indirect Expenses	Total Expenses	2024 Annual Surplus (Deficit)
Acupuncture	ACU1	$ 5,359		$ -	$ 5,359	$ 6,651	$ 2,954	$ 416	$ 3,370	1,864	$ 5,234	$ 11,885	$ (6,526)
Architects, Engineer	AEL1	$ 971,065	$ 466	$ 4,427	$ 975,958	$ 337,247	202,200	$ 3,681	205,881	84,564	290,445	627,692	348,266
Athletic Trainers	ATH1	$ 5,900		$ -	$ 5,900	$ 1,642	1,840	$ 261	2,101	437	2,538	4,180	1,720
Audiology and Speech Pathologists	AUD1	$ 55,607		$ -	$ 55,607	$ 41,069	26,976	$ 1,880	28,856	12,458	41,314	82,383	(26,776)
Barbers & Hairdressers	BAH1	$ 1,146,245	$ 958	$ -	$ 1,147,203	$ 364,706	195,618	$ 4,252	199,870	99,546	299,416	664,122	483,081
Behavior Analysts	BEV1	$ 4,892		$ -	$ 4,892	$ 8,861	3,161	$ 799	3,960	2,422	6,382	15,243	(10,351)
Chiropractors	CHI1	$ 22,988	$ 4,957	$ -	$ 27,945	$ 194,286	8,500	$ 970	9,470	37,466	46,936	241,222	(213,277)
Collection Agencies	COA1	$ 48,065		$ -	$ 48,065	$ 11,743	18,476	$ 1,072	19,548	3,347	22,895	34,638	13,427
Concert Promoters	CPR1	$ 2,513		$ -	$ 2,513	$ 44	622	$ 139	761	13	774	818	1,695
Construction Contractors	CON1	$ 413,740	$ 255	$ -	$ 413,995	$ 607,170	228,891	$ 4,012	232,903	101,040	333,943	941,113	(527,118)
Home Inspectors	HIN1	$ 20,180		$ -	$ 20,180	$ 19,253	3,006	$ 840	3,846	5,846	9,692	28,945	(8,765)
Dental	DEN1	$ 206,952	$ 2,075	$ -	$ 209,027	$ 350,066	60,378	$ 3,946	64,324	92,699	157,023	507,089	(298,062)
Dietitians/Nutritionists	DTN1	$ 28,075		$ -	$ 28,075	$ 24,885	12,283	$ 1,301	13,584	7,561	21,145	46,030	(17,955)
Direct Entry Midwife	MID1	$ 12,949	$ 914	$ -	$ 13,863	$ 24,961	1,140	$ 546	1,686	1,582	3,268	28,229	(14,366)
Dispensing Opticians	DOP1	$ 9,500		$ -	$ 9,500	$ 24,239	4,353	$ 958	5,311	7,361	12,672	36,911	(27,411)
Electrical Administrator	EAD1	$ 164,215		$ -	$ 164,215	$ 96,254	25,058	$ 2,202	27,260	18,821	46,081	142,335	21,880
Euthanasia Services	EUT1	$ 300		$ -	$ 300	$ 488	363	$ 37	400	148	548	1,036	(736)
Geologists	GEO1	$ 350		$ -	$ 350	$ 991	285	$ 342	627	298	925	1,916	(1,566)
Guardians/Conservators	GCO1	$ 4,977		$ -	$ 4,977	$ 6,758	622	$ 326	948	1,933	2,881	9,639	(4,662)
Guide-Outfitters	GUI1	$ 1,097,850	$ 800	$ -	$ 1,098,650	$ 434,101	45,244	$ 3,449	48,693	117,814	166,507	600,608	498,042
Marine Pilots	MAR1	$ 30,150	$ 742	$ -	$ 30,892	$ 85,392	3,498	$ 1,500	4,998	15,288	20,286	105,678	(74,786)
Foreign Pleasure Craft	FPC1	$ 23,440		$ -	$ 23,440		-	$ 334	334		334	334	23,106
Marital & Family Therapy	MFT1	$ 33,128		$ -	$ 33,128	$ 29,916	4,250	$ 758	5,008	8,621	13,629	43,545	(10,417)
Massage Therapists	MAS1	$ 353,315	$ 1,021	$ 178	$ 354,514	$ 225,078	35,967	$ 2,503	38,470	57,185	95,655	320,733	33,781
Mechanical Administrator	MEC1	$ 109,585		$ -	$ 109,585	$ 95,639	15,729	$ 1,362	17,091	15,341	32,432	128,071	(18,486)
Medical	MED1	$ 852,030	$ 40,368	$ 1,071	$ 893,469	$ 1,707,753	198,909	$ 4,436	203,345	279,194	482,539	2,190,292	(1,296,823)
Mortuary Science	MOR1	$ 2,905		$ -	$ 2,905	$ 8,230	3,680	$ 424	4,104	2,420	6,524	14,754	(11,849)
Naturopaths	NAT1	$ 66,660		$ -	$ 66,660	$ 4,147	1,322	$ 228	1,550	1,194	2,744	6,891	59,769
Nurse Aides	NUA1	$ 359,415	$ 421	$ 205	$ 360,041	$ 101,931	87,975	$ 2,842	90,817	19,838	110,655	212,586	147,455
Nursing	NUR1	$ 1,810,803	$ 9,233	$ 4,083	$ 1,824,119	$ 1,843,890	696,235	$ 4,599	700,834	444,309	1,145,143	2,989,033	(1,164,914)
Nursing Home Administrators	NHA1	$ 3,145		$ -	$ 3,145	$ 2,044	1,399	$ 163	1,562	13	1,575	3,619	(474)
Optometry	OPT1	$ 26,892	$ 15	$ 1,500	$ 28,407	$ 41,753	6,452	$ 1,272	7,724	11,689	19,413	61,166	(32,759)
Pawnbrokers	PAW1	$ 3,350		$ -	$ 3,350	$ 4,222	544	$ 208	752	1,283	2,035	6,257	(2,907)
Pharmacy	PHA1	$ 1,256,105	$ 120,240	$ 1,588	$ 1,377,933	$ 658,578	177,660	$ 4,664	182,324	182,464	364,788	1,023,366	354,567
Physical/Occupational Therapy	PHY1	$ 487,089	$ 71	$ 264	$ 487,424	$ 185,128	69,007	$ 3,054	72,061	52,302	124,363	309,491	177,933
Prescription Drug Monitoring Program	PDMP	$ 20		$ 2,976	$ 2,996	$ 1,721	-	$ -	-	-	-	1,721	1,275
Professional Counselors	PCO1	$ 294,869	$ 326	$ -	$ 295,195	$ 204,504	31,536	$ 2,988	34,524	57,157	91,681	296,185	(990)
Psychology	PSY1	$ 33,220	$ 553	$ -	$ 33,773	$ 173,098	9,381	$ 1,614	10,995	48,200	59,195	232,293	(198,520)
Public Accountancy	CPA1	$ 600,898	$ 1,154	$ 8,980	$ 611,032	$ 318,407	45,711	$ 1,953	47,664	82,926	130,590	448,997	162,035
Real Estate	REC1	$ 639,645	$ 4,859	$ -	$ 644,504	$ 391,392	107,928	$ 1,985	109,913	81,767	191,680	583,072	61,432
Real Estate Appraisers	APR1	$ 75,640	$ 111	$ -	$ 75,751	$ 104,135	10,598	$ 1,171	11,769	27,534	39,303	143,438	(67,687)
Social Workers	CSW1	$ 428,284	$ 413	$ 568	$ 429,265	$ 197,753	37,030	$ 3,184	40,214	57,580	97,794	295,547	133,718
Storage Tank Workers	UST1	$ 7,730		$ -	$ 7,730	$ 11,150	1,788	$ 514	2,302	3,389	5,691	16,841	(9,111)
Veterinary	VET1	$ 56,611	$ 157	$ 1,037	$ 57,805	$ 147,383	22,467	$ 1,712	24,179	42,878	67,057	214,440	(156,635)
No longer existent board/commission (ie Athletic)			$ -									-	-
Totals All Boards		**$ 11,776,651**	**$ 190,109**	**$ 26,877**	**$ 11,993,637**	**$ 9,098,659**	**$ 2,411,036**	**$ 74,897**	**$ 2,485,933**	**$ 2,089,792**	**$ 4,575,725**	**$ 13,674,384**	**$ (1,680,747)**
							-	-			-	-	
ABL & Corporations	DA0801005	$ 4,372,277		$ -	$ 4,372,277	$ 405,904	$ 1,249,390	$ 10,213	$ 1,259,603	$ 238,098	$ 1,497,701	$ 1,903,605	

Last Update 10/17/2024

DIVISION INDIRECT EXPENSES	Total	Prof Lic	Corp & Bus Lic
Percentage of program direct Personal Services:			
Business Supplies	25,873	25,788	85
Office Equipment	57,608	55,009	2,599
State Vehicles	5,220	4,594	626
Storage and Archives	16,130	13,559	2,571
Legal Support	49,391	49,391	-
Central Mail Services Postage	48,961	23,719	25,242
Software Licensing and Maintenance	117,711	117,711	-
Division Administrative Expenses - all other	311,628	307,788	3,840
Division allocated by percentage of direct personal services:	632,522	597,559	34,963
Percentage of board licenses/total licensees:			
Investigations indirect Personal Services	437,677	409,626	28,051
Division Administration Personal Services	2,828,868	1,654,796	1,174,073
Division allocated by percentage of board licenses/total licensees:	3,266,545	2,064,422	1,202,124
Total Division Indirect Expenses	3,899,067	2,661,981	1,237,087

DEPARTMENT INDIRECT EXPENSES	Total	Prof Lic	Corp & Bus Lic
Percentage of program direct Personal Services:			
Commissioner's Office	289,356	254,633	34,723
Administrative Services - Director's Office	73,527	64,704	8,823
Administrative Services - Human Resources	71,235	62,687	8,548
Administrative Services - Fiscal	102,783	90,449	12,334
Administrative Services - Budget	66,633	58,637	7,996
Administrative Services - Information Technology	322,717	283,991	38,726
Administrative Services - Information Technology - Network & Database	-	-	-
Administrative Services - Mail	13,230	11,642	1,588
Administrative Services - Facilities - Maintenance	-	-	-
Department allocated by percentage of direct personal services:	939,481	826,743	112,738
Percentage of board licenses/total licensees:			
Department administrative services support: Fiscal, IT, Procurement	393,880	346,614	47,266
Receipting transaction % by Personal Services:			
Department certified transactions % by Fiscal Revenue $	85,110	74,897	10,213
Total DEPARTMENT INDIRECT EXPENSES	**1,418,471**	**1,248,254**	**170,217**

STATEWIDE INDIRECT EXPENSES	Total	Prof Lic	Corp & Bus Lic
Percentage of program direct Personal Services:			
Accounting and Payroll Systems	81,101	71,369	9,732
State Owned Building Rental (Building Leases)	258,230	227,242	30,988
State OIT Server Hosting & Storage	7,792	6,857	935
State OIT SQL	6,958	6,432	526
State Software Licensing	-	-	-
Human Resources	69,278	60,965	8,313
IT Non-Telecommunications (Core Cost)	297,578	261,869	35,709
IT Telecommunications	32,270	28,398	3,872
Risk Management	2,680	2,358	322
Statewide allocated by percentage of direct personal services:	**755,887**	**665,490**	**90,397**

FY24 TOTALS BY METHODOLOGY	Total	Prof Lic	Corp & Bus Lic
Percentage of program direct Personal Services:	2,327,890	2,089,792	238,098
Percentage of board licenses/total licensees:	3,660,426	2,411,036	1,249,390
Receipting transaction % by Personal Services:	85,110	74,897	10,213
Grand Total	**6,073,426**	**4,575,725**	**1,497,701**

ALASKA PDMP

PRESCRIPTION DRUG MONITORING PROGRAM

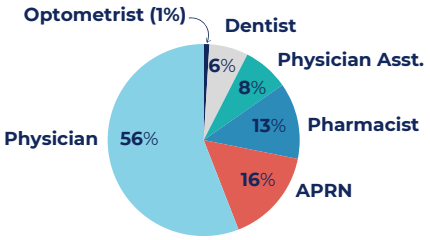
Q3 2024

78,338 PATIENTS

Alaskan patients receiving at least one controlled substance prescirption.

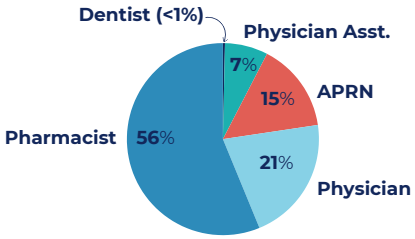
9,279 REGISTERED USERS

% registered by license type, excluding IHS, military, VA, and delegates.



258,261 SEARCHES

% of searches by user type, excluding IHS, military, VA, and delegates.



83% EHR ACCESS

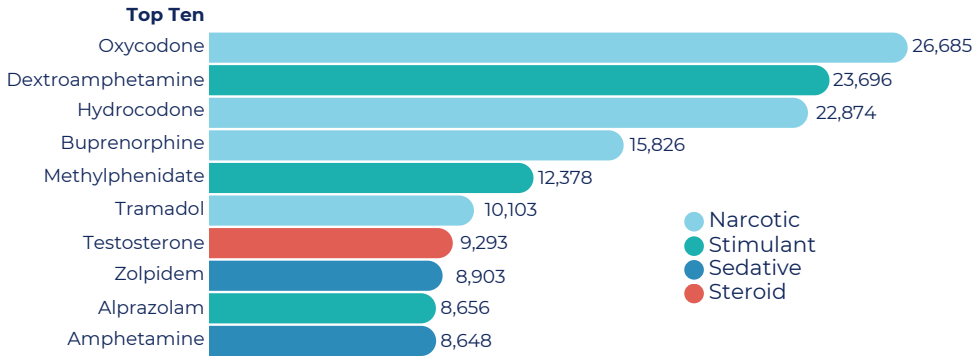
% of providers using electronic health record system (EHR) integration to search patient information within their clinical workflow.

258 DISPENSERS

Pharmacies or dispensing providers with at least one controlled substance dispensation to Alaska patients.

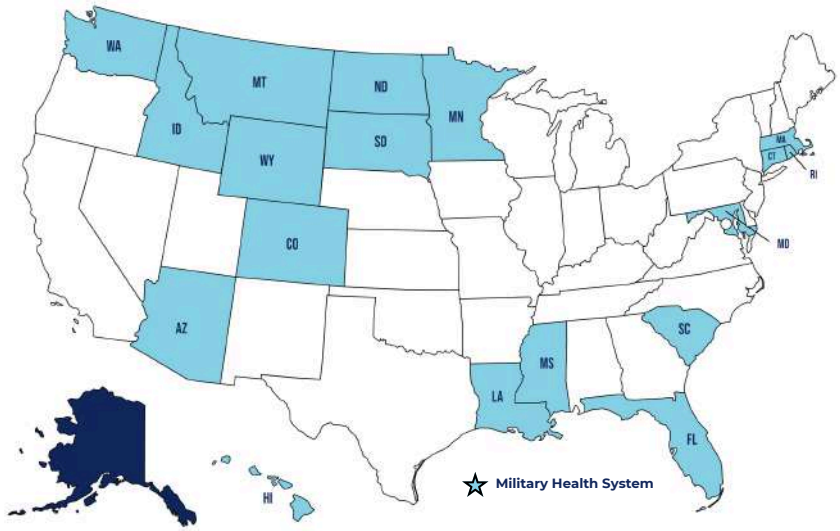
Data is presented for informational purposes only. Data represents prescription and dispensation activity reported to Alaska Prescription Drug Monitoring Program (PDMP) from July 01, 2024 to September 30, 2024. For more in formation, visit pdmp.alaska.gov.

192,846 CONTROLLED SUBSTANCE DISPENSATIONS

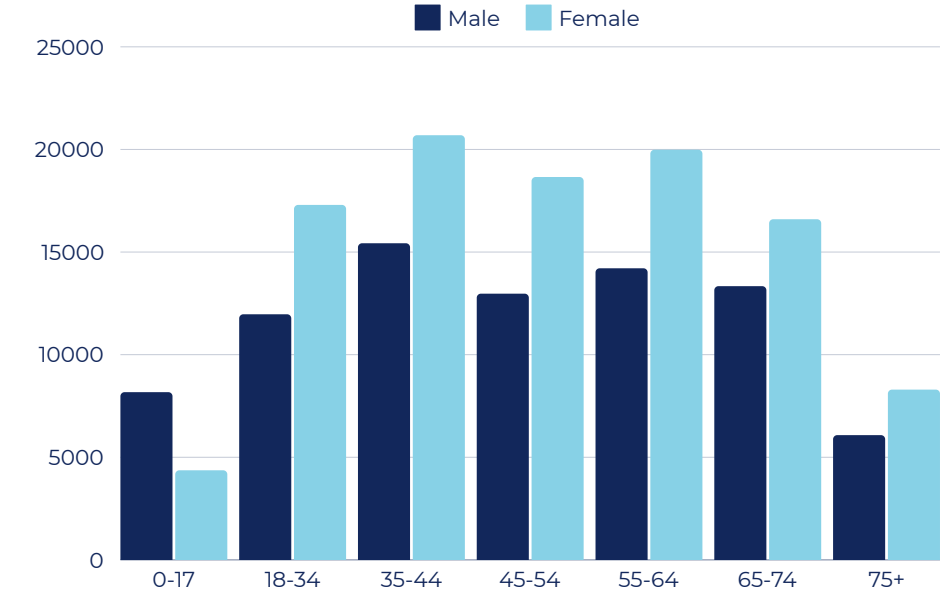


19 PARTNER STATES

Interstate data sharing including military health system.



PRESCRIPTION COUNT BY PATIENT AGE & GENDER



Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Quarterly FSMB Update on USMLE®

October 2024, Vol. 5, No. 3

USMLE Orientation for State Board Members and Staff

Pictured (L-R): *Erica Lamy, Freda Pace, Tiffany Seamon, Camille Lindsay, Dr. Kenneth Cleveland, Rebecca Robbins, Christopher Palazola*

On October 2, 2024, the FSMB and NBME hosted 21 members and staff from 12 state medical boards at FSMB's offices in Euless, Texas, and virtually for the 18th annual USMLE Orientation for State Board Members and Staff.

The orientation, first held in 2007, provides members and staff from state medical and osteopathic boards with an opportunity to learn about the USMLE program and engage directly with program staff. The goals of the workshop remain: (1) to inform and educate the medical board/regulatory community on the USMLE program, including new developments and key issues; (2) to create and facilitate relationships with USMLE program staff to ensure that state boards have an immediate resource for any USMLE-related questions; and (3) to share opportunities for state board members and staff to participate directly with the USMLE program.

This year's meeting included a brief history of medical licensing examinations, which spotlighted two key principles upholding the value of the medical licensing examination: (1) acting as an independent audit of the medical education/training system and (2) providing a common national standard for the assessment of physicians for purposes of initial medical licensure. The meeting also provided an overview of the USMLE program, research, examination security and how state board members and staff can participate.

Attendees (in-person and virtual) included:

- Rebecca Robbins, Alabama (Commission)
- Tiffany Seamon, Alabama (Commission)
- Randy Ho, Hawaii
- Camile Lindsay, Illinois
- Lynne Weinstein, Maine-Medical
- Valerie Hunt, Maine-Medical
- Rebecca Mueller, MD, Indiana
- Kiko Dixon, Indiana
- Elizabeth Huntley, JD, CMBE, Minnesota
- Kita Nelson, Minnesota
- Kenneth Cleveland, MD, Mississippi
- Erica Lamy, New Hampshire
- Antonia Winstead, New Jersey
- Lawrence Muka, New Jersey
- Christopher Palazola, Texas
- Mandy Moreno, Texas
- Abigail Revuelta, Texas
- Becky McElhiney, Washington-Osteopathic
- Danielle Dooley, Washington-Osteopathic
- Freda Pace, Washington-Medical
- Kyle Karinen, Washington-Medical

Since the creation of USMLE in 1992, more than 209 individuals from 60 medical and osteopathic boards have participated in the USMLE orientation. Sixty-five past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as serving on the USMLE Management Committee, the USMLE Composite Committee, and/or item writing and item review committees.

The USMLE program sincerely thanks all current and past state board volunteers for their participation, which is integral to the success of the program!

Physicians and public members of state medical and osteopathic boards interested in attending the next orientation should contact Frances Cain, MPA, Director of Assessment Services at FSMB, at fcain@fsmb.org.

USMLE Committee Member Social Media Campaign

The USMLE program is launching a social media campaign to feature USMLE committee members. These posts will help to humanize the program by showcasing the many medical educators and regulators who contribute behind the scenes to the success of the USMLE program. Participating is as easy as sharing a headshot and completing a quick questionnaire. The Marketing & Communications team will use these materials to create social media posts. If you're a USMLE committee member, or served previously in this capacity, and are interested in participating in this campaign, please contact Alyssa Yeroshefsky, Communications Manager of the USMLE Program, at ayeroshefsky@fsmb.org.

Anomalous Performance on USMLE Step Examinations

The USMLE program is committed to protecting the integrity of the exam sequence and continues to evaluate and enhance exam security policies and initiatives. Routine analyses are performed as part of the scoring process to detect unusual examinee response behavior. As part of an ongoing investigation, the USMLE program recently took action to invalidate exam scores based on a pattern of anomalous performance detected that indicates prior knowledge of secure examination content. Invalidated scores appear on transcripts as "Score Not Available".

The USMLE program also revised policies applicable to performance data for failing outcomes that raise concerns about an examinees' readiness or motivation to pass the exam. Examinees who meet such criteria may be contacted by the USMLE program and required to allow a twelve (12) month period to pass before attempting USMLE again. The mandatory twelve (12) month bar on access to the exam cannot be appealed and is intended to encourage adequate study time and to pace exam content exposure for individuals who are not performing at a level predictive of passing on the next attempt without additional preparation.

Should an examinee reach out to your board about appealing any USMLE decision, please feel free to contact Frances Cain, MPA, Director of Assessment Services at FSMB, at fcain@fsmb.org to gain clarification.

ECFMG Update Regarding Change to Accreditation Body for Medical Schools in Canada Effective in 2025

According to a recent update from the Educational Commission for Foreign Medical Graduates (ECFMG), a member of Intealth™, individuals who graduate from Canadian medical schools on or after July 1, 2025, will be considered international medical graduates for the purpose of entry into GME programs in the United States. In order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located.

More detailed information is available in this ECFMG update.

2024 USMLE Meetings Calendar

Composite Committee - October 21

State Board Advisory Panel - November 13

Patient Characteristics Advisory Panel - November 22

Management Committee - December 3-4

Committee for Individualized Review - December 3-4

Follow USMLE on Social Media

We encourage state board staff to follow USMLE on social media for timely USMLE news and updates!

Facebook LinkedIn X

Contact

Frances Cain, MPA

Director, Assessment Services

Fcain@fsmb.org

Resources

USMLE.org

Bulletin of Information

FAQs

Federation of Podiatric Medical Boards
12116 Flag Harbor Drive ◆ Germantown, MD 20874 ◆ 202-810-3762 ◆ www.fpmb.org

Office of the Executive Director
Russell J. Stoner, CAE

Elevate Your Impact with FPMB

Member Podiatric Medical Boards have the power to protect the public, shape the future of podiatry, and enjoy key benefits through:

- Engaging with FPMB's **Interstate Podiatric Medical Licensure Compact** project to help drive more efficient, streamlined licensure processes.
- Participating in focused, **topic-driven membership meetings** to gain valuable insights and share expertise on crucial issues.
- Strengthening FPMB's collective knowledge by responding to **requests for information**, enabling you to make more informed, timely, and defensible decisions.
- Upholding high standards by submitting **Disciplinary Action notifications** and **Member Board updates**, reinforcing accountability across the profession.
- Ensuring efficient licensing operations by accessing **FPMB score and disciplinary action reports** in a timely manner.

MISSION

To serve as the national voice for state podiatric medical boards while collaborating with allied organizations, supporting member boards with services and initiatives that protect and promote patient safety, integrity of podiatric medicine, access to high-quality healthcare, and regulatory best practices.

MEMBER BENEFITS

- **Public Policy and Advocacy**
- **Collaboration & Communication**
- **Primary Source Verification**
- **Representation**

- 10/30/2024: Community of Practice Session
- **11/30/2024: Member Dues Payment Deadline**
- 12/18/2024: Fall/Winter Meeting

MISSION

To serve as the national voice for state podiatric medical boards while collaborating with allied organizations, supporting member boards with services and initiatives that protect and promote patient safety, integrity of podiatric medicine, access to high-quality healthcare, and regulatory best practices.

VISION

A podiatric medical regulatory system that protects patients and ensures access to high-quality healthcare services, sustaining the integrity and excellence of podiatric medicine.

IMPACT

An effective and efficient podiatric medical regulatory system that: a) acts in the public interest, b) provides patient protection, c) sustains the integrity of podiatric medicine, and d) supports license portability

FPMB MEMBER BOARDS BENEFITS

"Serving Podiatric Medical Licensing Boards Protecting the Public"

➲PUBLIC POLICY & ADVOCACY

- Establishing an interstate podiatric medical licensure compact to increase license portability and information sharing and reduce administrative burden
- Monitoring and reporting on occupational licensure reform to aid Member Boards in responding to federal/state legislative and regulatory initiatives
- Providing key national data that shape and support federal/state legislation

AZ SB 1078 (2023), CA AB 826 (2023-2024), IA HF 635 (2023-2024)

➲COLLABORATION & COMMUNICATION

- Collecting and disseminating national information, including contact, general, licensure and regulatory data, that empowers Member Boards to make informed, timely, and defensible decisions
- Hosting membership meetings via Zoom featuring topic-based, member-to-member interaction and knowledge-sharing (no registration fees)
- Publishing an informative newsletter and legislative updates for Member Boards to stay informed, enhance knowledge, and access resources

Continuing Education, License Portability, Rulemaking, Scope of Practice

➲PRIMARY SOURCE VERIFICATION

FPMB provides accurate, efficient online ordering and electronic delivery of:

- American Podiatric Medical Licensing Examinations:
  - NBPME's APMLE Part I, II, II CSPE, and III (PMLexis)
- Podiatric Physician Discipline:
  - FPMB Disciplinary Action Reports

APMLE American Podiatric Medical Licensing Examination

NCQA Measuring quality. Improving health care.

Under 1 Business Day: Median time between DPM order and Member Board download

➲REPRESENTATION

fsmb FEDERATION OF STATE MEDICAL BOARDS

National Board of Podiatric Medical Examiners 1956

apma Advancing foot and ankle medicine and surgery

CPME Council on Podiatric Medical Education

- Federal Agencies and Legislatures
- American Podiatric Medical Association (APMA)
- American Society of Podiatric Executives (ASPE)
- Council on Podiatric Medical Education (CPME-CEC)
- Federation of State Medical Boards (FSMB)
- Interstate Healthcare Collaborative (IHC)
- National Board of Podiatric Medical Examiners (NBPME)
- Professional Licensing Coalition (PLC)

FPMB represents all state podiatric medical licensing boards across the nation

Federation of Podiatric Medical Boards / www.fpmb.org / fpmb@fpmb.org / 202-810-3762 / 12116 Flag Harbor Drive, Germantown, MD 20874

Included Forms

➲FY2024-2025 MEMBER BOARD DUES STATEMENT

sent to primary and billing contacts at your licensing board

Remit the attached dues statement at your earliest opportunity. The payment due date is **November 30, 2024.**

As a 501(c)(6) nonprofit organization, annual Member Board dues are a critical source of funding for the vital services the FPMB provides to Member Boards, the public, and the entire podiatric community:

- Public Policy and Advocacy
- Collaboration and Communication
- Primary Source Verification
- Representation

REMINDER: Voting, ability to nominate to FPMB's Board of Directors, and other rights & privileges are restricted to dues-paid Member Boards.

"[FPMB] is a clearinghouse resource and point of communication for all podiatric boards in the country. If we have a question about how other states are doing something, we can submit a request for information and within a day or so they will email a survey to all the boards, and we can then receive that information. They provide immediate access to license candidate's national exam data. They provide national webinar meetings on topics impacting the national podiatric picture. Ongoing topics include exam testing changes and reentry of podiatrists into the profession after drug treatment, a timely subject given the opioid crisis, CME auditing, fees, license portability, scope or practice, etc. During the battle against COVID-19, we participated in [FPMB-hosted] calls with other state licensing organizations and boards to figure out how best to handle issues such as [suspended] test taking [APMLE Part II CSPE]."

-Steve Uecker, MPH, Health Professions Program Specialist
Podiatric Advisory Board, **Texas Department of Licensing and Regulation**

➲FY2024-2025 DISCIPLINARY ACTION REPORT FORM

sent to primary and enforcement/complaints contacts at your licensing board

Report all disciplinary actions on podiatrists in a timely manner for inclusion in FPMB's disciplinary action database. [link to form]

Your participation is critical to ensuring the safety of podiatry for all Member Boards and the public. The form is a fillable PDF file for easier and faster data entry, includes data not published on Member Boards' websites, and can be sent securely to FPMB.

INTERSTATE PODIATRIC MEDICAL LICENSURE COMPACT

The issue of license portability in podiatry is critical, especially in the context of evolving healthcare delivery methods such as telehealth. The creation of an Interstate Podiatric Medical License Compact (Podiatry Compact) represents a significant step towards addressing these challenges and facilitating greater access to care across state lines.

By modeling this Compact after the successful Interstate Medical Licensure Compact (IMLC) – which is now established in 42 states licensing allopathic (MD) and osteopathic physicians (DO) – FPMB is poised to create a robust framework that will enhance the ability of podiatrists to practice in multiple jurisdictions. This initiative will be particularly beneficial for areas experiencing shortages of healthcare providers, as well as for military personnel and their families who frequently move between states.

The Podiatry Compact's emphasis on adhering to the patient's location for practice jurisdiction underscores a commitment to maintaining high standards of care while providing flexibility for podiatric physicians. This is essential for ensuring that care is both accessible and compliant with local regulations.

Moreover, FPMB has entered into a memorandum of understanding with the Interstate Medical License Compact Commission (IMLCC), which will be pivotal in leveraging existing IMLCC technological and administrative resources. This partnership aims to streamline the licensing process for podiatric physicians and foster a collaborative approach among participating states.

Overall, the Podiatry Compact not only promises to enhance license portability but also aims to uphold the integrity of the profession by allowing state licensing boards to retain their disciplinary authority, regulate scope of practice, and enforce state regulations. This balance between flexibility and accountability is crucial for ensuring patient safety and maintaining trust in podiatric medical care across state lines.

For more information, visit www.ipmlc.org and/or reach out to Jay S. LeBow, DPM, IPMLC Primary Contact, at ipmlc@fpmb.org or 202-810-3762.

➲FY 23/24 HIGHLIGHTS

FPMB's establishment of a memorandum of understanding with the IMLCC is a strategic move that will significantly enhance the development of the Podiatry Compact. By securing support for technological infrastructure and administrative assistance, this partnership aims to streamline processes and utilize existing efficiencies, avoiding the need to "reinvent the wheel."

FPMB has drafted a Model Law based on the current MD/DO compact, incorporating valuable insights gained from that experience. To ensure the legislation is well-suited for podiatry, a Task Force comprised of board members and staff from Member Boards was created to review and tailor it, including defining the eligibility requirements for podiatric physicians.

FPMB was awarded a five-year HRSA federal grant in July 2024, funding that will expand resources dedicated to the creation of the Podiatry Compact and facilitate the establishment of a Compact Commission. This support highlights the commitment of the federal government toward this effort.

➲NEXT STEPS

Complete Review of Model Law

FPMB is broadening its efforts beyond the initial Task Force by engaging all Member Boards in the review of the Model Law. This process will further expand to include podiatric organizations involved in education, training, certification, professional development, advocacy, support, etc. at both state and national levels.

Seek Legislative Approval

Ratification by Participating States

Activate the Compact Commission

Implement the Compact

FPMB DATA, INFORMATION, & KNOWLEDGE

➲REQUESTS FOR INFORMATION

FPMB's core competency of data collection, analysis, and reporting empowers Member Boards to make informed, timely, and defensible decisions. FPMB has conducted the following "requests for information" on behalf of Member Boards and allied organizations:

CONTINUING EDUCATION

- AMA PRA Category 1 Credits
- COVID-19 Accommodations & Changes
- In-Person, Virtual, and/or Real-Time Requirements
- Mandated Courses, including Opioids and/or Pain Management
- Recognized Providers
- Renewal Periods & Required Hours

LICENSURE/REGULATION

- APMLE Part II – Requirements for Residencies, Limited Licenses, and/or Unsupervised Practice
- APMLE Part II CSPE – Requirements for Residencies and/or Unsupervised Practice
- APMLE Part III – Recency requirements, and Policy for DPMs Not Taking Exam (licensed prior to creation of exam)
- Board Certification
- Code of Ethics
- Hyperbaric Oxygen Therapy (HBO), including Podiatrist Supervision
- Licensing Boards – Composition, Structure, and Funding
- License Portability – Compacts, Universal Recognition, etc.
- License Types & Counts
- Limited Licenses and Temporary Licenses for Educational Purposes
- National Standards of Practice (U.S. VA)
- Nitrous Oxide (N20)
- Podiatric Medical Assistants & Certification
- Practice Re-Entry – Laws or Regulations
- Radiology
- Regaining Lapsed License
- Renewal Requirements
- Residency Requirements
- Scope of Practice – Pre-Operative Evaluations (history & physical exams), Treatment of the Skin, Skin-Related Structures and Subcutaneous Masses, etc.
- Telehealth Regulations

BOARD

- Impact of NC Dental v. FTC & Restoring Board Immunity
- Meeting Frequency
- Newsletters & Advertising
- Quality Assurance Programs
- Scope of Practice Interpretation Requests – Ability to Respond

IMPACT

"During a sunset review, the Podiatric Medical Board of California (PMBC) identified a renewal requirement for podiatry that was not required by other medical boards in California. PMBC engaged the FPMB to collect and report podiatric licensure renewal requirements nationwide that confirmed that PMBC's requirement was an outlier.

At PMBC's invitation, FPMB presented the research findings and the occupational licensure reform implications at the March 2021 Board Meeting. After analysis, the Board voted to delete the additional requirement.

PMBC began working with leadership at the California Podiatric Medical Association (CPMA) resulting in Assembly Bill 826 (AB 826). The bill had no opposition, no financial impact, and was fully documented with history and current reporting that indicated the additional renewal requirement was outdated and needed to be eliminated.

AB 826 was analyzed by Assembly and State Committees and staff, and FPMB's recorded presentation to PMBC was instrumental in that analysis. The bill was signed by the Governor on July 27, 2023, to become effective on January 1, 2024."

– Brian K. Naslund, Executive Officer, **Podiatric Medical Board of California**

FPMB DATA, INFORMATION, & KNOWLEDGE

MEMBER BOARD MEETINGS & COMMUNITY OF PRACTICE SESSIONS

FPMB hosts accessible *(via Zoom with **no registration fees**)* membership meetings that provide relevant data and information via updates, announcements, and presentations. Each meeting also features topic-based, member-to-member interaction and knowledge-sharing.

UPDATES, ANNOUNCEMENTS, & PRESENTATIONS

- Advocacy Efforts
- Council on Podiatric Medical Education
- COVID-19 Pandemic
  - FPMB Response
  - Impact on CME, Examinations, etc.
- Federal/State Legislation (CA AB 826, DEA MATE Act, U.S. Federal: H.R.7939)
- FPMB Resources Available to Member Boards
- FSMB Annual Meeting & House of Delegates
- License Portability, including Interstate Podiatric Medical Licensure Compact
- National Standards of Practice
- Occupational Licensure Reform
- Podiatric Licensing Examinations
  - APMLE Examination Series
  - APMLE Part II CSPE Suspension
  - Score Release and Reporting
  - Testing Contractor Transition
- Podiatric Medical Education (including application trends)
- Podiatry Physician Re-Entry Programs
- Restoring Board Immunity
- Scope of Practice
- Student Recruitment Effort

COMMUNITY OF PRACTICE SESSIONS

- Board Members (public/consumer & physician members)
- Board Structure, Composition, & Funding
- Continuing Medical Education (requirements, approval, tracking)
- Controlled Substances, Opioids, & PDMP
- Discipline
- DPM Supervision (PAs, HBO, etc.)
- Interstate Podiatric Medical Licensure Compact
- Licensing Examinations
- License Portability / Reciprocity
- Licensure vs. Credentialing
- Occupational Licensure Reform
- Physician Assistants, Podiatric Medical Assistants, & Radiology
- Scope of Practice
- Telemedicine

WHY ATTEND?

"There is a wealth of information available. Much of which would be difficult to obtain without participation. Also provides a live format to discuss issues and address questions in real time."

"These meetings are a great way to get an overview of the state of podiatry as a whole without having to travel or spend a bunch of money."

"To gain knowledge of other jurisdictions policies, procedure and structure which may be helpful when restructuring or making decisions for your own Board."

"To become well informed about that which is occurring within the profession regionally and nationally as well as to share information that may be useful to colleagues in other jurisdictions."

"Situational awareness. It seems like change is gradually accelerating overall and it's important to keep abreast of it."

"Your board may also make important contacts from the other boards that may prove very worthwhile."

"How well people listened to each other" and *"the open communication."*

FPMB DATA, INFORMATION, & KNOWLEDGE

➲FPMB WEBSITE: MEMBER BOARDS INFO

FPMB's website features a "Member Boards Info" data visualization webpage that provides general, contact, licensure, and regulatory information about each Member Board.

Data is presented in map, list, and table formats to meet the informational needs of Member Board and additional stakeholders, including podiatrists, podiatric organizations, hospitals, and other government agencies.

GENERAL

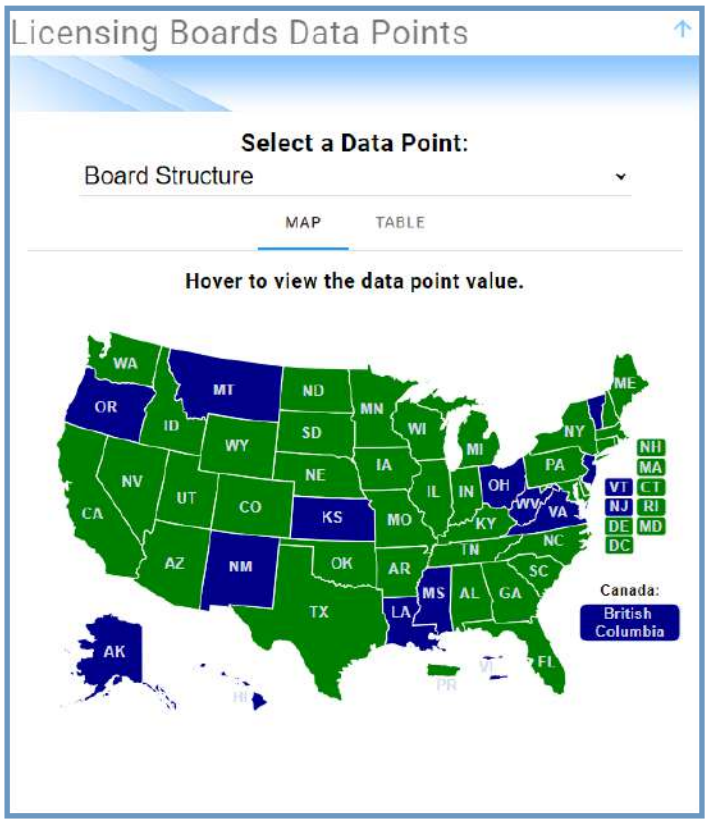
- Board Structure
- Board Composition
- Number of DPMs (registered)
- Number of DPMS (board positions)
- Number of DPMS (serving on board)
- Disciplinary Actions on Website
- Licensee Search/Verification URL

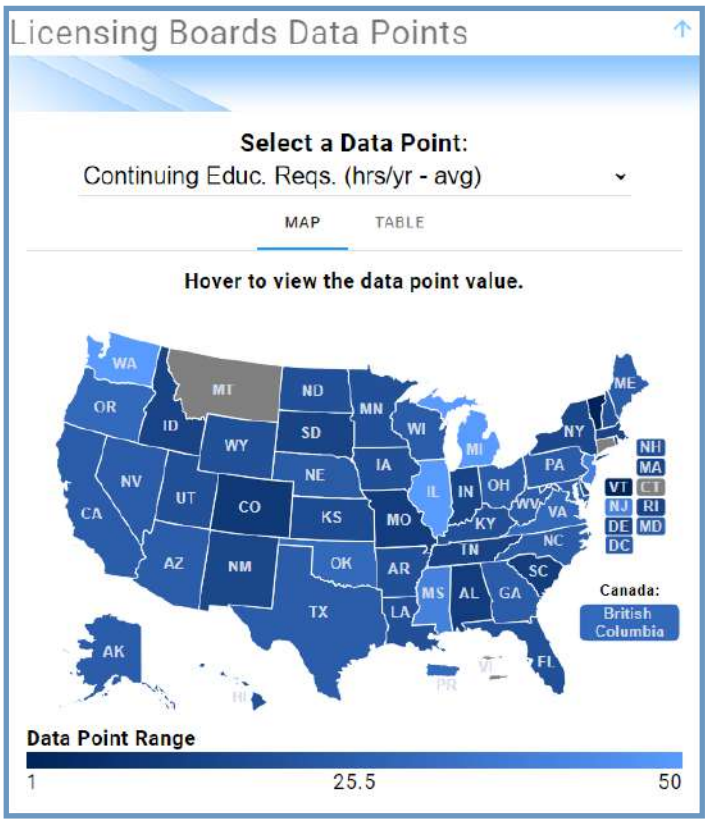
CONTACT

- Member Board
  - Name
  - Address
  - Website URL
- Primary Contact
  - Name & Title
  - Phone & Fax Number
  - Email Address
- Board Members
  - Name
  - Member Type
  - Role

LICENSURE

- National Board
- State Exam
- Post Graduate Training (years)
- Application Deadline
- Exam Fees
- Duration of License Fees (years)
- Continuing Educational Requirements (average hours per year)
- Part III Required (licensure)
- Part III Required (residency)
- Temporary Resident License Offered
- Number of Residency Programs





FEDERATION OF PODIATRIC MEDICAL BOARDS

➲UPCOMING MEMBERSHIP MEETINGS

Community of Practice Session

Wednesday, October 30, 2024 | 2:00 - 3:30 PM ET

Topic-based, member-to-member interaction and knowledge-sharing. Special Focus on Physicians Health Program with a presentation from the **Federation of State Physician Health Programs**.

Linda R. Bresnahan, MS
Executive Director

Edwin Kim, MD
President Elect

Federation of State Physician Health Programs

Fall/Winter Meeting

Wednesday, December 18, 2024 | 12:00 - 2:00 PM ET

Contact fpmb@fpmb.org with agenda items and/or proposed presentations.

This is your FPMB, and your feedback is highly valued and encouraged.

Feel free to reach out whenever you require assistance or support.

Federation of Podiatric Medical Boards

www.fpmb.org
fpmb@fpmb.org

o: 202-810-3762
f: 202-318-0091

12116 Flag Harbor Drive
Germantown, MD 20874

July 25, 2024

ALASKA MEDICAL BOARD
550 W 7TH AVE, STE 1500
ANCHORAGE, AK 99501-3567

Attn: Alaska Medical Board

Over the years I have had countless people approach me with the following comment "I wish 'THEY' would do something to improve hospital healthcare in this area!" In many cases the general public doesn't know what to do or who to contact about the problems.

CMS ratings can be found for most hospitals, but are very hard to find and in some cases it's impossible. I would like to see each hospital's CMS rating posted in their Lobbies and Emergency Rooms. When an individual is being admitted as a patient they should be given that rating in writing. I believe all patients and the general public should have a right to know this information so they can make informed decisions regarding their healthcare.

I have talked with 12 – 15 different organizations involved in healthcare. They also believed that it is a great idea. **I believe this idea should be written into law and enforced.** Patients nationwide should receive this notice at the same time the HIPPA form is given to them.

I believe this requirement would cause more competition between all hospitals and develop an innovative approach to better improve healthcare.

I believe better healthcare should be the most important issue for today and into the future.

I would appreciate your feedback and all the effort you put forth to make this a law.

Thank you,

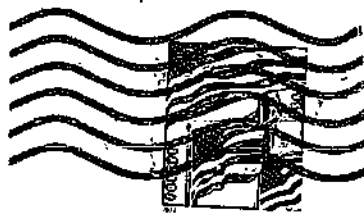
Larry E. Cook

Larry E. Cook
1305 Skyview Trail
Martinsville, VA 24112

If you have any questions call me at 276-618-2850.

LARRY E. COOK
1305 SKYVIEW TRAIL
MARTINSVILLE VA 24112

GREENSBORO NC 270
PIEDMONT TRIAD AREA
25 JUL 2024 PM 6 L



ALASKA MEDICAL BOARD
550 W 7TH AVE, STE 1500
ANCHORAGE, AK 99501-3567

99501-356775

From:	Myisha Churchwell on behalf of Humayun Chaudhry
Cc:	Joe Knickrehm; Andrea Ciccone
Subject:	Feedback Requested on Draft Recommendations from Advisory Commission on Additional Licensing Models
Date:	Wednesday, October 2, 2024 10:02:03 AM
Attachments:	image002.png

Dear Executive Directors, Board Chairs and Presidents,

I am alerting you to the opening of a public comment period for draft preliminary recommendations for assisting the state and territorial medical boards and legislators in developing or modifying additional licensing pathways for physicians who have completed training internationally. These preliminary recommendations were drafted by the Advisory Commission on Additional Licensing Models, a group formed by FSMB, the Accreditation Council for Graduate Medical Education (ACGME), and Intealth.

I encourage you and your board to review the draft guidance document and recommendations and to provide your comments and feedback to the Advisory Commission by December 6, 2024. Please find links below to a press release announcing the public comment period, the guidance document with draft preliminary recommendations, and the survey instrument to provide your comments and feedback.

View the press release here.
View the supporting draft guidance document and its nine recommendations linked here.
Provide your comments and feedback to the draft recommendations by December 6 here.

Your participation in this public comment period is instrumental in helping the Advisory Commission on Additional Licensing Models create supplemental recommendations that will be considered later in 2025.

If you have any questions, please do not hesitate to reach out to me or FSMB's VP of Engagement, Andrea Ciccone, JD, copied on this email. FSMB is grateful for your willingness to participate in this public comment period and we look forward to your valuable feedback.

Thanks,
Hank

Humayun "Hank" Chaudhry, DO, MACP, FRCP
President and Chief Executive Officer

Federation of State Medical Boards
1775 Eye Street NW | Suite 410 | Washington, DC 20006
o. 817-868-4044 | hchaudhry@fsmb.org | www.fsmb.org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From: Bowles, Michael P (CED)
To: Wolf, Patty J (CED); Norberg, Natalie M (CED)
Cc: Saviers, Glenn A (CED); Robb, Sylvan S (CED)
Subject: Chief Pharmacist Officer Response to AMA
Date: Thursday, October 3, 2024 2:12:51 PM
Attachments: MEMO - EO - RDML Battese Response to AMA (002).pdf
image001.png
image002.png
image003.png

Patty/Natalie,

I wanted to make you aware of a letter that was recently sent out by the Chief Pharmacist Officer of the United States Public Health Service in response to a statement the AMA made regarding collaborative practice agreements between providers and pharmacists. Pharmacists are being utilized more regularly in patient care models in facilities that fall under federal jurisdiction. This is a focus in the Pharmacy world and it's likely you may see an uptick in public comments during your board meetings addressing this issue.

Michael Bowles
Executive Administrator, Board of Pharmacy
Corporations, Business and Professional Licensing

michael.bowles@alaska.gov
Office: 907-465-1073
www.commerce.alaska.gov

NABP
National Association of Boards of Pharmacy

1600 Feehanville Dr
Mount Prospect, IL 60056

1.847.391.4406
help@nabp.pharmacy

TO: EXECUTIVE OFFICERS – STATE BOARDS OF PHARMACY

FROM: Lemrey “Al” Carter, Executive Director/Secretary

DATE: October 3, 2024

RE: RDML Kelly J. Battese Response to AMA

Rear Admiral (RDML) Kelly J. Battese, PharmD, MBA, Chief Pharmacist Officer of the United States Public Health Service, has issued a statement in response to claims of the American Medical Association (AMA) regarding scope creep in pharmacy practice. RDML Battese’s statement is attached.

Attachment

cc: NABP Executive Committee

REAR ADMIRAL KELLY BATTESE
CHIEF PROFESSIONAL OFFICER (CPO)
PHARMACIST CATEGORY

In response to the AMA's concerns about scope creep in pharmacy practice, it's important to recognize the urgency and need for collective action in addressing the health disparities impacting our communities. Racial and ethnic minority communities continue to be disproportionately affected by conditions such as heart disease, cancer and HIV/AIDS resulting in poor health outcomes. [1] For example, Black and Hispanic/Latino people account for the majority of people for whom HIV PrEP is recommended but have the lowest rates of PrEP use among all racial/ethnic groups. Another example, according to the CDC, American Indian and Alaska Native people have the lowest life expectancy compared with other racial and ethnic groups.[1a] Disparities like these are emblematic of access to care gaps as well as other social determinants of health which pharmacists have had a historic role in addressing. Since the 1930s, evidence-based practices across federal (i.e., Indian Health Service (IHS), Federal Bureau of Prisons (BOP), Immigration and Customs Enforcement (ICE), United States Coast Guard, Veteran's Health Administration) healthcare settings have highlighted the profound impact of interprofessional collaborative practices towards improving patient outcomes across the healthcare landscape. [2]

The United States Public Health Service National Clinical Pharmacy Specialist Committees publication in 2019 is one such report underscoring the value of collaborative practice agreements (CPA) in improving clinical outcomes in chronic disease management. [3]All 50 states currently have legislation allowing pharmacists and other prescribers to enter into CPA's, creating efficiencies, patient-centered, team-based care and utilizing a pharmacist's medication expertise to improve patient outcomes such as medication adherence, hospital re-admissions and prevention of adverse drug events.

Pharmacists are integrated into a variety of settings, not exclusive to community pharmacies. Their practice is also varied, and they can specialize and receive board certification in 14 different specialties such as oncology, geriatrics, and ambulatory care. Pharmacists rely on their knowledge, experience, judgment, and ongoing reviews of high-quality, evidence-based, peer-reviewed published literature to provide care to their patients. This expertise has been formed through six to eight years of collegiate and doctoral-level training, including over 1,700 hours of hands-on experiential education in patient care settings. Every year, thousands of pharmacists successfully finish a clinical residency program, with more than 4,000 such programs available nationwide.

Trusted by patients to provide accurate and timely medical advice, pharmacists have been on the leading edge of healthcare accessibility at critical times. Throughout the COVID-19 pandemic, pharmacists provided over 350 million clinical interventions to more than 150 million people through countermeasures that included test-to-treat, antibody therapeutics, vaccinations and more.[4] Several

[1] National Center for Health Statistics. Health, United States, 2020–2021: Annual Perspective. Hyattsville, Maryland
[1a] National Center for Health Statistics, CDC, 2022. https://www.cdc.gov/nchs/fastats/american-indian-health.htm
[2] Giberson S, Yoder S, Lee MP. Improving patient and health system outcomes through advanced pharmacy practice. A report to the U.S. Surgeon General 2011
[3] Bott AM, Collins J, Daniels-Costa S, et al. Clinical Pharmacists Improve Patient Outcomes and Expand Access to Care. *Fed Pract*. 2019;36(10):471-475
[4] Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. *J Am Pharm Assoc (2003)*. 2022;62(6):1929-1945.e1

states, such as California, New Mexico, North Carolina, Idaho, and Montana, have observed the advantages of broadened scope and autonomous practitioners while states such as Tennessee have expanded pharmacists' scope of practice.[5] These states have acknowledged that pharmacists are frequently the most accessible healthcare providers, particularly in underserved areas. Expanding their scope of practice can aid in mitigating inequalities in healthcare access and enhancing health equity for all patients.

In our nation, we are battling multiple issues causing health disparities such as the opioid epidemic, surging cases of syphilis, and mental health concerns in addition to heart disease, cancer, and diabetes. It is time for unity amongst our professions, where the public health of our nation is at the focus of our efforts. [6]We need to work synergistically to achieve what no profession can achieve on their own. We all know that shortages of healthcare providers abound – The Association of American Medical Colleges reported a shortage of ~ 40, 000 primary care physicians by 2030.[7] We advocate for pharmacists to provide the care they are trained to provide and for public and private payers to ensure access to this care for patients by covering pharmacists' services. We do not want your scope, rather we want your partnership and collaboration. We want everyone's scope focused on the health of our nation. In the end, it's crucial that we come together, united in our efforts to combat disease and illness.

In the service of health,

RDML Kelly J. Battese, Pharm.D., MBA
United States Public Health Service – Chief Pharmacist Officer

The USPHS Commissioned Corps is one of the eight uniformed services and is part of the U.S. Department of Health and Human Services. Public Health Service officers serve throughout the federal government to provide essential health care services to underserved and vulnerable populations, respond to public health emergencies or global emergencies, and lead public health programs and policy development.

[5] Tennessee governor signs expansion of pharmacy scope of practice into law | NCPA
[6] Healthy People 2030 | health.gov
[7] Research Shows Shortage of More than 100,000 Doctors by 2030 | AAMC

From: Norberg, Natalie M (CED)
To: phcak@alaska.net
Cc: Lipker, Sonia L (CED)
Subject: RE: board request
Date: Wednesday, August 28, 2024 4:03:45 PM
Attachments: image003.png
image004.png
image005.png

Dear Ms. Ventgen and Dr. Foland,

This is to respond to the request submitted on August 6 by the Physician Health Committee to the State Medical Board to either allow the PHC to assume the responsibility for drug testing or increase the frequency of testing through the Division.

Administrative support functions for the medical board, including the procurement of contracts for services is the responsibility of the Division. The Division currently has a contract with Tech Analytics to provide drug testing services. While exploring this matter I was advised that the information you were provided with respect to there being a "cap" of 24 tests per year is false, and in fact, the volume of testing may be increased on a case-by-case basis, depending on the treatment team's recommendation for a particular consent agreement monitoree. Hopefully, this matter is now addressed, but please feel free to bring it to either my or Sonia Lipker's attention if the PHC encounters a case in which the volume of drug testing by the Division is not deemed adequate by the PHC.

If the PHC remains interested in taking over drug testing functions it was suggested that this service may be incorporated into the proposal when it's time to renew the PHC contract with the Division in 2026.

Medical board members frequently express their appreciation for the work of the PHC and its dedication to rehabilitation and accountability of board licensees to ensure patient safety, and I personally very much value our partnership in this work.

Please let me know if you have any additional concerns or questions.

Best regards,

Natalie Norberg, LMSW
Executive Administrator, State Medical Board
Corporations, Business & Professional Licensing
natalie.norberg@alaska.gov
Office: 907-465-6243 | Fax: 907-465-2974
www.commerce.alaska.gov

From: phcak@alaska.net <phcak@alaska.net>
Sent: Tuesday, August 6, 2024 11:07 AM
To: Norberg, Natalie M (CED) <natalie.norberg@alaska.gov>
Subject: board request

Hi Natalie,
Will you please take this to the board on Friday? I'm happy to answer any questions.
Thanks so much.
Pam

Pam Ventgen, Coordinator
Alaska Physician Health Committee
907-244-7266

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

STATE MEDICAL BOARD

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
Fax: 907.465.2974

September 5, 2024

Juan Uson, Administrator
Surgery Center of Wasilla
3190 E Meridian Park Loop, Suite 111
Wasilla, AK 99654
Transmitted by email: juson@surgerycenterwasilla.com

Re. Letter of Inquiry

Dear Mr. Uson,

The Alaska State Medical Board has been made aware of an unfortunate instance of wrong-site surgery that occurred in March 2022. We recognize that this type of "never event" is a serious matter and reflects a significant concern regarding patient safety. The Alaska State Medical Board holds Medical Doctors, Doctors of Osteopathy, Doctors of Podiatry, and Physician Assistants accountable for such incidents, understanding that they may point to broader systemic issues.

As an organization dedicated to protecting the public from unsafe medical practices, the Board trusts that The Surgery Center of Wasilla understands the gravity of this situation. We assume that your team has thoroughly reviewed the incident and made the necessary adjustments to your processes to ensure that such an event does not happen again.

The Board would appreciate being informed of the proactive steps that have been taken by your surgery center to prevent any future occurrences of this nature.

Thank you in advance for your response.

Sincerely,

Natalie Norberg

Natalie Norberg
Executive Administrator

cc. Adam Ellison, MD – Board President, Surgery Center of Wasilla

SURGERYCENTER OF WASILLA

September 11, 2024

Natalie Norberg, Executive Administrator
P. O. Box 110806
Juneau, AK 99811
Sent via email: natalie.norberg@alaska.gov

Re: Responding to your letter of inquiry

Dear Miss Norberg,

On behalf of the Governing Board and the Medical Executive Committee of the Surgery Center of Wasilla, this unfortunate situation of wrong-site surgery that took place at our facility in March 2022, has been taken very seriously and been given significant focus in the aftermath. Immediately after the incident, the Clinical team and executive leaders both at SCOW and at Regent Surgical Health, managing partner of SCOW, have taken steps concerning patient safety to prevent another "never event".

After undergoing root cause analysis of this "never event", steps were taken as listed below:

1. In the pre-op area where the problem started,
    a. The pre-op nurse reads the surgical consent immediately before or as the patient is changing to a surgical gown.
    b. Attention is also given to when a nurse inserts intravenous access, opposite the laterality of the operative site if it is not contraindicated.
    c. Application of ted hose, sequential stocking device referencing the laterality of the surgical site.
    d. Surgical consent is once again read by the patient and when the patient is settled on the stretcher and free from any distraction.
2. SCOW's "surgical time-out policy" was reviewed and revised.
    a. Added to the policy is the verbalization of the entire team and is stated "I SEE THE MARK" on the operative site.
    b. An indelible marking pen has been used to mark the surgical site by the surgeon.
    c. Employee education to all the members of the clinical team have undergone re-training and annually after that.

3. A “Stop the Line” policy was developed. The purpose of this policy is an act of intervention to protect patient safety by using direct communication to ANY caregiver/provider engaged in or about to be engaged in an action that is believed to be unintentional threat to patient’s safety.
4. Regent Surgical Health, SCOW’s managing partner extended this revised Universal Protocol-Surgical “Time-out” policy to all the ASCs managed by RSH. Employee education was also conducted at all these facilities.
5. The surgeon who did the surgery underwent peer review. The recommendation that was made by the Medical Executive Committee and approved by the Governing Board was implemented.
6. SCOW continues to carry out a surgical “time-out” study on random cases, at least 10% of the total case volume.
7. There hasn’t been any occurrence of wrong site of surgery since the incident in March 2022.

SCOW would like to end this letter by saying our organization was a recipient of “Clinical Excellence Award” prior to and after the incident. However, this “Never Event” has motivated our organization to do better, to bring quality with our services and protect the people of our community who seek medical care at SCOW.

We would like to take this opportunity to express our appreciation for your dedication to protecting the public and welcome recommendations should you have any to add to our current policy and procedures. Please do not hesitate to contact me if you have any questions, comments or concerns.

Best,

Juan Uson
Administrator
Surgery Center of Wasilla

From:	Norberg, Natalie M (CED)
To:	General, Attorney (LAW sponsored)
Cc:	Dizon, Ninia R (LAW); Paton-Walsh, Margaret A (LAW); Robb, Sylvan S (CED); Saviers, Glenn A (CED); Eric Nimmo
Subject:	Message from State Medical Board re. 3AN-19-11710CI
Date:	Friday, September 20, 2024 3:59:15 PM
Attachments:	image003.png image004.png Medical Board Letter to AG 9-20-24.pdf image005.png

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Good afternoon, Attorney General Treg Taylor,

Please see the attached communication from the State Medical Board.

Best regards,

Natalie Norberg, LMSW
Executive Administrator, State Medical Board
Corporations, Business & Professional Licensing
natalie.norberg@alaska.gov
Office: 907-465-6243 | Fax: 907-465-2974
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THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

STATE MEDICAL BOARD

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Main: 907.465.2550
Fax: 907.465.2974

September 20, 2024

Treg Taylor
Attorney General
1031 West 4th Ave., Suite 200
Anchorage, AK 99501-1994

Transmitted by Email: attorney.general@alaska.gov

Dear Attorney General Treg Taylor,

At its meeting on September 19, 2024, the members of the Alaska State Medical Board approved a motion to urge you to appeal the judge's decision in 3AN-19-11710CI. Several members of the board expressed concern about the judiciary deciding who is authorized to perform an invasive medical procedure; making what they believe is a decision that belongs in the realm of medical regulation.

Again, the State Medical Board urges you to appeal this decision.

Sincerely,

Eric Nimmo MD

Eric Nimmo, MD
Board Chair

cc. Ninia Dizon, Executive Secretary
Margaret Paton Walsh, Assistant Attorney General
Sylvan Robb, Director, Div. of Corporations, Business & Professional Licensing
Glenn Saviers, Deputy Director, Div. of Corporations, Business & Professional Licensing

THE TRI-REGULATOR SYMPOSIUM

2025

Federation of State Medical Boards
National Association of Boards of Pharmacy
National Council of State Boards of Nursing

SAVE THE DATES

MARCH 6 & 7, 2025 | TYSONS CORNER, VA

2025 TRI-REGULATOR SYMPOSIUM

Thursday, March 6, 2025

2025 OPIOID REGULATORY COLLABORATIVE (ORC) SUMMIT

Friday, March 7, 2025

Join together with members from FSMB, NABP and NCSBN to discuss opportunities for interprofessional cooperation and the challenges facing state medical, nursing and pharmacy boards. Look for more information coming soon.

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NCSBN Leading Regulatory Excellence

Federation of Podiatric Medical Boards
12116 Flag Harbor Drive ◆ Germantown, MD 20874 ◆ 202-810-3762 ◆ www.fpmb.org

September 23, 2024

Dear Member of the Podiatric Medical Board:

The Federation of Podiatric Medical Boards (FPMB) is pleased to provide you with key documents related to the development of the Interstate Podiatric Medical Licensure Compact (IPMLC). These materials outline the value and progress of this initiative, which aims to streamline the licensure process for podiatric physicians across state lines:

- **IPMLC One-Page Overview**
  - A summary of the Compact's key benefits, including expanded access to care, cost savings, and telemedicine support.
- **IPMLC Briefing Document**
  - A detailed explanation of the Compact, its need, and its impact on license portability and regulatory barriers.
- **IMPLC Draft Model Law**
  - The proposed legislative framework for states, tailored to podiatric medical regulations. Developed and approved by a national Task Force of podiatric medical board representatives.

Please distribute these documents to the relevant Board Members and staff of your Board for thorough review, with special attention to the Draft Model Law. Your feedback is critical to shaping the final version of the Compact.

We invite your Board to participate in an upcoming Zoom meeting on Tuesday, October 1, 2024 at 12 PM ET where FPMB will answer questions and gather feedback on the Model Law. Your input will help ensure that the Compact aligns with the needs of podiatric physicians and state regulations.

Finally, in addition to the IPMLC, please note that FPMB is always available to support your Board by collecting and disseminating national information, including licensure and regulatory data, that empowers you to make informed, timely, and defensible decisions.

Fraternally,
Jay S. LeBow, DPM
IPMLC Primary Contact
ipmlc@fpmb.org
202-810-3762

CC: Russell J. Stoner, CAE, FPMB Executive Director

Why should States be part of the Interstate Podiatric Medical Licensure Compact?

It's a real asset for Podiatric Physicians

Many podiatric physicians who want to practice medicine across state lines face duplicative, costly paperwork, which impedes providing care to underserved areas, to patients with complex needs, or via telemedicine. **The Interstate Podiatric Medical Licensure Compact will streamline the licensing process for podiatric physicians through a single application.**

BENEFITS FOR THE STATE

Cost Savings & Efficiency: The Compact reduces administrative costs and increases efficiency by streamlining licensure processes for state boards.

State Control Maintained: States retain full authority over podiatric practice within their borders. Podiatrists must comply with all state laws and regulations.

BENEFITS FOR RESIDENTS

Better Access to Care: The Compact expands access to podiatric physicians, particularly in underserved and rural areas.

Telemedicine Growth: By enabling cross-state practice, the Compact boosts telemedicine, ensuring patients receive timely, specialized foot and ankle care close to home.

BENEFITS FOR HEALTH CARE SYSTEMS

Filling Podiatric Gaps: Hospitals and clinics can address podiatric physician shortages by recruiting from nearby states.

Workforce Growth: Participating states can anticipate an increase in their podiatric physician workforce, as demonstrated by the results of the similar MD/DO compact.

BENEFITS FOR PODIATRIC PHYSICIANS

Simplified Licensing: The Compact streamlines licensure, saving time and money for podiatric physicians seeking to practice in multiple states.

Expanded Opportunities: Podiatrists near state borders can easily treat patients in neighboring states, increasing flexibility and patient reach.

Find out more about how the Compact can benefit your state and its residents at www.ipmlc.org.

INTERSTATE PODIATRIC MEDICAL LICENSURE COMPACT

CONTENTS

INTRODUCTION

The Federation of Podiatric Medical Boards (FPMB) is a national non-profit association representing podiatric medical licensing boards (Licensing Boards) across all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. FPMB serves as the national voice for its member Licensing Boards while collaborating with allied organizations, supporting Member Boards with services and initiatives that protect and promote patient safety, integrity of podiatric medicine, access to high-quality health care, and regulatory best practices. With a focus on regulatory best practices, FPMB aims to establish an effective and efficient podiatric medical regulatory system that safeguards patient interests while ensuring the integrity of podiatric medicine and supporting license portability.

Building upon its track record of collaboration with Licensing Boards to address licensure barriers, FPMB is leveraging past successes to advance telemedicine provision across state lines. The creation of an Interstate Podiatric Medical License Compact (Compact) is a strategic avenue to further reduce statutory and regulatory barriers to telemedicine by enhancing the portability of podiatric physicians' licenses. This Compact is modeled after the existing Interstate Medical Licensure Compact (IMLC) that currently has participation of 42 jurisdictions that license and regulate allopathic (MD) and osteopathic (DO) physicians. The IMLC is overseen by the Interstate Medical Licensure Compact Commission (IMLCC). FPMB has established a memorandum of understanding with the IMLCC, securing their support in providing technological infrastructure and administrative assistance for the successful implementation of this Compact.

Recognizing the evolving landscape of healthcare delivery and the imperative to strengthen access to care, the Compact aims to provide a streamlined pathway for podiatric physicians to obtain licenses in multiple states. Furthermore, the Compact adheres to the prevailing standards for licensure and emphasizes that the practice of podiatric medicine is governed by the location of the patient during the physician-patient encounter. As such, it mandates that podiatric physicians operate under the jurisdiction of the Licensing Board in the patient's location. Additionally, Licensing Boards participating in the Compact retain the authority to take disciplinary action against a podiatric physician's license issued within their jurisdiction through the processes outlined in the Compact.

In the United States, the regulation of podiatric medical practice is managed at the state or territorial level, resulting in the creation of state-based licensing boards responsible for establishing and enforcing licensure standards and professional ethics. While the existing regulatory structure guarantees patient safety by verifying the credentials of podiatric physicians and offering avenues for addressing misconduct, changes in healthcare delivery methods, notably the rise of telemedicine, have emphasized the necessity for enhanced license portability. With telehealth's growing integration into conventional healthcare services, policymakers and stakeholders across all tiers of governance acknowledge the imperative to adjust regulatory frameworks to ensure equitable access to healthcare.

Enhanced license portability holds significant potential in harnessing telehealth technologies to address healthcare access disparities, especially for vulnerable populations like individuals residing in rural or remote areas, those requiring specialized care (i.e., diabetes), the elderly or homebound, and patients who speak languages other than English. By facilitating easier access to specialized care and consultations, the Compact endeavors to mitigate disparities in healthcare distribution and reduce structural barriers that restrict the availability of podiatric physicians, ultimately leading to improved health outcomes, including better limb preservation.

The Compact provides a balanced solution, streamlining licensure procedures while maintaining unwavering commitment to patient safety. FPMB is leading this initiative, drawing on its wealth of expertise and track record in fostering collaboration among member Licensing Boards. Recognizing patient safety as paramount, FPMB remains dedicated to upholding rigorous regulatory standards throughout discussions on licensure portability. With a legacy spanning over 88 years, FPMB has consistently demonstrated its unwavering commitment to public protection, adapting to evolving healthcare landscapes while ensuring the highest standards of regulatory integrity.

An Interstate Podiatric Medical Licensure Compact Commission (Commission), consisting of representation from each participating Licensing Board, will oversee the Compact's operations. It will also foster interstate collaboration for sustainability. The Commission will ensure that the Compact addresses various barriers, including varying licensure qualifications, redundant application processes, administrative and financial burdens for podiatric physicians, time-consuming licensure procedures, and inadequate sharing of complaints and investigations between state boards.

Podiatry is well-suited for participation in this Compact. With roughly 18,000 podiatric physicians practicing in the United States, over half are licensed in multiple states according to the American Podiatric Medical Association (APMA). The Compact offers a chance to expedite licensure processes for podiatric physicians aiming to practice across state borders, addressing existing challenges. Through enhanced healthcare accessibility and interstate collaboration, the Compact aims to fortify patient safeguards while promoting license portability and telemedicine objectives.

NEED

Vulnerable populations, including individuals in rural or remote areas, those requiring specialized care such as diabetes management, the elderly or homebound, and non-English-speaking patients, face disparities in healthcare distribution that can be alleviated through telemedicine.

Additionally, license portability for veterans and spouses became Federal law January 5, 2023, H.R.7939 - Veterans Auto and Education Improvement Act of 2022 - Portability of Professional Licenses of Members of the Uniformed Services and Their Spouses. This law federally requires portability for professional licenses, other than a law license, of service-members and their spouse, if they must relocate due to military orders.

In the United States, regulation of podiatric medical practice is overseen at the state or territorial level, leading to state-based licensing boards responsible for setting and enforcing licensure standards and professional ethics. However, this decentralized system results in barriers such as varying licensure qualifications, redundant application processes, administrative and financial burdens for podiatric physicians, lengthy licensure procedures, and insufficient sharing of complaints and investigations between state boards.

In 1999, FPMB drafted a Model Law to promote consistency among state licensing requirements and enhance license portability. Recognizing the need for additional solutions, FPMB participated in a 2017 Federal Trade Commission roundtable on enhancing occupational license portability that identified interstate licensure compacts as a potential solution. In 2023, FPMB's Board of Directors developed an Impact Statement advocating for an efficient podiatric medical regulatory system that supports license portability.

With the maturity of the IMLC and support from IMLCC for technological infrastructure and administrative assistance, FPMB initiated the development of the Compact. This was in response to increased demand for license portability from patients and legislators. The Compact aims to streamline the licensing process for podiatric physicians, enabling them to practice in multiple states more easily and promptly. By promoting healthcare professionals' mobility to address workforce shortages, enhance access, and optimize licensing systems, the initiative mitigates disparities in healthcare distribution and reduces structural barriers hindering podiatric physician availability, ultimately leading to improved health outcomes, including better limb preservation.

APPROACH

The United States Constitution's Compact Clause empowers states to collaboratively address shared interests, operating as a contract among participating states and standalone statute within each state's legal framework. Forming a compact requires agreement from at least two states, with oversight delegated to a Compact Commission comprising representatives from each participating state. This governance structure fosters efficiency and effectiveness, facilitating the exchange of best practices and focused efforts toward compact objectives.

Interstate compacts have demonstrated efficacy in addressing complex multi-state issues, such as telemedicine. A prime example is the Interstate Medical Licensure Compact (IMLC), which currently boasts participation from 42 jurisdictions regulating allopathic (MD) and osteopathic (DO) physicians. Since its inception in April 2017 through April 2023, the IMLC has facilitated over 15,000 physicians in securing more than 63,000 licenses across member states.

Given the educational, training, and licensure parallels between podiatric physicians and their allopathic and osteopathic counterparts, FPMB and its Licensing Boards recognize the potential of an interstate podiatric medical licensure compact. Such a compact offers a promising avenue to streamline regulatory processes and foster multi- state medical practice, building upon the successes seen with the IMLC.

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DRAFT Interstate Podiatric Medical Licensure Compact Model Language (September 23, 2024 – DRAFT Version)

INTERSTATE PODICATIC MEDICAL LICENSURE COMPACT

SECTION 1. PURPOSE

In order to strengthen access to healthcare, and in recognition of the advances in the delivery in health care, the member states of the Interstate Podiatric Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state podiatric medical boards, provides a streamlined process that allows podiatric physicians to become licensed in multiple states, thereby enhancing the portability of a podiatric medical license and ensuring the safety of patient. The Compact creates another pathway for licensure and does not otherwise change a state's existing Podiatric Medical Practice Act. The Compact also adopts the prevailing standard for licensure and affirms that the practice of podiatric medicine occurs where the patient is located at the time of the podiatric physician- patient encounter, and therefore, requires the podiatric physician to be under the jurisdiction of the state podiatric medical board where the patient is located. State podiatric medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice podiatric medicine in that state issued to a podiatric physician through the procedures in the Compact.

SECTION 2. DEFINITIONS

In this Compact:

(a) "Bylaws" means those bylaws established by the Interstate Commission pursuant to Section 11.

(b) "Commissioner" means the voting representative appointed by each member board pursuant to Section 11.

(c) "Conviction" means a finding by a court that an individual is guilty of a criminal

offense through adjudication, or entry of a plea of guilt or no contest ot the charge by the offender. Evidence of an entry of conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(d) “Expedited License” means a full unrestricted podiatric medical license granted by a member state to an eligible podiatric physician through the process set forth in the Compact.

(e) “Criminal background check” means that the member board is authorized to obtain a Federal Bureau of Investigations fingerprint based Federal Criminal Records Check Information report from the authorized state agency for the exclusive purpose of determining eligibility for certification of qualification that would allow for an expedited license.

(f) “Federal Criminal Records Check Information” means any information obtained by a member board from the Federal Bureau of Investigations relating to a federal criminal records check performed by a member board under Public Law 92-544.

(g) “Interstate Commission” means the interstate commission created pursuant to Section 11.

(h) “License” means authorization by a member state for a podiatric physician to engage in the practice of podiatric medicine, which would be unlawful without authorization.

(i) “Podiatric Medical Practice Act” means laws and regulations governing the practice of podiatric medicine within a member state.

(j) “Member Board” means a state agency in a member state that acts in the sovereign interest of the state by protecting the public through licensure,

regulation, and education of podiatric physicians as directed by the state government.

(k) “Member State” means a state which has enacted the Compact.

(l) “Practice of Podiatric medicine” means that clinical prevention, diagnosis, or treatment of human disease, injury, or condition requiring a podiatric physician to obtain and maintain a license in compliance with the Podiatric Medical Practice Act of a member state.

(m) “Podiatric physician” means any person who:

1) Is a graduate of a podiatric medical school accredited by the Council of Podiatric Medical Education;
2) Passed Parts I, II, and III (PMLexis) of the National Board of Podiatric Medical Examiners’ (NBPME) / American Podiatric Medical Licensing Examination (APMLE), or their NBPME/APMLE recognized replacement examinations;
3) Successfully complete a podiatric residency program approved by the Council on Podiatric Medical Education;
4) Holds specialty certification from a specialty board recognized by the Council on Podiatric Medical Education;
5) Possesses a full and unrestricted license to engage in the practice of podiatric medicine issued by a member board;
6) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
7) Has never held a license authorizing the practice of podiatric medicine subjected to discipline by a licensing agency in any state, federal, or

foreign jurisdiction, excluding any action related to the non-payment of fees related to a license;

8) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration or voluntarily surrendered such license after notification of investigation;

9) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction.

(n) "Offense" means a felony, gross misdemeanor; or which is the result of intentional, willful, reckless misconduct and which occurred less than ten (10) years ago; or a misdemeanor related to the practice of podiatry.

(o) "Rule" means a written statement by the Interstate Commission promulgated pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule.

(p) "State" means any state, commonwealth, district, or territory of the United States.

(q) "State of Principal License" means a member state where a podiatric physician holds a license to practice podiatric medicine and which has been designated by such a podiatric physician for purposes of registration and participation in the Compact.

SECTION 3. ELIGIBLITY

(a) A podiatric physician must meet the eligibility requirements as defined in Section 2(l) to receive an expedited licensure under the terms and provisions of the

Compact.

(b) A podiatric physician who does not meet the requirements of Section 2(l) may obtain a license to practice podiatric medicine in a member state if the indifidual complies with all laws and requirements, other than the Compact, relating to the issuance of a license to practice podiatric medicine in that state.

SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A podiatric physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the Compact if the podiatric physician possesses a full and unrestricted license to practice podiatric medicine in that state, and the state is:

1) The state of principal residence for the podiatric physician, or
2) The state where at least 25% of the practice of podiatric medicine occurs, or
3) The location of the podiatric physician's employer, or
4) If no state qualifies under subsection (1), subsection (2), or subsection (3), the state designated as state of residence for purpose of federal income tax.

(b) A podiatric physician may redesignate a member state as state of principal license at any time, as long as the state meetings the requirements of subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5. APPLICATION AN ISSUANCE OF EXPEDITED LICENSURE

(a) A podiatric physician seeking licensure through the Compact shall file an application for an expedited license with the member board of the state selected

by the podiatric physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the podiatric physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the podiatric physician's eligibility to, and in the manner established through rule by, the Interstate Commission.

1) Static qualification, which include verification of podiatric medical education, podiatric graduate medical education, results of any podiatric medical licensing examination, and other qualifications as determined by the Interstate Commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

2) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation with the exception of federal employees who have suitability determination in accordance with 5 C.F.R. § 731.202.

i. Communication between a member board and the Interstate Commission and communication between member boards regarding the verification of eligibility in Section (3) through the Compact shall not include any information received from the Federal Bureau of Investigations relating to a federal criminal records check performed by a member board under Public Law 92-

544, including Federal Criminal Records Check Information.

ii. Federal Bureau of Investigation information obtained by a member board may not be shared with the Interstate Commission.

3) Appeal of the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of that state.

(c) Upon verification in subsection (b), podiatric physician's eligibility for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (a), including the payment of any applicable fees.

(d) After receiving versification of eligibility under subsection (b) and any fees under subsection (c), a member board shall issue an expedited license to the podiatric physician. This license shall authorize the podiatric physician to practice podiatric medicine in the issuing state consistent with the Podiatric Medical Practice Act and all appliable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other podiatric physicians holding a full and unrestricted license within the member state.

(f) An expediated license obtained through the Compact shall be terminated if a podiatric physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the

application process, including payment of any applicable fees, and the reporting of the issuance of an expediated license by a member board to the Interstate Commission.

SECTION 6. FEES FOR EXPEDIATED LICENSURE

(a) A member state issuing an expedited license authorizing the practice of podiatric medicine in that state may impose a fee for a license issued or renewed through the Compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited licenses.

SECTION 7. RENEWAL AND CONTINUED PARTICIPATION

(a) A podiatric physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the podiatric physician:

1) Maintains a full and unrestricted license in a state of principal license;
2) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
3) Has not had a license authorizing the practice of podiatric medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, or voluntarily surrendered such license in lieu of discipline, excluding any action related to non-payment of fees related to a license; and
4) Has not had a controlled substance license or permit suspended or revoke by a state or the United States Drug Enforcement Administration or voluntarily surrendered such license or permit after notification of

investigation.

(b) Podiatric physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(c) The Interstate Commission shall collection any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(d) Upon receipt of any renewal fees collected in subsection (c), a member board shall renew the podiatric physician’s license.

(e) Podiatric physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(f) The Interstate Commission is authorized to develop rules to address renewal of licenses obtained through the Compact.

SECTION 8. COORDINATED INFORMATION SYSTEM

(a) The Interstate Commission shall establish a database of all podiatric physicians licensed, or who have applied for licensure, under Section 5.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or public complaints against a licensed podiatric physician who has applied or received an expedited license through the Compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any non-public complain, disciplinary, or investigatory information not required by subsection (c) to the Interstate Commission.

(e) Member board shall share complaint or disciplinary information about a podiatric physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9. JOINT INVESTIGATIONS

(a) Licensure and disciplinary records of podiatric physicians are deemed investigative.

(b) In addition to the authority granted to a member board by its respective Podiatric Medical Practice Act or other applicable state law, a member board may participate with other member boards in joint investigations of podiatric physicians license by the member boards.

(c) A subpoena issued by a member state as part of a joint investigation shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

(e) Any member state may investigate actual or alleged violation of the statutes authorizing the practice of podiatric medicine in any other member state in which a podiatric physician holds a license to practice podiatric medicine.

SECTION 10. DISCIPLINARY ACTIONS

(a) Any disciplinary action taken by any member board against a podiatric physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Podiatric Medical Practice Act or regulations in that state.

(b) If a license granted to a podiatric physician by a member board in the state of

principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the podiatric physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board is the state of principal license subsequently reinstates the podiatric physician's license, a license issued to the podiatric physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the Podiatric Medical Practice Act of that state.

(c) If disciplinary action is taken against a podiatric physician by a member board not in a state or principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

1) Impose the same or lesser sanction(s) against the podiatric physician so long as such sanctions are consistent with the Podiatric Medical Practice Act of that state; or

2) Pursue separate disciplinary action against the podiatric physician under its respective Podiatric Medical Practice Act, regardless of the action taken in other member states.

(d) If a license granted to a podiatric physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license(s) issued to a podiatric physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Podiatric Medical Practice Act of that state.

(e) A member board may terminate the automatic suspension under subsection (b)

or (d) of a license it issued, in a manner consistent with the Podiatric Medical Practice Act of that state.

SECTION 11. INTERSTATE PODIATRIC MEDICAL LICENSURE COMPACT COMMISSION

(a) The member states hereby create the “Interstate Podiatric Medical Licensure Compact Commission”.

(b) The purpose of the Interstate Commission is the administration of the Interstate Podiatric Medical Licensure Compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the Compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the Compact.

(d) The Interstate Commission shall consist of one voting representative appointed by each member state who shall serve as a Commissioner. A Commissioner shall be a(n):

1) Podiatric physician appointed to a member board;
2) Executive director, executive secretary, or similar executive of a member board; or
3) Member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting shall be a business meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each Commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of Commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subsection (d).

(h) The Interstate Commission shall provide public notice of all meeting and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that any open meeting would be likely to:

1) Relate solely to the internal personnel practice and procedures of the Interstate Commission;
2) Discuss matters specifically exempted from disclosure by federal statute;
3) Discuss trade secrets, commercial, or financial information that is privileged or confidential;
4) Involve accusing a person of a crime, or formally censuring a person;
5) Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
6) Discuss investigative records compiled for law enforcement purposes;
7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes which shall fully describe all

matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the Compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the Compact including enforcement and compliance with the provisions of the Compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission shall establish other committees for governance and administration of the Compact.

SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION

(a) Oversee and maintain the administration of the Compact;

(b) Promulgate rules which shall be binding to the extent and in the manner provided for in the Compact;

(c) Issue, upon the request of a member state or member board, advisory opinions concerning the meeting or interpretation of the Compact, its bylaws, rules, and actions;

(d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

(e) Establish and appoint committees including, but not limited to, an executive committee as required by Section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(f) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(g) Establish and maintain one or more offices;

(h) Borrow, accept, hire, or contract for services of personnel;

(i) Purchase and maintain insurance and bonds;

(j) Employ an executive director who shall have the power to employ, select or appoint employees, agents, consultants, and to determine their qualifications, define their duties, and fix their compensation;

(k) Establish personnel policies and programs relating to conflicts of interest, rates of compensation, and qualification of personnel;

(l) Accept donations and grants of money, equipment, supplies, materials, and services to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use, any property, real, personal, or mixed;

(n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(o) Establish a budget and make expenditures;

(p) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(q) Report annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year.

Such reports shall also include reports of financial audits, and financial statements, and any recommendations that may have been adopted by the Interstate Commission;

(r) Coordinate education, training, and public awareness regarding the Compact, its implementation, and its operation;

(s) Maintain records in accordance with the bylaws;

(t) Seek and obtain trademarks, copyrights, and patents; and

(u) Perform such functions as may be necessary or appropriate to achieve the purpose of the Compact.

SECTION 13. FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit or any of the member states, except by, and with the authority of, the member state.

(d) The Interstate Commission shall maintain financial records in accordance with the bylaws.

SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall, by a majority of Commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the Compact within twelve (12) months of the first Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its Commissioners, a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers selected in subsection (b) shall serve without remuneration for the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suite and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of the Interstate Commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(e) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The

Interstate Commission is considered to be an instrumentality of the states for the purpose of such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(f) The Interstate Commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by the Interstate Commission representative, shall defend such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of the Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(g) To the extent not covered by the state involved, member state, or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgement, including attorney’s fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of the Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall promulgate rules in order to effectively and efficiently achieve the purpose of the Compact. Notwithstanding the foregoing, in the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules deemed appropriate for the operations of the Interstate Commission shall be made pursuant to the rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(c) Not later than thirty (30) days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16. OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of the Compact and the rules promulgated hereunder shall have standing as

statutory law but shall not override existing state authority to regulate the practice of podiatric medicine.

(b) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the Compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all services of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render judgement or order void as to the Interstate Commission, the Compact, or promulgated rules.

SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT

(a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the Compact.

(b) The Interstate Commission may, by majority vote of the Commissioners present and voting, initiate legal action in the United States Court for the District of Columbia, or, at the discretion of the Interstate Commission, in federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

(c) The remedies herein shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies

available under state law or regulation of a profession.

SECTION 18. DEFAULT PROCEDURES

(a) The grounds for default include, but are not limited to, failure of a member board to perform such obligations or responsibilities imposed upon it by the Compact, or the rules and bylaws of the Interstate Commission promulgated under the Compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the Compact, or the bylaws or promulgated rules, the Interstate Commission shall:

1) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

2) Provide remedial training and specific technical assistance regarding the default.

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the Compact upon an affirmative vote of the majority of the Commissioners present and voting, and all rights, privileges, and benefits conferred by the Compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(d) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the governor, the

majority and minority leaders of the defaulting state's legislature, and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and podiatric physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination including obligations, the performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the Compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of litigation including reasonable attorney's fees.

SECTION 19. DISPUTE RESOLUTION

(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the Compact and which arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(a) Any state is eligible to become a member of the Compact.

(b) The Compact shall become effective and binding upon legislative enactment of the Compact into law by no less than four (4) states. Thereafter, it shall become effective and binding on a state upon enactment of the Compact into law by that state.

(c) The governors of non-member states, or their designees, shall be welcome to participate in the activities of the Interstate Commission on a non-voting basis prior to adoption of the Compact by all states.

(d) The Interstate Commission may propose amendments to the Compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate Commission and other member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21. WITHDRAWAL

(a) Once effective, the Compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the Compact by specifically repealing the statute which enacted the Compact into law.

(b) Withdrawal from the Compact shall be by the enactment of a statute repealing the same, but shall not take effect until one (1) year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(c) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the Compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the

withdrawing state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection (c).

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred throughout the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing date reenacting the Compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to podiatric physicians who designated the withdrawing member state as the state of principal license.

SECTION 22. DISSOLUTION

(a) The Compact shall be dissolved effective upon the date of the withdrawal or default of the member state which reduces the membership of the Compact to one (1) member state.

(b) Upon the dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded, and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23. SEVERABILITY AND CONSTRUCTION

(a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of the Compact shall be liberally construed to effectuate its

purposes.

(c) Nothing in the Compact shall be construed to prohibit the applicability of other interstate compacts to which the member states are members.

SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS

(a) Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.

(b) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon all member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(e) In the event of any provision of the Compact that exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

The foundational principles of the Interstate Podiatric Medical Licensure Compact echo those of the Interstate Medical Licensure Compact (IMLC):

- Maintain State Authority and Control: The Compact upholds the authority and control of state-based licensure, ensuring that Licensing Boards retain jurisdiction over the licensing process. While streamlining license application and renewal for eligible podiatric physicians, it's important to note that the Compact does not establish a national license. Licensing Boards retain their autonomy and are not compelled to relinquish their fee-generating capabilities.
- Establish High Standards for Physician Eligibility: The Compact adheres to stringent eligibility standards for podiatric physicians practicing within its framework, prioritizing patient safety and protection. Participation is reserved for podiatrists meeting rigorous requirements, emphasizing the maintenance of quality standards. Podiatric physicians who do not meet Compact criteria can pursue additional state licenses through existing procedures.
- Ensure a Well-Coordinated and Fairly-Applied System of Oversight and Discipline: The Compact implements a cooperative system for sharing information and swiftly addressing disciplinary matters across participating states. This mechanism underscores the commitment of Licensing Boards to uphold robust oversight of podiatric medicine, reassuring both boards and the public of the system's effectiveness.

Moreover, akin to the IMLC, the Compact enshrines the following eight key principles:

- Voluntary Participation: Both podiatric physicians and Licensing Boards have the voluntary option to participate in the Compact.
- Additional Pathway for Licensure: Generally, Compact participation offers an alternative route for licensure without altering a state's existing Podiatric Medical Practice Act.
- Patient-Centric Jurisdiction: The Compact reaffirms that podiatric medicine practice occurs where the patient is situated during the physician-patient encounter, necessitating the podiatric physician's jurisdiction under the Licensing Board where the patient is located.
- State Board Jurisdiction: It establishes a mechanism by which any podiatric physician practicing in a state fall under the jurisdiction of that state's Licensing Board.
- Retained Regulatory Authority: Regulatory authority remains with participating Licensing Boards and is not delegated to any external entity administering the Compact.
- Compliance Obligation: Podiatric physicians practicing under Compact-issued licenses must adhere to the statutes, rules, and regulations of each Compact state in which they choose to practice.
- Information Sharing: Licensing Boards participating in the Compact are mandated to share complaint and investigative information with one another.
- License Revocation: Any or all Compact states reserve the right to revoke the license to practice podiatric medicine.

The process to apply for licenses via the Compact is as follows:

- Eligible podiatric physician receives license in a Compact state (state of principal license)
- Eligible Physician applies for expedited licensure in the state of principal license. State of principal license verifies eligibility.
- State of Principal License sends attestation to commission. Eligible Podiatric Physician transmits appropriate fees to Commission
- Compact commission sends fees and podiatric physician information to other Compact states indicated by the podiatric physicians
- Indicated Compact states issue podiatric physician a license
- Ongoing - Commission used as clearinghouse for shared discipline and investigatory information.

It is crucial to emphasize that the Compact's pathway to multi-state licensure complements rather than replaces the traditional licensure application process. Podiatric physicians retain the option to utilize the Compact process for acquiring licensure in multiple jurisdictions; it's not obligatory.

In October 2023, FPMB created the IPMLC Task Force (Task Force), composed of representation from podiatric medical licensing boards across the country, to draft proposed legislative language for a model interstate podiatric medical licensure compact. While the model law draws inspiration from the existing IMLC model, the Task Force meticulously examined all 24 sections to tailor them to the unique requirements of podiatric medical licensure and regulation. This entailed refining terms related to podiatric physician eligibility, disciplinary information sharing, expedited licensure implementation, and Commission establishment. With the Task Force's completion of this comprehensive review and consensus-building process, the model law has undergone legal review by a compact law specialist to ensure its legal soundness. Now it is being presented to all Podiatric Licensing Boards for further evaluation.

Following this review by all Podiatric Licensing Boards, it will undergo review and endorsement by stakeholders, including national and state podiatric medical associations, education and training organizations, and certification bodies. Leveraging the IMLC model law as a foundation is expected to streamline this process and minimize hurdles.

RESOLUTION OF CHALLENGES

The FPMB, along with its participating member Licensing Boards and allied organizations, will tackle challenges during the design and implementation of this project. The FPMB has a commitment to and a strong record of working with Licensing Boards to overcome licensure barriers.

The FPMB is prepared to assist Licensing Boards by offering research and support as Licensing Boards and their respective state legislatures deliberate on the Compact legislation. While this Compact follows a pathway established by the IMLC, there is no guarantee that this will expedite the legislative process.

Finally, the FPMB is dedicated to addressing and dispelling any misconceptions and misinformation surrounding interstate compacts in general, and this Compact in particular. Ensuring that interested Licensing Boards, state legislators, podiatric physicians, and other stakeholders have access to accurate and up-to-date information regarding how the Compact will streamline the process for podiatric physicians to acquire licensure across multiple states, thereby reducing statutory and regulatory barriers to telemedicine and enhancing health outcomes for patients in their respective states, will promote participation in this initiative.

ORGANIZATIONAL INFORMATION

FPMB fulfills its mission to support its member Licensing Boards through various means, including public policy and advocacy, collaboration and communication, primary source verification, and representation. In the realm of primary source verification, FPMB plays a crucial and direct role in the podiatric licensure process by supplying certified podiatric licensing examination scores and disciplinary action reports to Licensing Boards.

Moreover, FPMB ensures the representation of its member podiatric Licensing Boards in numerous podiatric organizations, including the American Association of Colleges of Podiatric Medicine, American Podiatric Medical Association, Council on Podiatric Medical Education, and National Board of Podiatric Medical Examiners. Additionally, FPMB holds membership in the Federation of State Medical Boards (FSMB), the organization that established the IMLC and IMLCC.

Through its affiliation with FSMB and its direct relationship with IMLCC, FPMB is strategically leveraging its connections to establish the podiatric Compact and Commission, furthering its commitment to advancing podiatric medicine licensure initiatives that increase license portability.

In recognition of the need for a podiatric compact and support this effort, the Health Resources and Services Administration (HRSA), Department of Health and Human Services is providing financial support for this Compact project. The award provides 91% of total costs and totaled $750,000. Overall, FPMB will prioritize transparency, accountability, and compliance with grant regulations throughout the project's duration to ensure the effective and efficient use of federal funds.

For additional information, please contact Jay S. LeBow, DPM, IPMLC Primary Contact at ipmlc@fpmb.org or call 202-810-3762.

NOTE: The contents of this document are those of FPMB and may not reflect the policies of the Department of Health and Human Services or the U.S. government.

15. Applicant Review / License Approvals – Doctors of Osteopathic Medicine

	Lic Type	First Name	Last Name
1.	DO	James	Bauman
2.	DO	Daniel	Fisher
3.	DO	Sarah	Feenstra
4.	DO	Zachary	Gee
5.	DO	Roger	Kasendorf
6.	DO	Donna	Woods

15. Applicant Review / License Approvals – Doctors of Allopathic Medicine

	Lic Type	First Name	Last Name
1.	MD	Amy	Brockmeyer
2.	MD	Joel	Brownell
3.	MD	Cheryl-Lynn	Bugailiskis
4.	MD	Mitchell	Cahn
5.	MD	Michael	Chen
6.	MD	Nancy	Cooper
7.	MD	Ruxandra	Costa
8.	MD	Andrew	Diamond
9.	MD	Alan	Donnenfeld
10.	MD	Ivana	Dzeletovic
11.	MD	Samuel	Fadare
12.	MD	Lisa	Flora
13.	MD	John	Harrison
14.	MD	Howard	Harper
15.	MD	Allison	Lam
16.	MD	Jean	Leveque
17.	MD	Nathaniel	Miller
18.	MD	Kathleen	Moen
19.	MD	Milton	Nathan
20.	MD	Nathaniel	Ord
21.	MD	Stephen	Perez
22.	MD	Scott	Puza
23.	MD	Esteban	Ramirez
24.	MD	Ivan	Rohena-Quinquilla
25.	MD	David	Steidley
26.	MD	Mark	Smethurst
27.	MD	Joanna	Tavarez
28.	MD	Matthew	Thompson
29.	MD	Priti	Vyas
30.	MD	Binod	Wagle
31.	MD	Adam	Wolfberg
32.	MD	Judith	Wolfstein
33.	MD	Christopher	Wyatt
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	Lic Type	First Name	Last Name
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15. Applicant Review / License Approvals – Physician Assistants

	Lic Type	First Name	Last Name
	PA	Claire	Antoszewski
	PA	Christopher	Robertson
	PA	Tyler	Tennant