



STATE OF WISCONSIN
Department of Safety and Professional Services
1400 E Washington Ave.
Madison WI 53703

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: <http://dsps.wi.gov>

Governor Scott Walker Secretary Dave Ross

Voice: 608-266-2112 • FAX: 608-267-0644 • TTY: 608-267-2416

MEDICAL EXAMINING BOARD MEETING
Room 121A, 1400 E. Washington Avenue, Madison
DRL Contact: Tom Ryan (608) 261-2378
February 15, 2012

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

8:00 A.M.

OPEN SESSION

- 1. Call to Order – Roll Call**
- 2. Declaration of Quorum**
- 3. Approval of the Agenda (insert) (1-6)**
- 4. Approval of Minutes of January 18, 2011 (insert) (7-18)**
- 5. Case Presentations**

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

- a. Michael A. Dehner, MD - 09 MED 028 **(175-184)**
 - Attorney Arthur Thexton
 - Case Advisor – Sujatha Kailas
- b. Dale E. Bauwens, MD – 09 MED 108 **(185-192)**
 - Attorney Arthur Thexton
 - Case Advisor – James Conterato
- c. Clifford T. Bowe, MD – 09 MED 033 **(193-204)**
 - Attorney Kim Kluck
 - Case Advisor – Suresh Misra
- d. James A. Shapiro, MD – 09 MED 367 **(205-212)**
 - Attorney Kim Kluck
 - Case Advisor – Raymond Mager

- e. Susan J. Frazier, MD – 11 MED 249 (213-220)
 - Attorney Kim Kluck
 - Case Advisor – Sheldon Wasserman
- f. Richard Banchs, MD – 10 MED 304 (221-226)
 - Attorney Pamela Stach
 - Case Advisor – Jude Genereaux
- g. Brian Fox, MD – 10 MED 313 (227-232)
 - Attorney Pamela Stach
 - Case Advisor – Ian Munro
- h. Ronald K. Meyer, MD – 11 MED 058 (233-240)
 - Attorney Pamela Stach
 - Case Advisor – Azita Hamedani

Presentation of Petition(s) for Summary Suspension

8:30 A.M. – APPEARANCES – DOE Attorney Pamela Stach, Attorney Mary Lee Ratzel and Respondent regarding Petition for Summary Suspension in the following matter:

- a. 09 MED 258 and 10 MED 363 – Victoria J. Mondloch, MD (241-296)
 - Attorney Pamela Stach
 - Case Advisor – Sheldon Wasserman

6. Items Received After Mailing of Agenda

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

7. 9:00 A.M. – Public Hearing on Ch. MED 8 Relating to the Physician to Physician Assistant Ratio (insert) (19-30)

- a. Review and Discuss Legislative Clearinghouse Comments and Public Comments Regarding Ch. MED 8 Related to the Physician to Physician Assistant Ratio

8. Items for Board Discussion

- a. ARRA Grant – Demonstration Of Online Verification System – **APPEARANCE – 9:30 A.M. – Ari Oliver, DSPS, ARRA Program Analyst (insert) (31-104)**
- b. ARRA Grant Declaration of Cooperation – Board Review and Approval - **APPEARANCE – 9:45 A.M. – Ari Oliver, DSPS, ARRA Program Analyst (insert) (105-116)**
- c. Budget Lapse Report – **APPEARANCE – 9:55 A.M. – Karen Vanschoonhoven, DSPS Budget Director (insert) (117-124)**
- d. Maintenance of Licensure Pilot Projects
- e. FSMB Matters
- f. Chapter MED 10 Update
- g. DSPS Website Improvement Opportunities **(insert) (125-126)**
- h. Medical Board Newsletter
- i. Upcoming Outreach Opportunities

9. Executive Director Matters

10. Legislative Report

- a. Senate Bill 306 **(insert) (127-144)**
- b. Assembly Bill 487 **(insert) (145-152)**

11. Screening Panel Report

12. Informational Item(s) (insert) (153-174)

13. Public Comment(s)

14. Other Business

CLOSED SESSION

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

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

- a. Michael A. Dehner, MD - 09 MED 028 **(insert) (175-184)**
 - o Attorney Arthur Thexton

- b. Dale E. Bauwens, MD – 09 MED 108 **(insert) (185-192)**
 - o Attorney Arthur Thexton
- c. Clifford T. Bowe, MD – 09 MED 033 **(insert) (193-204)**
 - o Attorney Kim Kluck
- d. James A. Shapiro, MD – 09 MED 367 **(insert) (205-212)**
 - o Attorney Kim Kluck
- e. Susan J. Frazier, MD – 11 MED 249 **(insert) (213-220)**
 - o Attorney Kim Kluck
- f. Richard Banchs, MD – 10 MED 304 **(insert) (221-226)**
 - o Attorney Pamela Stach
- g. Brian Fox, MD – 10 MED 313 **(insert) (227-232)**
 - o Attorney Pamela Stach
- h. Ronald K. Meyer, MD – 11 MED 058 **(insert) (233-240)**
 - o Attorney Pamela Stach

CS-2 Deliberation of Petition(s) for Summary Suspension

- a. Victoria J. Mondloch, MD – 09 MED 258 and 10 MED 363 **(insert) (241-296)**
 - o Attorney Pamela Stach

CS-3 Deliberation of Proposed Administrative Warning(s)

- a. 09 MED 439 (J.G., MD) **(insert) (297-300)**
 - o Attorney Kim Kluck
 - o Case Advisor – Raymond Mager

CS-4 Review of Administrative Warning - APPEARANCES – 11:00 A.M. - DOE Attorney Kim Kluck, Attorney Gary Bridgewater and Respondent in the following matter:

- a. 10 MED 176 (G.B., MD) **(insert) (301-304)**
 - o Attorney Kim Kluck

CS-5 Consideration of Complaint(s)

- a. **09 MED 028** (M.A.D., MD) **(insert) (305-310)**

CS-6 Request(s) for Equivalency of ACGME Approved Post-Graduate Training

- a. Denis M. Jones, MD **(insert) (311-362)**

CS-7 Monitoring (insert) (363-364)

- a. Rudy V. Byron, MD – Request for Modification **(insert) (365-374)**
- b. Steven B. Greenman, MD – Request for Modification/Reinstatement **(insert) (375-422)**
- c. Kirsten D. Peterson, MD – Request for Modification **(insert) (423-442)**

CS-8 Case Closings (insert) (443-444)

CS-9 Consulting with Legal Counsel

Deliberation of Items Received in the Bureau after Preparation of Agenda

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

Division of Enforcement – Meeting with Individual Board Members

Division of Enforcement – Case Status Reports and Case Closings

Ratifying Licenses and Certificates

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

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

Other Business

ADJOURNMENT

12:30 PM

CLOSED SESSION

Examination of 2 Candidates for Licensure – Drs. Osborn, Magiera, Musser and Wasserman

**MEDICAL EXAMINING BOARD
MINUTES
JANUARY 18, 2012**

PRESENT: Carolyn Bronston; LaMarr Franklin; Jude Genereaux; Sujatha Kailas, MD (excused at 12:32 p.m.); Raymond Mager, DO; Christopher Magiera MD; Suresh Misra, MD; Gene Musser, MD; Sandra Osborn, MD; Kenneth Simons, MD; Sheldon Wasserman, MD

EXCUSED: James Conterato, MD

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

GUESTS: Mark Grapentine, Wisconsin Medical Society; Eric Jensen, WAPA; Anne Hletko, Council on Physician Assistants; Nancy Sugden, UWSMPH; Tom Walsh, DWD; Jeremy Levin, RWHC; Kristen Wilhelm, Donna Harmon, Debbie Harmon, Della Haugen, Scott Becher, Stephanie Beaver

CALL TO ORDER

Dr. Sheldon Wasserman, Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) members was confirmed.

ADOPTION OF AGENDA

Amendments:

- Under PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS, add:
 - c. Thomas A. Gennarelli, MD – 09 MED 114
 - Attorney Pamela Stach
 - Case Advisor – Sandra Olson
 - d. Jon M. Burch, MD – 10 MED 303
 - Attorney Pamela Stach
 - Case Advisor – LaMarr Franklin
 - e. John G. Hoffmann, MD – 11 MED 343
 - Attorney Jeanette Lytle
 - Case Advisor – Suresh Misra
- Item 7a – PHYSICIAN WORKFORCE SURVEY, insert additional materials after page 16
- Item 7h – WIS ADMIN CODE CHAPTER MED 8 UPDATE, insert additional materials after page 104
- Item 7i – WIS ADMIN CODE CHAPTER MED 10 UPDATE, insert additional materials after page 104
- Item 7k – MEDICAL BOARD NEWSLETTER, insert additional materials after page 106

- Item 9b – BUDGET LAPSE PLAN, insert after page 148
- Item 13a – under OTHER BUSINESS, insert article from ABC News Abortion Without Doctor On-Site Gets High Grades in Iowa
- Item CS-1 – DELIBERATION OF STIPULATIONS, FINAL DECISIONS AND ORDERS, add:
 - c. Thomas A. Gennarelli, MD – 09 MED 114 – Attorney Pamela Stach (after page 162)
 - d. Jon M. Burch, MD – 10 MED 303 – Attorney Pamela Stach (after page 162)
 - e. John G. Hoffmann, MD – 11 MED 343 – Attorney Pamela Stach (after page 162)
- Item CS-6 – MONITORING, insert after page 230:
 - b. Monitoring Presentation on Proposed CE Course
- Under DELIBERATION OF ITEMS RECEIVED AFTER PREPARATION OF AGENDA, add under COMPLAINTS:
 - a. 09 MED 258 and 10 MED 363
 - b. 11 MED 201
- Case Status Report – insert at the end of the agenda in closed session

MOTION: Sujatha Kailas moved, seconded by Kenneth Simons, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF DECEMBER 14, 2011

MOTION: Sandra Osborn moved, seconded by Jude Genereaux, to approve the minutes of December 14, 2011 as written. Motion carried unanimously.

DISCUSSION REGARDING LATE ADDITIONS TO THE AGENDA

The Board members were concerned with the volume of late additions to the agenda. Board members need adequate time to review all agenda items. The Board determined that any late additions to the MEB agenda must be received by the Division of Board Services (DBS) staff no later than noon on the Friday prior to the MEB meeting. This will enable DBS staff to email all late items to Board members that same day, allowing adequate review time. Any agenda items received after that time must be of an urgent nature and must be approved by the Board Chair for inclusion on the agenda. Items not approved by the Board Chair will be postponed to the next month.

PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

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

Blair L. Lewis, MD	09 MED 392
Roger Pinc, MD	10 MED 307
Thomas A. Gennarelli, MD	09 MED 114

Monitoring Program and to authorize the Chair to appoint a representative to testify at the Public Hearing. Motion carried unanimously.

Gene Musser will represent the Board at the Public Hearing.

Maintenance of Licensure Pilot Projects

Tom Ryan reviewed the Maintenance of Licensure Pilot projects with the Board. Sheldon Wasserman asked the Maintenance of Licensure Workgroup to review this information and to bring recommendations back to the Board.

FSMB Matters

- **FSMB Annual Meeting, April 26-28, 2012, Fort Worth, Texas**
MOTION: Raymond Mager moved, seconded by Jude Genereaux, to authorize Sheldon Wasserman to attend as the Board's delegate at the FSMB Annual Meeting to be held April 26-28, 2012, in Fort Worth, Texas. Motion carried unanimously.

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

- **Consideration of Sheldon Wasserman for the FSMB Nominating Committee**
MOTION: Carolyn Bronston moved, seconded by Sujatha Kailas, to recommend Sheldon Wasserman for consideration to the FSMB Nominating Committee. Motion carried unanimously.
- **FSMB Request for Letter of Support for Grant Application**
This item was noted.
- **Report from FSMB Special Committee on Ethics and Professionalism**
This item was informational.
- **Report from FSMB Workgroup to Define a Minimal Data Set**
This item was reviewed.

Wis. Admin. Code Chapter MED 8 regarding Physician Assistants

The Board reviewed the final draft of MED 8 relating to the physician assistant to physician supervision ratio. Shawn Leatherwood reviewed the rules process with Board and the public hearing will be held at the February 15, 2012 Board meeting.

Gene Musser and Sheldon Wasserman thanked all involved for their effort on this rule.

Wis Admin. Code Chapter MED 10

Sandy Nowack provided a side-by-side comparison of the MED 10 working draft, current MED 10 and the FSMB Model Code, and the existing working draft of MED 10.

Sheldon Wasserman referred this document to the MED 10 workgroup for review and asked the workgroup to report back at the February meeting with recommendations and for further discussion. All board members and other interested parties are encouraged to email comments and suggestions to Legal Counsel Sandy Nowack. The workgroup members are Sandy Nowack, LaMarr Franklin, Kenneth Simons, Gene Musser, Christopher Magiera and Sheldon Wasserman.

Board Appointments

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

ARRA Grant Liaisons: Sujatha Kailas (alternate), Raymond Mager

Division of Enforcement Liaisons: Carolyn Bronston, Sandra Osborn

Evaluation Work Group (Ch. 10 revisions): LaMarr Franklin, Christopher Magiera, Gene Musser, Sandy Nowack, Kenneth Simons, Sheldon Wasserman

Legislative Liaisons: Christopher Magiera, Suresh Misra, Gene Musser, Kenneth Simons, Sheldon Wasserman

Maintenance of Licensure Work Group: Sujatha Kailas, Raymond Mager, Kenneth Simons, Gene Musser (advisor)

Monitoring Liaisons: James Conterato, Sandra Osborn (alternate)

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

Professional Assistance Program Liaison: Raymond Mager, Sandra Osborn (alternate)

Medical Board Newsletter Liaison: Jude Genereaux

Medical Board Newsletter

The Board reviewed the articles submitted for the Medical Examining Board Newsletter. The projected publication date for the Newsletter is March 2012.

MOTION: Kenneth Simons moved, seconded by LaMarr Franklin, to approve the Newsletter content and to designate Jude Genereaux and Sheldon Wasserman to do a final review as to content. Motion carried unanimously.

For future Newsletters, articles should be submitted no later than noon on the Friday preceding the Board meeting.

Upcoming Outreach Opportunities

Sandy Osborn will give a presentation at the Aurora Physicians Group in Wisconsin Dells on March 1, 2012, and has also been asked to speak as part of the physician impairment lecture to

first year medical students in the Doctors in Society class at the UW Medical School in March 2012.

Sujatha Kailas presented at Grand Rounds at Waukesha Memorial Hospital on January 10, 2012.

Sheldon Wasserman spoke to the psychiatry residency program at the Medical College of Wisconsin on January 11, 2012, Drs. Wasserman and Mager also gave a presentation to the surgery residents at the Medical College of Wisconsin on November 2, 2011. Dr. Wasserman will present at Grand Rounds at Columbia St. Mary's' Hospital in Milwaukee on February 14, 2012.

EXECUTIVE DIRECTOR MATTERS

Tom Ryan reviewed the Department policies with the Board. Board members were asked to sign and return the last page in the Board Members Guide Book.

Sujatha Kailas stated her concern that Medical Examining Board designated staff have been assigned duties outside of the Board. Tom Ryan reviewed staffing assignments and the need to balance the work load between Executive Directors and other staff.

LEGISLATIVE REPORT

DOA Lapse Plan

Gene Musser reviewed the DOA lapse plan for fiscal year 2011-12. By statute, the Medical Examining Board is to receive 90% of the application and renewal fees; the remaining 10% is lapsed to the DOA to go to the general fund. The Department of Safety and Professional Services has spending authority over this budget, which includes staff salaries, supplies and expenses.

The budget repair bill required the DOA to request lapse monies from all State agencies. The DSPS lapse plan includes \$1.25 million from the MEB budget, which is approximately 66% of the total spending authority, and was made with no input from the Board. Gene Musser has communicated with the DSPS Administration to inquire on the impact this will have and the loss of support for the Medical Examining Board's functions.

The Joint Finance Committee (JFC) has the opportunity to override these proposed lapse plans. Objections to proposed lapse plans can be submitted to the JFC.

Sheldon Wasserman stated the physician licensing fees are being diverted from what they are intended. The fees are supposed to pay for staff to investigate and to protect the citizens of the State of Wisconsin. The Medical Examining Board, the Wisconsin Medical Society and the Department of Safety and Professional Services all favored an increase in the licensing fees for specific purposes; a designated Executive Director, and to increase staff numbers to decrease case loads and to process cases in a timely and accurate manner.

MOTION: Raymond Mager moved, seconded by Sujatha Kailas, to empower the Board Chair, Sheldon Wasserman, to send a letter to the Joint Finance Committee stating the Medical Examining Board's opposition to the proposed lapse plan. Motion carried. Christopher Magiera opposed.

Mark Grapentine, Wisconsin Medical Society (WMS), spoke and said the WMS is against the proposed lapse plan. Gene Musser stated any individual can contact the members of the JFC to express an opinion if they so desire.

Board Appointments

Governor Walker appointed Suresh Misra, Kenneth Simons, Christopher Magiera, Raymond Mager and James Conterato to the Board. Drs. Misra, Simons and Magiera have been confirmed; however Drs. Mager and Conterato still need Senate confirmation.

Senate Bill 306

This item was informational and no Board action was taken.

SCREENING PANEL REPORT

Carolyn Bronston reported twenty nine (29) cases were screened. Five (5) cases were opened and two (2) ten-day letters were sent.

INFORMATIONAL ITEMS

The informational items were noted.

PUBLIC COMMENTS

Kristen Wilhelm, Dawn Harmon, Stephanie Beaver, Della Haugan and Debbie Harmon all addressed the Board in support of Dr. Hoffmann and asked to the Board to be more transparent in its disciplinary actions.

OTHER BUSINESS

There was no other business.

RECESS TO CLOSED SESSION

MOTION: Kenneth Simons moved, seconded by LaMarr Franklin, to convene to closed session to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)). Roll call: Carolyn

Bronston-yes; LaMarr Franklin-yes; Jude Genereaux-yes; Sujatha Kailas-yes; Raymond Mager-yes; Christopher Magiera-yes; Suresh Misra-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Sheldon Wasserman-yes. Motion carried unanimously.

Open session recessed at 10:05 a.m. Mr. Franklin was excused at this time.

RECONVENE IN OPEN SESSION

MOTION: Suresh Misra moved, seconded by Sandra Osborn, to reconvene in open session. Motion carried unanimously.

Open session reconvened at 12:54 p.m.

VOTING ON ITEMS CONSIDERED/DELIBERATED IN CLOSED SESSION

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

PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

**BLAIR L LEWIS, MD
09 MED 392**

MOTION: Sujatha Kailas moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Blair L. Lewis, MD. Motion carried unanimously.

**ROGER PINC, MD
10 MED 307**

MOTION: Gene Musser moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Roger Pinc, MD. Motion carried unanimously.

**THOMAS A GENNARELLI, MD
09 MED 114**

MOTION: Sujatha Kailas moved, seconded by Raymond Mager, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against Thomas A. Gennarelli, MD. Motion carried. Kenneth Simons was excused during deliberation and abstained from voting.

**JON M BURCH, MD
10 MED 303**

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

**JOHN GREGORY HOFFMANN, MD
11 MED 343**

MOTION: Raymond Mager moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Interim Order in the disciplinary proceedings against John Gregory Hoffmann, MD. Motion carried unanimously.

PROPOSED ADMINISTRATIVE WARNINGS

MOTION: Sujatha Kailas moved, seconded by Kenneth Simons, to issue the Administrative Warning in case **09 MED 349 against respondent J.P.H, MD.** Motion carried unanimously.

MOTION: Carolyn Bronston moved, seconded by Suresh Misra, to issue the Administrative Warning in case **10 MED 212 and 10 MED 239 against respondent J.J.Y., MD.** Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by Christopher Magiera, to issue the Administrative Warning in case **11 MED 240 against respondent R.T.K, MD.** Motion carried unanimously.

PETITIONS FOR EXTENSION OF TIME

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

MOTION: Sandra Osborn moved, seconded by Sujatha Kailas, to adopt the Petition for Extension of time in the disciplinary proceedings against Clifford T. Bowe, MD. Motion carried unanimously.

**S DALIP SINGH, MD
10 MED 404**

MOTION: Suresh Misra moved, seconded by Jude Genereaux, to deny the Petition for Extension of Time and to issue an Administrative Warning in the disciplinary proceedings against S. Dalip Singh, MD. Motion carried unanimously.

REQUEST FOR WAIVER OF CME REQUIREMENT

FB, MD

MOTION: Sujatha Kailas moved, seconded by Jude Genereaux, to deny the request for waiver of the CME requirement to F.B., MD, as there is not sufficient justification for the waiver. Motion carried unanimously.

REQUEST FOR EQUIVALENCY OF ACGME APPROVED POST-GRADUATE TRAINING

ALEXANDRA S BULLOUGH, MD

MOTION: Carolyn Bronston moved, seconded by Sandra Osborn, to approve the request from Alexandra S. Bullough, MD, for equivalency of the ACGME approved post-graduate training. Motion carried. Kenneth Simons abstained.

MONITORING

CHANDRA S REDDY, MD

MOTION: Carolyn Bronston moved, seconded by Sandra Osborn, to grant the request from Chandra S. Reddy, MD, for full licensure. Motion carried unanimously.

COMPLAINTS

MOTION: Carolyn Bronston moved, seconded by Kenneth Simons, to find probable cause to issue a complaint in the matter of **11 MED 201**. Motion carried unanimously.

MOTION: Sandra Osborn moved, seconded by Carolyn Bronston, to find probable cause to issue a complaint in the matter of **09 MED 258 and 10 MED 363**. Motion carried unanimously.

CASE CLOSINGS

MOTION: Sandra Osborn moved, seconded by Jude Genereaux, to close cases **11 MED 258** for no violation. Motion carried unanimously.

MOTION: Sandra Osborn moved, seconded by Kenneth Simons, to close case **11 MED 153** for no violation. Motion carried unanimously.

MOTION: Jude Genereaux, moved, seconded Carolyn Bronston, to close case **11 MED 189 against respondent G.A.P.** for no violation. Motion carried unanimously.

MOTION: Kenneth Simons, moved, seconded Suresh Misra, to close case **11 MED 355 against respondent R.S.W.** for no violation. Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by Kenneth Simons, to close case **11 MED 279** for prosecutorial discretion. Motion carried unanimously.

MOTION: Carolyn Bronston moved, seconded by Suresh Misra, to close case **09 MED 114 against respondent P.A.W.** for no violation. Motion carried. Kenneth Simons was excused during deliberation and abstained from voting.

OTHER BUSINESS

There was no other business.

ADJOURNMENT

MOTION: Kenneth Simons moved, seconded by Suresh Misra to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:55 p.m.

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**State of Wisconsin
Department of Regulation and Licensing**

AGENDA REQUEST FORM

Name and Title of Person Submitting the Request: Shawn Leatherwood, Paralegal, Division of Board Services		Date When Request Submitted: 01/19/2012
		Items will be considered late if submitted after 5 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before meeting for all other boards
Name of Board, Committee, Council: Medical Examining Board		
Board Meeting Date: 02/15/12	Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	How should the item be titled on the agenda page? Public Hearing for ch. Med 8 regarding physician to physician assistant ratios.
Place Item in: <input checked="" type="checkbox"/> Open Session at 9:00 AM <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	Is an appearance before the Board being scheduled? If yes, by whom? <input checked="" type="checkbox"/> Yes by <u>Members of the Public</u> (name) <input type="checkbox"/> No	Name of Case Advisor(s), if required:
Describe the issue and action the Board should address: The Board will hold a public hearing and receive comments from the public regarding the proposed rule. The Board will review the clearinghouse report and accept or reject the amendments recommended by the clearinghouse. The Board will approve the proposed rule draft as amended for filing with the legislature.		
If this is a "Late Add" provide a justification utilizing the Agenda Request Policy: 		
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Documents submitted to the agenda must be single-sided. 3. Only copies of the original document will be accepted. 4. Provide original documents needing Board Chairperson signature to the Bureau Director or Program Assistant prior to the start of a meeting.		
Authorization:		
<i>Shancethea N. Leatherwood</i>	01/19/12	
Signature of person making this request	Date	
Supervisor signature (if required)	Date	
Bureau Director signature (indicates approval to add late items to agenda)	Date	

STATE OF WISCONSIN
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

IN THE MATTER OF RULE-MAKING : PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE : MEDICAL EXAMINING
MEDICAL EXAMINING BOARD : BOARD
: ADOPTING RULES
: (CLEARINGHOUSE RULE 12-)

PROPOSED ORDER

The Wisconsin Medical Examining Board proposes an order to repeal Med 8.10 (2); to renumber Med 8.02 (1); to renumber and amend Med 8.01 and Med 8.10 (3) and (4); to amend Med 8.05 (2) (title), Med 8.05 (2) (b), Med 8.05 (2) (b) (7), Med 8.05 (2) (c), Med 8.07 (1), Med 8.07 (2) (a) and (e), Med 8.08 (title), Med 8.08 (1), Med 8.08 (3) (b), Med 8.10 (title), Med 8.10 (1); to repeal and recreate Med 8.08 (2) and Med 8.08 (3) (a) and to create Med 8.01 (2), Med 8.02 (1), Med 8.02 (4m), Med 8.02 (7), Med 8.05(2) (e), Med 8.07 (1) (a) and (b), and Med 8.08 (1) (a), (b), (c) and (d), and Med 8.08 (3) (c) and (d) (e) relating to definitions, practice prescribing limitations, employment requirements and supervising physician responsibilities.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Sections 448.21 (2) and (3), Stats.,

Statutory authority:

Sections 15.08 (5) (b), 227.11 (2) (a), 448.05 (5), 448.20 (3) (a), 448.40 (2) (f), Stats.,

Explanation of agency authority:

The legislature, via Wis. Stats. §§ 15.08 (5) (b), and 227.11 (2) (a), conferred upon the Medical Examining Board general powers to promulgate rules for the guidance of the profession and to interpret the provisions of statutes it enforces. Section 448.05 (5) authorizes the Board to promulgate rules that establish licensing and practice standards for physician assistants. Section 448.40 (2) (f), Stats., directs the board to promulgate rules regarding the prescriptive practice of physician assistants. Therefore, the Medical Examining Board is both generally and specifically authorized to promulgate these proposed rules.

Section 448.20(3)(a) confers upon the Council on Physician Assistants the authority to advise the Medical Examining Board on revisions of standards in licensing, practice, education and training of physician assistants.

Related statute or rule:

Sections 448.01 (6), 448.20 (3), Stats., Wis. Admin. Code §MED 10.02(2) (t)

Plain language analysis:

Physician assistants practice as part of a physician-led team with physicians supervising the health care services they provide. Currently, one physician may supervise no more than two physician assistants at one time without permission from the Medical Examining Board (Board). The proposed rule increases the maximum number of physician assistants a physician may concurrently supervise from 2 to 4.

Under current law the Board may, in an exercise of discretion, authorize a physician to supervise more than two physician assistants concurrently. A physician requesting an increase in the numbers of physician assistants to be supervised must submit a written plan for the Board's review. The Board may grant the request if the Board is satisfied that the increased number of physician assistants will not compromise patient safety. The proposed rules retain the Board's authority to increase the number of physician assistants a physician may concurrently supervise on a case-by-cases basis.

The proposed rule defines terms necessary to clarify responsibilities in the physician-led teams in which physician assistants work. It further eliminates any reference to the outdated term, "substitute supervising physician."

Current law provides that applicants for licensure as physician assistants may be required to submit to an oral examination. The existing term is outdated and does not reflect that during a personal appearance the Board may also require an applicant to submit to an interview, or a review of credentials, or both. The proposed rule clarifies that the Board may require, as a prerequisite to licensure, successful completion of an oral examination or a personal appearance or both.

Finally, the proposed rule explains that the periodic review of physician assistant prescribing practices must occur at least annually, with more frequent review optional, depending upon applicable standards of care and other factors.

SECTION 1. rennumbers and amends Med 8.01

SECTION 2 creates a statement of intent and add it to the authority and purpose provision.

SECTION 3. rennumbers Med 8.02 (1) to 8.02 (1m).

SECTION 4. defines the terms “adequate supervision”, “general supervision” and “supervising physician”.

SECTION 5. clarifies that in addition to written and oral examinations, the Board may require satisfactory performance of a personal appearance for the purpose of an interview, a review of credential, or both.

SECTION 6. amends Med 8.05(2) (b) (7) to remove outdated references to particular mental health disorders.

SECTION 7. amends Med 8.05 (2) (c) to allow a personal appearance as well as an oral examination if required by the application review panel.

SECTION 8. creates Med 8.05 (2) (e) a provision regarding the components of a satisfactory personal appearance.

SECTION 9. amends Med 8.07(1) by clarifying that a physician assistant’s practice may be supervised by one or more supervising physicians.

SECTION 10. creates Med 8.07 (1) (a) and (b) regarding physician assistant’s scope of practice.

SECTION 11. amends Med 8.07 (2) (a) and (e) by striking repetitive and ambiguous language.

SECTION 12. amends Med 8.08 (title) and Med 8.08 (1) to specify that the supervising physician and the physician assistant shall review guidelines for supervised prescriptive practice at least annually and clarifies the requirement that the guidelines for supervised prescriptive practice shall include the process and schedule for the supervising physician’s review.

SECTION 13. creates Med 8.08 (1) (a), (b), (c) and (d) specifying the contents of the written guidelines for the required supervised prescriptive practice.

SECTION 14. repeals and recreates Med 8.08 (2) to simplify when physician assistants are authorized to prescribe.

SECTION 15. repeals and recreates Med 8.08 (3) (a).

SECTION 16. amends Med 8.08 (3)(b) to require supervising physicians to document review of the physician assistant’s prescriptive practice in the patient records.

SECTION 17. creates Med 8.08 (3) (c) and (d) regarding documenting the periodic review.

SECTION 18. amends Med 8.10 (1) by increasing the number of physician assistants a physician may supervise from 2 to 4, and clarifying the nature of supervision.

SECTION 19.. repeals Med 8.10 (2) eliminating the provision regarding substitute supervising physicians.

SECTION 20. amends Med 8.10 (3) and (4) striking repetitive language regarding supervising physicians.

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

There is no comparative existing or proposed federal rule.

Comparison with rules in adjacent states:

Illinois: The state of Illinois limits the physician assistant to physician ratio to 2:1; unless the supervising physician designates an alternate supervising physician. An alternate supervising physician may supervise more than two physician assistants at the same time when the supervising physician is unable to fulfill the duties. 225 ILL. COMP. STAT. 95/7

Iowa: The state of Iowa limits the physician assistant to physician ratio to 2:1. 645 IAC 326.8 (3) (148 C)

Michigan: The state of Michigan allows a physician assistant to physician ratio of 4:1 when the supervising physician is a solo practitioner who practices in a group of physicians and treats patients on an outpatient basis. Physicians who have privileges at a health facility or agency or a state correctional facility may supervise more than four physician assistants; but the physician assistant to physician ratio is 2:1 if the physician supervises a physician assistant at more than one location. MCLS § 333.17048

Minnesota: The state of Minnesota allows a physician to supervise five physician assistants simultaneously. In the case of an emergency a physician may supervise more than five physician assistants at any given time. MINN. STAT. §147A.01

Summary of factual data and analytical methodologies:

In recognition of physician work-force shortages and at the request of the Council on Physician Assistants, the Medical Examining Board created a work group to research and advise the board on whether or not to increase the supervision ratio of physician assistants to physicians, and if so under what circumstances. The work group consisted of members of the Medical Examining Board, who are licensed physicians, the chairperson of the Council on Physician Assistants and consultation from the State Medical Society, the Wisconsin Council of Physician Assistants and the Wisconsin Hospital Association. Members of the work group examined the statutes and regulations of other states as well as recommendations of the Federation of State Medical Boards, the

American Medical Association, the American Association of Family Practitioners and the American Academy of Physician Assistants.

The national trend, as recognized by the Federation of State Medical Boards and the American Academy of Physician Assistants, is to increase the number of physician assistants a physician may supervise. Both organizations have, as a national model, recommended that regulatory bodies refrain from specifying a particular number of physician assistants a physician may concurrently supervise. Rather, the recommendation is that supervising physicians make the determination based on prevailing standards for competent medical practice, day-to-day realities, and the nature of the physician's actual practice.

The work group presented its findings to the Medical Examining Board with a recommendation that the board increase the ratio from 1:5. The board considered several factors including practice setting in which physician and physician assistants carry out their duties and patient care issues such as a growing shortage of health care practitioners in underserved communities. The board emphasized the need for adequate physician supervision of physician assistant's practice and adopted the work group's recommendation to increase the ratio of physician assistants a physician may supervise. However, after extensive discussion, the board decided to authorize a physician to physician assistant supervision ratio of 1:4. The proposed rule would continue to allow the board, in its discretion, to increase the ratio in individual circumstances.

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

The department finds that this rule will have no effect on small business as small business is defined in 227.114 (1), Stats.

Anticipated costs incurred by the private sector:

The department finds that this rule will incur no additional cost to the private sector.

Fiscal Estimate and Economic Impact Analysis:

The proposed rule is not anticipated to have any fiscal impact on businesses, public utility rate payers, local government units or the state's economy as a whole. The proposed rule was posted on the department's website for 14 days. Comments were solicited. The department did not receive any comments regarding an economic impact from local government units, specific business sectors or public utility rate payers. Therefore, the department finds the proposed rule will have no economic impact.

Effect on small business:

The department finds that this rule will have no effect on small business as small business is defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted at Bill.Wendle@wisconsin.gov or by calling (608) 267-2435.

Agency contact person:

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

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

Comments may be submitted to Shawn Leatherwood, Paralegal, Department of Safety and Professional Services, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708-8935, or by email to Shancethea.L Leatherwood@wisconsin.gov. Comments must be received on or before February 15, 2012, to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Med. 8.01 is renumbered Med 8.01 (1) and amended to read:

Med 8.01 Authority and purpose. (1) The rules in this chapter are adopted by the medical examining board pursuant to authority in ss 15.08 (5), 227.11, 448.04 (1) (f) and 448.40, Stats., and govern the licensure and regulation of physician assistants.

SECTION 2. Med 8.01 (2) is created to read

Med 8.01 (2) Physician assistants provide health care services as part of physician-led teams, the objectives of which include safe, efficient and economical health care. The realities of the modern practice of medicine and surgery require supervising physicians and physician assistants to use discretion in delivering the health care services, typically at the level of general supervision. The constant physical presence of a supervising physician is often unnecessary. The supervising physician and the physician assistant are jointly responsible for employing more intensive supervision when circumstances require direct observation or hands-on assistance from the supervising physician.

SECTION 3. Med 8.02 (1) is renumbered 8.02 (1m)

SECTION 4. Med 8.02 (1), (4m) and (7) are created to read:

Med. 8.02 Definitions. (1) "adequate supervision" means the supervising physician has knowledge of the physician assistant's training, skill and experience pertaining to the acts undertaken; the supervising physician knows the scope of the health care to be provided; the supervising physician is competent and credentialed to perform

the act; and there is an adequate physician-to-physician assistant ratio, taking into consideration the training, skill and experience of the physician assistant, risk of harm to the patient due to the nature of the procedure, and risk of harm due to characteristics of the patient.

(4m) "General supervision" means off-premises supervision, and may include on- premises or face-to-face contact between the supervisor and the physician assistant being supervised as necessary. Between direct contacts, the supervisor is required to maintain indirect, off-premises telecommunication contact such that the physician assistant can, within 15 minutes, establish direct telecommunication with the supervisor.

(7) "Supervising physician" means a physician licensed in this state, who has an unlimited and unrestricted license, and who has accepted responsibility for providing adequate supervision of medical services provided by a physician assistant.

SECTION 5. Med 8.05 (2) (title), Med 8.05 (2) (b), are amended to read:

Med 8.05 (2) (title) EXAMINATIONS, PERSONAL APPEARANCE, PANEL REVIEW OF APPLICATIONS

Med 8.05 (2) (b) An applicant may be required to complete an oral examination or a personal appearance or both if the applicant:

SECTION 6 Med 8.05 (2) (b) (7) is amended to read:

Med 8.05 (2) (b) (7) ~~Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.~~ Has been diagnosed with any condition, impairment, or illness, including a personality disorder, which presents a risk of harm to another person.

SECTION 7 Med 8.05 (2) (c) is amended to read:

(c) An application filed under this chapter shall be reviewed by an application review panel of at least 2 council members designated by the chairperson of the board to determine whether an applicant is required to complete an oral examination or a personal appearance or both under par. (a) (b). If the application review panel is not able to reach unanimous agreement on whether an applicant is eligible for licensure without completing an oral examination or a personal appearance or both, the application shall be referred to the board for a final determination.

SECTION 8. Med 8.05 (2) (e) is created to read:

(e) The board may require an applicant to complete a personal appearance for purposes of interview or review of credentials or both. An applicant's performance at a personal appearance is satisfactory if the applicant establishes to the board's satisfaction

that the applicant has met requirements for licensure and is minimally competent to practice medicine and surgery.

SECTION 9. Med 8.07 (1) is amended to read:

Med 8.07 Practice. (1) SCOPE AND LIMITATIONS. ~~In providing medical care, the entire~~ The practice of any physician assistant shall be under the supervision of a licensed physician one or more supervising physicians. The scope of practice is limited to providing medical care specified in sub. (2). ~~A physician assistant's practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the supervising physician. A medical care task assigned by the supervising physician to a physician assistant may not be delegated by the physician assistant to another person.~~

SECTION 10. Med 8.07 (1) (a) and (b) are created to read:

Med 8.07 (1) (a) A physician assistant's practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the supervising physician.

Med 8.07 (1) (b) A medical care task assigned by the supervising physician to a physician assistant may not be delegated by the physician assistant to another person.

SECTION 11. Med 8.07 (2) (a) and (e) are amended to read

Med 8.07 (2) (a) Attending initially a patient of any age in any setting to obtain a personal medical history, perform an appropriate physical examination, and record and present pertinent data concerning the patient ~~in a manner meaningful to the supervising physician.~~

Med 8.07 (2) (e) Assisting the supervising physician in a hospital or facility, as defined in s. 50.01 (1m), Stats., by assisting in surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries and accurately writing or executing orders ~~under the supervision of a licensed physician.~~

SECTION 12. Med 8.08 (title) and Med 8.08 (1) are amended to read:

Med 8.08 Prescribing ~~limitations; authority; written guidelines for supervised prescriptive practice required; written guidelines for periodic review of prescriptive practice required.~~ (1) Written guidelines for supervised prescriptive practice are required. A physician assistant may not prescribe or dispense any drug independently. A physician assistant may ~~only~~ prescribe or dispense a drug medication pursuant to written guidelines for supervised prescriptive practice. ~~The guidelines shall be kept on file at the practice site and made available to the board upon request.~~

SECTION 13. Med 8.08 (1) (a), (b), (c) and (d) are created to read:

Med 8.08 (1) (a) The written guidelines shall specify the patient situations and categories of medication for which prescriptions or dispensing are authorized. The situations and categories shall be determined by mutual agreement between supervising physician and physician assistant, taking into account the physician assistant's training experience and the requirements of competent medical practice.

Med 8.08 (1) (b) The written guidelines shall include a process and schedule for periodic review of the prescriptive practice of the physician assistant, including the frequency of review and the method used to select prescriptive orders and patient records to be reviewed.

Med 8.08 (1) (c) The written guidelines shall be maintained at the practice site and shall be made available upon request of the board or its designee. The written guidelines shall be updated in response to changes in the practice and experience of the physician assistant.

Med 8.08 (1) (d) The supervising physician and physician assistant shall review the written guidelines at least once annually, unless more frequent review is necessary for competent medical practice. Dated signatures of the supervising and the physician assistant, verifying that the review has occurred shall be maintained with the written guidelines.

SECTION 14. Med 8.08 (2) is repealed and recreated to read:

Med 8.08 (2) Physician assistants are authorized to prescribe if all of the following conditions apply:

- (a) The supervision requirements of s. Med 8.10 are met.
- (b) The prescription orders contain all information required under s. 450.11 (1) Stats.
- (c) The prescriptive practice conforms to s. 448.21 Stats.
- (d) The prescriptive practice is not otherwise prohibited by law.

SECTION 15. Med 8.08 (3) (a) is repealed and recreated to read:

Med 8.08 (3) (a) The periodic review of the physician assistant's prescriptive practice required by Med 8.08 (1) (b) shall include at least one of the following:

SECTION 16. Med 8.08 (3) (b) is amended to read:

Med 8.08 (3) (b) The supervising physician shall determine the method and frequency of the periodic review based upon the nature of the prescriptive practice, the

experience of the physician assistant, and the welfare of the patients. The periodic review of prescriptive practice shall be performed according to the written guidelines required under Med. 8.08 (1) (b). The process and schedule for review shall indicate the minimum frequency of review and identify the selection of prescriptive orders or patient records to be reviewed.

SECTION 17. Med 8.08 (3) (c), (d), and (e) are created to read:

Med 8.08 (3) (c) The periodic review of prescriptive practice must occur at least annually. Additional review of prescriptive practice may occur, as set out in the written guidelines for supervised prescriptive practice, or if the supervising physician determined additional review is necessary for competent patient care.

Med 8.08 (3) (d) At least annually, the supervising physician and the physician assistant shall document compliance with the guideline's requirement of periodic review. Documentation of compliance shall be dated signatures, and shall indicate that during the preceding period of time, the periodic review of prescriptive practice occurred as set out in the written guidelines.

Med 8.08 (3) (e) Documentation of the periodic review must occur at least annually but may occur more frequently at the discretion of the supervised physician or as agreed upon in the written guideline. Documentation that the periodic review has occurred need not be documented during each review. The documentation that the periodic review has occurred shall be maintained with the written guidelines for supervised prescriptive practice.

SECTION 18. Med 8.10 (title) and Med 8.10 (1) are amended to read:

Med 8.10 Employment requirements; supervising physician responsibilities
Supervising physicians; physician to physician assistant ratio. (1) No physician may concurrently supervise more than 2 physician assistants unless the physician submits a written plan for the supervision of more than 2 physician assistants and the board approves the plan. A physician assistant may be supervised by more than one physician. A supervising physician shall supervise physician assistants as part of a physician-led team in a manner consistent with competent medical practice, considering the type and circumstance of the physician's practice and the authority delegated to the physician assistant. The physician assistant's scope of practice must be mutually understood by the physician and physician assistant, and consistent with the physician assistant's level of competence. A supervising physician may not concurrently supervise more than four physician assistants unless a written plan to do so has been submitted to and approved by the board.

SECTION 19. Med 8.10 (2) is repealed

SECTION 20. Med 8.10 (3) and (4) are renumbered and amended to read:

(3 2) The supervising physician or substitute supervising physician shall be available to the physician assistant at all times for consultation either in person or within 15 minutes of contact by telecommunications or other electronic means.

(4 3) A supervising physician shall visit and conduct an on-site review of facilities attended by the physician assistant at least once a month. Any patient in a location other than the location of the supervising physician's main office shall be attended personally by the physician consistent with his or her medical needs. The constant physical presence of a supervising physician is not required, however the methods utilized for supervision must allow the physician to fulfill all supervisory duties required by law including competent medical practice.

(END OF TEXT OF RULE)

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

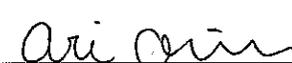
Dated _____

Agency _____

Chairperson
Medical Examining Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Ari Oliver, Program and Policy Analyst		2) Date When Request Submitted: January 31, 2012 <small>Items will be considered late if submitted after 4:30 p.m. and less than:</small> <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Wisconsin Medical Examining Board			
4) Meeting Date: February 15, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? ARRA Grant – Online Verification System Live Demonstration	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input checked="" type="checkbox"/> Yes by Ari Oliver, Nikhil Zaveri, Kevin Spaulding (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: For informational purposes, the ARRA Grant Project Staff will provide the MEB with a live demonstration of the new Online Verification System ("OVS"). The Online Verification System is a web-based application that electronically receives and fulfills requests to verify professional credentials issued by the Wisconsin Department of Safety and Professional Services to Medical and Osteopathic Boards and Third Parties. The Online Verification System is currently in testing and will go live in March 2012.			
11) Authorization			
 Signature of person making this request		01/31/2012 Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. 			



STATE OF WISCONSIN
Department of Safety and Professional Services
1400 E Washington Ave.
Madison WI 53703

Governor Scott Walker Secretary Dave Ross

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: <http://dsps.wi.gov>

Voice: 608-266-2112 • FAX: 608-267-0644 • TTY: 608-267-2416

Midwest Licensure Portability Task Force

Hybrid Online Verification System

January 2012

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I. INTRODUCTION

On March 1, 2010, the Health Resources and Services Administration of U.S. Department of Health and Human Services awarded a \$498,000 grant to the Wisconsin Department of Safety and Professional Services. The purpose of the grant was to create a multi-state Task Force that would collaborate to reduce and eliminate barriers to the cross-border practice of medicine. The Task Force identified improving the quality and increasing the quantity of information shared amongst State Medical and Osteopathic Boards as essential to reducing barriers to the cross-border practice of medicine. Therefore, a significant portion of the grant funding was dedicated to the development of the Online Verification System (OVS). The primary purposes of OVS is to improve communication amongst State Medical and Osteopathic Boards and other state licensing and regulatory agencies by developing a licensure verification process that is more relevant to licensing decisions and more efficient to request and review.

The purpose of this document is to explain how the Hybrid Online Verification System (OVS) functions, how OVS is designed and how a Medical Board may link to OVS. The document and appendices are intended to provide a comprehensive overview of all aspects of OVS and provide Executive Directors and State IT Staff the information required to determine if and when it may link to OVS.

To get the most from this document, please review the definitions in Appendix 1 and keep them in mind as you read the Hybrid Online Verification System document.

A. Purpose of the Hybrid Online Verification System

The purpose of the Hybrid Online Licensure Verification System (OVS) is to electronically receive and fulfill requests to verify professional credentials issued by Linked Boards to Medical Boards and Third Parties.

B. Current Issues & Improvements

The primary goal of the Licensure Portability Grant Program is to reduce barriers to the cross-border licensing of physicians and, therefore, increase the portability of physician licenses. Improving how states' Medical Boards share information among themselves is instrumental to breaking down barriers to the cross-border practice of medicine and to increasing licensure portability. Currently, most information pertinent to licensing decisions that is shared among Medical Boards is shared through the licensure verification process. Yet, current licensure verification processes may actually impede licensure portability instead of facilitating it. To improve licensure portability, licensure verification processes must evolve to allow Medical Boards to fully rely upon information obtained from other Medical Boards' licensing and regulatory processes in making licensing decisions.

The current licensure verification processes through which Medical Boards verify information to one another are inherently inefficient, widely variable and offer no assurances that the shared information is current and complete. Specifically, licensure verification processes rely on static information, do not indicate whether a licensee is under investigation and do not facilitate communication among the Medical Boards sharing information. Due to these issues, Medical Boards are put in precarious situations in which they must make licensing decisions based on information that they cannot be certain is current or complete.

The first issue is that all of the currently available licensure verification processes rely on static information. Static information is either printed on paper or displayed as a fixed electronic document, such as a .pdf document. A Medical Board's reliance on static information in making its licensure decisions is an issue because licensing decisions are not made upon receipt of the verification information. Rather, a Medical Board makes its licensing decision only after receiving all of the required documentation, and the licensure verification is merely one of many documents that a Board typically requires. Therefore, there is a gap of time between the creation of licensure verification by one Medical Board and the licensing decision of another Medical Board. While the gap of time can be a matter of days, more typically it is a matter of weeks or months. In that time, there are no indications as to whether the static licensure information encapsulated in the licensure verification has changed. Still, a Medical Board has few other realistic options than to completely rely on the static information.

The second issue is that most licensure verification documents do not indicate whether a Medical Board is currently investigating the licensee. When verification documents do not include any mention of pending investigations, a Medical Board receiving the licensure verification does not know if there are no investigations pending or that the Medical Board verifying the license does not share the information. Therefore, Medical Boards are forced to rely wholly on the applicant disclosing the fact of any pending investigations on his or her application without having any expedient way to verify the applicant's statements. Not having access to complete and current information about an applicant hinders the licensure process of the Medical Board receiving the verification document.

The third issue is the lack of dialogue between Medical Boards that verify a license and Medical Boards that receive the verification. The lack of dialogue is an issue because, as described above, verification documents do not convey all of the licensing information critical to another Medical Board's licensure decision-making process.

The Hybrid Online Verification System solves the three issues inherent with the current verification processes described above. It is uniquely situated to implement enhancements to the current verification processes because it was developed and is housed by the Wisconsin Department of Safety and Professional Services, of which the Wisconsin Medical Examining Board is a part. It was developed in consultation with licensing and credentialing staff for many types of regulatory boards and does not rely on non-governmental entities to fulfill verification requests. Therefore, OVS is truly designed to improve interstate communication among boards and to enable all board to share more information with one another. Further, OVS was developed to address critiques of current licensure verification processes gathered from Wisconsin's nine partner Medical Boards that are taking part in the Licensure Portability Grant Program.¹

First, OVS relies on real-time information instead of static information. Therefore, the Recipient of a licensure verification processed by OVS is able to rely on the most up-to-date licensure information available. The Online Verification System displays real-time verification information that is securely extracted from the Linked Board's existing database each and every time a Recipient views the secured Certification Webpage. Moreover, the Certification Webpage displays the most up-to-date licensure information, including any changes or additions, for up to one year. The one-year period to access real-time information enables a Recipient to do an initial review of the licensure verification and recheck it to

¹ The nine partner Medical Boards that participated in the Licensure Portability Grant Program with Wisconsin were from: Illinois, Indiana, Iowa, Kansas, Michigan (medical and osteopathic), Minnesota, Missouri and South Dakota.

see if anything has changed prior to finalizing any decisions in reliance of the licensure verification information.

Second, in addition to displaying real-time licensure information, OVS is enabled to indicate whether the licensee is currently under investigation in real-time. If a Medical Board is able to share whether a licensee is under investigation, OVS will automatically indicate whether a licensee is under investigation on the Certification Webpage. Further, each Linked Board is able to define at what point in its own complaint and investigation process it will constitute a “pending investigation” that OVS will display. However, as all information regarding investigations is sensitive in nature, OVS is designed only to indicate whether a licensee is under investigation to other Medical Boards explicitly designated as Enhanced Medical Boards by the Linked Boards. The Hybrid Online Verification System will never display an indication as to whether a licensee is under investigation to Third Parties or Non-Enhanced Medical Boards.

Third, OVS facilitates communication among Medical Boards with the “Communication Log” and “Document Upload” features on each Certification Webpage viewed by an Enhanced Medical Board. Along with the indication of investigation status described above, Enhanced Medical Boards have access to the communication features that enable them to send and receive secure messages and view additional documentation uploaded by a Linked Board. The communication features correlate to a specific Certification Webpage and are only available to the specific Recipient of that verification. Therefore, both the Enhanced Medical Board and the Linked Board are able to securely communicate with one another without fear that the information will extend beyond the two parties involved with the exact verification transaction.

C. Background

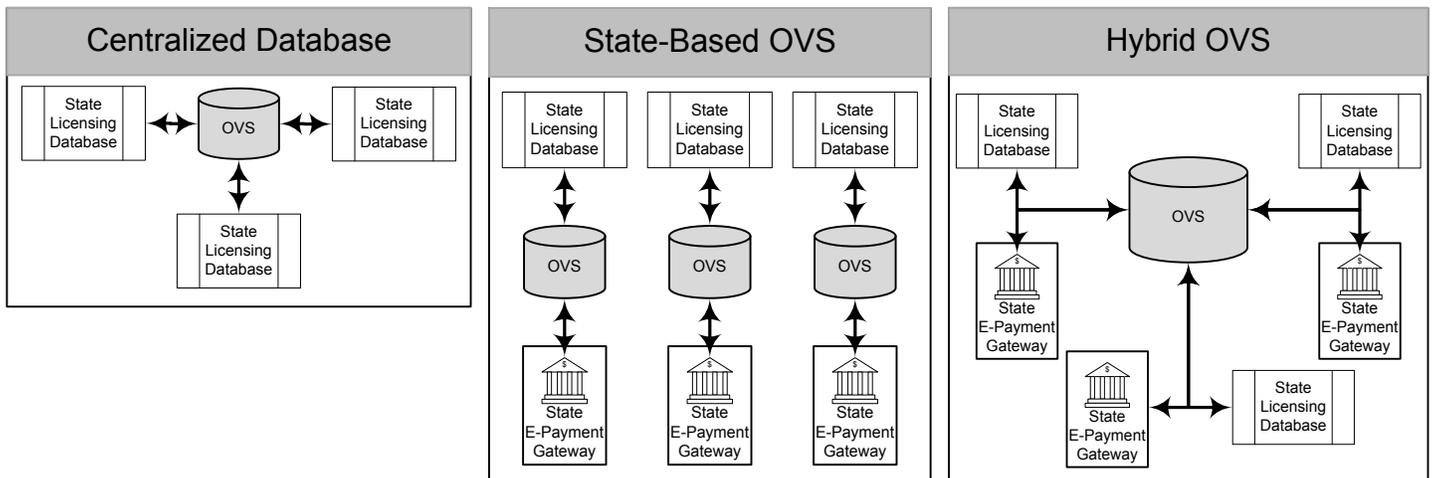
As originally scoped in the Licensure Portability Grant Program application, OVS was designed to be a centralized licensing database. Basically, each Medical Board would have been required to periodically upload a duplication of the information stored in its licensing database to the centralized database. Each Medical Board would have had access to the information stored in the centralized database at all times. Further, OVS would have supplanted the current verification processes and licensees would no longer have been the initiate of the interstate information-sharing process.

A centralized database would have fundamentally improved the way Medical Boards share information with one another. However, offsetting the improved flow of information among Medical Boards were concerns over the high estimated maintenance costs and the lack of statutory authority to create and fund a centralized database. Further, the significant logistical and security concerns made a centralized database an undesirable long-term solution.

In its next iteration, OVS was designed to be a state-based web application that Medical Boards and other licensing authorities could deploy in their own IT environments. The intent was to design OVS to be deployable in any IT environment to minimize deployment and long-term maintenance costs for each deploying Medical Board. However, requiring each Medical Board to procure the required hardware and software and to undertake separate and redundant deployments made the state-based deployment plan an impractical solution. Further, maintaining multiple replications of OVS that would have been housed in different IT environments would have compounded the logistic and extensive human resources issues. Therefore, OVS has evolved into a “hybrid” system.

The Online Verification System is a hybrid system because it is designed utilizing a combination of the centralized database system and state-based system designs. That is, while some components of OVS are centralized, the components that made a completely centralized database undesirable remain at each individual Medical Board.

The below graphics demonstrate how the three system designs fundamentally differ. Each graphic depicts how OVS would have been deployed with three participating Medical Boards.



The Centralized ‘OVS’ Database graphic illustrates how each Medical Board would have connected directly to one database. Each Medical Board would have only been responsible for creating the web services to connect to OVS and periodically upload its licensing information. In return, each Medical Board would have access to the data stored in the central database at all times.

The State-Based OVS graphic illustrates how separate OVS replications would have been deployed at each Medical Board. Each Medical Board would have been responsible for: ensuring its IT environment has all of the necessary hardware, software and licenses; deploying OVS within its IT environment; and, making the two dependent connections to OVS. The two dependent connections would have been a connection between the Medical Board’s existing licensing database and OVS and a connection between the Medical Board’s existing payment gateway and OVS. Like the current licensure verification process, the process would have been initiated by requests for verifications from a Physician, who would still have had to pay a verification fee each time they request a licensure verification. Unlike the centralized database design, the Medical Boards could not merely connect to each others’ databases to obtain licensure information.

The Hybrid OVS graphic illustrates that it is designed using a combination of the Centralized ‘OVS’ Database design and the State-Based OVS design. With the Hybrid design, there will be a single, hosted OVS to which each Medical Board may link. However, the Hybrid OVS only facilitates information sharing among Medical Boards and does not store any Medical Board’s licensing information as it would have as a centralized database. That is, information currently stored in a Medical Board’s licensing database would never be stored by the Hybrid OVS. Similar to the State-Based OVS design, Physicians still act as catalysts for the information sharing process by submitting requests for

verification of their licenses. The Medical Boards cannot merely connect to each others' databases to obtain licensure information.

Like the State-Based design, under the Hybrid OVS design, each Board is responsible for making two connections to OVS: 1) a connection between its existing licensing database and OVS; and 2) a connection between its existing payment gateway and OVS. However, unlike the State-Based design, Medical Boards are not required to undertake duplicative deployments of OVS within each Medical Board's IT environment.

Because of its design, the Hybrid OVS lessens deployment costs and ongoing maintenance costs for all Medical Boards using OVS. Deploying the Hybrid OVS is much more cost effective than deploying the State-Based system because of the hosted components. In fact, with the Hybrid OVS, a Medical Board incurs no hardware or licensing costs to link to OVS. The only cost a Linked Board incurs to link to the OVS are the payroll costs, or vendor costs, for an IT Developer to create the two connections between the Medical Board and OVS. On average, a skilled IT Developer should be able to create the required linkages in approximately 50 to 80 hours.²

Moreover, the estimated ongoing maintenance costs for each Medical Board are significantly less than they would have been with the State-Based OVS. Under the State-Based System, Medical Boards would have been responsible for all maintenance costs associated with its replication of OVS. Under the Hybrid OVS, Linked Boards have little to no ongoing maintenance costs because the hardware will be hosted by DSPS. The only maintenance costs are associated with passively monitoring the two connections among a Linked Board's licensing database, the payment gateway and OVS.

² The estimated 50-80 hours of time it takes for an IT Developer to create the linkages between a Medical Board and OVS will vary depending on each specific Medical Board's IT environment and IT Staff.

II. BUSINESS PROCESSES

A. Introduction

In addition to understanding how the Hybrid Online Verification System came to be, it is important to understand how OVS functions and the benefits it affords each of the three user types. The three user types are: the Physician, the Recipient and the Linked Board. Each user type interacts with OVS at different points in the licensure verification process and has a different role to play. Yet, OVS is designed to streamline each user type's interaction with OVS and make the entire licensure verification process more efficient.

Below are high-level summaries of each user type's interaction with OVS. Appendix 2 provides a much more detailed exploration of the user interfaces and functioning of OVS and how each user type interacts with OVS.

B. The Physician's Experience

A Physician³ interacts with OVS by searching for his or her license, requesting that a Linked Board verify his or her license to a Medical Board or Third Party and paying a fee, if required by the Linked Board. Similar to current licensure verification processes, a Physician is still the impetus for the interstate sharing of licensure information and must request a license from each Linked Board directly. In the first iteration, a Physician may only request one verification per transaction. In the future, a Physician will be able to make requests for multiple licenses from multiple states during one verification request transaction.

The first step a Physician completes is entering OVS. The easiest way for a Physician to enter OVS is through a link displayed on the Linked Board's website. By clicking the link, OVS recognizes from which Linked Board a Physician is being routed and display headers and other information specific to that Linked Board.

Next, a Physician reads about the online verification process and instructions on how to use OVS. He or she then enters search criteria to enable OVS to query a Linked Board's licensing database. The search criteria is determined by the Linked Board and can be any combination of first and last name, license number, last four digits of a SSN or date of birth. Based on the entered information, OVS returns all results matching the criteria entered by a Physician for his or her review.

After reviewing search results, a Physician selects the license that he or she would like the Linked Board to verify. A Physician then enters his or her contact information to be used for any necessary communications regarding the verification request. Next, a Physician chooses a Recipient: either a U.S. Medical Board or a Third Party. If a Physician chooses a U.S. Medical and Osteopathic Board from the pre-populated list, the Physician does not need to enter any contact information for the Board. For the convenience of a Physician, the hosted component of OVS maintains the relevant contact information for all U.S. Medical and Osteopathic Boards so that a Physician simply needs to know to which Medical Board he or she would like to verify a license.

³ The 'Physician' user category includes anyone who submits a verification request through OVS. While the physician may submit a request him or herself, others (such as: employers, hospitals or insurance companies) may as well.

If a Physician would like to verify a license to an entity other than a Medical Board, such as an employer, insurance company or board other than a Medical Board, he or she may manually enter the Recipient's contact information. However, the Physician is responsible for the accuracy of the information that he or she manually enters.

Next, the Physician reviews a summary of his or her verification request and confirms the accuracy of the information. Once the Physician confirms the information, OVS displays and emails the Physician a request confirmation page to reference if there is an issue during the payment process. The confirmation page informs the Physician that the verification request is not complete until payment is submitted. To submit online payment, OVS routes the Physician to the Linked Board's payment gateway. Once payment is complete, the Physician is returned to a final confirmation page in OVS and the Physician receives a final email informing him or her that the verification request is complete and has been submitted to the Linked Board.

After receiving the confirmation emails, a Physician does not have any further interaction with OVS. A Physician does not have access to the Certification Webpage or any further communications sent to the Linked Board or Recipient relating to the verification request. Further, a Physician does not have access to the Communication Log or Document Upload features.

C. The Recipients' Experiences

There are three categories of Recipients, which have slightly different interactions with OVS. The three categories are: Enhanced Medical Boards, Non-Enhanced Medical Boards and Third Parties. As described below, each category of Recipients receive licensure verifications from OVS, but has varying access to the enhanced communication features of OVS. By designating categories of Recipients, OVS ensures that the Linked Boards' licensing information is only sent to the intended Recipient.

1. Enhanced Medical Boards

An Enhanced Medical Board is a Medical Board designated by the Linked Boards as suitable to: (1) view whether a licensee is currently under investigation; and (2) have access to the Communication Log and Document Upload features as well as basic licensure information. An Enhanced Medical Board's interaction with OVS begins after it receives an OVS-generated email informing the Medical Board that there is a licensure verification available for its review. The email includes a secured link to the Certification Webpage. The Certification Webpage displays the licensure verification information and is only accessible through the link included in the email.

When an Enhanced Medical Board accesses the Certification Webpage via the secured link, the Certification Webpage displays real-time basic licensure information that is extracted from the Linked Board's licensing database including: name, status of the license, issuance and expiration dates, whether the licensee has ever been the subject of disciplinary orders and links to the disciplinary orders, if any. Additionally, a Certification Webpage viewed by an Enhanced Medical Board includes an indication as to whether the licensee is currently under investigation and the Communication Log and Document Upload features of OVS.

The Communication Log feature is a component of the Certification Webpage that is only visible to an Enhanced Medical Board. It enables the Linked Board and Enhanced Medical Board to securely

communicate with one another on the Certification Webpage. It also maintains a record of the messages connected with the Certification Webpage for future reference.

The Document Upload feature is also a component of the Certification Webpage that is only visible to an Enhanced Medical Board. It enables Linked Boards to upload additional documentation regarding the specific license being verified directly to the Certification Webpage. An Enhanced Medical Board may request additional documentation from the Linked Board but is not able to upload documents itself.

The OVS sends three types of emails on behalf of the Linked Board to an Enhanced Medical Board. The first type of email informs an Enhanced Medical Board that a licensure verification is ready for review. The second type of email notifies an Enhanced Medical Board of a message from the Linked Board in the Communication Log. The email indicates the general topic of the message, as determined by the Linked Board, but does not contain the substance of the message. By indicating the topic of the message, staff at an Enhanced Medical Board is able to distinguish which members of the staff are most suited to respond to the communication. The third type of email informs an Enhanced Medical Board that a Linked Board uploaded a document to the Certification Webpage. For example, a Linked Board may upload investigatory information about the licensee or any other information that may be useful to the Enhanced Medical Board's licensing decision. The email to an Enhanced Medical Board does not include the document itself or a direct link to the document. The email merely indicates the topic of the document and a link to the Certification Webpage where the document can be accessed. The document is only accessible through the Certification Webpage.

2. Non-Enhanced Medical Boards

A Non-Enhanced Medical Board is a Medical Board that the Linked Boards have not designated as an "Enhanced Medical Board." A Non-Enhanced Medical Board is only able to view basic licensure information. All Non-Enhanced Medical Boards are included in the pre-populated list of U.S. Medical and Osteopathic Boards from which a Physician may designate the Recipient of the licensure verification. That way, there are no distinctions among Medical Boards apparent to the Physician.

A Non-Enhanced Medical Board's interaction with OVS begins when OVS sends it an email indicating that there is a licensure verification ready for review. The email explains the online verification process and includes a link to the Certification Webpage. As with all other Recipient types, a Non-Enhanced Medical Board can only access the Certification Webpage through the secure link in the email.

The Certification Webpage accessible to a Non-Enhanced Medical Board only displays basic licensure information including: name, status of the license, issuance and expiration dates, whether the licensee has ever been the subject of disciplinary orders and links to the disciplinary orders, if any. The Certification Webpage does not indicate whether the licensee is currently under investigation. Further, a Non-Enhanced Medical Board may not access the Communication Log or Document Upload features.

3. Third Parties

A Third Party is an entity that is not a Medical Board. Similar to a Non-Enhanced Medical Board, a Third Party is only able to view basic licensure information, including: name, status of the license, issuance and expiration dates, whether the licensee has ever been the subject of disciplinary orders and links to the disciplinary orders, if any.

Similar to a Non-Enhanced Medical Board, a Third Party's only interaction with OVS begins when OVS sends it an email indicating that there is a licensure verification ready for review. As with all other Recipient types, a Third Party can only access the Certification Webpage through the secure link in the email. The email indicating that an online verification is available for review and the basic licensure information displayed on the Certification Webpage is the only interaction that a Third Party has with OVS. A Third Party does not have access to the Communication Log or Document Upload features of OVS.

D. The Linked Board's Experience

A Linked Board is a Medical Board or other licensing authority that creates the necessary linkages to OVS. Most noteworthy, the linkages include web services to connect the Linked Board's licensing database to OVS and a connection between the Linked Board's payment gateway and OVS. For more information, Section IV and Appendix 3 provide a detailed overview of the technical linking process. Once all linkages are tested and deployed to the Linked Board's satisfaction, a Linked Board's interaction with OVS regards the verification request process and the Verification Administration Module.

Once deployed, a Linked Board's interaction begins after a Physician submits a request through OVS for the Linked Board to verify a license to a Recipient. In most verification request transactions, a Linked Board does not have to do anything to successfully fulfill the verification request because OVS will automatically process the verification request. However, if the licensee has any disciplinary history or is currently under investigation, OVS will not automatically process the verification request. Instead, OVS will designate the verification request as "pending" and send an email to the Linked Board informing it that a verification request requires attention before it is fulfilled. Upon receipt of the email indicating that a verification request is pending, staff at the Linked Board is able to review the Certification Webpage and licensure information prior to fulfilling the verification request. By requiring manual review of these licensure verifications, OVS gives Linked Boards the opportunity to ensure that verifications indicating potentially adverse information are accurate and appropriate.

As described above, OVS differentiates between the three types of Recipients: an Enhanced Medical Board, a Non-Enhanced Medical Board and a Third Party. While all Recipient types have access to basic licensure information, a Linked Board is only able to utilize the Communication Log and Document Upload features of OVS when the Recipient of the verification is a Medical Board designated as an Enhanced Medical Board. The indication of pending investigations, Communication Log and Document Upload features are not available to a Linked Board when the Recipient is a Non-Enhanced Medical Board or Third Party.

Similar to an Enhanced Medical Board's interaction with OVS, OVS informs a Linked Board of messages in the Communication Log from an Enhanced Medical Board through OVS-generated emails. The emails do not include the substance of the messages but do indicate the topic of the messages. To view the messages, a Linked Board may go directly to the Certification Webpage or log into its OVS Verification Administration Module. Further, a Linked Board may upload documents directly to the Certification Webpage through the OVS Verification Administration Module.

1. Verification Administration Module

The Verification Administration Module is each Linked Board's hub for information about all of its licensure verification requests and gateway to the Communication Log and Document Upload features of OVS. Basically, the Module has two facets, which are: (1) a verification request log; and (2) access to the communication features of OVS. A Linked Board can log in to the Verification Administration Module at any time to search records of its verification requests, track the progress of verification requests, review a Certification Webpage and utilize the Communication Log and Document Upload features of OVS.

The Module is designed with an intuitive interface to enable staff at a Linked Board to quickly and easily access the information stored by OVS regarding verification requests. It is important to note that while OVS does not ever store a Linked Board's licensing information, it does store basic information regarding verification requests. The information is limited to: (1) information entered regarding the Physician's license number and contact information; (2) information regarding the Recipient's contact information; and (3) whether or not payment was successfully completed. Access to this information is limited to the specific Linked Board to which it pertains. Further, the Module allows staff of a Linked Board to utilize the information regarding verification requests for its own purposes and to provide efficient customer support to the public. For example, a quick search in the Module allows staff to instantaneously respond to inquiries regarding the status of specific verification requests.

Further, the Verification Administration Module enables a Linked Board to access the Communication Log and Document Upload features of OVS. Therefore, when a Certification Webpage is intended for an Enhanced Medical Board, a Linked Board can log in to the Module to easily communicate with the Recipient and upload additional documentation.

Each Linked Board has its own Verification Administration Module and does not have any access to another Linked Board's Module. Further, a Linked Board cannot use OVS to access another Linked Board's licensing database or verification information. A Linked Board's Module is only accessible to staff at the Linked Board that have the Board's Log-In Password. The Log-In Password is assigned by OVS and must be manually entered to access a Linked Board's Module.

III. DESIGN

A. Hosted Hardware

The Online Verification System is a hybrid system because components of it are hosted by the Wisconsin Department of Safety and Professional Services (DPS), of which the Wisconsin Medical Examining Board is part, while each Linked Board's licensing information remains stored in each Linked Board's licensing database.

The DPS-hosted hardware was procured specifically and solely for OVS using funds from the Licensure Portability Grant. The hardware is physically located at DPS headquarters in Madison, Wisconsin. It resides in a secure server room and utilizes the State of Wisconsin's network and topology. The hardware is in a system environment where DPS IT Staff continually monitor system performance, perform upgrades, apply security patches, and undertake occasional reboots. All DPS-hosted OVS components are securely backed up off-site to the State of Wisconsin's data center where the backups are retained for two months. While no system configuration can guarantee 100% service availability, OVS is designed to be available at all times, except when down for routine maintenance and upgrading.

The hosted components of OVS are configured to emphasize stability, data security and reliability. There are multiple layers of redundancy to ensure OVS service is uninterrupted and that no data stored by OVS could be lost. To begin, there is a mirrored set of Hard Disk Drives (HDD) for the primary operating system partition and three HDD for the data partition configured in a RAID 5 configuration. Further, one HDD is a global hot spare that can be utilized if any of the other HDD fails. Based on the configuration of the DPS-hosted hardware, even if one HDD fails, OVS service will not be significantly interrupted.

Additionally, the OVS server has redundant power supplies. The redundant power supplies enable the OVS server to continue operating uninterrupted in the event one of the power supplies fail. Therefore, the OVS server will not experience any down time if a power supply fails and must be replaced.

The configuration of the server consists of a host Windows Server 2008 R2 operating system. It will utilize Microsoft's latest Virtualization technology called Hyper-V with hyper-threading. By utilizing Hyper-V, OVS system relies on the Microsoft Enterprise license for the host operating system, which allows a 4:1 virtual server to license ratio. In other words, OVS utilizes four virtual guest operating systems that are housed on the same physical machine. This virtualization configuration allows OVS to not only save licensing costs, but to utilize a SQL server, Web Server, and a test server all on the same physical machine. Importantly, if this system requires upgrading or needs to be moved to a newer server in the future, OVS is designed to minimize down time because OVS is on virtual disks that can be efficiently moved to another virtual environment and mounted therein.

B. Dependent Linkages

In order to become a Linked Board, a Board must develop the two linkages between itself and OVS. The first link is a web service to connect its licensing database to OVS. The second link is between an e-payment gateway to process electronic payments for verification requests and OVS, if payment is required by the Linked Board.

Section IV and Appendix 3 provide a more thorough exploration of the information required to enable a Board to create the required linkages to OVS. At a high level, a Board must develop a web service to communicate with the OVS Credential Data Service to securely transfer licensing information. The web service enables: the Physician to search and identify which license he or she would like the Linked Board to verify; OVS to determine if the verification will include potentially adverse licensure information; and, OVS to display real-time licensure information on the Certification Webpage.

If a Board charges for licensure verifications, it must also develop a linkage between OVS and the Board’s e-payment gateway. That is, the linkage must be able to receive traffic routed from OVS, accept payment, reroute the Physician back to OVS and send OVS an indication that the payment transaction was successfully completed. These responsibilities are basic functions that most e-payment gateways possess.

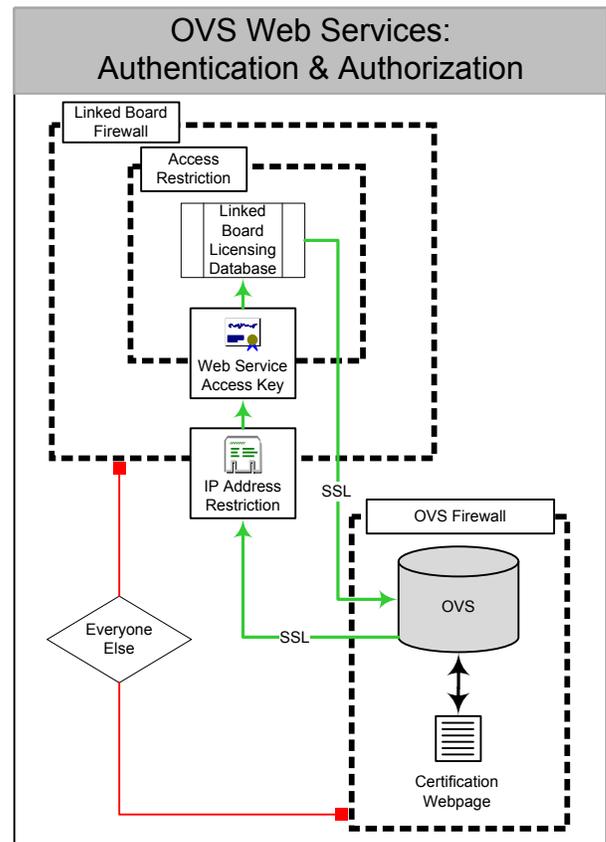
C. Security

Security is integral to the usefulness of OVS. Therefore, all aspects of OVS are highly secure; including the exposure of a Linked Board’s licensing database to OVS, the web services linking a Board to OVS and the hosted components of OVS. A Systems Architect and a State of Wisconsin Network Administrator designed the security features to ensure access is restricted to the intended users of OVS and that all information is protected at every stage of the verification request and fulfillment process. Below is a more detailed explanation of the critical security features of OVS.

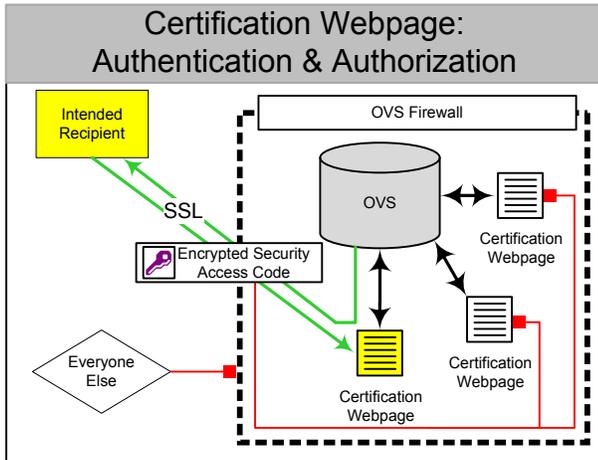
The graphic to the right illustrates how OVS uses secured web services (the green lines) to securely extract information from a Linked Board’s licensing database. It also illustrates that a Linked Board and OVS are able to prevent unauthorized attempts to access the licensing database and OVS (the red lines).

Authentication and authorization of OVS transmissions are vital to the overall security of OVS. Therefore, there are two layers of security that protect a Linked Board’s licensing database while allowing OVS to interact with the licensing database. The first layer of security relies on the authentication of OVS through IP Address Restriction. Each Linked Board will be given the IP Address corresponding to OVS. By knowing the IP Address, a Linked Board is able to authenticate transmissions to and from OVS while continuing to prohibit unauthorized attempts to access its licensing database.

The second layer of security protecting a Linked Board’s licensing database entails authorizing OVS to access the licensing database through a Web Service Access Key. All OVS transmissions to a Linked Board



include an embedded Web Service Access Key. Each Linked Board will be assigned a unique Web Service Access Key that it can rely on to verify the legitimacy of OVS transmissions.



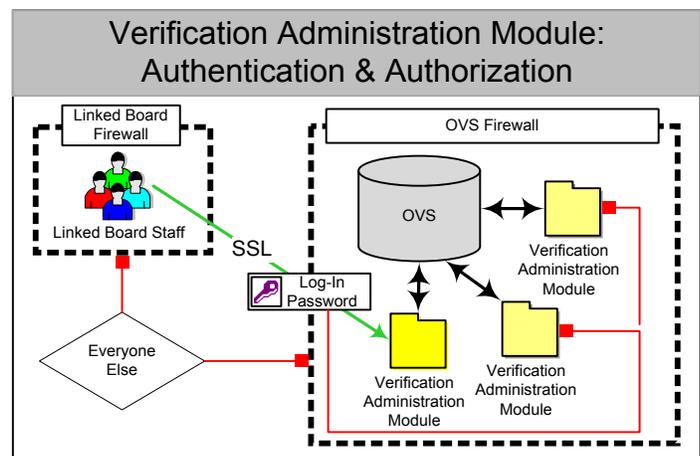
As a Linked Board’s information is in transit between its licensing database and OVS, the information is encrypted using Secure Sockets Layer (SSL) Certificates (indicated by the green lines in all of the graphics). Likewise, SSL Certificates encrypt data while in transit from OVS to a Linked Board or Recipient. This is the same technology that protects credit card information during online transactions.

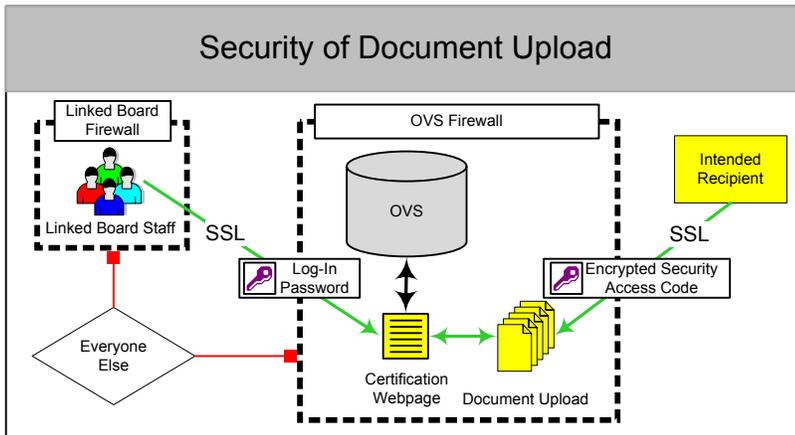
In addition to securing the transmissions between a Linked Board and OVS, the graphic to the left illustrates that OVS also utilizes authentication and authorization technology to ensure only the intended

Recipient is able to access an intended Certification Webpage. The authentication and authorization relies on the randomly-generated Encrypted Security Access Code embedded in each link emailed to an intended Recipient. The Encrypted Security Access Code embedded in the link is the sole way to access each Certification Webpage. Therefore, OVS authenticates an intended Recipient by verifying that the link and Encrypted Security Access Code are valid.

Next, OVS uses the Encrypted Security Access Code embedded in the emailed link to authorize an intended Recipient to access a specific Certification Webpage. The Encrypted Security Access Code corresponds to a single Certification Webpage (as indicated by the yellow highlighting). Therefore, a Recipient is only able to view the Certification Webpage embedded within the link emailed to it. A Recipient is not able to access a Certification Webpage for which it is not the intended Recipient. Last, each link expires after one-year and will no longer access the corresponding Certification Webpage.

Below, the graphics illustrate the security of the Verification Administration Module and Document Upload features of OVS. First, only a Linked Board is able to access the features. Both features rely on data transmissions from a Linked Board that are encrypted through SSL Certificates. Further, staff at the Linked Board is required to enter a unique Log-In Password to access the Verification Administration Module and Document Upload features of OVS. Each Linked Board is assigned a unique randomly-generate alphanumeric Log-In Password. The Log-In Password enables a Linked Board to access its own Verification Administration Module and Document Upload features. In other words, a Linked Board is only able to access its own Verification Administration Module and does not have access to the Verification Administration Module or Document Upload features pertaining to any other Linked Board.





Further, intended Recipients of a verification that includes one or more uploaded documents are only able to access documents associated with the specific verification using the Encrypted Security Access Code described above. In other words, a Recipient is only able to access documents uploaded to a Certification Webpage of which it is the intended Recipient. A Recipient does not have access to any documents associated with another Certification Webpage.

Finally, a Certification Webpage is merely an empty form when it is not in use. When the Certification Webpage is in use, OVS populates it by extracting data from a Linked Board's licensing database. The Certification Webpage does not ever store verification information or display verification information when it is not being actively viewed by an intended Recipient.

IV. LINKING A BOARD

A. Cost

There is no direct cost to link to or use OVS. Neither the Wisconsin Department of Safety and Professional Services nor the Wisconsin Medical Examining Board charge other Boards or state agencies to use OVS. Therefore, there are no required fees, either to link to or use OVS. The Hybrid Online Verification System will only generate income for a Linked Board, should it require a fee to verify a license.

Still, there are some costs involved in linking and maintaining the links to OVS. The cost a Linked Board will incur to link to OVS is the payroll costs for an IT Developer to create the linkages between the Board and OVS. On average, a skilled IT Developer should be able to create the required linkages in approximately 50 to 80 hours.⁴

Beyond developing the linkages to OVS, a Linked Board may also incur minimal costs to monitor and maintain its linkages with OVS. However, these maintenance costs would only be incurred when a Linked Board upgrades or otherwise changes its IT environment.

B. Linking Process

In general, when a Board decides to become a Linked Board, there are seven steps that it must complete to begin verifying licenses through OVS. Below is an overview of each step.

1. Licensing Agreement

The first step that a Board must complete is signing the licensing agreement. The licensing agreement describes the relationship between the Wisconsin Department of Safety and Professional Services (DPS), of which the Wisconsin Medical Examining Board is part, and the Linked Board. The licensing agreement is intended to identify each party's rights and responsibilities and to protect all of the user types of OVS. The licensing agreement is included as Appendix 4.

2. Professions

The second step is to identify which Linked Board's regulated health profession licenses will be verified through OVS. While OVS was initially intended to be specific to Doctors of Medicine (MD) and Doctors of Osteopathic Medicine (DO), it is capable of verifying all types of health profession licenses. In determining which health profession licenses will be verified through OVS, staff at a Board will work with DPS IT Staff. To avoid scalability issues and exponent increases in maintenance costs, DPS cannot guarantee that all desired health profession licenses can be verified through OVS. Yet, DPS Staff will consider all requests to verify a specific health profession license through OVS.

Further, when choosing professions to verify through OVS, a Linked Board has a decision to make. There are two ways professions can be added to OVS. They are: (1) add a profession to the Linked Board's web services; or (2) add a profession as a separate Linked Board. Adding a profession to the Linked Board's web services will enable a Physician or other licensee to search for and verify a license of that profession. However, all other aspects of the business process, including staff contacts, cost of the verification, header information and other Linked Board-specific tokens will be identical to the

⁴ See footnote 2.

Linked Board. Professions added to the web services can be sent to Enhanced Medical Boards and have access to the communication features available only on a Certification Webpage intended for an Enhanced Medical Board.

By adding a profession as a separate Linked Board, the Board has more customization options, including all of the Linked Board-specific tokens identified above. Still, professions added as a separate Linked Board will not be able to be sent to Enhanced Medical Boards as that is limited to Medical Boards. At this time, there are no ‘Enhanced’ Recipients for a Linked Board that is not a Medical Board.

As an example, DSPS plans to verify the health profession licenses of the Medical Board and affiliated credentialing boards by adding the professions to its web services. The professions include: Dietitians, Perfusionists, Respiratory Care Practitioners, Occupational Therapists, Physical Therapists, Physician Assistants, Occupational Therapy Assistants, Physical Therapist Assistants and Podiatrists. The Department is adding these professions to the web services because it does not need to customize any visible content or contacts.

Beyond health profession licenses, OVS is also capable of verifying licenses from any regulated profession. However, verifying non-health profession licenses requires content and business process changes within OVS. Therefore, DSPS will provide the OVS source code to a Board upon request to allow them to deploy a replicate of OVS within its IT environment to verify non-health profession licenses. To receive the source code, a Board must accept the terms and conditions of an open source agreement.

3. Web Services: Credential Data Service

The third step in becoming a Linked Board is to develop the required web services, known as the Credential Data Service (CDS). The CDS is essential to the functioning of OVS and is one of OVS’s two dependencies; the other is the e-payment gateway. The CDS is the web service linking a Linked Board’s licensing database and OVS. Through the CDS, the Linked Board exposes its licensing database to OVS and enables OVS to complete secure queries and transfers of data to fulfill verification requests. The CDS is not a constant connection and is only active when a Physician completes a verification request and when a Recipient clicks the link to access a Certification Webpage.

The data being transferred through CDS is limited to the information required to fulfill a verification request. To begin, OVS will use the CDS to query a Linked Board’s licensing database when a Physician is searching for his or her license to verify. The data sent by OVS depends on what search criteria a Linked Board specifies. In most cases, it includes first and last name, license number or date of birth. After receiving the query from OVS, a Linked Board’s licensing database will use the CDS to return search results to OVS. The Online Verification System will display the search results from which the Physician chooses his or her license.

Once the verification request is complete, OVS will send out an email to the intended Recipient. The email will include the link to the Certification Webpage. The moment that a Recipient clicks the link to view the Certification Webpage, OVS will use the CDS to query a Linked Board’s licensing database for the specified verification information, which includes: name, license status, and disciplinary history.

4. E-Payment Gateway

The fourth step in becoming a Linked Board is programming a link between an e-payment gateway and OVS, if required. This link is the second of OVS's two dependencies. The link to the e-payment gateway allows OVS to remain flexible and function with each Board's existing e-payment system.

The e-payment process involves OVS directing a Physician to the Linked Board's e-payment gateway to pay for a verification request. The OVS anticipates an "accepted" response from the e-payment gateway once a Physician completes a payment and for the e-payment gateway to direct a Physician back to OVS to confirm successful completion of the verification request. It is important to note that OVS is not an accounting system and only tracks payment attempts and completed payments. It is designed to work with a Board's existing payment tracking and reconciliation processes.

Last, during the linking process, a Board must establish payment parameters to enable a smooth connection to its e-payment gateway. The payment parameters are specific to each e-payment gateway and allow OVS to remain flexible in fulfilling Board-specific functions. Beyond tracking payment attempts, the redirection, "accepted" response and payment parameter requirements, the functioning of an e-payment gateway is not implicated by linking to OVS.

5. System Settings & Tokens

The fifth step a Board must complete to link to OVS is to collaborate with DSPS to define its specific settings and tokens. During this step, the Board completes a form designating its headers, fees, search criteria, support contacts and other customization options. Also during this step, DSPS will assign the Board a custom, randomly-generated Log-In Password for the Verification Administration Module. A Linked Board may submit requests to change its settings and/or tokens at any time by contacting DSPS.

Also during this step, the Board must review the list of Enhanced Medical Boards and determine if any of the already Medical Boards designated as 'Enhanced' could be an issue in regards to the Board's confidentiality policies. If the Board foresees an issue, it should communicate that to DSPS, which will propose amendments to the list to other Linked Boards. In this iteration there will be a single list of Enhanced Medical Boards that Linked Boards must agree upon. In the future, each Linked Board may be able to designate its own list of Enhanced Medical Boards.

6. Testing

The sixth step involves ensuring that all aspects of the transaction function as intended and are secure between OVS and a Linked Board. The testing process involves collaboration between the Linked Board and DSPS. It varies for each Board.

7. "Go Live"

Finally, the seventh step is to "go live," meaning that the Linked Board announces its new verification process and directs licensees wanting to verify their licenses to OVS through a link on the Board's website.

Appendix 1: Definitions of Terms

- **Enhanced Medical Board:** A Recipient Medical Board or other licensing authority that is able to view whether a licensee is currently under investigation, has access to the Communication Log to communicate with a “Linked Board” and may view documents uploaded by a “Linked Board” in addition to receiving basic licensure information such as name, credential type, license number, date of issuance, how the license was acquired, expiration date, status of license(s) and orders on the OVS verification website.
- **Host:** The Wisconsin Medical Examining Board in conjunction with the Department of Safety and Professional Services (DSPA).
- **Hybrid Online Verification System (OVS):** A web-based application that receives and fulfills licensure verification requests on behalf of Linked Boards.
- **Linked Board:** A Medical Board or other licensing authority who adopts OVS to fulfill its licensure verification process by creating the two links between itself and OVS. The two links are the payment gateway and credential data web service.
 - A “Linked Board” can upload documents and communicate through the Communication Log with “Enhanced Medical Boards.”
- **Medical Board:** A Medical and Osteopathic Board or other licensing authority that regulates the practice of medicine in a jurisdiction in the United States and its Territories.
- **Medical Board Pick-List:** A list of the Medical Boards on the user interface from which the Physician chooses which Medical Board he or she would like to receive the verification of a license.
- **Medical Board Registry:** A list of all Medical and Osteopathic Boards and their contact information in the OVS database. The Medical Board Registry is maintained by the Host.
- **Non-Enhanced Medical Board:** A Recipient Medical Board or other licensing authority that is able to view basic licensure information such as name, credential type, license number, date of issuance, how the license was acquired, expiration date, status of license(s) and orders on the OVS verification website.
- **Physician:** A person who submits a verification request to OVS.
 - A Physician includes licensees, employers, hospitals and insurance companies.
- **Recipient:** Any entity to which a Physician requests OVS send licensure verification information.
- **Third Party:** An Recipient that is not a Medical Board that is only able to view licensure information such as name, credential type, license number, date of issuance, how the license was acquired, expiration date, status of license(s) and orders on the OVS verification website.
 - A “Third Party” can be anyone and includes insurance companies, hospitals and other employers.

Appendix 2: User Experiences

Online Verification System User Categories & Experiences

The purpose of this Appendix is to demonstrate how the different categories of users interact with the Online Verification System (OVS). There are three categories of users. They are: **Physician**, **Recipient** and **Linked Board**. Each category of users will interact with OVS differently at specific steps of the online licensure verification process. On a high level, the process involves a **Physician** making a request to verify his or her license through OVS. Next, OVS completes the verification process on behalf of the **Linked Board** by sending a link to view the Certification Webpage to a **Recipient**.

The three categories of users are defined by the specific functions they execute on OVS:

- A **Physician** is a person who submits a verification request to OVS. A **Physician** includes licensees, employers, hospitals and insurance companies.
- A **Recipient** is either a **Medical Board** or a **Third Party** identified by a **Physician** to which OVS sends a verification link on behalf of a **Sending Board**.
 - o A **Medical Board** may be an **Enhanced Medical Board** or a **Non-Enhanced Medical Board**.
 - o A **Non-Enhanced Medical Board** and **Third Party** are treated the same way by OVS.
- A **Linked Board** is a **Medical Board** or other licensing authority that adopts OVS to fulfill its licensure verification process by creating the two links between itself and OVS. The two links are the payment gateway and credential data web service.

The sections of this document break down each of the three categories of users' interaction with OVS based on concept screenshots. The screenshots demonstrate basic content and function. However, the screenshots are not finalized. Therefore, some of the layout and content may change prior to complete deployment of OVS. The screenshots still provide the most effective foundation to demonstrate the interaction that each category of users will have with OVS once it is deployed.

Also, most pages include a Flow Chart that pertains to each category of user. The highlighted step corresponds to the interaction displayed on the screenshot. The Flow Charts are intended to provide context to the screenshots in terms of each user's interaction with OVS.

Table of Contents	
User Category	Page Number
Physician	22
Enhanced Medical Board	38
Non-Enhanced Medical Board or Third Party	43
Linked Board	46

Online Verification System User Experience: Physician

The purpose of this section is to demonstrate how a **Physician** experiences the Online Verification System (OVS). A **Physician** is the user who searches for his or her license, requests that the **Linked Board** verify his or her license to a **Medical Board** or **Third Party** and pays the fee, if required. A **Physician** includes licensees, employers, hospitals and insurance companies.

The screenshot shows a web browser window with the URL <https://www.verification.dsps.wi.us>. The page title is "Online Licensure Verification". The main content area has a yellow background and contains the following text:

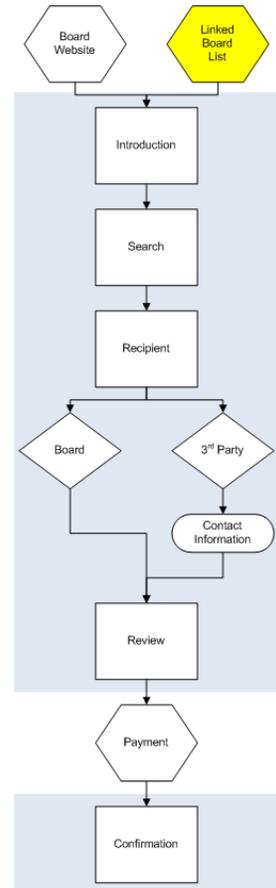
Welcome to the Online Licensure Verification System! A Licensee or Credential Holder can request that a participating state medical or osteopathic board send an official verification of his or her license and exam scores to another state board, an employer, insurance company or other interested party. To continue, please select the board that you would like to verify a license from the list below.

Professional Licensing Boards

Wisconsin Medical Examining Board

If the state medical or osteopathic board that granted you the license that you would like to verify is not listed above, please contact it directly to determine how to request a verification of your license.

Start Filing >>



Screen 1: List of **Linked Boards**. If the **Physician** does not enter OVS from a **Linked Board**'s existing website, the **Physician** must indicate from which **Linked Board** he or she would like to verify a license on this page.

https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Welcome

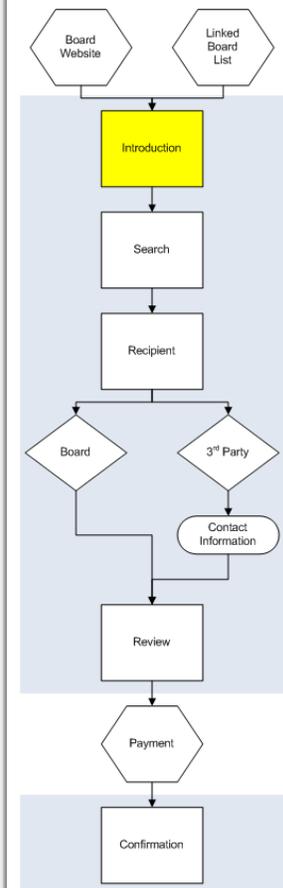
The Wisconsin Medical Examining Board is now able to officially verify licenses and exam scores electronically. By completing a Verification Request online, a licensee can request official verifications of his or her license and exam scores to be sent to state boards, employers, insurance companies and other interested parties. Upon receiving a request, the Wisconsin Medical Examining Board will send a secured link to the verification website to the recipient that the licensee designates.

The real-time information displayed on the verification website is primary source information of the Wisconsin Medical Examining Board. Further, it is consistent with JCAHO and NCQA standards for primary source verification and is as it appears in the database of the Wisconsin Medical Examining Board as of the moment it is viewed.

The fee for licensure verifications has not changed. It is still **\$10.00 per verification**.

The verification website constitutes official certification of licensure information and should be accepted just like a paper verification. However, should a recipient of an online licensure verification question its authenticity, please contact the Wisconsin Medical Examining Board directly.

Next >>



Screen 2: Introduction. On this page, the **Physician** reads background information about OVS. This page also displays the fee that the **Linked Board** charges to complete a verification request.

← →
 https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)
Wisconsin Medical Examining Board

Online Licensure Verification
Directions

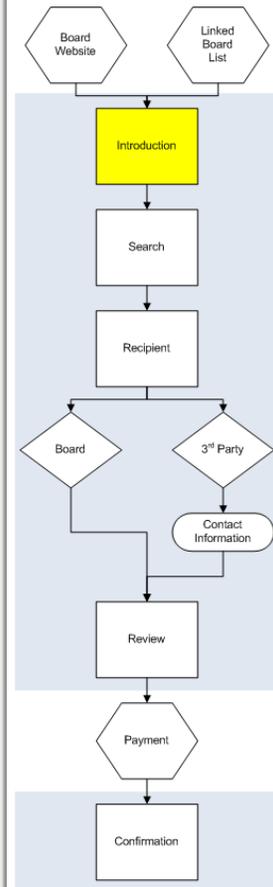
5 Steps to Submit a Verification Request

1. Find the License, Credential or Permit
2. Enter your Contact Information
3. Designate the Recipient of the Online Licensure Verification
4. Review your Verification Request
5. Pay for your Online Licensure Verification

Important Notes:

- Fields marked with * are required.
- Only use the navigation buttons located within the Verification Request. **Do not** use your browser's back/forward/reload buttons.
- Once you begin the Verification Request, you must complete all of the steps to make a request. Your information will not be saved for you to complete at a later time.
- Verification Requests are not processed until payment is confirmed.
- Print the Confirmation Page for your records.

Next >>



Screen 3: Directions. On this page, the **Physician** reads directions to submit a verification request for an online licensure verification from the **Linked Board**.

← →
 https://www.verification.dsp.s.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Step 1: Find Your License, Credential or Permit

License Search

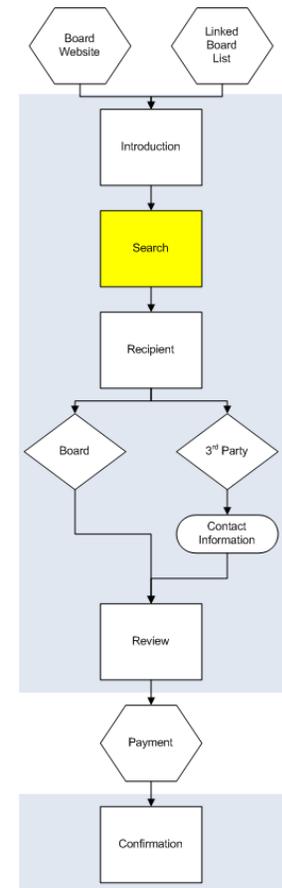
Click "Choose License" below to search for your credential.
[Choose License](#)

Next >>

Help

You can do a search for your credential.

Please call **123-123-1234** if you need assistance in completed the online verification process.



Screen 4: License Search. On this page, the **Physician** begins the process of searching for his or her license by selecting “Choose License.”

https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Finding Your License

Enter your License/Credential/Permit number or your name and date of birth

Credential Number (xxxxxx-xxx)

First Name

Last Name

Help

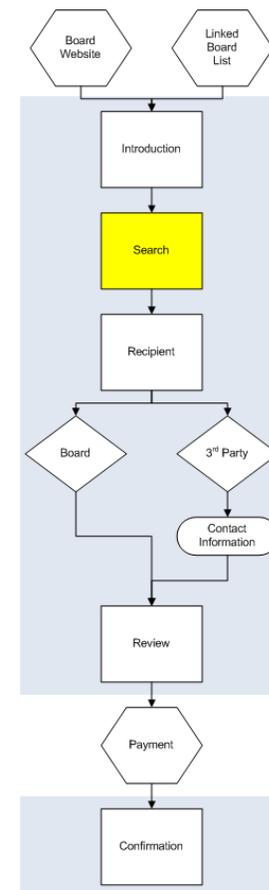
You can do a search for a specific License by entering a Credential Number. A credential number is in format xxxxxx-xxx and consists of a license number, dash (-) and profession type number.

- OR -

You can do a search for a specific License by entering exact last name and a first name or partial first name of Licensee.

The first 100 records will be returned.

Please call **123-123-1234** if you need any assistance in completing the online verification process.



Screen 5: License Search. On this page, the **Physician** enters the **Linked Board**-specific search criteria to identify the license that he or she would like the **Linked Board** to verify to a **Medical Board** or **Third Party**. The search criteria could be First and Last Name, License Number, DOB, etc. If applicable, asterisks indicate which fields are required by the **Linked Board**.

https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS) Wisconsin Medical Examining Board

Selecting Your License

Your Searched Criteria:

Credential Number
(xxxxxx-xxx)

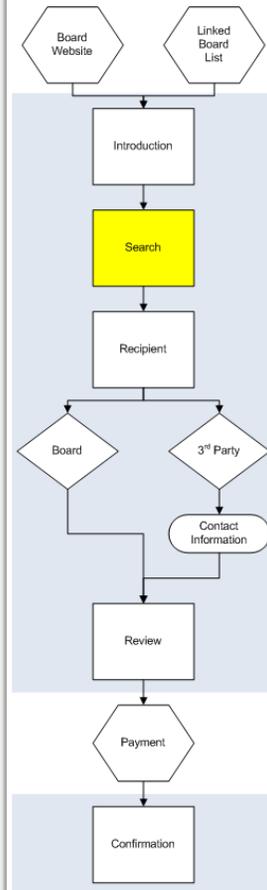
First Name John Joseph

Last Name Smith

License Search Results:

1 record(s) returned.

	Profession	Name	Location	Issue Date	Expiration Date
Select	Medicine & Surgery, MD	SMITH, JOHN JOSEPH	MADISON, WI	03/01/1977	10/31/2011



Screen 6: Search Results. On this page, the **Physician** selects the license that he or she would like the **Linked Board** to verify to a **Medical Board** or **Third Party**.

https://www.verification.dps.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Step 1: Find Your License, Credential or Permit

License Search

Licensee: JOHN JOSEPH SMITH
 License ID: 14444-20

If this is not the correct license, click "Choose License" below to search for your credential.

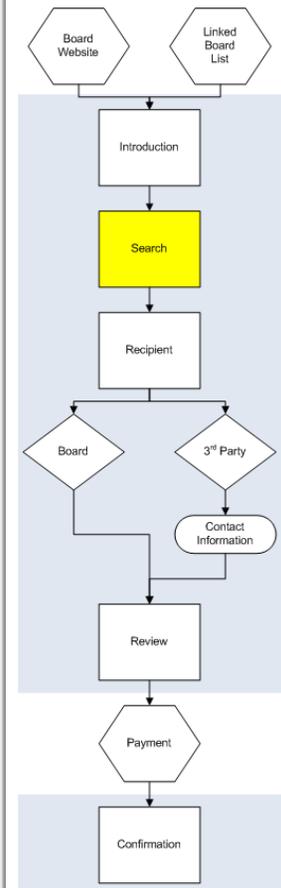
[Choose License](#)

Next >>

Help

You can do a search for your credential.

Please call **123-123-1234** if you need assistance in completed the online verification process.



Screen 7: License Confirmation. On this page, the **Physician** confirms the license that he or she searched for and selected is the exact license that he or she would like the **Linked Board** to verify to a **Medical Board** or **Third Party**.

https://www.verifaction.dps.wi.us

Wisconsin Department of Safety and Professional Services (DPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Step 2: Enter Your Contact Information

Contact Name

Full Name *

Organization

Contact Email

E-Mail Address *

Repeat *

Contact Number

Phone Number *

Extension

Fax

Contact Address

Address Line 1

Address Line 2

City

State

Zip Code

Help

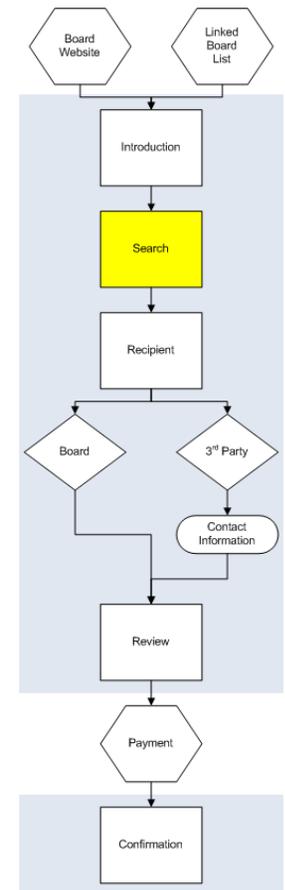
Enter your contact information to be used for any necessary communication regarding the verification request.

The E-Mail address provided will receive an E-Mail confirming that the online verification process was successfully completed.

The accuracy of the information is essential.

Asterisks * indicate which fields are required to complete your filing request.

Please call **123-123-1234** if you need any assistance in completing the online verification process.



Screen 8: Contact Information. On this page, the **Physician** enters his or her contact information to be used for communications regarding the verification request. OVS stores the information entered on this page for the **Linked Board**'s reference. Asterisks indicate which fields are required to complete the transaction.

← →
<https://www.verification.dsp.wi.us>

Wisconsin Department of Safety and Professional Services (DSPS)
Wisconsin Medical Examining Board

Online Licensure Verification
Step 3: Designate Recipient

Medical and Osteopathic Boards

Select the medical or osteopathic board that you would like to receive a verification of your license.

Iowa Board of Medicine
Professional Licensing Board of Indiana
Kansas Board of Healing Arts
Minnesota Board of Medical Practice

- OR -

Other Organization

If the organization you would like to receive a verification of your license, credential or permit is not listed above, please enter the entity's contact information below.

Organization *

Contact Name *

Address 1

Address 2

City

State

Zip Code

E-Mail Address *

Repeat *

Phone Number *

Extension

Fax

<< Previous Quit Filing Next >>

Help

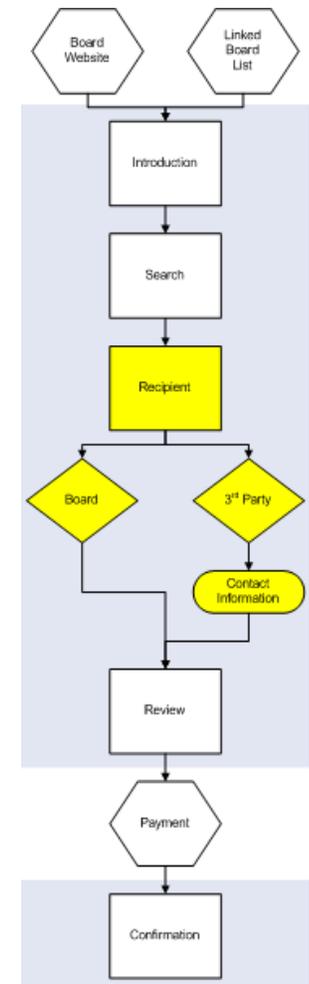
Choose the recipient of your licensure verification by selecting a medical or osteopathic board from the pre-populated list or entering the contact information of the organization, entity or other professional board you would like to receive your verification.

If you choose a medical or osteopathic board from the pre-populated list, you do not need to enter any contact information.

To ensure expedient processing of your verification request, all contact information must be accurate.

Asterisks * indicate which fields are required to complete your filing request.

Please call 123-123-1234 if you need any assistance in completing the online verification process.



Screen 9: Choose Recipient. On this page, the **Physician** chooses to which **Medical Board** from a list that he or she would like the **Linked Board** to verify his or her license or indicates that he or she would like the **Linked Board** to verify his or her license to a **Third Party**. If the **Physician** indicates that the verification is to be sent to a **Medical Board** by selecting a **Medical Board** from the **Pick-List**, the **Physician** does not enter any more information. However, if the **Physician** indicates that the verification is to be sent to a **Third Party**, the **Physician** must manually enter the **Third Party**'s contact information.

← →
 https://www.verification.dps.wi.us

Wisconsin Department of Safety and Professional Services (DPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Step 4: Review Your Verification Request

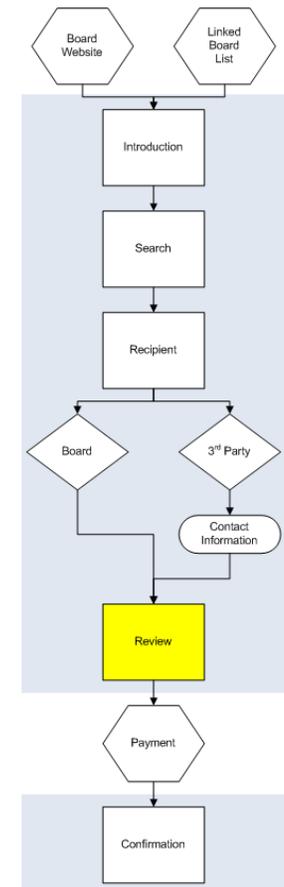
Review your Verification Request and correct any inaccurate information by returning to the corresponding page using the "Previous" navigation button.

License	
Issued By:	Wisconsin Medical Examining Board
Licensee:	JOHN JOSEPH SMITH
License ID:	14444-20

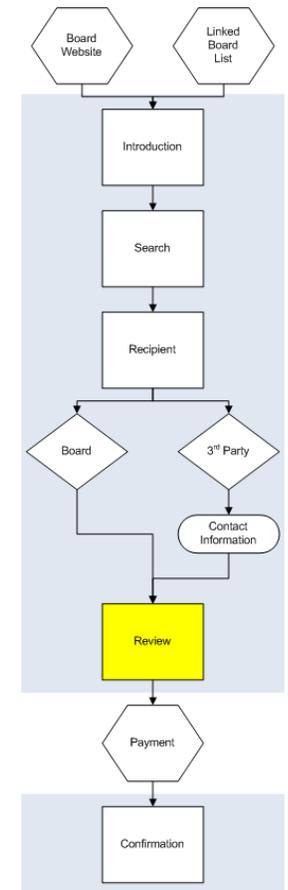
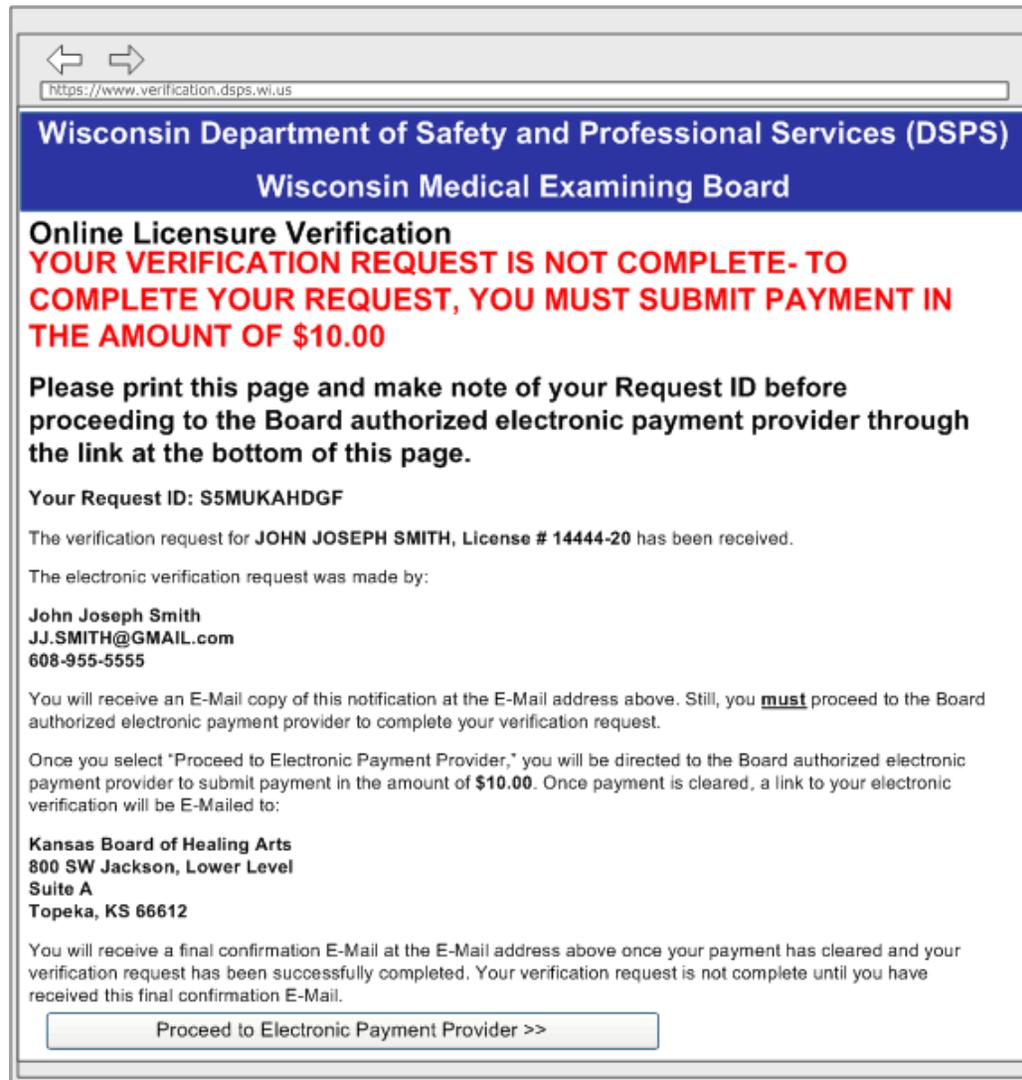
Contact Information	
Full Name:	John Joseph Smith
Organization:	
E-Mail Address:	JJ.SMITH@GMAIL.com
Phone Number:	608-955-5555
Extension:	
Fax:	
Address 1:	123 E. Main Street
Address 2:	
City:	Madison
State:	WI
Zip:	53777

Recipient	
Name:	Kansas Board of Healing Arts
Address 1:	800 SW Jackson, Lower Level
Address 2:	Suite A
City:	Topeka
State:	KS
Zip:	66612

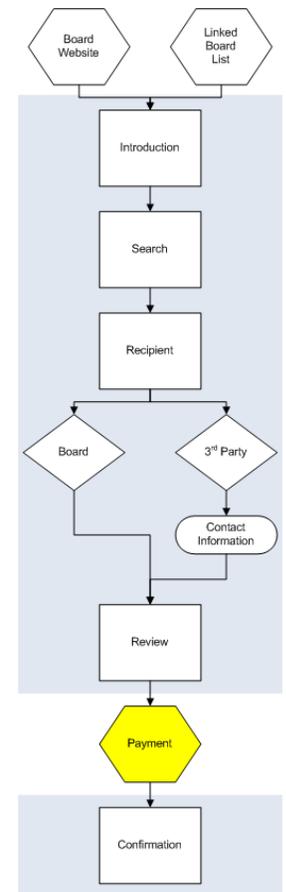
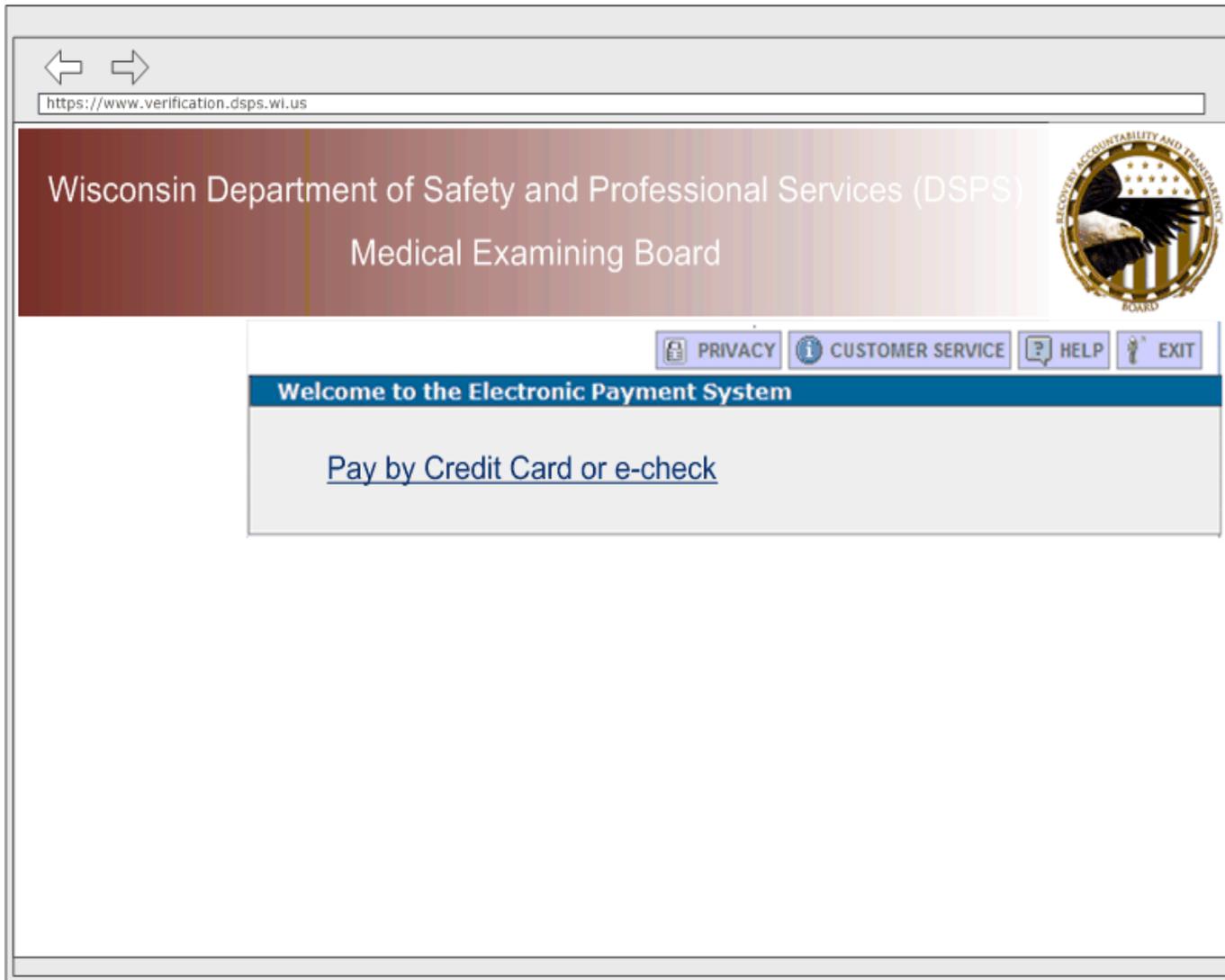
Total Payment Due	
Fee Amount:	\$10.00



Screen 10: Verification Request Review. On this page, the **Physician** reviews his or her verification request. He or she ensures all of the information is accurate and correct. The **Physician** also sees the **Linked Board**'s fee to verify the **Physician**'s license in this transaction.



Screen 11: Request Confirmation. This screen confirms that OVS registered the **Physician**'s verification request. However, it makes it clear that the transaction is not complete and the **Physician** must still submit payment to the **Linked Board**. The **Physician** must proceed to the electronic payment provider and pay the required fee to complete the verification request and for the license verification to be sent to the Recipient. If the **Physician** has difficulty completing the payment process, the **Physician** can request assistance from the **Linked Board** by referencing their Request ID noted on this page. The **Physician** also receives an email containing this information for his or her records.



Screen 12: **Linked Board's E-Payment Gateway**. This screen is merely a placeholder and is not seen by any user. It is included to indicate at which point the **Physician** is redirected to the **Linked Board's** existing E-Payment Gateway. Because OVS does not process any payment transactions, each **Linked Board** that charges for licensure verifications must provide access to its E-Payment Gateway. Therefore, this page is state-specific and corresponds to the appropriate **Linked Board**. Further, OVS does not store any payment information.

https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Medical Examining Board

Online Licensure Verification

Please print this page for your records

Your Request ID: S5MUKAHDGF

The verification request for **JOHN JOSEPH SMITH**, License # **14444-20** has been received and electronically processed.

The electronic verification request was made by:

John Joseph Smith
JJ.SMITH@GMAIL.com
608-955-5555

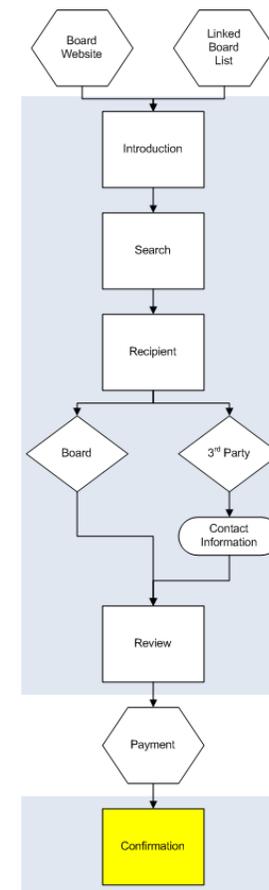
A link to your electronic verification will be E-Mailed to:

Kansas Board of Healing Arts
800 SW Jackson, Lower Level
Suite A
Topeka, KS 66612

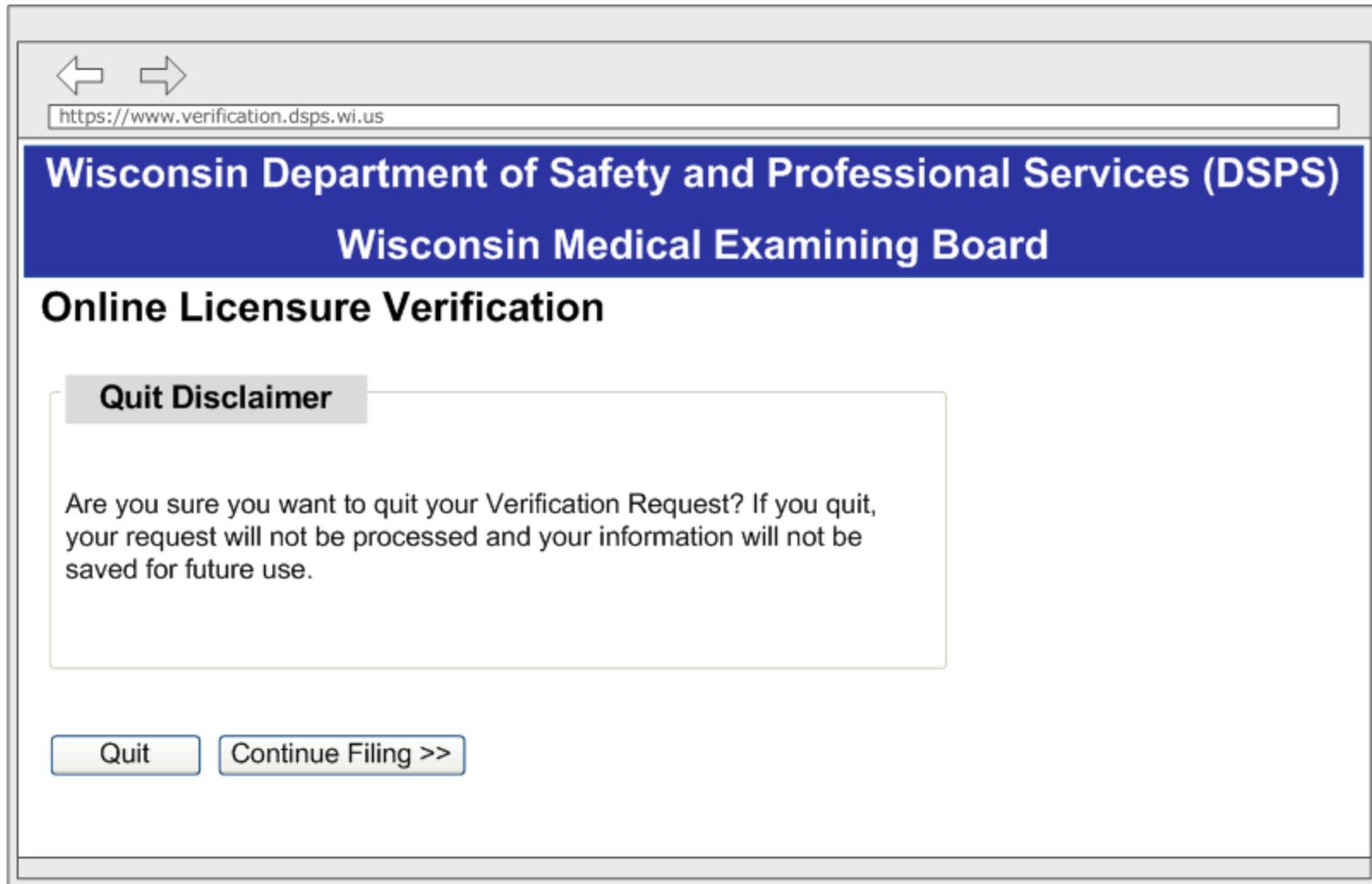
You will receive a final confirmation E-Mail at the E-Mail address.

Please contact the recipient using the information above to confirm receipt of your verification.

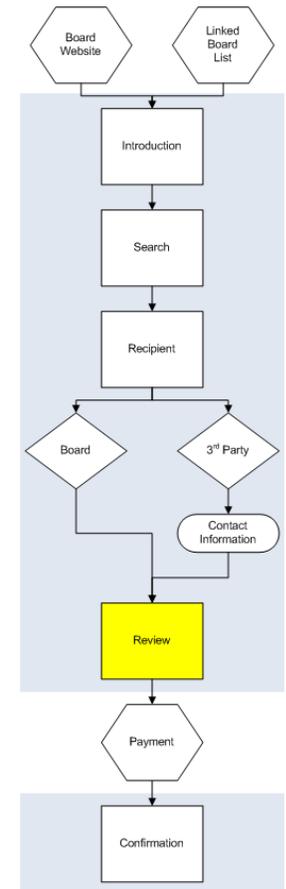
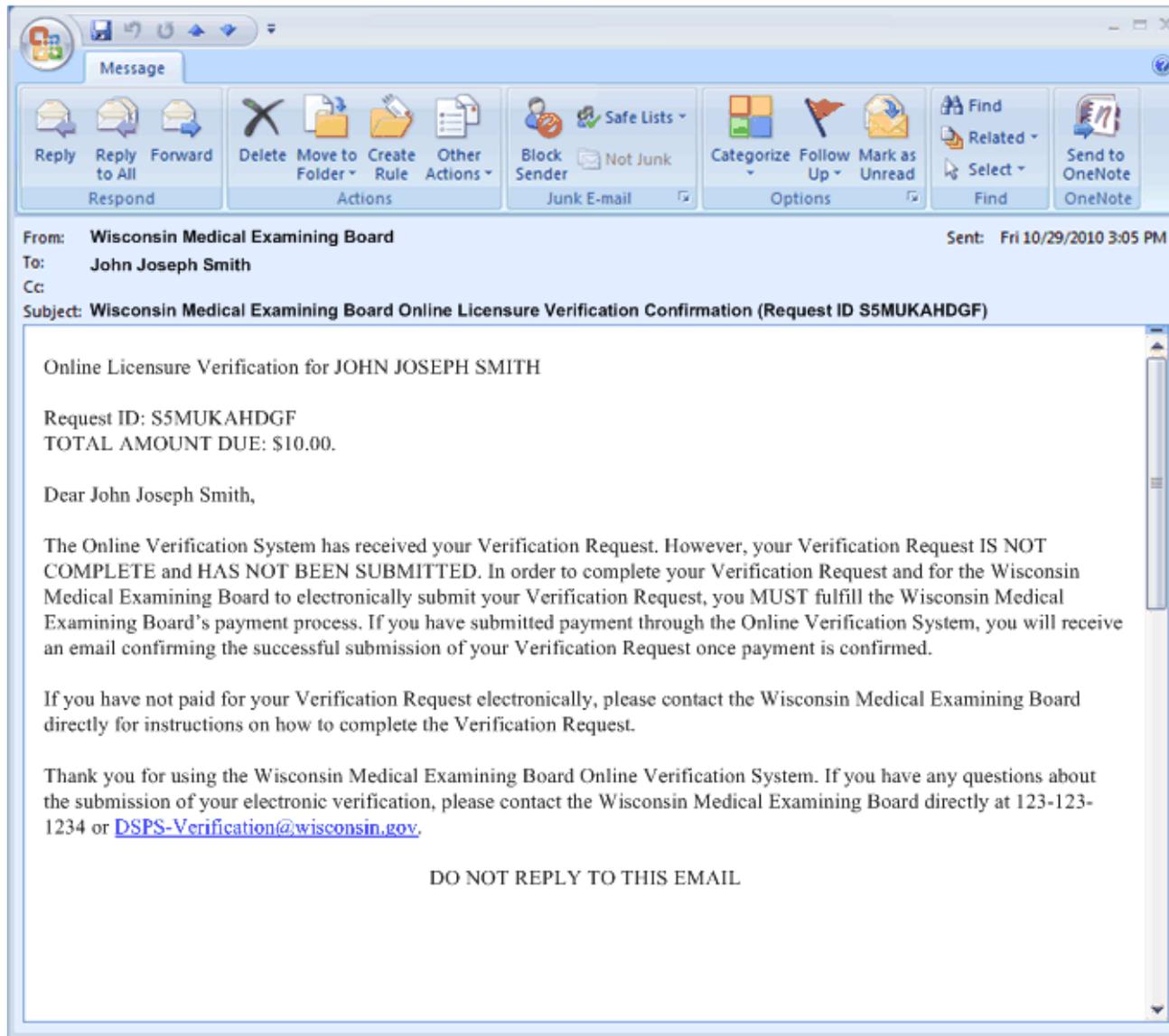
[Start New Verification Filing >>](#)



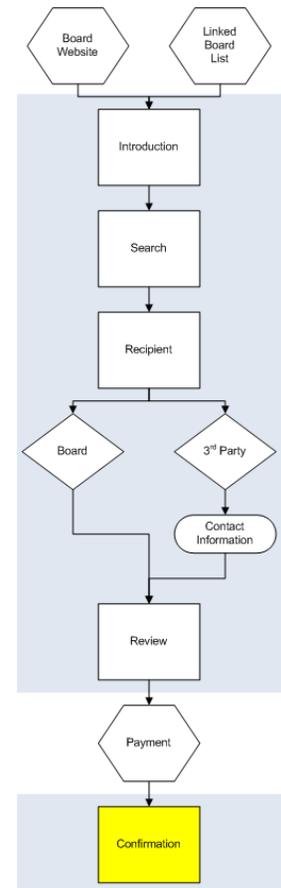
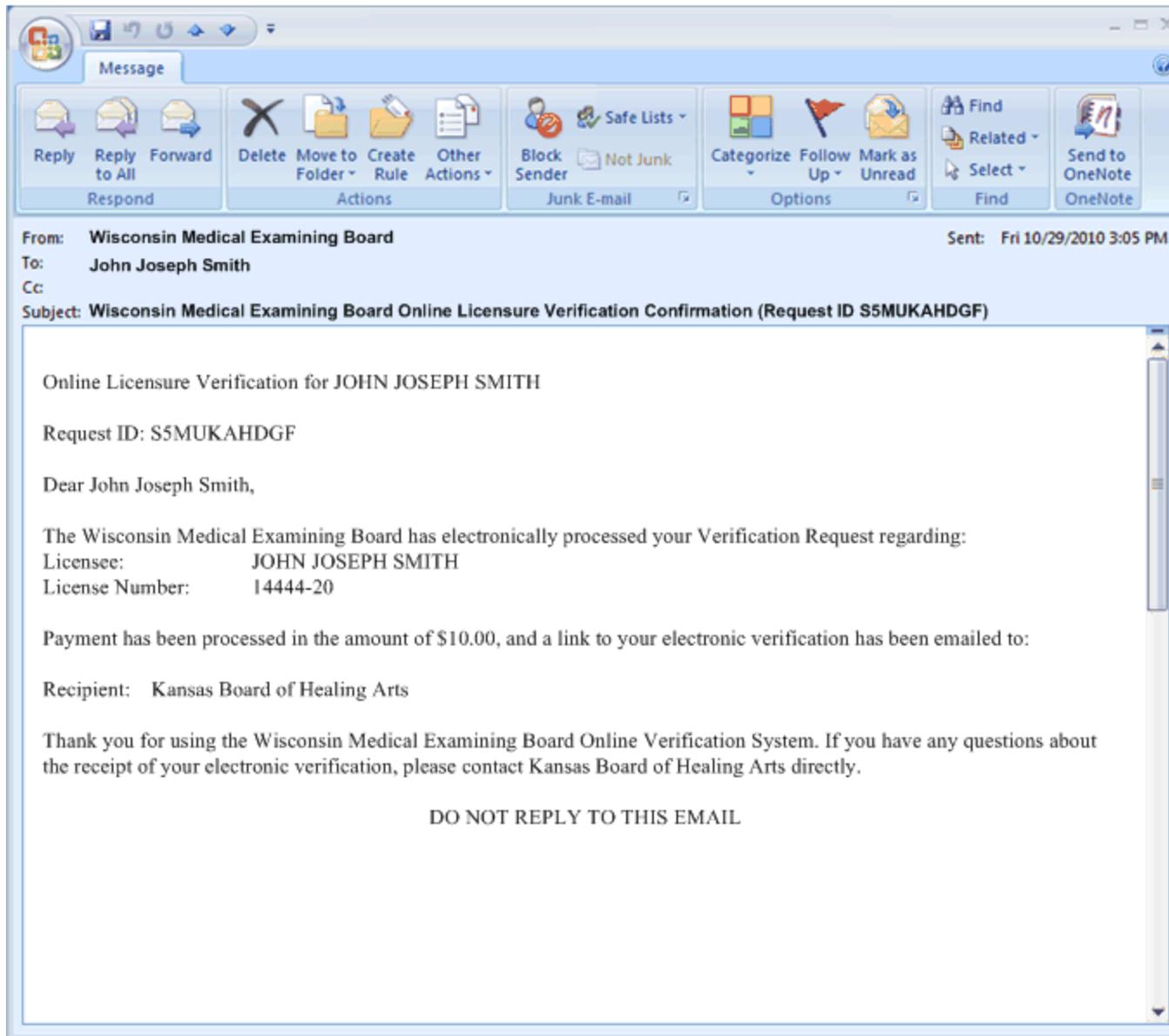
Screen 13: Final Confirmation. After the **Physician** completes payment through the **Linked Board's** E-Payment Gateway and the E-Payment Gateway indicates to OVS that the payment is complete, the **Physician** reviews the receipt of the transaction on this page. If payment fails while the **Physician** is using the **Linked Board's** E-Payment Gateway, the **Physician** does not see this page and the transaction is not processed. This page is an electronic receipt for the **Physician's** future reference.



Screen 14: Quit Disclaimer. The **Physician** sees this page any time he or she clicks the “Quit” button of any of the pages. Therefore, the **Physician** does not see it unless he or she attempts to quit his or her verification request.



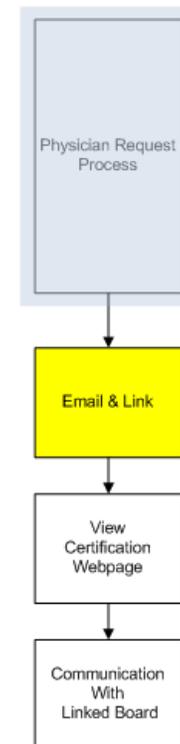
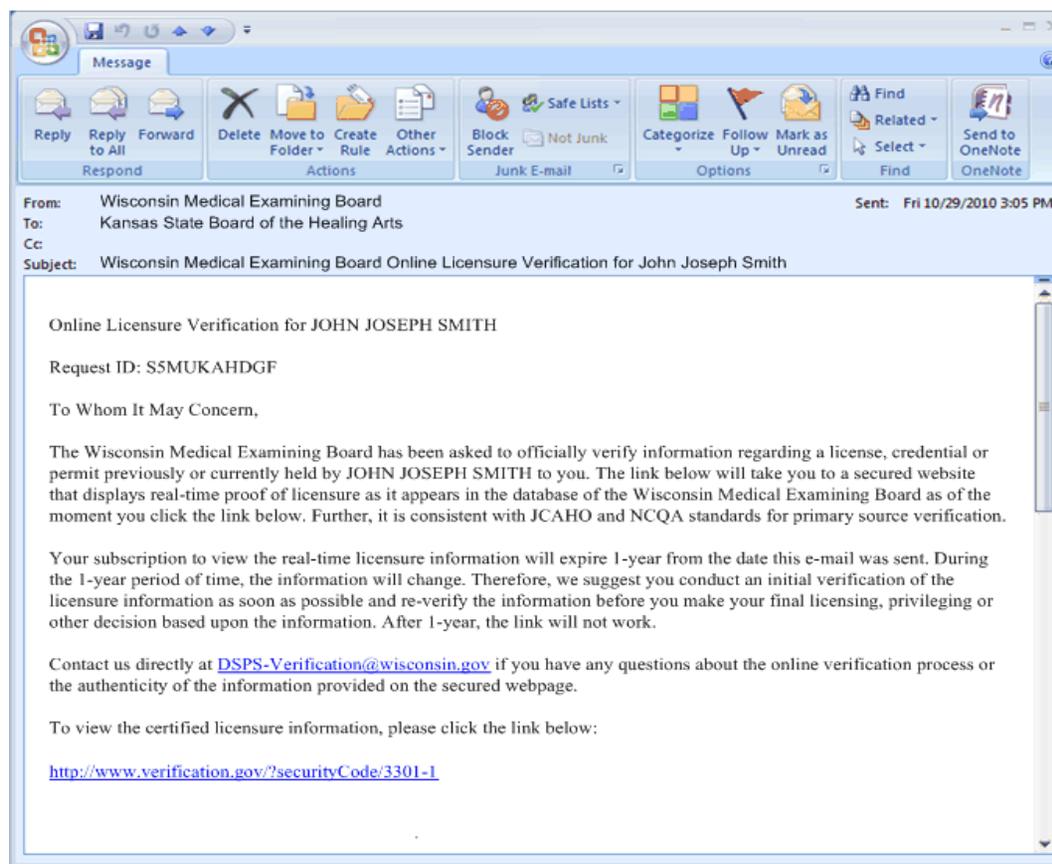
Screen 15. Request Confirmation Email. After OVS registers the verification request, OVS notifies the **Physician** that OVS registered his or her request, but that it is still incomplete. The **Physician** must submit payment in order to complete the Verification Request and for the **Linked Board** to electronically submit his or her license verification. If the **Physician** has difficulty completing the payment process, the **Physician** can request assistance from the **Linked Board** by referencing the Request ID noted in this email.



Screen 14: Confirmation E-Mail. After OVS processes the **Physician**'s verification request, OVS notifies the **Physician** of the completed transaction on behalf of the **Linked Board**. This e-mail is an electronic receipt for the **Physician**'s future reference.

Online Verification System User Experience: Enhanced Medical Board

The purpose of this section is to demonstrate how an **Enhanced Medical Board** interacts with the Online Verification System (OVS). An **Enhanced Medical Board** is a Recipient Medical Board or other licensing authority who is able to view whether a licensee is currently under investigation, has access to the Communication Log to communicate with a **Linked Board** and is able to view documents uploaded by a **Linked Board** in addition to receiving basic licensure information such as name, credential type, license number, date of issuance, how the license was acquired, expiration date, status of license(s) and orders on the OVS verification website.



Screen 1: Verification E-Mail. After OVS processes a **Physician**'s verification request, either automatically or after the **Linked Board**'s manual review, OVS sends an e-mail on behalf of the **Linked Board** to the **Enhanced Medical Board**. The e-mail explains the electronic verification process and includes a link to the Certification Webpage that display licensure information of the **Physician**. The OVS allows the **Enhanced Medical Board** to access information regarding investigations, the Communication Log and Document Upload features in addition to basic licensure information through the link to the Certification Webpage.

https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Medical Examining Board

Online Licensure Verification ID – S5MUKAHDF

This real-time Licensure Verification page is electronically certified proof of licensure, as request, and as it appears in the files of the Wisconsin Medical Examining Board as of Wednesday, January 10, 2012 10:36:15 AM – Central Standard Time.

License #14444-20

Name: Smith, John Joseph
License Type: Medicine and Surgery
Status: Active
Issue Date: 03/01/1977
Expiration Date: 10/31/2011
Disciplinary Order(s): No
Pending Investigation(s): No

Events

Description	Code	Date	Link
Graduated from Marshall College	Graduated From	1976-12-15	None

Communication Log

Description	Submitted By:	Date
Can you verify his address change?	Kansas Board of Healing Arts	2012-01-05
Uploaded address change document	Wisconsin Medical Examining Board	2012-01-06

New Message

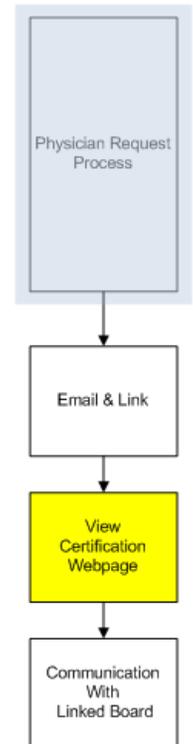
Enter Your Message Here.

Submit Clear

Once you submit a message, the Wisconsin Medical Examining Board will be notified of it. You will be notified of the response.

Uploaded Documents

Title	Subject	Date
Address Change Confirmation	Credentialing	2012-01-06



Screen 2: **Enhanced Medical Boards – Clean Certification Webpage**. The link in the e-mail described on Screen 1 connects the **Enhanced Medical Board** to the Certification Webpage. This page is considered “clean” because the **Physician** does not have any board orders or pending investigations. In addition to basic verification information, **Enhanced Medical Boards** have access to the OVS communication features. The first feature is the Communication Log. This feature enables the **Linked Board** and **Enhanced Medical Board** to securely communicate to one another on the Certification Webpage itself. OVS maintains a log of the communications and displays the messages on the Certification Webpage for future reference. The second feature is the Upload Documents. This feature enables the **Linked Board** to upload additional documentation relevant to the **Physician** whose license information OVS is displaying. For example, a **Linked Board** can upload investigatory information about the **Physician** or other information that may be useful to the **Enhanced Medical Board’s** licensure decision on the **Physician**. All communications and uploaded documents are only accessible to the specific **Linked Board** and **Enhanced Medical Board** involved in the verification transaction.

Wisconsin Department of Safety and Professional Services (DPS)
 Wisconsin Medical Examining Board

Online Licensure Verification ID – S5MUKAHDGF

This real-time Licensure Verification page is electronically certified proof of licensure, as request, and as it appears in the files of the Wisconsin Medical Examining Board as of Wednesday, January 10, 2012 10:36:15 AM – Central Standard Time.

License #14444-20

Name: Smith, John Joseph
License Type: Medicine and Surgery
Status: Active
Issue Date: 03/01/1977
Expiration Date: 10/31/2011
Disciplinary Order(s): Yes
Pending Investigation(s): Yes

Events

Description	Code	Date	Link
Graduated from Marshall College	Graduated From	1976-12-15	None
Final Decision and Order	Board Order	2011-01-05	MED0054766

Communication Log

Description	Submitted By:	Date
Can you please upload the complaint?	Kansas Board of Healing Arts	2012-01-05
Uploaded missing details	Wisconsin Medical Examining Board	2012-01-06

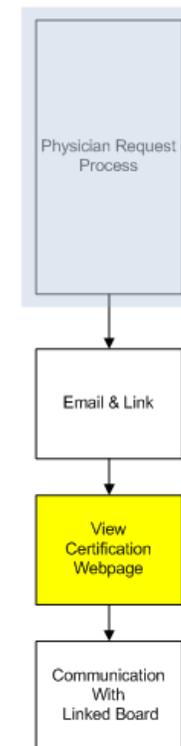
New Message

Enter Your Message Here.

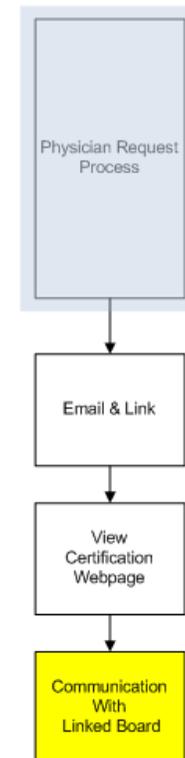
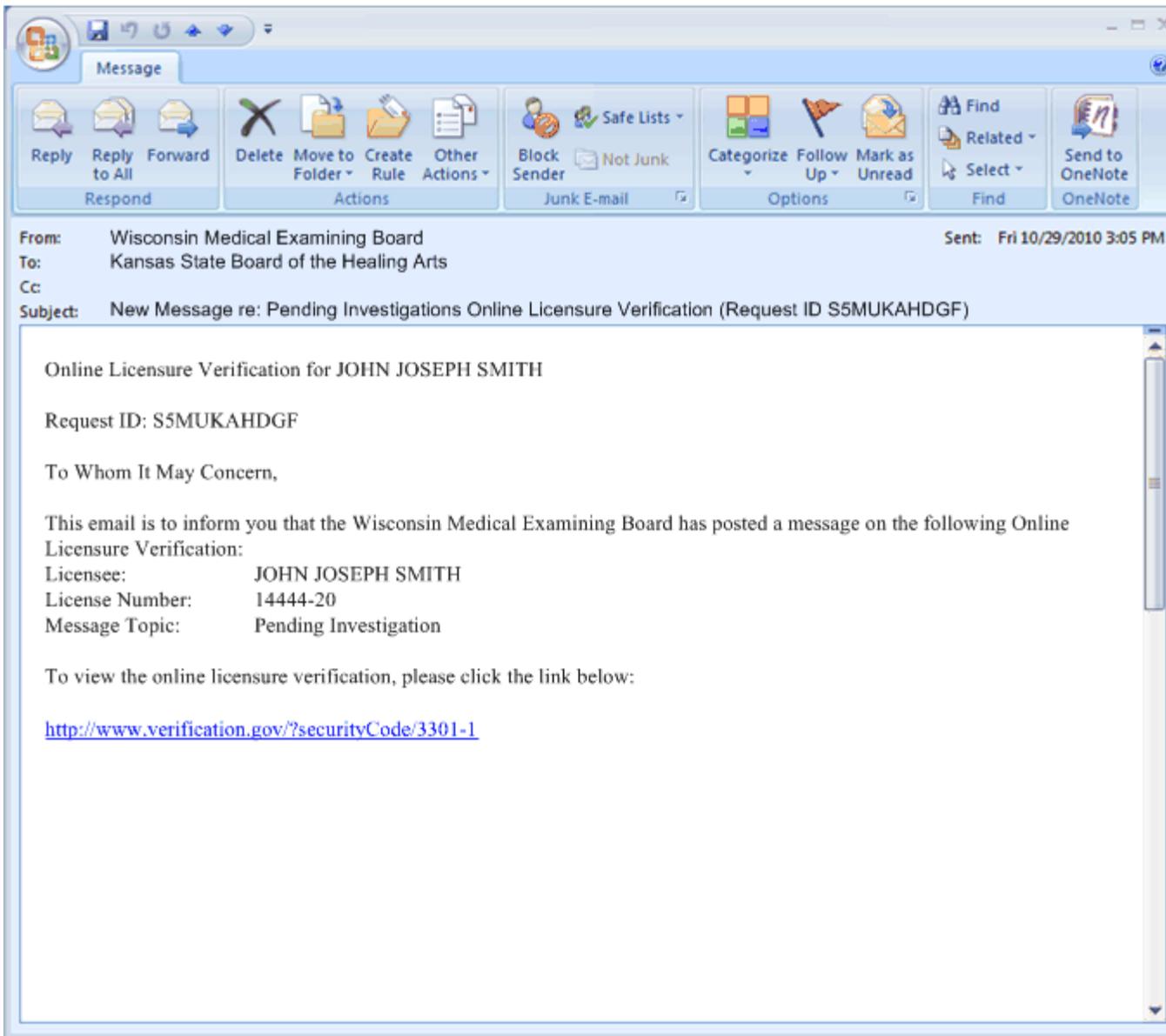
Once you submit a message, the Wisconsin Medical Examining Board will be notified of it. You will be notified of the response.

Uploaded Documents

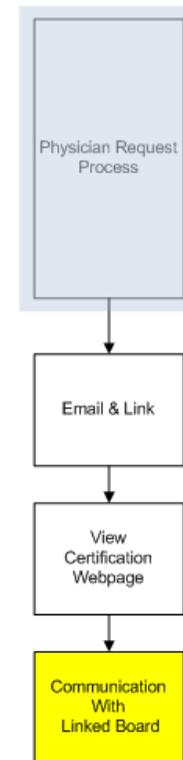
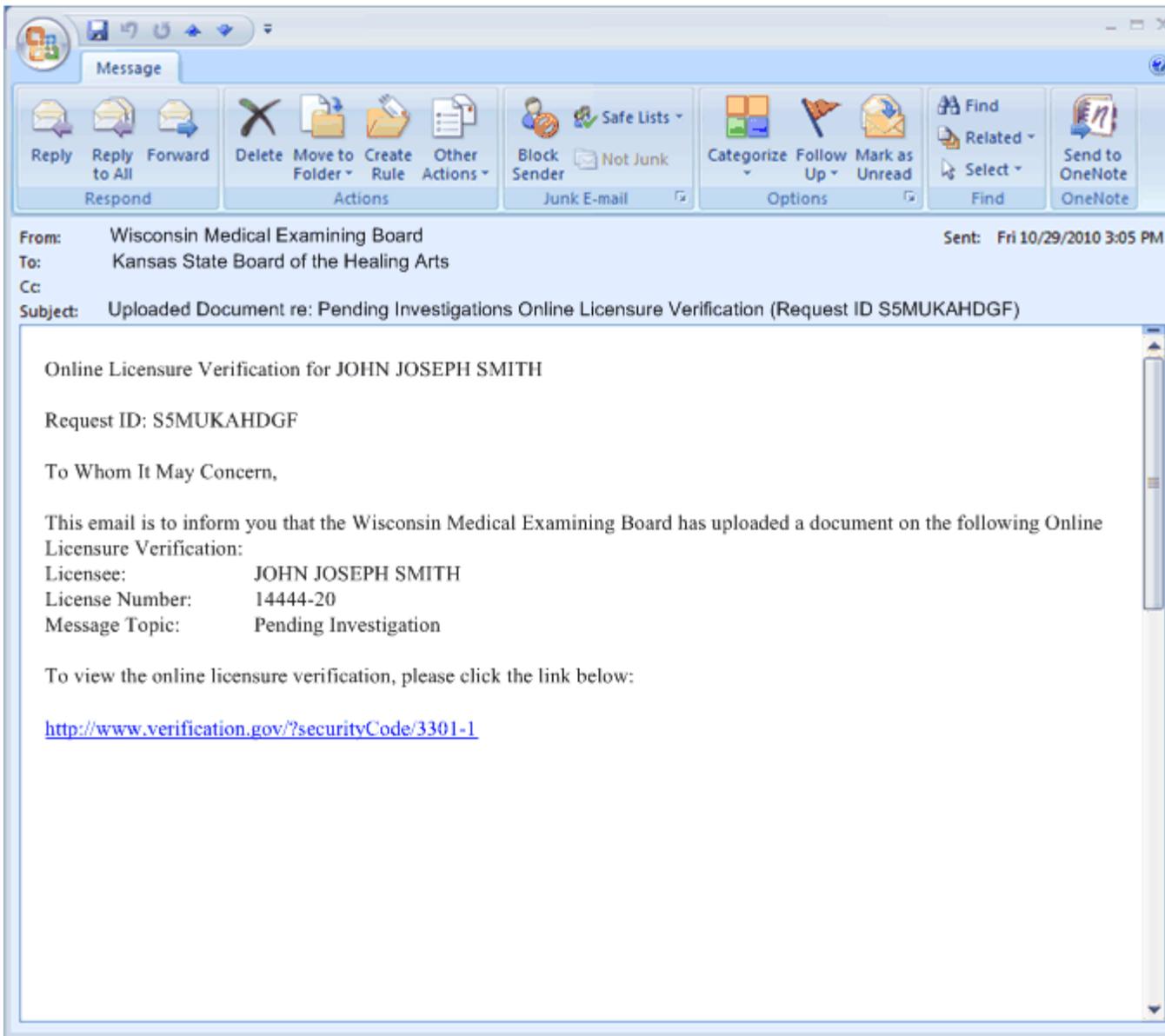
Title	Subject	Date
Complaint X 00545755600	Investigation	2012-01-06



Screen 3: **Enhanced Medical Boards – Unclean Certification Webpage**. The link in the e-mail described on Screen 1 will connect the **Enhanced Medical Board** to this Certification Webpage. This page illustrates the electronic verification an **Enhanced Medical Board** would receive if the **Physician** has board orders and/or pending investigations. Like Screen 2, in addition to basic verification information, **Enhanced Medical Boards** have access to the OVS communication features. The first feature is the Communication Log. This feature enables the **Linked Board** and **Enhanced Medical Board** to securely communicate to one another on the Certification Webpage itself. OVS maintains a log of the communications and displays the messages on the Certification Webpage for future reference. The second feature is the Upload Documents. This feature enables the **Linked Board** to upload additional documentation relevant to the **Physician** whose license information OVS is displaying. For example, a **Linked Board** can upload investigatory information about the **Physician** or other information that may be useful to the **Enhanced Medical Board's** licensure decision on the **Physician**. All communications and uploaded documents are only accessible to the specific **Linked Board** and **Enhanced Medical Board** involved in the verification transaction.



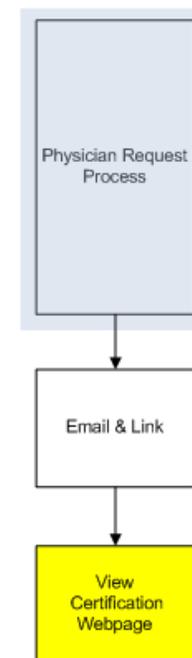
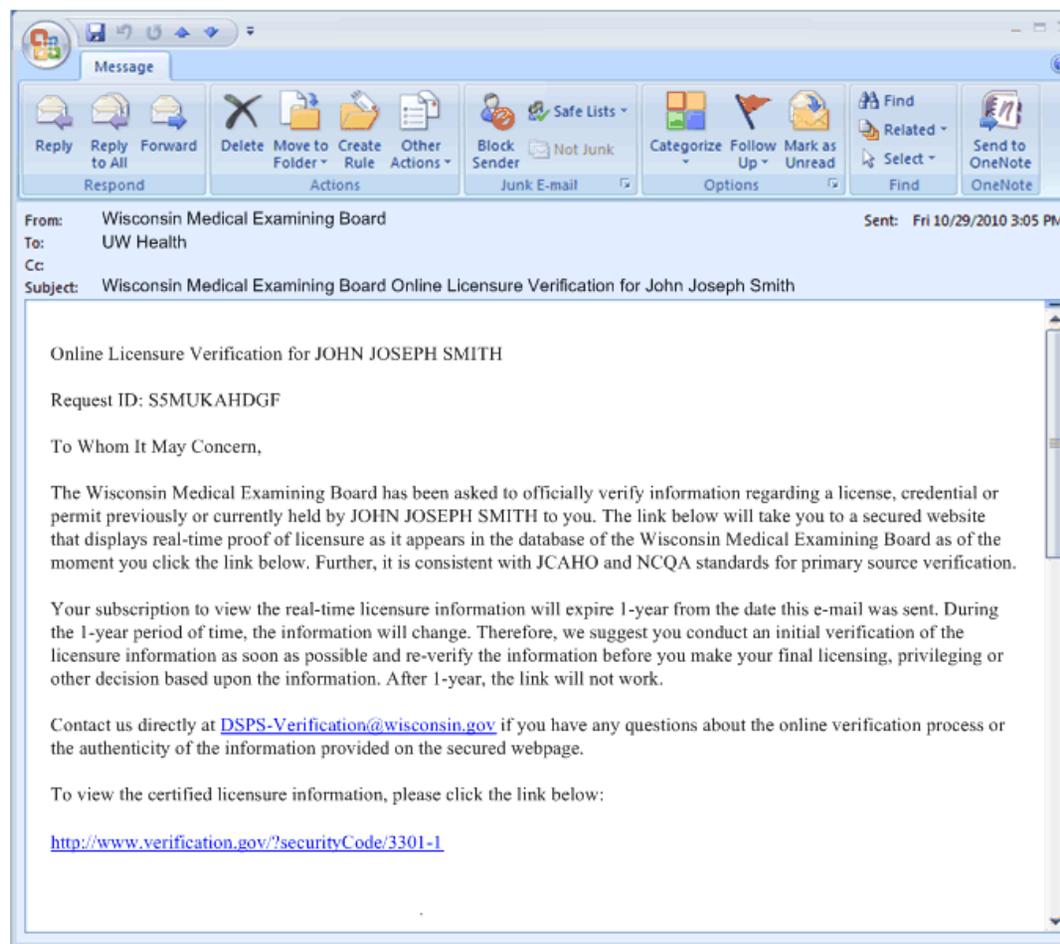
Screen 4: **Enhanced Medical Board – Communication E-Mail.** **Enhanced Medical Boards** have access to the OVS communication features. The Communication Log feature allows an **Enhanced Medical Board** and a **Linked Board** to securely communicate with one another on the Certification Webpage itself. The OVS informs the **Enhanced Medical Board** of a message from the **Linked Board** through a system-generated e-mail like the one above. The e-mail does not include the substance of the message, but does display the topic of the message.



Screen 5: **Enhanced Medical Board – Document E-Mail**. **Enhanced Medical Boards** have access to the OVS communication features. The Document Upload feature allows the **Linked Board** to upload additional documentation relevant to the **Physician** whose license information OVS is displaying. The OVS informs the **Enhanced Medical Board** that the **Linked Board** has uploaded a document through a system-generated e-mail. The e-mail does not include the document itself, but does display the topic of the document. The **Enhanced Medical Board** does not have the ability to upload documents to the Certification Webpage.

Online Verification System User Experience: Non-Enhanced and Third Party

The purpose of this section is to demonstrate how **Non-Enhanced Medical Boards** and **Third Parties** interact with the Online Verification System (OVS). A **Non-Enhanced Medical Board** is a Medical or Osteopathic Board who is able to view basic licensure information. A **Third Party** is an entity that is not a **Medical Board** who is only able to view basic licensure information. A **Non-Enhanced Medical Board** or **Third Party** is identified by a **Physician** to which OVS send a verification link on behalf of a **Linked Board**.



Screen 1: Verification E-Mail. After OVS processes a **Physician**'s verification request, either automatically or after the **Linked Board**'s manual review, OVS sends an e-mail on behalf of the **Linked Board** to the **Non-Enhanced Medical Board** or **Third Party**. The e-mail explains the electronic verification process and includes a link to the Certification Webpage that displays the licensure information of the **Physician**. The OVS allows the **Non-Enhanced Medical Board** or **Third Party** to view basic licensure information such as name, credential type, license number, date of issuance, how the license was acquired, expiration date, status of license(s) and orders through the secured link in the e-mail.

← →
<https://www.verification.dsps.wi.us>

Wisconsin Department of Safety and Professional Services (DSPS)
Wisconsin Medical Examining Board

Online Licensure Verification ID – S5MUKAHDGF

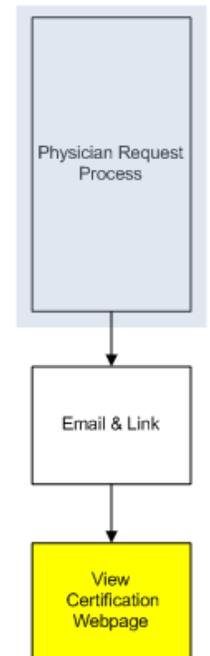
This real-time Licensure Verification page is electronically certified proof of licensure, as request, and as it appears in the files of the Wisconsin Medical Examining Board as of Wednesday, January 10, 2012 10:36:15 AM – Central Standard Time.

License #14444-20

Name: Smith, John Joseph
License Type: Medicine and Surgery
Status: Active
Issue Date: 03/01/1977
Expiration Date: 10/31/2011
Disciplinary Order(s): No

Events

Description	Code	Date	Link
Graduated from Marshall College	Graduated From	1976-12-15	None



Screen 2: **Non-Enhanced Medical Board or Third Party – Clean Certification Webpage**. The link in the e-mail described on Screen 1 connects the **Non-Enhanced Medical Board or Third Party** to this Certification Webpage. This page is considered “clean” because the **Physician** does not have any board orders. The OVS only allows **Non-Enhanced Medical Board or Third Party** to have access to basic verification information. Still, the Certification Webpage includes links to relevant orders. The above e-mail and Certification Webpage is the only interaction between the **Linked Board** and **Non-Enhanced Medical Board or Third Party** through OVS.

← →
 https://www.verification.dsp.wi.us

Wisconsin Department of Safety and Professional Services (DSPS) Wisconsin Medical Examining Board

Online Licensure Verification ID – S5MUKAHDGF

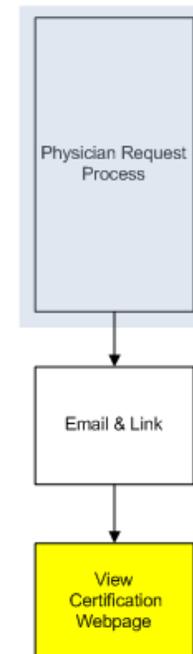
This real-time Licensure Verification page is electronically certified proof of licensure, as request, and as it appears in the files of the Wisconsin Medical Examining Board as of Wednesday, January 10, 2012 10:36:15 AM – Central Standard Time.

License #14444-20

Name: Smith, John Joseph
License Type: Medicine and Surgery
Status: Active
Issue Date: 03/01/1977
Expiration Date: 10/31/2011
Disciplinary Order(s): Yes

Events

Description	Code	Date	Link
Graduated from Marshall College	Graduated From	1976-12-15	None
Final Decision and Order	Board Order	2011-01-05	MED0054766



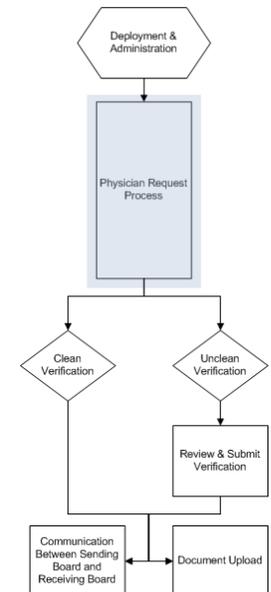
Screen 3: **Non-Enhanced Medical Board or Third Party – Unclean Certification Webpage**. The link in the e-mail described on Screen 1 connects the **Non-Enhanced Medical Board or Third Party** to this Certification Webpage. This page is considered “unclean” because the **Physician** has board orders. The OVS only allows **Non-Enhanced Medical Board or Third Party** to have access to basic verification information. Still, the Certification Webpage includes links to relevant orders. The above e-mail and Certification Webpage is the only interaction between the **Linked Board** and **Non-Enhanced Medical Board or Third Party** through OVS.

Online Verification System User Experience: Linked Board

The purpose of this section is to demonstrate how a **Linked Board** interacts with the Online Verification System (OVS). A **Linked Board** is a Medical or Osteopathic Board who adopts OVS to fulfill its licensure verification process by creating the two links between itself and OVS. The two links are the Web Services and E-Payment Gateway. The **Linked Board** interacts with OVS after the **Physician** submits a request for the **Linked Board** to verify his or her license. In most verification transactions, the **Linked Board** does not need to do anything to fulfill the verification request. However, if the **Physician** has any disciplinary history or is currently under investigation, OVS does not automatically process the **Physician's** verification request; the **Linked Board** must review the license information and manually submit the verification. This review and manual submission process allows the **Linked Board** to ensure that any verifications indicating potentially adverse information are accurate. A **Linked Board** can also upload documents and communicate through the Communication Log with Recipients that are designated as **Enhanced Medical Boards**.

The screenshot shows a web browser window with the URL <https://www.verification.dps.wi.us>. The page title is "Online Verification System Administration". The main content area has a yellow background and contains the following text and form elements:

- Welcome to the Online Verification System!
- To continue, select a Medical or Osteopathic board and enter your assigned Access Code.
- Professional Licensing Boards**
- A dropdown menu with "Wisconsin Medical Examining Board" selected.
- Access Code**
- An input field for the access code.
- A "Login >>" button.



Screen 1: Verification Administration Module Login. On this page, the **Linked Board** selects the **Medical Board** they represent and enters their assigned Access Code to gain access to the Verification Administration Module. There is one Access Code per **Medical Board**.

<https://www.verification.dps.wi.us>

Wisconsin Department of Safety and Professional Services (DPS)

Wisconsin Medical Examining Board

Online Verification System Administration

Search By

Request ID:

Licensee:

License #:

Requested By:

Status:

Request Date: to (mm/dd/yyyy)

Recipient Board:

Other Organization:

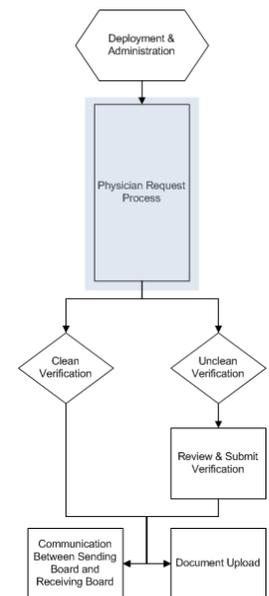
Verification Key:

Results

Results count: 2 Page 1 of 1 Items 1 to 2 Go to page: Page size:

* Click on column header for sorting.

Request ID	Received Date	Requested By	License ID	Licensee	Recipient	Status	Available Views/Tasks	Verification Key
S5MUKAHDGF	01/05/2012	John Joseph Smith	14444-20	John Joseph Smith	Kansas Board of Healing Arts	Submitted	Enhanced Certification Filing Receipt Status History Communication Log Uploaded Documents	709JK
RTKFRACAM	01/05/2012	John Joseph Smith	14444-20	John Joseph Smith	Meriter Hospital	Submitted	Basic Certification Filing Receipt Status History	50KF7



Screen 2: Verification Administration Module. On this page, the **Linked Board** can query verification requests, review their statuses, upload documents to a Certification Webpage and contact **Enhanced Medical Boards**. All pertinent information gathered as part of the verification is stored in the Verification Administration Module and is accessible to the **Linked Board**.

[←](#) [→](#)
 https://www.verification.dps.wi.us

Wisconsin Department of Safety and Professional Services (DPS)
Wisconsin Medical Examining Board

Online Verification System Administration

Request ID: S5MUKAHDGF

Verification Fee: \$10.00

The verification request for **John Joseph Smith, License # 14444-20**, has been received.

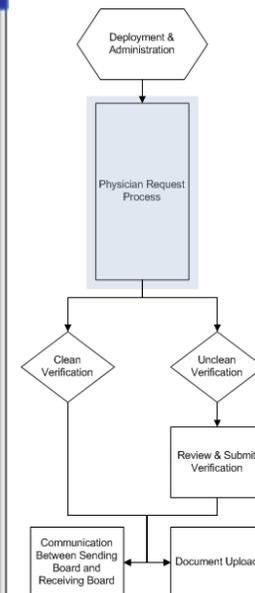
The electronic verification request was made by:

John Joseph Smith
JJ.SMITH@GMAIL.com
608-955-5555

The electronic verification request was made to:

Kansas Board of Healing Arts
800 SW Jackson, Lower Level
Suite A
Topeka, KS 66612
785-296-7413

Back



Screen 3: Verification Administration Module – Filing Receipt. This page only appears if the **Linked Board** selects “Filing Receipt” on Screen 2. On this page, the **Linked Board** can view the request summary of each verification request.

← →
 https://www.verification.dps.wi.us

Wisconsin Department of Safety and Professional Services (DPS)

Wisconsin Medical Examining Board

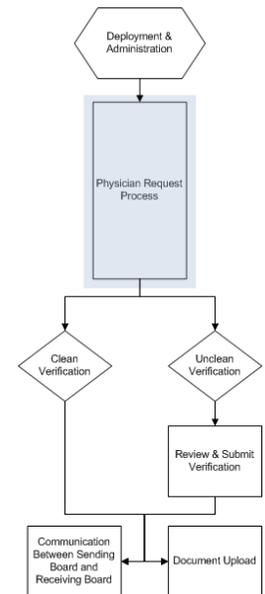
Online Verification System Administration

Status History

Request ID: S5MUKAHDGF
Licensee: JOHN JOSEPH SMITH
License #: 14444-20
Received Date: 01/05/2012 12:05:39 PM
Requested By: John Joseph Smith
Recipient: Kansas Board of Healing Arts

Log Date	Status	Log Message
01/05/2012 12:05:39 PM	Received	Received
01/05/2012 12:05:39 PM	Electronic Payment	Electronic Payment
01/05/2012 12:05:39 PM	Paid	Paid
01/05/2012 12:05:39 PM	Email Queued	Email Queued
01/05/2012 12:05:39 PM	Submitted	Submitted

[Back](#)



Screen 4: Verification Administration Module – Status History. This page only appears if the **Linked Board** selects “Status History” on Screen 2. On this page, the **Linked Board** can review the status history of a verification request.

← →
 https://www.verification.dps.wi.us

Wisconsin Department of Safety and Professional Services (DPS)
Wisconsin Medical Examining Board

Online Verification System Administration

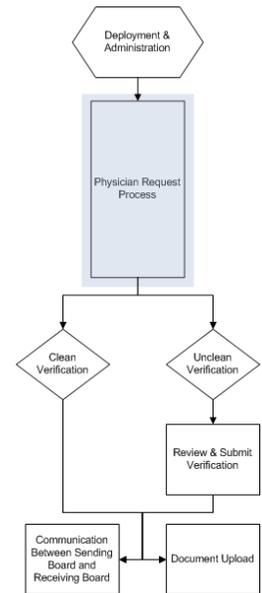
Documents

Request ID: S5MUKAHDGF
 Licensee: JOHN JOSEPH SMITH
 License #: 14444-20
 Received Date: 01/05/2012 12:05:39 PM
 Requested By: John Joseph Smith
 Recipient: Kansas Board of Healing Arts

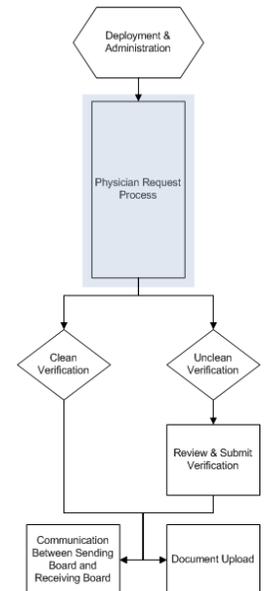
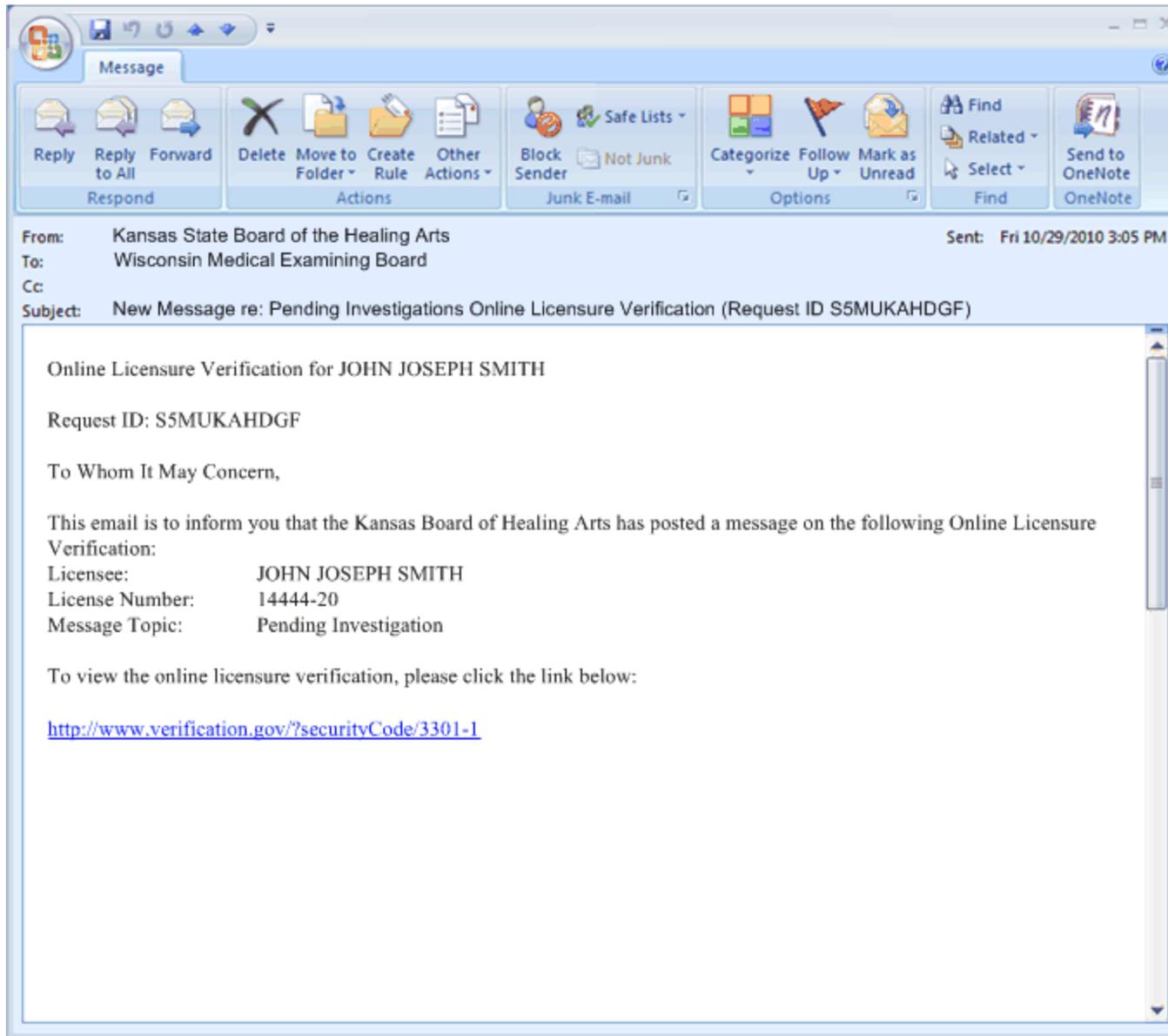
No documents found.

New Document:

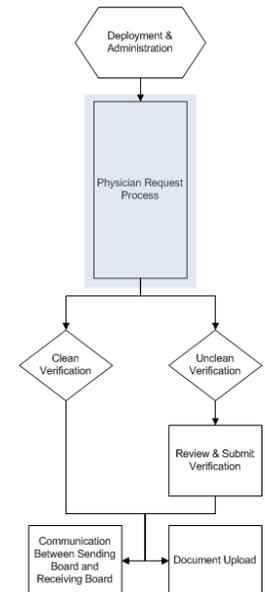
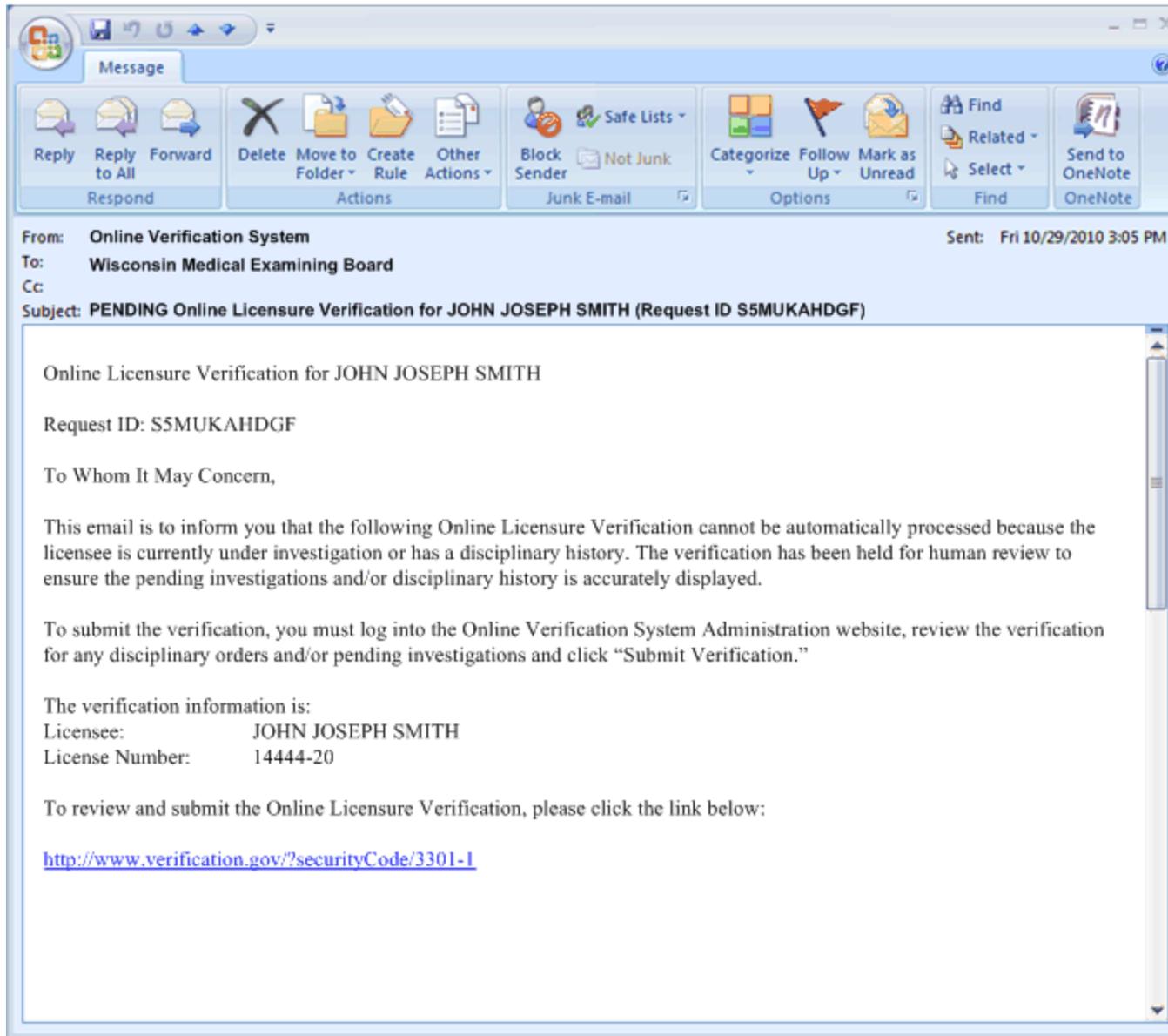
Description:



Screen 5: Verification Administration Module – Document Upload. This page only appears if the **Linked Board** selects “Uploaded Document” on Screen 2. On this page, the **Linked Board** may upload additional documentation relevant to the **Physician** whose license information OVS is displaying on the Certification Webpage.



Screen 6: Communication E-Mail. A **Linked Board** may communicate with an **Enhanced Medical Board** through the OVS communication features. The Communication Log feature allows an **Enhanced Medical Board** and a **Linked Board** to securely communicate with one another on the Certification Webpage itself. The OVS informs the **Linked Board** of a message from the **Enhanced Medical Board** through a system-generated e-mail like the one above. The e-mail does not include the substance of the message, but does display the topic of the message. To view the message, the **Linked Board** may go directly to the Certification Webpage or log into its Verification Administration Module.



Screen 7: Pending Request E-Mail. The **Linked Board** receives an e-mail notification when OVS does not automatically process a verification request due to the **Physician** having a disciplinary history or currently being under investigation. The **Linked Board** must review the license information and manually submit the verification through the Verification Administration Module. This review and manual submission process enables the **Linked Board** to ensure that any verifications indicating potentially adverse information are accurate.

Appendix 3: Hybrid Online Verification System Documentation

UPDATED:
October 2011

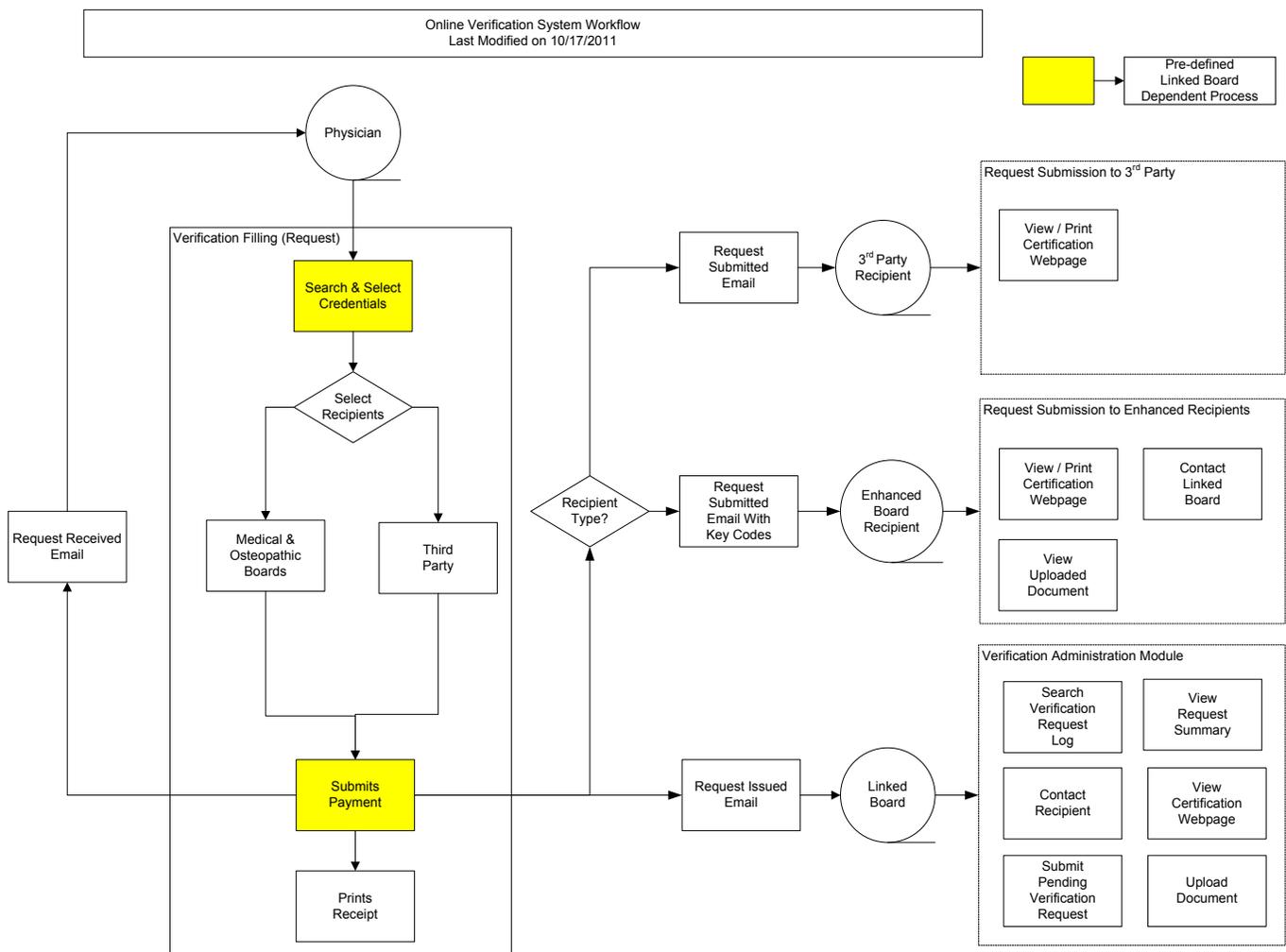
Prepared By:
Nikhil Zaveri, ARRA IT Architect

1. Introduction

This document is intended for IT Staff and software developers who will be linking a Board to the Online Verification System (OVS). This document will describe the linkages and enable you to create your Board's linkages to OVS.

The Online Verification System is designed and being developed to integrate with your existing licensing software and to be compatible with your current business processes.

The following diagram illustrates the OVS verification request and fulfillment workflow:



As illustrated in the above diagram, the Online Verification System will require following two linkages, or existing software service components (as shown in yellow) from your Board in order to operate:

1. Credential Data Service (License Lookup Web Service)
2. Electronic Payment Gateway.

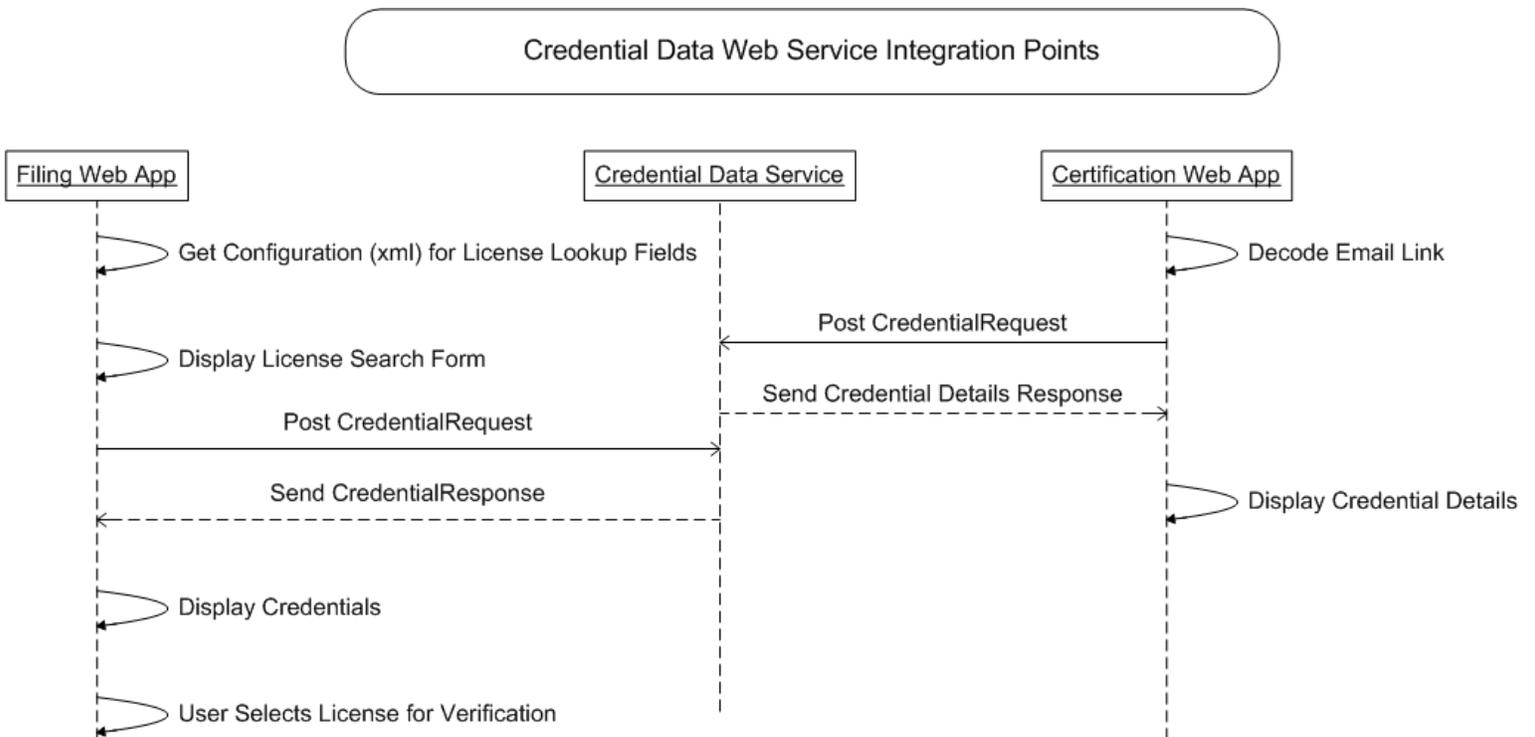
2. The Credential Data Service

- **Communicating with Existing Credentialing & Enforcement Systems**

One of the principal functions of OVS is to communicate with your state’s existing licensing and investigation software. To communicate with the existing systems, OVS relies on a communication infrastructure and application programming interface that has been developed. The communication occurs via a web service implementation called “Credential Data Service”.

- **Sequence Diagram**

The following is a sequence diagram that shows the integration points between OVS components and the Credential Data Service:



- **Credential Search Request Configuration and Mapping in the Verification Filing Application**

While the Online Verification System software is designed to communicate with your Board’s existing licensing and investigation software, your Board likely has different search criteria for identifying a credential holder or license than other Boards. To solve this issue, OVS provides the means to map License Lookup criteria to HTML controls in the user interface. Further, the OVS allows you to map the user input values to the parameters sent to your state’s credential service.


```

    <value></value>
    <isRequired>>false</isRequired>
    <validator>
      <expression><![CDATA[^[a-zA-Z'-]+\s*]{2,5}$]></expression>
      <errorMessage>Last Name entry is invalid. Please correct it and try
again.</errorMessage>
    </validator>
  </control>
</controls>
<helpText>
  <![CDATA[
  <p>
    You can do a search for a specific License by entering Credential Number. A
credential number is in format xxxxxxxx-xxx and consists of a license number, dash (-)
and profession type number.
  </p>
  - OR -
  <p>
    You can do a search for a specific License by entering exact last name and a first
name or partial first name of Licensee.
  </p>
  <p>
    The first {0} records will be returned.
  </p>
  <p>
    If you cannot find a license please contact Customer Support by clicking <a
href="">here.</a>
  </p>
]]>
</helpText>
</licenseSearch>

```

- **Web Service Communication via Standardized Interface**

Because each Board likely verifies different licensure data, stores the licensure data differently and has a different application development environment, you will need to implement the pre-defined web service interface and schema in your state to adopt OVS.

Implementing the web service interface and schema will bridge the communication between the Online Verification System's web applications and your Board's licensing & investigation storage systems.

- **Web Service Description Language:**

The follow are examples of the web service description language, (WSDL) and schema, for the web service:

```

<?xml version="1.0" encoding="utf-8"?>
<wsdl:definitions
xmlns:wsap="http://schemas.xmlsoap.org/ws/2004/08/addressing/policy"
xmlns:wsa10="http://www.w3.org/2005/08/addressing"
xmlns:tns="http://verification.dsps.wi.gov/CredentialDataService"
xmlns:msc="http://schemas.microsoft.com/ws/2005/12/wsdl/contract"
xmlns:soapenc="http://schemas.xmlsoap.org/soap/encoding/"
xmlns:wsx="http://schemas.xmlsoap.org/ws/2004/09/mex"
xmlns:wsp="http://schemas.xmlsoap.org/ws/2004/09/policy"
xmlns:i0="http://tempuri.org/"
xmlns:wsam="http://www.w3.org/2007/05/addressing/metadata"
xmlns:soap12="http://schemas.xmlsoap.org/wsdl/soap12/"
xmlns:wsa="http://schemas.xmlsoap.org/ws/2004/08/addressing"
xmlns:wsaw="http://www.w3.org/2006/05/addressing/wsdl"
xmlns:soap="http://schemas.xmlsoap.org/wsdl/soap/" xmlns:wsu="http://docs.oasis-
open.org/wss/2004/01/oasis-200401-wss-wssecurity-utility-1.0.xsd"
xmlns:xsd="http://www.w3.org/2001/XMLSchema" name="SearchService"
targetNamespace="http://verification.dsps.wi.gov/CredentialDataService"
xmlns:wsdl="http://schemas.xmlsoap.org/wsdl/">
  <wsdl:import namespace="http://tempuri.org/"
location="http://localhost/CredentialDataService/SearchService.svc?wsdl=wsdl0" />
  <wsdl:types>
    <xsd:schema
targetNamespace="http://verification.dsps.wi.gov/CredentialDataService/Imports">
      <xsd:import
schemaLocation="http://localhost/CredentialDataService/SearchService.svc?xsd=xsd0"
namespace="http://verification.dsps.wi.gov/CredentialDataService" />
      <xsd:import
schemaLocation="http://localhost/CredentialDataService/SearchService.svc?xsd=xsd1"
namespace="http://schemas.microsoft.com/2003/10/Serialization/" />
    </xsd:schema>
  </wsdl:types>
  <wsdl:message name="ISearchService_CredentialSearch_InputMessage">
    <wsdl:part name="parameters" element="tns:CredentialSearch" />
  </wsdl:message>
  <wsdl:message name="ISearchService_CredentialSearch_OutputMessage">
    <wsdl:part name="parameters" element="tns:CredentialSearchResponse" />
  </wsdl:message>
  <wsdl:message name="ISearchService_CredentialDetailsSearch_InputMessage">
    <wsdl:part name="parameters" element="tns:CredentialDetailsSearch" />
  </wsdl:message>
  <wsdl:message name="ISearchService_CredentialDetailsSearch_OutputMessage">
    <wsdl:part name="parameters" element="tns:CredentialDetailsSearchResponse" />
  </wsdl:message>
  <wsdl:portType name="ISearchService">
    <wsdl:operation name="CredentialSearch">

```

```

    <wsdl:input
wsaw:Action="http://verification.dsps.wi.gov/CredentialDataService/ISearchService/Cre
dentialSearch" message="tns:ISearchService_CredentialSearch_InputMessage" />
    <wsdl:output
wsaw:Action="http://verification.dsps.wi.gov/CredentialDataService/ISearchService/Cre
dentialSearchResponse"
message="tns:ISearchService_CredentialSearch_OutputMessage" />
    </wsdl:operation>
    <wsdl:operation name="CredentialDetailsSearch">
    <wsdl:input
wsaw:Action="http://verification.dsps.wi.gov/CredentialDataService/ISearchService/Cre
dentialDetailsSearch"
message="tns:ISearchService_CredentialDetailsSearch_InputMessage" />
    <wsdl:output
wsaw:Action="http://verification.dsps.wi.gov/CredentialDataService/ISearchService/Cre
dentialDetailsSearchResponse"
message="tns:ISearchService_CredentialDetailsSearch_OutputMessage" />
    </wsdl:operation>
    </wsdl:portType>
    <wsdl:service name="SearchService">
    <wsdl:port name="BasicHttpBinding_ISearchService"
binding="i0:BasicHttpBinding_ISearchService">
    <soap:address location="http://localhost/CredentialDataService/SearchService.svc"
/>
    />
    </wsdl:port>
    </wsdl:service>
</wsdl:definitions>

```

○ Schema

```

<?xml version="1.0" encoding="utf-8"?>
<xs:schema xmlns:tns="http://verification.dsps.wi.gov/CredentialDataService"
elementFormDefault="qualified"
targetNamespace="http://verification.dsps.wi.gov/CredentialDataService"
xmlns:xs="http://www.w3.org/2001/XMLSchema">
    <xs:element name="CredentialSearch">
    <xs:complexType>
    <xs:sequence>
    <xs:element minOccurs="0" name="serviceAccessKey" nillable="true"
type="xs:string" />
    <xs:element minOccurs="0" name="searchCriteria" nillable="true"
type="tns:CredentialRequest" />
    <xs:element minOccurs="0" name="searchResultLimit" type="xs:int" />
    </xs:sequence>
    </xs:complexType>
    </xs:element>
    <xs:complexType name="CredentialRequest">

```

```

    <xs:sequence>
      <xs:element minOccurs="0" name="Criteria" nillable="true"
type="tns:ArrayOfCriterion" />
    </xs:sequence>
  </xs:complexType>
  <xs:element name="CredentialRequest" nillable="true" type="tns:CredentialRequest"
/>
<xs:complexType name="ArrayOfCriterion">
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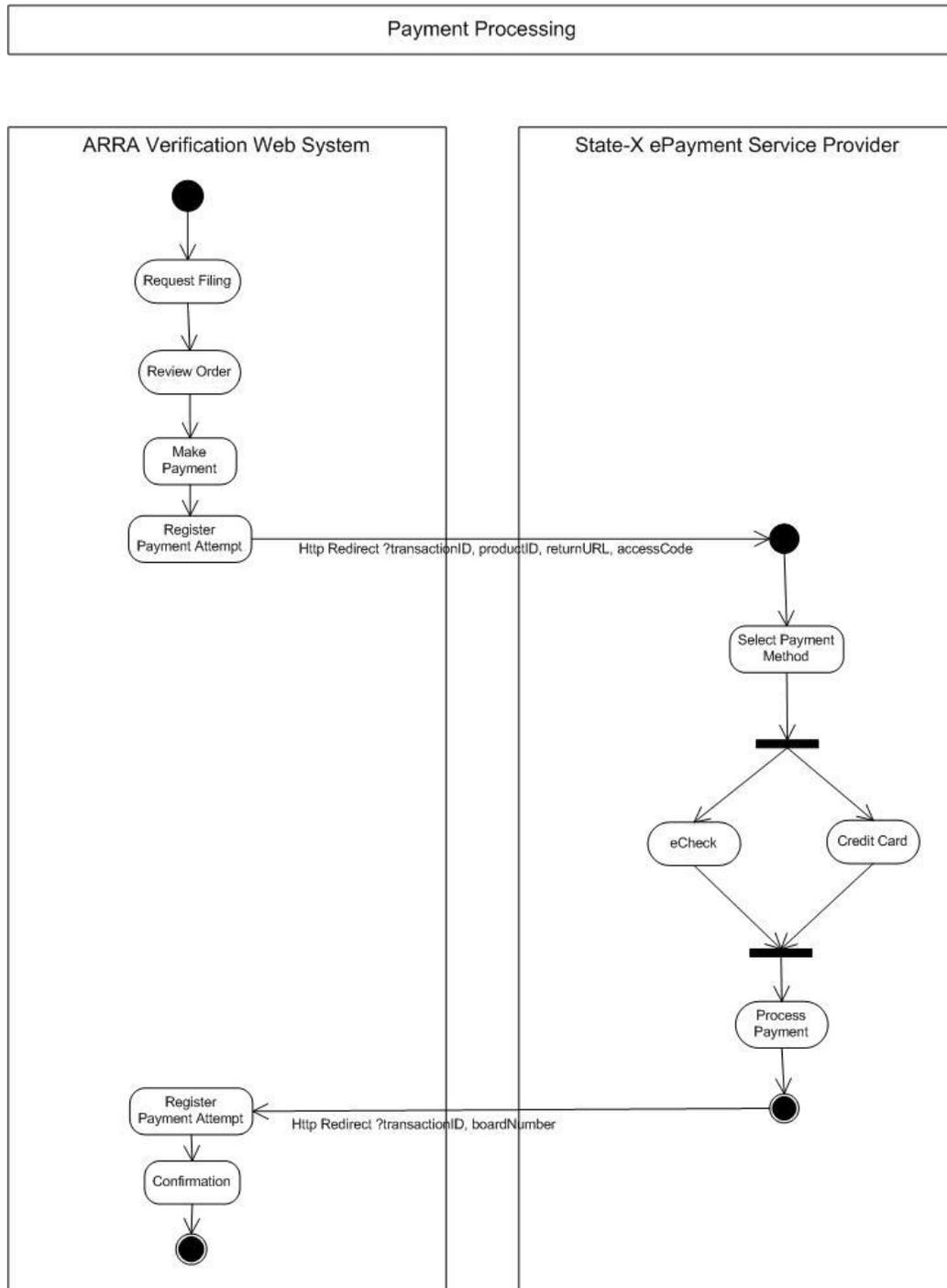
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3. E-Payment Service Gateway

The following diagram illustrates the integration process of the Linked Medical Board's existing E-Payment Service Gateway.



4. Configuring OVS Settings

For customization, OVS will provide the following configuration settings for each Linked Medical Board:

- User Interface
 - Board Name
 - Verification Fee
 - Support Email Address
 - Support Phone
 - License Search HTML Controls Definition
- Credential Data Service
 - Web service URL
 - Primary Search Key Field(s)
- Payment Gateway Service
 - Website URL
 - Payment Attempt with Session Redirect and Product Field(s)

For linking and administration, OVS will provide following settings information to each Linked Medical Board:

- Board Number
This is a unique OVS generated number for each Linked Medical Board.
- Access Code for Verification Log Viewer Login
This login access code will be utilized by each Linked Medical Board's staff to view their state specific log of verification requests
- Access Code for Credential Data Service
This access code will be used by OVS to authenticate a web service request.
- Access Code for Payment Gateway Service
This access code will be used by OVS to authenticate a web service request.
- Confirmation/Return URL
This URL will be used by each Linked Medical Board's Payment Gateway to redirect the Physician back to OVS upon a successful payment attempt.

Appendix 4: Online Verification System Licensing Agreement

Terms and Conditions

Wisconsin Department of Safety and Professional Services Application Hosting Agreement

IMPORTANT – READ CAREFULLY: This Terms and Conditions (“Agreement”) is a legal agreement between you, the organization or entity (“Customer”), and the Wisconsin Department of Safety and Professional Services (“WDSPS”) that covers the hosting by WDSPS of its Online Verification System to which the Customer (“Hosting Service”) subscribes.

WDSPS agrees to provide Hosting Service to Customer and Customer agrees to the following terms and conditions:

1. Term, Renewal and Termination:

- a. The effective date of this Agreement shall be the date on which Customer is first notified by a WDSPS representative of Hosting Service availability.
- b. This Agreement shall be for an initial trial period of ninety (90) days unless terminated by either party by giving five (5) days written notice to the other party prior to expiration of the initial trial period.
- c. Should the Customer continue to use the Hosting Service after the ninety (90) day initial trial period has concluded, this Agreement shall be automatically renewed for twelve (12) months and shall be automatically renewed every twelve (12) months for twelve (12) months, unless terminated by either party by giving forty-five (45) days written notice to the other party prior to expiration of any successive term.
- d. Thirty (30) days after notice of termination of Hosting Service, WDSPS shall delete information related to a Customer. Customer assumes all responsibility for any remaining obligations to provide verifications.

2. Services Provided:

- a. WDSPS shall provide Customer with application level access to its Online Verification System via an internet Uniform Resource Locator (URL) together with a User ID and password. No direct access to server hardware, operating system, database management system or other system resources shall be provided.
- b. WDSPS shall store all information related to a Customer created and managed by its Online Verification System, including files, text and parameters; data shall be backed-up on a separate storage system at regular intervals.
- c. Hosting Service is provided subject to the terms of the following WDSPS documents:

Application Hosting Service Level Policy

Application Hosting Service Usage Policy

3. Nature of Hosting Service: This Hosting Service provides users with online access to credential information supplied by the Customer's system. In addition it acts as a communication medium to facilitate interaction among Boards. Customers subscribe to the Hosting Service; the Hosting Service then allows individual Boards to determine the scope and nature of the information to make available to other Boards and entities through the Hosting Service.

4. Authorized Usage: Customer shall use industry best practices to protect User IDs, passwords and all other access information.

5. Limited Warranty: WDSPS warrants that the Hosting Service will conform substantially in accordance with the Application Hosting Service Level Policy for the term of the Hosting Service. WDSPS makes no other warranty regarding the Hosting Service. Customer acknowledges that WDSPS does not warrant that the Hosting Service shall be uninterrupted or error-free.

6. Customer Remedies: WDSPS's entire liability and Customer's exclusive remedy shall be as defined in this Agreement. No other remedies are provided to Customer under this Agreement.

7. NO OTHER WARRANTIES: EXCEPT FOR THE EXPRESS WARRANTIES STATED ABOVE, AND TO THE MAXIMUM EXTENT PERMITTED BY LAW, WDSPS DISCLAIMS ALL OTHER WARRANTIES WHETHER EXPRESS OR IMPLIED. BY WAY OF EXAMPLE BUT NOT LIMITATION, WITH RESPECT TO THE SOFTWARE AND ANY ACCOMPANYING USER DOCUMENTATION AND MEDIA, WDSPS MAKES NO REPRESENTATIONS OR WARRANTIES OF MERCHANTABILITY OR FITNESS FOR ANY PARTICULAR PURPOSE.

8. NO LIABILITY FOR CONSEQUENTIAL DAMAGES: IT IS EXPRESSLY AGREED THAT IN NO EVENT SHALL WDSPS OR ITS LICENSORS BE LIABLE FOR ANY DAMAGES WHATSOEVER (INCLUDING, WITHOUT LIMITATION, DAMAGES FOR LOST PROFITS, LOSS OF DATA, BUSINESS INTERRUPTION, OR OTHER CONSEQUENTIAL, EXEMPLARY, SPECIAL OR INDIRECT LOSSES) ARISING FROM YOUR USE, OR INABILITY TO USE, THE SERVICE, REGARDLESS OF WHETHER WDSPS HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

9. Prior Agreements: This Agreement overrides all prior written and oral communications regarding the Hosting Service and sets out the entire agreement between WDSPS and you, the Customer. You irrevocably waive any right you may have to claim damages or to rescind (in the case of misrepresentation) the Agreement for any misrepresentation or warranty not set out in this Agreement.

10. No Waiver: Any failure by either party to exercise an option or right conferred by this Agreement shall not itself constitute or be deemed a waiver of such option or right.

11. Severability: If any provision in this Agreement is declared void or unenforceable by any judicial or administrative authority this shall not nullify the remaining provisions of this Agreement which shall remain in full force and effect.

12. Governing Law: This Agreement shall be governed by the laws of the State of Wisconsin and the Customer agrees to submit to the exclusive jurisdiction of the Courts of the State of Wisconsin with venue located in Dane County, Wisconsin, in connection with any legal action hereunder.

13. General: This Agreement may only be modified by a written document that has been signed by both Customer and WDSPS. Should Customer have any questions concerning this Agreement, or if Customer desires to contact WDSPS for any reason related to this Agreement, please contact Michael Berndt, Chief Legal Counsel, at 608-267-2914.

APPLICATION HOSTING SERVICE LEVEL POLICY
Wisconsin Department of Safety and Professional Services

THIS DOCUMENT DEFINES SERVICE LEVELS AND CONDITIONS APPLICABLE TO WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES CUSTOMER UNDER A DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES APPLICATION HOSTING AGREEMENT AND FORMS AN INTEGRAL PART THEREOF.

Technical Support: The Wisconsin Department of Safety and Professional Services (“WDSPS”) will provide Customer with technical support on setting up and configuring Customer account, access to the server, and other issues related to the System provided by WDSPS. WDSPS will not provide support for web applications, scripts, or components, either from third parties or for those developed by Customer.

E-mail technical support:

Email Hours: 7:45 a.m. to 4:30 p.m. Central Standard Time, Monday through Friday, excluding state holidays.

Email Address: DSPSHelpDesk@Wisconsin.Gov

Upon contacting WDSPS technical support Customer will be required to provide Customer account username and a full description of the problem including error messages, screenshots, and other troubleshooting information as requested by technical support personnel.

WDSPS’s response time to technical support issues depends on the level of severity, complexity of the inquiry and support request volume. WDSPS’ technical support Department assigns the highest priority to customer inquiries related to the servers’ unavailability. These issues are addressed first upon notification from a customer.

If Customer has unresolved concerns with DSPS’s service or technical support issues, please contact the Michael Berndt, Chief Legal Counsel, at Michael.Berndt@Wisconsin.Gov or 608-267-2914. The initial response should arrive within one business day. As issues may be complex or require extensive investigation, resolution cannot be guaranteed within any certain time period.

Maintenance:

Scheduled Maintenance: To ensure optimal performance of the servers, WDSPS will perform routine maintenance on the servers on a regular basis, requiring servers to be removed from service. WDSPS anticipates one hour of server unavailability per month for maintenance purposes. The maintenance is typically performed during off-peak hours. WDSPS will provide Customer with advanced notice of maintenance whenever possible.

Emergency Maintenance: Under certain circumstances WDSPS may need to perform emergency maintenance, such as security patch installation or hardware replacement. WDSPS will not be able to provide Customer with advanced notice in case of emergency maintenance.

APPLICATION HOSTING SERVICE USAGE POLICY
Wisconsin Department of Safety and Professional Services

THIS DOCUMENT DEFINES SERVICE USAGE AND CONDITIONS APPLICABLE TO WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES CUSTOMER UNDER WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES APPLICATION HOSTING AGREEMENT AND FORMS AN INTEGRAL PART THEREOF.

Scope

This Service Usage Policy (“Policy”) governs the usage of the Wisconsin Department of Safety and Professional Services’ products and services (“Services”). This Policy is incorporated by reference into each contract the Wisconsin Department of Safety and Professional Services (“WDSPS”) enters into with a customer (“Customer”), for the use of such Services. Every Customer is subject to this Policy, and by virtue of using WDSPS Services, agrees to be bound by this Policy.

WDSPS may modify this Policy at any time without notice. Any modification is effective upon posting on our website and continued use of WDSPS Services constitutes the Customer’s acceptance of such modifications.

Policy violations are determined by WDSPS in its sole and absolute discretion.

Prohibited Uses: A Customer violates this policy when it, its parent, subsidiaries, affiliates, users, employees, directors, or partners engage in the following prohibited activities.

Illegal Activities: WDSPS prohibits the use of Services in connection with any illegal activity, including but not limited to the following:

- Violations of intellectual property and copyright laws.

Inappropriate Content: All communication shall be professional in accordance with all appropriate laws and rules. WDSPS shall not be responsible for any content uploaded by Customer.

The determination of inappropriate content is made solely by WDSPS.

Customer Responsibilities

- Customer is solely responsible for information relating to Customer’s credential holders.
- Customer will use best efforts to ensure Customer Content is free from viruses or other malicious code.
- Customer will cooperate fully with WDSPS in connection with WDSPS’ performance of Services.
- Customer is solely responsible for providing its users with any required disclosures on its website.

Reservation of Rights: WDSPS reserves the right to cooperate fully with appropriate law enforcement agencies in connection with any and all illegal activities occurring on or through the Service. WDSPS has no obligation to notify any person, including the Customer, regarding the information being sought, provided, or transferred in cooperation with law enforcement or legal order.

Remedies: In general, WDSPS does not and is not under any obligation to monitor Customer website or activity to determine whether Customer is in compliance with this Policy or the Terms and Conditions. However, if WDSPS determines, at its sole discretion, that a Customer has violated this Policy, corrective action may be taken.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Ari Oliver, Program and Policy Analyst	2) Date When Request Submitted: February 2, 2012 <small>Items will be considered late if submitted after 4:30 p.m. and less than:</small> <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others
--	--

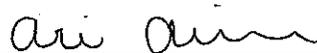
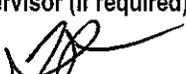
3) Name of Board, Committee, Council, Sections:
Wisconsin Medical Examining Board

4) Meeting Date: February 15, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Signing the Declaration of Cooperation
--	---	---

7) Place Item in: <input type="checkbox"/> Open Session <input checked="" type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:
---	---	--

10) Describe the issue and action that should be addressed:
The Wisconsin Medical Examining Board will sign the Declaration of Cooperation. The Wisconsin Medical Examining Board approved the Declaration on January 18, 2012.

11) Authorization

	02/02/12 Date
Signature of person making this request	2/2/12 Date
Supervisor (if required) 	2/2/12 Date
Bureau/Director signature (indicates approval to add post agenda deadline item to agenda) _____ Date	

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

Midwest Licensure Portability Task Force

Declaration of Cooperation

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

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

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

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

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

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

1. Definitions

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

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

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

2. Purposes

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

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

3. Scope & Authority

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

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

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

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

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

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

4. Effective Date

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

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

5. Withdrawal

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

6. Organization & Meetings

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

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

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

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

The Steering Committee may schedule additional meetings.

7. Reports to Parties

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

8. Amendments to this Declaration

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

9. Common Expedited Endorsement Process

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

10. Use of Confidential Information

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

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

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

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

11. Severability

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

12. Signatures

Party Name

Signature

Authorized Person Name

Date

Party Name

Signature

Authorized Person Name

Date

Party Name

Signature

Authorized Person Name

Date

Party Name

Signature

Authorized Person Name

Date

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Authorized Person Name

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Party Name

Signature

Authorized Person Name

Date

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

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

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

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

- Hold at least one verified, full, unrestricted, current and active license that was issued by any U.S. jurisdiction
- Not have ever held or currently hold a license that is or has ever been the subject of any Disciplinary Action¹
- Not currently hold a license that is the subject of any Pending Investigation²
- Not have ever withdrawn an application to practice medicine or ever had an application to practice medicine denied by any United States or Canadian jurisdiction's licensing authority
- Not be the subject of an unsatisfied Agreement for Corrective Action
- Have been engaged in the Active Practice of Medicine³ for at least five (5) years immediately preceding the application date

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

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

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

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

Education:

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

Postgraduate Training:

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

Examinations:

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

Specialty Board Certification:

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

Criminal Background Check:

- Have an acceptable criminal history as determined by the Party

State-Specific Requirements:

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

**ATTACHMENT 2:
COMMON EXPEDITED ENDORSEMENT
PROCESS**

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

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

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

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: February 15, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Budget Report	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? Karen Van Schoonhoven, DSPS Budget Director (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Ms. Van Schoonhoven will appear before the Board to deliver a budget report.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date



WISCONSIN DEPARTMENT OF
ADMINISTRATION

SCOTT WALKER
GOVERNOR

MIKE HUEBSCH
SECRETARY

Office of the Secretary
Post Office Box 7864
Madison, WI 53707-7864
Voice (608) 266-1741
Fax (608) 267-3842

Date: December 23, 2011

To: The Honorable Alberta Darling, Co-Chair
Joint Committee on Finance

The Honorable Robin Vos, Co-Chair
Joint Committee on Finance

From: Mike Huebsch, Secretary *MH*
Department of Administration

Subject: Lapse pursuant to Section 9255(1)(b) of 2011 Wisconsin Act 32

Enclosed is the fiscal year 2011-12 lapse plan as required pursuant to section 9255 of 2011 Wisconsin Act 32. Under section 9255(1)(b), this department is required to develop a plan for lapsing \$174.3 million during the 2011-13 fiscal biennium. The fiscal year 2011-12 lapse plan includes the allocation of \$123.2 million of the biennial requirement. Detailed summaries of each assigned agency's lapse allocation are included in the attached materials.

As provided in section 9255(1)(b), the plan will be approved on January 18, 2012, unless we are notified prior to that time that the Joint Committee on Finance wishes to meet in formal session about the requests.

Please contact Kirsten Grinde at 266-1353 in the Division of Executive Budget and Finance if you have any questions.

Attachments

cc Bob Lang, Legislative Fiscal Bureau



**WISCONSIN DEPARTMENT OF
ADMINISTRATION**

SCOTT WALKER
GOVERNOR

MIKE HUEBSCH
SECRETARY

Office of the Secretary
Post Office Box 7864
Madison, WI 53707-7864
Voice (608) 266-1741
Fax (608) 267-3842
TTY (608) 267-9629

December 23, 2011

The Honorable Alberta Darling, Co-Chair
Joint Committee on Finance
317 East, State Capitol
Madison, WI 53702

The Honorable Robin Vos, Co-Chair
Joint Committee on Finance
309 East, State Capitol
Madison, WI 53702

Dear Senator Darling, Representative Vos and Members:

As in past biennia, the 2011-13 biennial budget (2011 Wisconsin Act 32) was balanced in part on achieving and recognizing GPR and PR lapses to the general fund. Under section 9255 of Act 32, two lapse schedules are enumerated by agency and a third lapse of \$174.3 million over the biennium is to be allocated by the Department of Administration secretary. The secretary is to develop a plan for this discretionary lapse and submit it to the Joint Committee on Finance for approval.

The unallocated lapse of \$174.3 million is to be taken from GPR and PR sum certain appropriations with cash balances from executive branch agencies. Consistent with the last two biennia, the lapses for the Courts (\$16.9 million), the Legislature (\$9.2 million) and the Governor's Office (\$582,200) were established separately in Act 32. Of the total Department of Administration allocated lapse, it was assumed that \$123.2 million will occur in fiscal year 2011-12 in order for the State have a positive balance at the end of the fiscal year.

On October 14, 2011, I gave each executive branch agency a lapse target and directed agencies to send their plans for fiscal year 2011-12 to the State Budget Office by November 7, 2011. Two agencies asked for and received extensions to this deadline. Agencies were directed to avoid layoffs as a result of the unallocated lapse if at all possible.

In establishing the lapse targets, specific educational exemptions were granted to school aids, higher educational financial aid and technical college aids. In addition, Medical Assistance and other direct care programs at the Department of Health Services, and the Department of Children and Families' child welfare and certain Temporary Assistance for Needy Families programs were exempted. Certain correctional programs and other

The Honorable Alberta Darling
The Honorable Robin Vos
Page 2
December 23, 2011

institutions that operate 24/7 were exempted along with certain District Attorney and certain State Public Defender appropriations. After accounting for these exemptions, the remaining allocations were established on an across-the-board basis.

These lapses present operational challenges and opportunities to each agency in varying degrees. The tools that many agencies used included holding vacancies open, finding excess cash in PR accounts, reducing grants, reducing supplies and services or finding other operational savings. Because some agencies had less ability than others to absorb these lapses without negative ramifications on staff or programs, after reviewing each agency's lapse submission, further exemptions or reductions in the lapse targets were directed for the following agencies:

Board of Aging and Long-Term Care	\$137,030
Child Abuse Neglect Prevention Board	\$122,934
Board for People with Disabilities	\$1,349
DOJ – Sexual Assault Victim Services.	\$294,350
Medical College of Wisconsin	\$248,739
Military Affairs	\$531,616
Program Supplements	\$1,046,642
Secretary of State	\$26,754
DWD – WISCAP grants	\$200,600
DWD – Local youth apprenticeship grants	\$298,600
DWD – Employment transit aids	\$464,800

Agencies have also been directed to reallocate the lapses related to the following programs:

DATCP -- Animal health – inspection, testing and enforcement	\$45,164
DATCP – Aids to county and district fairs	\$102,083
DOC – Child pornography surcharge	\$41,800
DOC – Indian juvenile placements	\$5,600
DOJ – Child pornography surcharge	\$4,459

I have included the recommended allocations for each agency in Appendix I. In Appendix II, we have included for your information the allocation of the lapse amounts at the appropriation level. Finally, Appendix III includes the other two lapse requirements under Act 32 to ensure that you understand the full impact of all of these lapses on each agency.

I urge the Committee to approve the lapse amount for each agency as enumerated in Appendix I as quickly as possible as agencies have to manage these reductions in the final six months of this fiscal year. While each agency has a different lapse target and

The Honorable Alberta Darling
The Honorable Robin Vos
Page 3
December 23, 2011

different ways to achieve them, earlier notice will allow each to better manage to its target. The purpose, as you know, is to have a positive ending balance on June 30, 2012.

After working with each of the 40 agencies and program areas, this plan is forwarded for consideration to the Joint Committee on Finance. It represents a comprehensive attempt at fulfilling the intent of Act 32. We look forward to working with the Committee and with the Legislative Fiscal Bureau.

Sincerely,

A handwritten signature in cursive script, appearing to read "Mike Huebsch".

Mike Huebsch
Secretary

cc: Members, Joint Committee on Finance

**Summary of FY 2012 Lapse Plan
Department of Safety and Professional Services**

2% Lapse	PR Lapse	DOA Allocated	Total
FY 12 Lapse Target	\$ 268,500	\$4,275,257	\$7,796,057

DOA Allocated Lapse Items	Alpha	Lapse Amount	Fund Source
Cash Balances			
a) Professional Licensing Fees	20.165(1)(g)	\$2,525,257	PR
b) Medical examining board fees	20.165(1)(hg)	\$1,250,000	PR
c) Safety and building operations	20.165(2)(i)	\$ 500,000	PR
Lapse Plan Total		\$4,275,257	

Appendix 1. -- FY12 Lapse Allocation under Act 32 - Sections 9255 (1)(b)

<u>Agency</u>	<u>DOA-Allocated</u>
Administration	8,912,775
Agriculture, Trade and Consumer Protection	2,308,883
Children and Families	8,318,827
Corrections	9,461,595
Educational Communications Board	254,677
Employment Relations Commission	166,586
Financial Institutions	1,415,082
Government Accountability Board	227,335
Health Services	18,561,982
Higher Educational Aids Board	51,049
Historical Society	710,847
Insurance Commission	1,424,933
Justice	2,466,603
Lieutenant Governor's Office	20,498
Military Affairs	364,700
Miscellaneous Appropriations	605,675
Natural Resources	2,725,505
Office of State Employment Relations	295,777
Program Supplements	1,000,000
Public Defender Board	263,100
Public Instruction	1,975,377
Public Service Commission	10,418
Revenue	5,284,122
Safety and Professional Services	4,275,257
Shared Revenue and Tax Relief	2,374,892
State Fair Park	9,376
Tourism	747,810
Transportation	176,421
University of Wisconsin System	46,135,078
Veteran's Affairs	85,038
Wisconsin Economic Development Corporation	2,116,694
Workforce Development	547,425

Total

\$123,294,337

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: February 15, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? DSPS Website Improvement Opportunities	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Review the DSPS website on your own before the meeting in preparation for a discussion as to how the current website could be improved as a consumer protection tool.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

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LRB-3305/2

TJD/FFK/PJH:nwn&kjf:rs

2011 - 2012 LEGISLATURE

2011 SENATE BILL 306

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

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

Analysis by the Legislative Reference Bureau

VOLUNTARY AND INFORMED CONSENT AND INFORMATION ON DOMESTIC ABUSE SERVICES

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

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

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

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

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

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

RESTRICTIONS ON THE USE OF ABORTION-INDUCING DRUGS

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

REPEAL OF CERTAIN ABORTION PROHIBITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (b) Any person, except for a public official, who brings an
action under this
9 section shall do so under a pseudonym unless the person obtains the
written consent
10 of the woman upon whom an abortion was performed or induced, or
attempted to be
11 performed or induced, in violation of this section.

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

14 **SECTION 10.** 253.105 of the statutes is created to read:
15 **253.105 Prescription and use of abortion-inducing drugs. (1)**

16 In this
section:

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

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

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

20 (2) No person may give an abortion-inducing drug to a woman
unless the
21 physician who prescribed, or otherwise provided, the abortion-
inducing drug for the
22 woman:

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

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

- ▶ Home
- ▶ Lobbying in Wisconsin
- ▶ Organizations employing lobbyists
- ▶ Lobbyists

Presented by the Wisconsin Government Accountability Board

as of Thursday, February 02, 2012

2011-2012 legislative session
Legislative bills and resolutions

(search for another legislative bill or resolution at the bottom of this page)

Senate Bill 306

voluntary and informed consent to an abortion, information on domestic abuse services, giving a woman an abortion-inducing drug, repealing criminal sanctions against women who perform or obtain certain abortion procedures, and providing a penalty.

TEXT
sponsors
LRB analysis

STATUS
committee actions and
votes
text of amendments

COST & HOURS
of lobbying efforts
directed at this
proposal

Organization		These organizations have reported lobbying on this proposal:	Place pointer on icon to display comments, click icon to display prior comments		
Profile	Interests		Date Notified	Position	Comments
●	●	League of Women Voters of Wisconsin Education Fund Inc	12/13/2011	↓	
●	●	NARAL Pro-Choice Wisconsin	11/29/2011	↓	
●	●	National Association of Social Workers - Wisconsin Chapter	12/15/2011	↓	
●	●	Planned Parenthood Advocates of Wisconsin	12/12/2011	↓	
●	●	Pro-Life Wisconsin	12/14/2011	↑	
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●	●	Wisconsin Alliance for Women's Health, Inc.	12/12/2011	↓	
●	●	Wisconsin Association of Local Health Departments and Boards	12/20/2011	↓	
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Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine

Daniel Grossman, MD, Kate Grindlay, MSPH, Todd Buchacker, RN, Kathleen Lane, and Kelly Blanchard, MS

OBJECTIVE: To estimate the effectiveness and acceptability of telemedicine provision of early medical abortion compared with provision with a face-to-face physician visit at a Planned Parenthood affiliate in Iowa.

METHODS: Between November 2008 and October 2009, we conducted a prospective cohort study of women obtaining medical abortion by telemedicine or face-to-face physician visits. We collected clinical data, and women completed a self-administered questionnaire at follow-up. We also compared the prevalence of reportable adverse events between the two service delivery models among all patients seen between July 2008 and October 2009.

RESULTS: Of 578 enrolled participants, follow-up data were obtained for 223 telemedicine patients and 226 face-to-face patients. The proportion with a successful abortion was 99% for telemedicine patients (95% confidence interval [CI] 96–100%) and 97% for face-to-face patients (95% CI 94–99%). Ninety-one percent of all participants were very satisfied with their abortion, although in multivariable analysis, telemedicine patients had a higher odds of saying they would recommend the service to a friend compared with face-to-face patients (odds ratio, 1.72; 95% CI 1.26–2.34). Twenty-five percent of telemedicine patients said they would have preferred being in the same room with the doctor. Younger age,

less education, and nulliparity were significantly associated with preferring face-to-face communication. There was no significant difference in the prevalence of adverse events reported during the study period among telemedicine patients (n=1,172) (1.3%; 95% CI 0.8–2.1%) compared with face-to-face patients (n=2,384) (1.3%; 95% CI 0.9–1.8%) (82% power to detect difference of 1.3%).

CONCLUSION: Provision of medical abortion through telemedicine is effective and acceptability is high among women who choose this model.

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LEVEL OF EVIDENCE: II

Mifepristone was approved by the U.S. Food and Drug Administration in September 2000. Early medical abortion using mifepristone with misoprostol is effective and highly acceptable to U.S. women with some preferring it over vacuum aspiration.^{1–3} Medical abortion is not a surgical procedure and can be offered by nonspecialist clinicians,⁴ a fact that led some to believe that its availability would improve access to abortion services in the United States. However, a recent analysis found that almost all medical abortion-only providers were located within 50 miles of a large-volume surgical abortion provider.⁵

In approximately 15 states, certified nurse-midwives, physician assistants, and nurse practitioners are permitted to provide medical abortion.⁶ In the remaining states, laws that limit provision of abortion to physicians have been applied (or assumed to apply) to medical abortion as well.

Telemedicine, the delivery of health care services at a distance using information and communication technology, has been used in many fields of medicine to improve access to services. For example, telemedicine has been used to provide specialist consultation to primary care services and to deliver rural outpa-

From Ibis Reproductive Health, Oakland, California, and Cambridge, Massachusetts; the Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California San Francisco, San Francisco, California; Planned Parenthood of the Heartland, Des Moines, Iowa; Abortion Access Project, Cedar Rapids, Iowa.

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Corresponding author: Daniel Grossman, MD, Ibis Reproductive Health, 1330 Broadway, Ste 1100, Oakland, CA 94612; e-mail: DGrossman@ibisreproductivehealth.org.

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tient care, generally with patient outcomes that are comparable to in-person treatment.⁷ In 2008, Planned Parenthood of the Heartland, a clinic network located in Iowa that provided 74% of all abortions in the state that year,⁸ had 17 clinic sites. Three of these clinics had an on-site physician, whereas an additional three sites intermittently offered abortion care when a physician traveled to the clinic; the remaining 11 clinics did not provide abortions. In June 2008, Planned Parenthood of the Heartland launched a program to provide medical abortion using telemedicine at clinic sites not staffed by a physician to improve access to early abortion and reduce physician travel to outlying clinics. The objective of this study was to estimate the effectiveness and acceptability of the telemedicine provision model compared with the standard practice of a face-to-face visit with a physician.

MATERIALS AND METHODS

Between November 2008 and October 2009, women seeking medical abortion at six Planned Parenthood of the Heartland clinics in Iowa were invited to participate in the study. At four sites, medical abortion was offered only through telemedicine; at one site it was offered only with a face-to-face physician visit; and at one site both models were offered, depending on physician availability. Women seeking abortion at Planned Parenthood of the Heartland called a central call center, which gave them information about the nearest clinic and soonest appointment and informed them whether the service would be provided by telemedicine or not, and women selected the appointment they preferred. In the areas served by the telemedicine clinics, there was no other abortion clinic closer than the closest physician-staffed Planned Parenthood clinic. Once at the clinic, women who chose medical abortion and were eligible for the method (including being pregnant at 63 days gestation or less and not having other standard contraindications⁹), were 18 years old or older, able to speak English, and able to give informed consent were eligible to participate in the study.

Clinical information was collected at the participants' first clinic visit, including demographic information and gestational age according to ultrasonography. Participants were given the standard medical abortion regimen at the clinics: 200 mg mifepristone administered orally followed 24–48 hours later by 800 μ g misoprostol administered buccally at home.¹⁰ All women had ultrasonography performed by a trained technician, received information about medical abortion, and underwent standard informed con-

sent for the abortion. A physical examination was not routinely done, consistent with the standard of care.⁹ For face-to-face visit patients, one of two physicians reviewed the patient's medical history and ultrasonographic images and had a brief discussion with the patient. If the patient was eligible for a medical abortion, the physician handed her the mifepristone and misoprostol tablets, observed her swallow the mifepristone, and gave her final instructions. For those who received services through telemedicine, clinic staff uploaded the patient's medical history and ultrasonographic image to a secure server for the physician to review. One of the same two physicians then had a discussion with the patient using video teleconference equipment that was linked through a dedicated Multiprotocol Label Switching data connection. If the patient was eligible for medical abortion, the physician entered a password into her computer that remotely unlocked a drawer in front of the patient containing the mifepristone and misoprostol tablets. The physician observed her swallow the mifepristone and gave her final instructions through the video teleconference.

Women were scheduled for a follow-up visit within 2 weeks after receiving mifepristone. Pelvic ultrasonography was performed at follow-up to confirm completion of the abortion. If the abortion was incomplete, women were given the option of expectant management, additional misoprostol, or vacuum aspiration; ongoing pregnancies were treated with vacuum aspiration. If a telemedicine patient required a nonemergent vacuum aspiration, she was scheduled at a physician-staffed clinic for the procedure. If the abortion was not complete at the time of this visit, another visit was scheduled. Clinical information was collected at each follow-up visit, including the ultrasonographic result, any medications given, and whether a vacuum aspiration was performed. Effectiveness of medical abortion was defined as the proportion of women with a complete abortion not requiring a surgical procedure, including vacuum aspiration.

Once the abortion was complete, participants were asked to fill out a self-administered questionnaire focusing on their experience with the abortion service, including satisfaction with the service they received. If participants did not return for follow-up, they were contacted at least three times by phone and once by mail to schedule either an in-person follow-up visit or a telephone interview to complete the questionnaire. Information on adverse events was collected from participants at each follow-up visit or



during the telephone interview, and medical records from other facilities were reviewed when relevant.

All statistical analyses were performed using STATA 10.1. χ^2 analyses and *t* tests were used to compare study participants to all medical abortion patients aged 18 years or older seen during the study period to assess potential selection bias and to compare demographic, clinical, and acceptability information between telemedicine and face-to-face study participants. All analyses among cohort participants were conducted among women with complete follow-up information.

Univariable and multivariable analyses were conducted to identify potential associations between service delivery model (telemedicine compared with face-to-face) and the primary effectiveness and acceptability outcomes. To account for the possibility that a patient's experience might vary by the clinic she attended, clinic site was introduced into the multivariable model as a random effect, and the standard error was adjusted with a modified-sandwich estimator using STATA's *vce* (cluster *clustvar*) option for cluster-correlated data.^{11,12} Automated forward selection was used to build the multivariable models with the entry level set at $P < .20$. Demographic and clinical covariates with univariable significance of $P < .20$ not entered during forward selection were next added to the model in order of ascending univariable *P* value and were included in the final model if their inclusion changed the predictor variable's effect estimate by 10% or more. Gestational age was forced into the multivariable model assessing effectiveness because of evidence that the prevalence of ongoing pregnancy after medical abortion increases with increasing gestational age.¹ Covariates were added using these rules up to the maximum number of allowable covariates in a multivariable model based on the rule: number of events/10.¹³

Sample size was based on the acceptability outcome of overall satisfaction, because we anticipated that effectiveness would be comparable between groups. We also anticipated that acceptability of the telemedicine service would be high but might be somewhat lower than the standard provision model. Assuming 90% of women in the standard provision group reported being satisfied or very satisfied with their experience,¹⁰ a sample of 219 in each group was needed to detect a difference in acceptability among telemedicine patients of 10% or more (two-sided $\alpha = 0.05$, power = 80%). Recruitment was continued until the desired sample of participants with follow-up data was obtained.

Because of the relatively small sample size of the cohort study, we also analyzed deidentified data on all

adverse events after medical abortion reported to the Planned Parenthood Federation of America and Danco Laboratories by Planned Parenthood of the Heartland between July 1, 2008 (shortly after telemedicine was initiated) and October 31, 2009 (shortly after cohort recruitment ended). Planned Parenthood affiliates are required to report the following adverse events: ongoing pregnancy, emergency room treatment, hospitalization, transfusion, unrecognized ectopic pregnancy, allergic reaction, infection requiring intravenous treatment, and death. We calculated the prevalence, 95% confidence intervals (CIs), and χ^2 analyses of any adverse event, ongoing pregnancy, or blood transfusion, comparing telemedicine with face-to-face patients during this period. We also conducted a multivariable analysis of any adverse event comparing telemedicine with face-to-face patients during this period adjusting for possible confounders.

All cohort study participants gave informed consent to participate in the study. They received a \$10 gift card for completing the questionnaire. The study was approved by Allendale institutional review board.

RESULTS

The study flow diagram is shown in Figure 1. Fifty-six percent of patients aged 18 years or older seen during the study period were enrolled into the study. Reasons for nonparticipation were not collected, although study staff noted that fewer patients were enrolled on busy clinic days, possibly because staff did not have time to thoroughly explain the study. After excluding seven patients, 578 women were included in the cohort study. Among the 281 telemedicine patients, 205 (73%) had an in-person and 18 (6%) had a phone follow-up interview; 58 (21%) were lost to follow-up. Among the 297 face-to-face patients, 196 (66%) had an in-person and 30 (10%) had a phone follow-up interview; 71 (24%) were lost to follow-up. The proportion of patients that attended an in-person visit was not significantly different between the two groups ($P = .07$).

Age, marital status, and race were similar between cohort study participants and all patients receiving medical abortion aged 18 years or older seen during the study period. A lower proportion of study participants were Latina (4% compared with 7%, $P = .008$) and had a maximum completed education of 12 years or less (52% compared with 58%, $P = .03$). Table 1 shows the enrollment demographic and clinical information for cohort study participants with follow-up data. Among study participants, telemedicine and face-to-face patients were similar in terms of age, marital status, race, ethnicity, parity, and gesta-



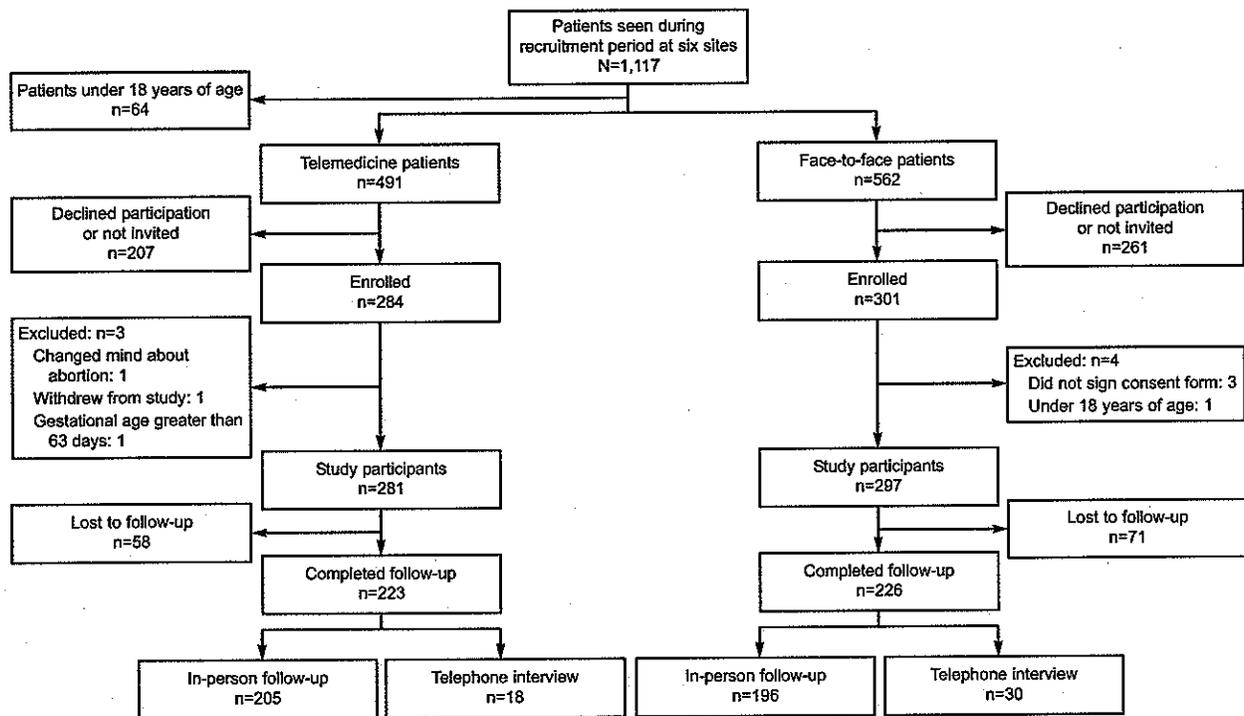


Fig. 1. Flow of patients through the study.

Grossman. *Telemedicine Provision of Medical Abortion. Obstet Gynecol* 2011.

tional age. Compared with telemedicine participants, more face-to-face participants had a maximum completed education of 12 years or less (58% compared with 46%, $P=.01$) and reported a prior abortion (38% compared with 26%, $P=.006$).

Follow-up information was obtained a median of 15 days after enrollment for those with in-person visits and 27 days after enrollment for those who had phone interviews. At follow-up, eight women (three telemedicine and five face-to-face patients) were given an additional dose of misoprostol and scheduled for a second follow-up visit.

Contraceptive uptake postabortion was slightly higher among participants with a face-to-face visit. Eighty-eight percent ($n=199$) of face-to-face participants and 80% ($n=179$) of telemedicine participants were given or had started a contraceptive method by the time of the follow-up visit or phone interview ($P=.02$). Use of specific contraceptive methods was not significantly different between the cohorts, except more face-to-face participants were given condoms (21% compared with 6%, $P<.001$) or had an intrauterine device inserted (23% compared with 12%, $P=.005$) at the follow-up visit.

Two of the 223 telemedicine patients underwent vacuum aspiration for ongoing pregnancy ($n=1$) or

incomplete abortion ($n=1$), and one woman elected to continue an ongoing pregnancy for a total effectiveness of 98.7% (95% CI 96.1–99.5%). Six of the 226 face-to-face patients underwent vacuum aspiration and one underwent dilation and curettage for ongoing pregnancy ($n=2$) or incomplete abortion ($n=5$) for a total effectiveness of 96.9% (95% CI 93.7–98.5%). The odds of successful abortion with telemedicine compared with face-to-face provision was not significantly different in the multivariable model, which adjusted for within-cluster correlation and gestational age (odds ratio [OR] 2.34, 95% CI 0.84–6.55).

There were no deaths or hospitalizations among the cohort study participants. Adverse events, including emergency room visits and visits to other clinics, occurred among 2.5% of participants and were not statistically different between groups ($P=.78$). One telemedicine participant received a blood transfusion in an emergency room. The telemedicine participant who decided to continue with an ongoing pregnancy reported her child was normal at 7 months of age.

Table 2 shows the prevalence of adverse events among all patients undergoing medical abortion from July 1, 2008, to October 31, 2009. A total of 46 adverse events were reported (1.3% of 3,556 medical abortions). No deaths were reported. There was no

Table 1. Characteristics of Cohort Study Participants

	Telemedicine Cohort (n=223)	Face-to-Face Cohort (n=226)	P
Age (y)			.65
18-25	137 (61)	130 (58)	
26-35	71 (32)	77 (34)	
36-45	15 (7)	19 (8)	
Median	23	24	
Mean	24.9	25.7	.11
Marital status			.72
Single	163 (74)	164 (73)	
Married or partnered	35 (16)	42 (19)	
Divorced, widowed, or separated	22 (10)	20 (9)	
Latina or Hispanic	5 (2)	12 (5)	.09
Race			.85
White	179 (82)	182 (85)	
African American	28 (13)	22 (10)	
Asian American	5 (2)	4 (2)	
Other*	6 (3)	6 (3)	
Highest grade completed	102 (46)	130 (58)	.01
12 y or less			
Median	13	12	
Mean	13.5	13.1	.01
Parous	112 (50)	133 (59)	.07
Mean	1.01	1.09	.49
Prior abortion	58 (26)	86 (38)	.006
Gestational age (d)			.79
49 or less	141 (63)	142 (63)	
50-56	53 (24)	50 (22)	
57-63	29 (13)	34 (15)	
Median	46	46	
Mean	46.7	47.1	.58

Data are n (%) unless otherwise specified.

* Other race includes women who reported more than one race and women who reported their race as Native American or Alaska Native.

significant difference in the prevalence of any adverse event, ongoing pregnancy, or blood transfusion between women who received services through telemedicine compared with face-to-face provision. With a one-sided α of 0.05, this sample size had 82% power to detect an increase in the prevalence of any adverse event from 1.3% among face-to-face patients to 2.6%

Table 2. Adverse Events Among All Medical Abortion Patients, July 1, 2008, Through October 31, 2009

	Telemedicine (n=1,172)	Face-to-Face (n=2,384)	P
Any adverse event	1.3 (0.8-2.1)	1.3 (0.9-1.8)	.96
Ongoing pregnancy	0.9 (0.5-1.7)	1.0 (0.6-1.4)	.94
Blood transfusion	0.3 (0.1-0.9)	0.1 (0.04-0.4)	.23

Data are % (95% confidence interval) unless otherwise specified.

among telemedicine patients. The odds of any adverse event among telemedicine compared with face-to-face patients was not significantly different in the multivariable model, which adjusted for within-cluster correlation, marital status, Latina ethnicity, and race (OR 0.96, 95% CI 0.48-1.91).

Table 3 shows information on acceptability of abortion services. Overall satisfaction was very high among participants, although more telemedicine patients (94%) reported being very satisfied compared with face-to-face patients (88%), which was significantly different in the univariable analysis ($P=.03$). However, when adjusted for within-cluster correlation (no additional covariates met the multivariable model inclusion criteria), this difference was no longer significant (OR 2.10, 95% CI 0.75-5.92).

More telemedicine patients (90%) said they would recommend the medical abortion service to a friend in a similar situation than face-to-face patients (83%, $P=.04$). In the multivariable model, which adjusted for within-cluster correlation, age, education, and prior abortion, telemedicine patients had greater odds of saying they would recommend the service compared with face-to-face patients (OR 1.72, 95% CI 1.26-2.34).

Patients in both groups reported liking similar aspects of the service, including the staff (58%), information received (30%), and the fact that they did not feel judged (11%). A minority of patients reported dislikes, and a significantly higher proportion of face-to-face patients (32%) complained about the waiting time in the clinic compared with telemedicine patients (7%, $P<.001$).

We asked women several questions about the factors that influenced their decision about what abortion method to have and which clinic to go to. Seventy-one percent of participants said they strongly wanted medical abortion when they were making their decision (no difference between cohorts), and 94% of participants said having the abortion as early as possible was very important to them (no difference between cohorts). However, 69% of telemedicine patients said having the abortion close to home was very important compared with 58% of face-to-face patients ($P=.02$).

Three fourths of patients reported being satisfied with the conversation with the doctor (the video teleconference for those receiving telemedicine services), and this did not differ between the two groups ($P=.89$). Among telemedicine patients, 99% said it was easy to see the doctor, and 99% said it was easy to hear the doctor; 89% said they felt comfortable asking the doctor questions during the video teleconference.



Table 3. Acceptability of Abortion Services

	Telemedicine Cohort (n=214)	Face-to-Face Cohort (n=217)	P
Overall satisfaction			
Very satisfied	201 (94)	191 (88)	.03*
Somewhat satisfied	10 (5)	21 (10)	
Somewhat or very dissatisfied	1 (.5)	1 (.5)	
Not sure or no response	2 (1)	4 (2)	
Would recommend a medical abortion in this clinic to a friend	192 (90)	180 (83)	.04
What liked best (more than one response possible)			
Staff	128 (60)	123 (57)	.51
Information received	67 (31)	61 (28)	.47
Did not feel judged	20 (9)	27 (12)	.30
Other	18 (8)	20 (9)	.77
Felt comfortable	14 (7)	16 (7)	.74
Privacy and confidentiality	14 (7)	11 (5)	.51
Fast	11 (5)	11 (5)	.97
Nothing or no response	10 (5)	8 (4)	.61
What liked least (more than one response possible)			
Nothing or no response	148 (69)	110 (51)	<.001
Waiting time	16 (7)	70 (32)	<.001
Other [†]	50 (23)	37 (17)	.10
Information received			
Very helpful	195 (91)	202 (93)	.45*
Somewhat or not helpful	16 (8)	13 (6)	
Not sure or no response	3 (1)	2 (1)	
Satisfaction with conversation with doctor			
Very satisfied	163 (76)	164 (76)	.89*
Somewhat satisfied	34 (16)	36 (17)	
Somewhat or very dissatisfied	11 (5)	6 (3)	
Not sure or no response	6 (3)	11 (5)	
Initial feelings about medical compared with surgical abortion			
Strongly wanted medical abortion	156 (73)	152 (70)	.51 [§]
Leaning toward medical abortion	33 (15)	36 (17)	
Strongly wanted surgical abortion	2 (1)	2 (1)	
Leaning toward surgical abortion	2 (1)	5 (2)	
No strong feeling either way	19 (9)	19 (9)	
No response	2 (1)	3 (1)	
Feelings about importance of having abortion close to home			
Very important	147 (69)	126 (58)	.02 [‡]
Somewhat important	38 (18)	50 (23)	
Not important	21 (10)	31 (14)	
Not sure or no response	8 (4)	10 (5)	
Feelings about importance of having an early abortion			
Very important	202 (94)	202 (93)	.58 [‡]
Somewhat important	8 (4)	10 (5)	
Not important or not sure	4 (2)	5 (2)	
Easy to see doctor during telemedicine encounter			
Yes	211 (99)		
No	3 (1)		
Easy to hear doctor during telemedicine encounter			
Yes	212 (99)		
No	2 (1)		
Comfortable asking questions during telemedicine encounter			
Yes	190 (89)		
No	24 (11)		
Would prefer doctor in room instead of telemedicine			
Yes	53 (25)		
No	154 (73)		
No response	5 (2)		

Data are n (%) unless otherwise specified.

* P value for very satisfied compared with not very satisfied.

† Other includes: staff (nine), telemedicine (nine), not enough information received (eight), having abortion (seven), lack of privacy (seven), distance (six), partner could not attend visit (five), and general (36).

* P value for very helpful compared with not very helpful.

§ P value for strongly wanted medical abortion compared with other responses.

‡ P value for very important compared with not very important.



One fourth of telemedicine patients said they would have preferred being in the same room with the doctor. Participants were allowed to write in comments about this response, which generally indicated that although they would have preferred to be in the same room, because that was not an option, they were satisfied with the video teleconference. These open responses are representative of some of the comments participants gave: "I am always generally more comfortable dealing with serious issues in person" and "It was rather irritating, but probably faster/more convenient. (I'm a face to face person)."

In multivariable analysis, the following covariates were associated with a preference for being in the same room with the physician: age 18–25 years (compared with 26 years or older; OR 1.58, 95% CI 1.20–2.09); education 12 years or less (compared with more than 12 years; OR 1.80, 95% CI 1.51–2.14); and nulliparous (compared with parous; OR 1.71, 95% CI 1.15–2.54).

DISCUSSION

We found that provision of medical abortion through telemedicine had comparable clinical outcomes to the face-to-face provision model with equivalent success rates and a low prevalence of adverse events. Both the high success rate and low prevalence of adverse events for the telemedicine service are similar to those reported for medical abortion in the literature.^{1,10,14} Although contraceptive uptake was slightly higher among the face-to-face cohort, this was most likely the result of the limited number of providers trained to insert intrauterine devices at telemedicine sites.

Acceptability was high among both groups of women in this study, and these results were similar to other studies on medical abortion with buccal mifepristone.^{10,15} We found one measure of acceptability—willingness to recommend the service to a friend—to be significantly higher among telemedicine patients, even after controlling for confounders. The fact that telemedicine patients reported high levels of satisfaction may be related to the convenience of receiving services closer to home or earlier in pregnancy, both of which were important for this group. Our results do not indicate that telemedicine patients were coerced to have a medical abortion despite this being the only method available at the clinics they accessed, because a high proportion reported strongly wanting medical abortion from the outset, and this did not differ from face-to-face patients. The fact that telemedicine patients had a restricted choice at the clinics they attended, if anything, might have biased them to have lower levels of satisfaction compared with

face-to-face patients, who also had the option of aspiration abortion.

We found that 25% of telemedicine patients would have preferred a face-to-face visit with the physician, and this was more common among younger, less educated, and nulliparous women. Another study of clinic-based medical abortion found that older age was an independent predictor of a positive experience, whereas education level was not.¹⁶ In our study, participants were told at the time they scheduled their appointment whether they would receive abortion services through telemedicine or not. It seems that some decided to have the abortion through telemedicine perhaps because the clinic was closer to their home or because they could get an appointment sooner, although ideally they would have preferred to be in the same room with the physician. This finding highlights the importance of informing women about what the telemedicine service involves so patients can weigh the options about which service they prefer.

This study has several limitations. Participants were not randomized and instead selected the treatment they received (telemedicine compared with a face-to-face visit), which might have introduced selection bias. However, because this was the first study of telemedicine provision of medical abortion, we felt it was important for women to be well informed of the two provision models and be allowed to choose which they preferred. In the future, a randomized controlled trial might be possible among women who have no real preference between the two models as has been done to compare medical and surgical abortion.^{17,18} Overall, 56% of patients aged 18 years or older seen during the study period agreed to participate in the cohort study, and participants were somewhat more educated and less likely to be Latina than the general medical abortion clinic population. This might have introduced selection bias, although the acceptance rate likely affected both cohorts similarly. In addition, 22% of participants were lost to follow-up despite multiple attempts to contact them. Although this loss to follow-up is high, it is similar to proportions reported in the literature¹⁹ and did not differ between cohorts. Finally, our results are specific to the provision models offered in this clinic system, and we cannot generalize our findings to other service delivery settings.

In states where physicians are required to perform medical abortion, the findings from this study indicate that telemedicine can be used to provide medical abortion in an effective and highly acceptable manner. Future research should evaluate whether

telemedicine provision improves access to services for women in rural areas as well as whether there are cost savings associated with the model. Just as telemedicine has been used to extend the reach of physicians in other disciplines, this provision model has the potential to provide abortion services earlier in pregnancy and closer to a woman's home and to help overcome the barriers to abortion access in the United States.²⁰

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: February 15, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Assembly Bill 487	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Discuss the bill.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

LRB-3383/1

RPN:jld:rs

2011 - 2012 LEGISLATURE

2011 ASSEMBLY BILL 487

January 24, 2012 - Introduced by Representatives SEVERSON, VAN ROY, VOS, SPANBAUER, BILLINGS, PASCH, ZEPNICK and PETROWSKI, cosponsored by Senators DARLING, SHILLING, KEDZIE and TAYLOR. Referred to Committee on Public Health and Public Safety.

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

Analysis by the Legislative Reference Bureau

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

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

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

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

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

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

The bill authorizes a student anesthesiologist assistant to perform only medical care tasks assigned by an anesthesiologist, who may delegate the supervision of a

student to a qualified anesthesiology provider. The bill also creates a five-member Council on Anesthesiologist Assistants to advise and make recommendations to the board.

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

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

SECTION 1. 15.407 (7) of the statutes is created to read:

15.407 (7) COUNCIL ON ANESTHESIOLOGIST ASSISTANTS;

DUTIES. There is created a council on anesthesiologist assistants in the department of safety and professional services and serving the medical examining board in an advisory capacity. The council's membership shall consist of the following members, who shall be selected from a list of recommended appointees submitted by the president of the Wisconsin Society of Anesthesiologists, Inc., after the president of the Wisconsin Society of Anesthesiologists, Inc., has considered the recommendation of the Wisconsin

Academy of Anesthesiologist Assistants for the appointee under par. (b), and who shall be appointed by the medical examining board for 3-year terms:

(a) One member of the medical examining board.

(b) One anesthesiologist assistant licensed under s. 448.04 (1)

(g).

(c) Two anesthesiologists.

(d) One lay member.

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

SECTION 3. 448.015 (1b) of the statutes is created to read:

448.015 (1b) "Anesthesiologist" means a physician who has completed a residency in anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, holds an unrestricted license, and is actively engaged in clinical practice.

SECTION 4. 448.015 (1c) of the statutes is created to read:

14 448.015 (1c) "Anesthesiologist assistant" means an individual
15 licensed by the
16 board to assist an anesthesiologist in the delivery of certain medical
17 care with
18 anesthesiologist supervision.

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

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

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

1 448.03 (2) (c) The activities of a medical student, respiratory
2 care student,
3 perfusion student, anesthesiologist assistant student, or physician
4 assistant student
5 required for such student's education and training, or the activities of
6 a medical
7 school graduate required for training as required in s. 448.05 (2).

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

9 448.03 (2) (e) Any person other than a physician assistant or
10 an
11 anesthesiologist assistant who is providing patient services as
12 directed, supervised
13 and inspected by a physician who has the power to direct, decide and
14 oversee the
15 implementation of the patient services rendered.

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

17 448.03 (2) (k) Any persons, other than physician assistants,
18 anesthesiologist
19 assistants, or perfusionists, who assist physicians.

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

21 448.03 (3) (g) No person may designate himself or herself as
22 an
23 "anesthesiologist assistant" or use or assume the title
24 "anesthesiologist assistant" or
25 append to the person's name the words or letters "anesthesiologist
26 assistant" or
27 "A.A." or any other titles, letters, or designation that represents or
28 may tend to
29 represent the person as an anesthesiologist assistant unless he or she
30 is licensed as
31 an anesthesiologist assistant by the board. An anesthesiologist

assistant shall be
clearly identified as an anesthesiologist assistant.

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

448.03 (7) SUPERVISION OF ANESTHESIOLOGIST ASSISTANTS.

An anesthesiologist
may not supervise more than the number of anesthesiologist
assistants permitted
by reimbursement standards for Part A or Part B of the federal
Medicare program
under Title XVIII of the federal Social Security Act, 42 USC 1395 to
1395hhh.

SECTION 12. 448.04 (1) (g) of the statutes is created to read:

448.04 (1) (g) *Anesthesiologist assistant license*. The board
shall license as an
anesthesiologist assistant an individual who meets the requirements
for licensure
under s. 448.05 (5w). The board may, by rule, provide for a temporary
license to
practice as an anesthesiologist assistant. The board may issue a
temporary license
to a person who meets the requirements under s. 448.05 (5w) and who
is eligible to
take, but has not passed, the examination under s. 448.05 (6). A
temporary license
expires on the date on which the board grants or denies an applicant
permanent
licensure or on the date of the next regularly scheduled examination
required under
s. 448.05 (6) if the applicant is required to take, but has failed to apply
for, the
examination. An applicant who continues to meet the requirements
for a temporary
license may request that the board renew the temporary license, but
an
anesthesiologist assistant may not practice under a temporary license
for a period
of more than 18 months.

SECTION 13. 448.05 (1) (d) of the statutes is amended to read:

448.05 (1) (d) Be found qualified by three-fourths of the
members of the board,
except that an applicant for a temporary license under s. 448.04 (1) (b)
1. and 3. ~~and~~
(e), ~~and~~ (g) must be found qualified by 2 members of the board.

SECTION 14. 448.05 (5w) of the statutes is created to read:

448.05 (5w) ANESTHESIOLOGIST ASSISTANT LICENSE. An
applicant for a license
to practice as an anesthesiologist assistant shall submit evidence
satisfactory to
board that the applicant has done all of the following:

23 (a) Obtained a bachelor's degree.

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

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

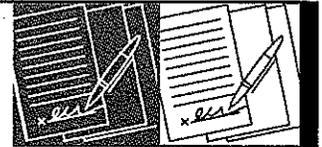
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**State of Wisconsin
Department of Safety & Professional Services**

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10) Describe the issue and action that should be addressed: Review and decide if any of the topics should be added to a future agenda.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



Jonathan Jagoda
FSMB Policy and Government Relations Associate

Maegan Carr Martin, J.D.
FSMB State Policy and Government Relations Associate

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Special Report: Prescription Drug Abuse

Prescription drug abuse—particularly abuse of opioid pain medication—continues to grow as a serious health threat in the United States, posing significant issues for regulatory agencies. The U.S. Centers for Disease Control recently reported that the number of annual deaths from overdoses of opioids nearly quadrupled between 1999 and 2008—reaching nearly 15,000 deaths in 2008.

News coverage has sparked growing awareness and increased activity among legislators and regulatory agencies to address the issue. State and national lawmakers and health policy officials have been crafting legislation and regulation intended to curb misuse while remaining sensitive to the legitimate needs of Americans who rely on these powerful drugs to manage both short-term and chronic pain. The unique considerations that must be balanced in forging policy have resulted in a wide range of proposals and enactments.

This update provides a sampling of recent activities throughout the United States.

Congress Introduces Pill Mill Legislation

The Pill Mill Crackdown Act of 2011 has been introduced with bipartisan support in both the U.S. House of Representatives (H.R. 1065) and U.S. Senate (S. 1760). This legislation would double the prison sentence and triple the fines for illegal distribution of controlled substances, as well as use seized assets to fund drug treatment programs and state drug-monitoring databases.

Senate Discussing VA Measures Aimed at Drug Monitoring

The Senate Committee on Veterans Affairs reported favorably on The Veterans Programs Improvement Act of 2011 (S. 914), which includes a provision to authorize the VA to disclose prescription drug data to state prescription drug monitoring programs.

State Legislators and Policymakers Push for Education, Awareness-Building Measures

Many states are seeking to address the educational disparities prevalent among practitioners, the public, and policymakers alike. In New York, SB 2723 has been introduced, which establishes a state chronic pain management education and training council. The council would be empowered to provide technical information and guidance to health care professionals to encourage better coordinated care in the treatment or elimination of chronic pain experienced by patients.

New Mexico, in its passage of HM 77, and West Virginia, in its introduction of SB 283, are exploring the prescription drug problems plaguing their

THE U.S. CENTERS FOR DISEASE CONTROL RECENTLY REPORTED THAT THE NUMBER OF ANNUAL DEATHS FROM OVERDOSES OF OPIOIDS NEARLY QUADRUPLED BETWEEN 1999 AND 2008—REACHING NEARLY 15,000 DEATHS IN 2008.

states through the creation of prescription drug task forces. In West Virginia, where creation of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team has been proposed, lawmakers are seeking to examine, review, and analyze the deaths of all individuals in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdose. New Mexico's HM 77 creates a task force to study the issues resulting in increasing rates of addiction and deaths due to accidental overdose of prescription drugs, review the programs and rules promulgated by the agencies intending to address the rate of addiction and accidental deaths, and report its findings and legislative recommendations to the legislative health and human services committee.

in the medical classroom. A drawback of this approach is that it may bring medical legal concerns in certain states.

Summary

Medical education is very consciously moving into the realm of ethics and professionalism; collaboration with state medical boards offers a new frontier for instilling medical professionalism in students. As healthcare professionals face increasingly complex ethical issues in practice, it becomes even more important for two of the institutions that have the most interaction with individuals on these terms—state medical boards and medical schools—to collaborate on methods for producing more ethical, conscientious physicians. We encourage state medical boards to reach out to medical schools to develop these partnerships on their own. Attendance by medical students at state medical board disciplinary hearings is just one way to achieve this goal. As more of these programs grow, it is clear that more research needs to be implemented to chart their effect on students.

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Scott Walker
Governor



Michael Waupoose
Chairperson

Duncan Shrout
Vice-Chairperson

Scott Stokes
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

This press release and the report, "Reducing Wisconsin's Prescription Drug Abuse: A Call to Action," are embargoed for release until January 30, 2012

Contacts:

Michael Waupoose, Chair, (608) 278-8200
State Council on Alcohol and Other Drug Abuse

Dorothy Chaney, Chair, (715) 221-8408
State Council on Alcohol and Other Drug Abuse
Prevention Committee Controlled Substances Workgroup

Cheryl Wittke, Executive Director, (608) 256-6713
Safe Communities of Madison/Dane County

The release of this report is being coordinated with the Safe Communities Drug Poisoning Summit: Stop the Overdose Epidemic, held January 30, 2012, 8:00 AM -- 4:00 PM, at the American Family Insurance Headquarters Training Center, 6000 American Parkway, Madison, Wisconsin. To schedule interviews, please contact Dorothy Chaney.

**State Council on Alcohol and Other Drug Abuse
Releases Report on Reducing
Wisconsin's Prescription Drug Abuse**

MADISON - After a year of study, the State Council on Alcohol and Other Drug Abuse today released its report, "Reducing Wisconsin's Prescription Drug Abuse: A Call to Action." The mission of the Council, created by the Wisconsin Legislature, is to enhance the quality of life for Wisconsin citizens by preventing alcohol and other drug abuse and their consequences through prevention, treatment, recovery, and enforcement and control activities.

The report is being released in conjunction with a summit on drug poisoning, "Stop the Overdose Epidemic," that begins today in Madison. "Drug overdose and related deaths are a very alarming trend throughout the state," said Michael Waupoose, Council chair. "This report offers timely recommendations for preventing further harm and death."

-MORE-

<http://www.scaoda.state.wi.us/>

According to Safe Communities of Madison/Dane County, Summit sponsors, poisoning is now Dane County's number one cause of injury death, surpassing motor vehicle crashes. "Some 85% of these poisoning deaths are caused by misuse or abuse of prescription, over-the-counter or illicit drugs, said Cheryl Wittke, Safe Communities Initiative executive director. "Of particular concern are opiate pain medications. These represent a significant proportion of deaths and non-fatal poisonings, can be over-prescribed and can lead to dependence and abuse."

Communities across Wisconsin report that problems associated with the misuse of prescription narcotics, such as oxycodone and hydrocodone, as well as with illegal narcotic substance, such as heroin, are on the rise. In 2009, 5.5 million prescriptions were dispensed each month in Wisconsin, including all prescription medications and refills. "With such an abundant supply of medication in society, it is not a surprise that prescription medications are commonly misused, abused and diverted for non-medical use," said Dorothy Chaney, Council workgroup study committee chair. Some 20.6 percent of Americans have abused prescription drugs in their lifetimes and the costs for health care, criminal justice and societal costs are high.

Proper disposal of unused or expired prescription drugs is also problematic in Wisconsin, according to Chaney. "Disposal of unused or expired prescription drugs should never be flushed down the toilet or sink, nor should they end up in our landfill," she said. "Those medications could have an impact on our environment by contaminating our waterways and potentially our drinking water. For proper disposal, individuals should contact their local law enforcement agency or health department."

The report has identified recommendations around eight broad areas that, if implemented, would significantly reduce prescription drug abuse in Wisconsin. These recommendations are related to fostering healthy youth; community engagement and education; health care policy and practice; prescription drug medication distribution and disposal; law enforcement and criminal justice; surveillance system; and providing early intervention, treatment and recovery across the lifespan.

The report estimates that a minimum of \$1.3 million would be needed to implement the Council's recommendations. The report concludes that funding to support these recommendations could be achieved through a two-cent surcharge on each prescription filled in Wisconsin. The Henry Kaiser Family Foundation estimates that some 66 million retail prescriptions were written in Wisconsin in 2009, or approximately 5.5 million prescriptions per month. Total retail sales of prescription drugs filled at pharmacies in the state in 2009 are estimated at \$3.9 billion. The report recommends that pharmaceutical companies be more active in preventing abuse of their products.

-MORE-

According to the report, Wisconsin is making strides in establishing a Prescription Drug Monitoring Program and permanent drop-off locations for prescription drug disposal, and is increasing community participation in national and state prescription “take back” events, such as those sponsored by the Drug Enforcement Administration.

To view the report, visit the State Council on Alcohol and Other Drug Abuse website: <http://www.scaoda.state.wi.us>.

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Controlled Substances Workgroup Recommendation Summary

► Priority Area: Fostering Healthy Youth

RECOMMENDATION 1: Support communities to foster healthy youth.

► Priority Area: Community Engagement and Education

RECOMMENDATION 2: Launch a public outreach and education campaign.

RECOMMENDATION 3: Support community coalitions as the vehicle through which communities will successfully prevent and reduce prescription drug diversion, abuse and overdose deaths.

► Priority Area: Health Care Policy and Practice

RECOMMENDATION 4: Mandate education and training for health care professionals.

RECOMMENDATION 5: Ensure that chronic pain sufferers have safe and consistent access to care.

RECOMMENDATION 6: Establish standard prescribing practices for urgent care and emergency departments.

RECOMMENDATION 7: Develop standard screening methodologies for drug-testing labs to use in detecting the presence of drugs to include all commonly misused opioids, benzodiazapines, psychostimulants, and related agents, and ensure that drug-testing methodologies used in clinical settings and in post-mortem settings (including the State Crime Lab system) are aligned in order to generate the most consistent and useful data.

RECOMMENDATION 8: Develop a standard set of treatment protocols for Opioid Treatment Programs (OTPs).

RECOMMENDATION 9: Establish guidelines to reduce the diversion of prescription drugs by those who handle prescription medications in the course of their daily work.

RECOMMENDATION 10: Equip healthcare providers and first responders to recognize and manage overdoses.

RECOMMENDATION 11: The Wisconsin Dental Association and Wisconsin Dental Examining Board should endorse the findings of the Tufts Health Care Institute Program on Opioid Risk Management and the School of Dental Medicine, Tufts University.

► Priority Area: Prescription Medication Distribution

RECOMMENDATION 12: Convene a workgroup to develop recommendations to increase security measures in the dispensing of prescriptions for controlled substances.

RECOMMENDATION 13: Implement a system to ensure that, for controlled substance prescriptions, patients are identified in a manner similar to picture identification as required to obtain pseudoephedrine.

RECOMMENDATION 14: Support a system that increases security and traceability of controlled substances from manufacturer to patient.

► Priority Area: Prescription Medication Disposal

RECOMMENDATION 15: Establish a coordinated statewide system for providing secure, convenient disposal of consumer medications from households.

RECOMMENDATION 16: Integrate medication collection with the Wisconsin Drug Repository.

RECOMMENDATION 17: Create an infrastructure for the destruction of drugs in compliance with state and federal environmental regulations.

Controlled Substances Workgroup Recommendation Summary (continued)

- RECOMMENDATION 18: Identify the causes for prescription drug waste and implement proactive solutions.
- RECOMMENDATION 19: Identify sustainable means for funding collection and disposal in cooperation with key stakeholders including pharmaceutical producers, local governments, law enforcement, waste management companies, health care providers, pharmacies and consumers.
- RECOMMENDATION 20: Establish a system for effective disposal of consumer medications in all care programs and facilities which complies with state and federal waste management laws.
- RECOMMENDATION 21: Establish regulations that would permit registered nurses, employed by home health agencies and hospices, to transport unused medications, including controlled substances, to designated drug drop-off and disposal facilities, so that when patient medications are no longer needed, such nurses are allowed by law to assist in their safe destruction.

► Priority Area: law Enforcement and Criminal Justice

- RECOMMENDATION 22: Build bridges between law enforcement and community-based prevention efforts.
- RECOMMENDATION 23: Make drugged driving a priority issue.
- RECOMMENDATION 24: Support drug courts.

► Priority Area: Surveillance System

- RECOMMENDATION 25: Design and implement an electronic Prescription Drug Monitoring Program (PDMP).
- RECOMMENDATION 26: Develop a community early warning and monitoring system that tracks use and problem indicators at the local level.
- RECOMMENDATION 27: Develop a community monitoring and early warning and monitoring system that tracks overdoses at the local level.
- RECOMMENDATION 28: Improve consistency in reporting drug use and abuse across the state.

► Priority Area: Early Intervention, Treatment & Recovery Across Lifespan

- RECOMMENDATION 29: Establish guidelines to screen for substance use in all health care settings.
- RECOMMENDATION 30: Promote and support evidence-based screening and early intervention for mental health and substance abuse.
- RECOMMENDATION 31: Integrate high quality medication management and psychosocial interventions for substance use disorders so that both are available to consumers as their conditions indicate.
- RECOMMENDATION 32: Make addiction treatment and recovery support services available both on a stand-alone basis and on an integrated basis with primary health care services, as well as in other relevant community settings.

December 2011

PRESCRIPTION PAIN RELIEVER ABUSE

Agencies Have Begun Coordinating Education Efforts, but Need to Assess Effectiveness

U.S. Government Accountability Office

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Highlights of GAO-12-115, a report to congressional requesters

PRESCRIPTION PAIN RELIEVER ABUSE

Agencies Have Begun Coordinating Education Efforts, but Need to Assess Effectiveness

Why GAO Did This Study

The Centers for Disease Control and Prevention has declared that the United States is in the midst of an epidemic of prescription drug overdose deaths, with deaths associated with prescription pain relievers of particular concern. To address this issue, federal agencies are raising awareness by educating prescribers and the general public. In response to your request, GAO (1) described recent national trends in prescription pain reliever abuse and misuse, (2) described how federal agencies are educating prescribers, (3) assessed the extent to which federal agencies follow key practices for developing public education efforts, and (4) identified educational efforts that use similar strategies and assessed how agencies coordinate those efforts.

GAO interviewed officials and reviewed documents and websites from seven agencies involved in federal drug control efforts and analyzed the most recent data from several data sources related to prescription pain reliever abuse and misuse. GAO also assessed the development of public education efforts and federal coordination efforts against key practices from prior GAO work.

What GAO Recommends

GAO recommends that the Director of ONDCP establish outcome metrics and implement a plan to evaluate proposed educational efforts, and ensure that agencies share lessons learned among similar efforts. ONDCP did not explicitly agree or disagree with GAO's recommendations, but noted that it will continue to work for improved coordination of educational efforts and evaluation of outcomes.

View GAO-12-115. For more information, contact Marcia Crosse at (202) 512-7114 or crosssem@gao.gov.

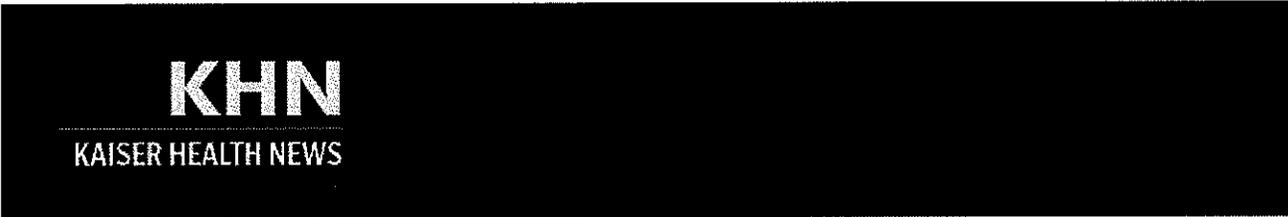
What GAO Found

Key measures of prescription pain reliever abuse and misuse increased from 2003 to 2009. The largest increases were in measures of adverse health consequences such as emergency department visits, substance abuse treatment admissions, and unintentional overdose deaths, though increases were not consistent across all measures. Federal officials suggested that increasing availability of prescription pain relievers and high-risk behaviors by those who abuse or misuse the drugs, such as combining prescription pain relievers with other drugs or alcohol, likely contributed to the rise in adverse health consequences, though data about the reasons for the increases are limited.

The Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA) use a variety of strategies to educate prescribers about issues related to prescription pain reliever abuse and misuse, but officials told us that more education is needed. The strategies used include developing continuing medical education programs, requiring training and certification in order to prescribe certain drugs, and developing curriculum resources for future prescribers. The Office of National Drug Control Policy (ONDCP) is working to develop a legislative proposal to require education for prescribers registering with the Drug Enforcement Administration (DEA) to prescribe controlled substances. Officials from some agencies said such a requirement would ensure all prescribers were starting from the same baseline of knowledge.

In their efforts to educate the public about prescription pain reliever abuse and misuse, DEA, FDA, NIH, ONDCP, and SAMHSA used almost all of the key practices for developing their consumer education efforts. Agencies varied in how they used the key practices when developing these efforts, which varied in size, scope, and duration. All agencies established metrics to monitor the implementation and functional elements of their educational efforts, but only two agencies have established or are planning to establish metrics to assess the impact of their efforts on audiences' knowledge, attitudes, and behavior. Without outcome evaluations, federal agencies have limited knowledge of how effective their efforts are in achieving their goals—in this case, reducing prescription pain reliever abuse and misuse.

Among federal initiatives to educate prescribers and the public about prescription pain reliever abuse and misuse, GAO found several instances of agencies engaging in similar efforts, directed at similar target audiences and using similar mediums. Officials said that these similarities in public education efforts are beneficial in addressing prescription drug abuse and misuse because having multiple, reinforcing messages about the same subject is valuable in public health communications and because federal agencies provide slightly different perspectives on the issues surrounding prescription drug abuse and misuse. Likewise, the prescriber education programs GAO identified, though similar, are different in content and focus. Though these similar programs have the potential to be duplicative if not effectively coordinated, federal agencies have recently begun to coordinate their educational efforts. Nevertheless, federal agencies have missed opportunities to share lessons learned and pool resources among similar education efforts.



Doctor, Did You Check Your Checklist?

TOPICS: DELIVERY OF CARE, HEALTH COSTS, HOSPITALS

By **BARA VAIDA**
 JAN 30, 2012

This story was produced in collaboration with **WASHINGTONIAN**

When Frances Barnes had a stroke in August 2008, she was taken by ambulance to Howard University Hospital. The 80-year-old grandmother was there for about two weeks when she began complaining about pain in her legs. Her daughter Althea Hart pulled back her mother’s blankets and noticed a strange odor.

Hart thought the smell was coming from the compression stockings wrapped around Barnes’s legs to help with circulation, so she took them off. She found that her mother’s left foot had turned black.

Hospital staff had failed to follow physician orders, which required taking off the compression stockings after each shift for at least 30 minutes, according to a DC Department of Health investigation.

"We called a nurse right away, and they tried to heal her infection," says Patricia Moss, another of Barnes's daughters. "But they couldn't."

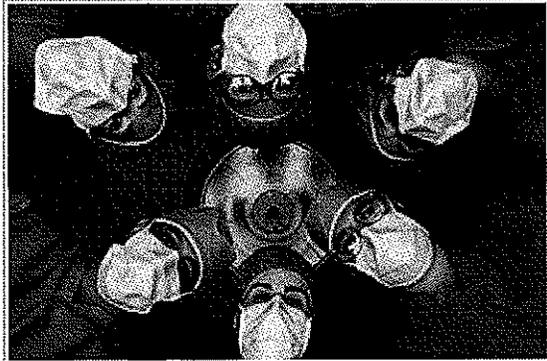


Photo by Keith Alstrin

Barnes's family moved her to Providence Hospital in Northeast DC, where she had to have her lower leg amputated. Barnes moved to a nursing home, where she continued to get infections; she died at Providence in February 2009, five months after her foot turned black. Barnes left behind eight children, 15 grandchildren, and 16 great-grandchildren. Moss filed a lawsuit against Howard University Hospital. The case was settled last year, but details weren't made public and the hospital denied liability.

"I miss her every day," Moss says. "She was doing okay until she went to Howard. She had no ulcers and no sores. Her feet were okay." If it weren't for the infection, Moss says, her mother might still be alive.

As sad as Barnes's story is, it's far from an isolated event. Alarms have been sounding for more than a decade, ever since the Institute of Medicine — the health arm of the National Academy of Sciences — estimated that as many as 100,000 people a year were dying in US hospitals due to preventable errors.

Despite those warnings, the situation has gotten worse. In 2010, the federal government estimated that faulty medical care contributed to the death of about 15,000 Medicare patients per month. By these measures, faulty hospital care is one of the leading causes of death, behind heart disease and cancer.

Why haven't hospitals made more progress on patient safety? The reasons are multiple and complex, but they boil down to the fact that hospitals are hierarchical organizations resistant to change, they haven't done enough to create environments in which patient safety is a priority, and they've been reluctant to share patient-safety data with the public.

Even getting full compliance on basic safety standards, such as washing hands, has proved elusive because hospitals are busy, high-stress places full of distractions.

"We are humans and are destined to make mistakes," says Nancy Foster, vice president of quality and patient-safety policy at the 5,000-member American Hospital Association. "The question in health care is: Can we design processes and have them in place so when an individual makes a natural mistake, that mistake doesn't result in harm to patients?"

I spoke with a dozen hospitals in the region to ask what they're doing to address patient safety. All are working on strategies—including using checklists to ensure that hospital employees consistently follow safety standards, ramping up pressure on employees to wash their hands, flattening hierarchies to improve communication between doctors and nurses, designing equipment to reduce errors, and digitizing patient records.

Five hospitals — Georgetown, Holy Cross, Inova Fairfax, Shady Grove Adventist, and Suburban — opened their doors to me to provide a fuller picture of what they're doing regarding patient safety. All five say they've improved but have more to do.

On September 22, 2010, Nadege Neim, a 28-year-old married medical student, was admitted to Baltimore's St. Agnes Hospital to have a cyst on her left ovary removed. Neim's doctor removed her right ovary and fallopian tube, according to a lawsuit she filed.

The case highlights a persistent problem: A small number of surgeries are conducted on the wrong body part. Neim didn't know about her doctor's alleged error until a month later, when she went to Howard County General Hospital's emergency room complaining about right pelvic pain and learned that her right ovary had been removed and that the cyst on her left ovary remained. Neim is now at risk for infertility.

"I felt so violated," she said in a statement. "I can't believe my doctor did this to my family and my future."

The doctor, Maureen Muoneke, has filed a response to the suit denying liability, according to the plaintiff's attorney.

There are safety measures in place designed to prevent such mistakes. Since 2004, the Joint Commission, the organization that accredits American hospitals, began requiring doctors and nurses to follow a short checklist called the "universal protocol" as a way to eliminate wrong-site surgeries. Before an operation, hospital staff are supposed to verify and mark the part of the body to be operated on, and surgical staff are supposed to take a time-out right before the surgery to ensure they're operating on the correct part of the body.

Yet wrong-site surgeries keep happening—as often as 40 times a week in US hospitals and clinics, according to the Joint Commission. Patient-safety experts aren't sure why, but they think it's related to increased time pressures in health care as well as doctors' tendency to underestimate their vulnerability to error.

How Safe Are Our Hospitals?

The Centers for Medicare and Medicaid Services and the state of Maryland have rated patient safety at hospitals in the District of Columbia, Maryland and Virginia.

"There is this conspiracy of exceptionalism" in the culture of health care, says Carol Haraden of the Institute for Healthcare Improvement, a Cambridge, Massachusetts-based nonprofit.

Because of the hierarchical nature of hospitals, in which the senior doctor is the leader, there often hasn't been a culture of collaboration and teamwork, Haraden says. That's been an obstacle to improving patient safety, because while doctors are expected to be confident about their decisions, they also have to accept that oversights can happen and that sometimes a nurse or another colleague might know better.

Haraden, who travels the world speaking to doctors and hospitals about changing their culture, says the only way to get people to change is by showing them data that underscores how standards and teamwork reduce errors. Then leaders of hospitals have to make it clear that they expect their staff to follow the protocols, and hospitals need to report information about errors so the public can compare their safety records.

"This is a very, very new set of learning and behavior expectations that haven't been true in health care," Haraden says. "It takes time. We have to have this conversation over and over again with every person."

Learning 'Dumb' Checklists

Some of the data Haraden uses in her talks comes from Atul Gawande's 2009 book, *The Checklist Manifesto: How to Get Things Right*, in which Gawande, a surgeon at Brigham and Women's Hospital in Boston, ponders his own fallibility and explores how to help others in health care.

"Avoidable failures are common and persistent, not to mention demoralizing and frustrating," Gawande writes. "We need a different strategy for overcoming failure. And there is such a strategy—though it will seem almost ridiculous in its simplicity, maybe even crazy to those of us who have spent years carefully developing ever more advanced skills and technologies. It is a checklist."

To create his list, Gawande looked to the aviation industry, a high-risk sector that has become reliably safe in part because everyone uses checklists. The military began using aircraft checklists in the 1940s when the complexity of planes reached the point that pilots couldn't remember every step needed to fly the plane.

As Gawande describes it, the checklist included seemingly "dumb" things such as making sure brakes were released, doors and windows were shut, and instruments were set. But when something becomes habitual and mundane, it's easy to forget. And overlooking any of those steps could cause a plane to crash.

Today there are multiple checklists for each aspect of airplane operation, including what to do if something goes wrong, such as an engine failure during flight.

Aviation checklists also encourage discussion and spread power among those in charge, creating a sense of teamwork. Assisting pilots participate in checklists and are encouraged to question their commanding officers if they sense there's danger. The idea is that there's "wisdom in the group" over the individual, writes Gawande: "Man is fallible, but maybe men are less so."

What You Can Do

Here's what Consumer Reports and Dr. Peter Pronovost, senior vice president for patient safety and quality at Johns Hopkins Medicine, say patients can do to keep themselves safe when they go to a hospital.

Do your homework. Go to the Web sites Hospital Compare and the Joint Commission and look up hospitals in your Zip code. Based on that information, ask your doctor which ones they trust.

Ask a malpractice lawyer which hospitals are safe.

Find out if the procedure you're having is one that both your physician and the hospital do often. "You don't want a doctor or hospital that dabbles in your procedure," Pronovost says.

Ask if the physician and hospital use a checklist.

When you go to the hospital, have a list of all your medications and medical problems and give it to the

Gawande took what he had learned from the aviation industry and worked on a checklist that covered mundane but essential tasks and fostered communication. He developed the list with other doctors through the World Health Organization, and the tool was deployed in eight hospitals worldwide in 2008. The results were telling. Hospitals that adopted his checklist reported a 36-percent drop in major surgical complications and a 47-percent decline in deaths, according to Gawande.

The hospitals reported that the list provided backup protection against lapses in memory due to fatigue or distractions. It also encouraged preoperative discussions, which came in handy when the unexpected occurred during surgery. "No one checklist could anticipate all the pitfalls," Gawande says, so just having hospital staff stop to talk through a case and its potential challenges reduced complications and deaths.

Relying On Lists, Not Memory

Dr. Michael Zenilman, regional director of surgery at Johns Hopkins Medicine in the National Capital Region, says physicians have resisted using checklists because "we believe we are different from the rest of the world." But Gawande's book has helped change minds.

Suburban Hospital began implementing a checklist in early 2011 just before Zenilman arrived in his job to align surgical care at Bethesda's Suburban, DC's Sibley, and Howard County General Hospital. All three belong to the Johns Hopkins Health System.

To demonstrate how a checklist is used, Zenilman invited me to watch a gallbladder surgery last August.

Suburban's checklist is modeled on the one Gawande developed with the WHO. It has three parts: one to be completed right before the patient is anesthetized, one right before the patient is opened, and one before the patient is wheeled out of the operating room. Each part provides moments for staff to stop and talk about potential problems.

The first part includes a confirmation of the patient's name, the type of procedure, whether the surgery site has been marked, and whether the anesthesiologist has any concerns. The second includes identification of the patient again and an introduction of everyone operating on the patient that day, plus ten other items such as what time an antibiotic was administered. The last part asks if there have been any equipment failures during the surgery, what tissue specimens have been taken during the operation, and whether all surgical equipment has been accounted for to ensure that nothing is left inside the patient. Each section is supposed to take about a minute to complete.

On the day of the surgery, each part of the checklist was encased in a plastic sheet and posted on a wall near the operating table. The circulating nurse that day, Megan Dinsmore, called out each item on the list and then used a black marker to check them off.

"I did a checklist before, but it was by memory," Dinsmore said. "This is much easier."

But she left on a break about halfway through the surgery and was replaced by Jessica Moscati. At the end of the operation, the patient was wheeled out of the room, and no one had checked off the third part of the list on the wall.

When I asked her why, Moscati told me she had conducted the third part of the checklist orally — including the count of instruments used in the surgery. Zenilman said he wouldn't have been permitted to finish his surgery until the instruments were counted. When pressed on why they didn't physically complete the checklist, Moscati said: "We should have."

doctors and nurses caring for you.

Ask if physicians and nurses have washed their hands before they touch you. You may feel uncomfortable asking this, but it's for your own safety.

If you have an invasive device in your body, such as a catheter, either you or a family member or a friend should ask every day if you need to have it in your body and when it can be taken out.

Bring a friend or family member with you to be your advocate, ask questions, and record the answers.

In a follow-up interview, Zenilman came to Moscati's defense. "What the checklist is doing is putting in writing a process of events that are already happening," he said. "You saw the third part is making sure the pathology report is sent off and making sure the count is right. Those things were done."

Hospitals that don't follow their own patient-safety protocols 100 percent of the time can't get to 100-percent safety, says Jeffrey Selberg, chief operating officer of the Institute for Healthcare Improvement, a nonprofit in Cambridge, Massachusetts. "If Suburban's process dictates that they document on the checklist, then they need to document on the checklist," Selberg says.

"What shouldn't be lost," he adds, "is that Suburban was willing to have you observe and you felt you could call them out and have a dialogue about it. That is great. I think it's terrific that the nurse said, 'We should have done the checklist.' That speaks well of them."

To get to 100-percent compliance, Selberg says, hospital staff have to feel free to talk about mistakes and what they learned from them.

Stopping Infections With A Marker

For a long time, many health-care providers believed it was inevitable that some small percentage of intensive-care patients would get infections after the insertion of a tube, catheter, or ventilator, often for multiple days, to keep them alive.

But Peter Pronovost, senior vice president for patient safety and quality at Johns Hopkins Medicine in Baltimore, proved them wrong. Dr. Pronovost began using a checklist at Johns Hopkins that led to a 90-percent drop in bloodstream infections in the hospital's intensive-care units and that in some cases got the infection rate to zero.

Pronovost's checklist has five items: wash hands; clean the patient's skin with antiseptic; put a sterile draping over the patient; wear a mask, hat, sterile gown, and gloves; and put a sterile dressing over the insertion site once the tube is in.

Gawande's *The Checklist Manifesto* details how Pronovost worked with hospitals in Michigan in a study published in 2006 on using a checklist in ICUs. The hospitals reported a 66-percent drop in infections, and many got their infection rates to zero.

Joanne Ondrush, a critical-care physician at Inova Fairfax Hospital, was inspired by Gawande's book and talked her colleagues into reading it. She then worked with doctors and nurses in the intensive-care unit to create a checklist in 2010 for Inova Fairfax's ICUs that's used when doctors and nurses talk about patients on rounds.

"The biggest resistance to this was that it's more work for someone who is already stressed and busy," Dr. Ondrush says. "But when people saw that it could be implemented with minimal change in the workflow, it was adopted in a relatively short period of time."

Inova's Medical Surgical ICU—one of nine full-time ICUs at the hospital—keeps track of its infections on a whiteboard in the staff lounge. The board is next to the refrigerator so that everyone tracks their progress. Each time a patient gets an infection, the doctors and nurses hold a "huddle" in which they discuss the cause. Then someone posts a brief explanation on the wall about how the infection occurred so everyone can learn from what happened.

In September, the Medical Surgical ICU showed that there had been six infections since the start of the year.

"Zero is always our goal," Ondrush says. "But zero isn't sustainable [forever] because we are dealing with sick people and there are going to be variables that are out of control. You can do every checklist and everything right and the patient is still going to develop an infection."

Questioning Their Superior

On an early August morning, 200 Georgetown Medical School students gather for coffee, bagels, and a talk on patient safety. Doctors haven't traditionally been trained to see patient safety as one of their priorities. That's changing.

Dr. Stephen Evans, chairman of surgery and the leader of patient safety at Georgetown University Hospital, moves to the lectern and begins with a question.

"When patients get admitted to the hospital, what is it that a patient wants?" He calls on a student at the table in front him, who answers: "To get cured?"

"No," Evans says.

The student tries again. "To feel safe?"

Evans nods. "They want to feel safe first," he says. "After they feel safe, they want to be cured of what ails them."

Evans stresses that every medical student and soon-to-be doctor plays a key role in keeping a patient safe.

"So what does that mean? If you are in a room and the attending physician walks in and doesn't wash his hands, you — not anyone else, you — can flatten the hierarchy. You say, 'Excuse me, Dr. Evans. You forgot to wash your hands going into the room. Would you mind? I think it's important for patient safety.'"

The room erupts in nervous laughter, as it does every time Evans gives this lecture. The reason, he says, is that he's telling students to question their superior—something that hasn't historically been part of med-school curriculums.

"I'm not laughing," Evans tells the students. "You have to be in a position where you can tap someone on the shoulder regardless of their level, age, or hierarchy so the best care is delivered to the patient."

The Association of American Medical Colleges, the group that speaks for the nation's medical schools, is encouraging schools to emphasize patient safety and to push new physicians to think in teams. Doctors are also being trained in the importance of washing their hands, something that seems obvious but wasn't part of med-school discussions in the past.

"Previously it was just how to treat a patient and how to take out a gallbladder," Evans says. "Now we have tons of data showing how many near misses and mistakes and errors occur, and so we try to make that painfully transparent to everyone."

Preventing 'Near Misses'

Examining the underlying factors in "near misses" and errors — known in engineering as a "root cause" analysis—is also a big change in health care. Terry Fairbanks, associate professor of emergency medicine at Georgetown and a patient-safety expert, says that among the reasons airlines are safe is that they track near misses and errors and conduct root-cause analyses.

"In the history of health care, what do we do if anyone makes a mistake?" says Dr. Fairbanks, also director of the MedStar National Center for Human Factors Engineering in Healthcare, a unit within MedStar's hospital system that focuses on patient safety. (MedStar owns Georgetown Hospital and eight others.) "We'd retrain them. We'd focus on the individual instead of recognizing that there are certain things that people will make errors with" and redesign the system accordingly.

Georgetown encourages staff to report instances in which actions nearly caused harm or caused only minor harm. These reports give an indication of where the hospital needs to bolster its processes to prevent a serious injury.

"In engineering, there are 600 misses for every adverse event," says Fairbanks. "You can build a system to prevent those near misses from turning into an adverse event, but you have to know what those near misses are."

Sometimes what's found in analyzing an injury is that hospital staff aren't following even the most basic safety precautions. Infections are known to spread through poor hand washing, for example, but hospitals continue to struggle to get their staff to wash their hands as often as they're supposed to. An estimated 1.7 million patients a year get infections in hospitals and 99,000 die from them, according to the Centers for Disease Control and Prevention.

At Shady Grove Adventist Hospital, the staff was 80 percent compliant with hand-washing rules and couldn't get that number higher until the hospital required employees to sign a letter committing to washing their hands, says Skip Margot, Shady Grove's vice president of patient-care services. The letter was then put into staff job-performance files. Compliance rose to almost 100 percent, Margot says. (Shady Grove knows its compliance rate because it periodically secretly observes staff on hand washing.)

At Shady Grove and at Georgetown, sinks and hand sanitizers have been positioned to take into account doctors' and nurses' workflows. Hand sanitizers are installed on walls near the entrance of rooms, for example. "When [doctors and nurses] don't wash their hands, it isn't a conscious decision," Fairbanks says. "You get interrupted by a nurse with a question just as you were about to wash your hands."

Georgetown says its hand-washing rate is 90 percent. Evans, the Georgetown patient-safety leader, says that as of mid-2011, there was a big decrease in the hospital's infection rate and other complications, but he declines to give specific numbers.

Digitizing Records For Safety

Another way hospitals are improving safety is by digitizing patient records. In September, the Joint Commission listed Silver Spring's Holy Cross as a top-performing hospital, one of only 405 in the country to receive that ranking. No other hospital in the region made the list. Holy Cross was judged on how well it followed recommended protocols for treating children's asthma, heart attack, heart failure, pneumonia, and surgical infection.

Dr. Yancy Phillips, Holy Cross's head of quality and care management, credits the hospital's investment in electronic records. Every patient admitted now has a digital record, and seven full-time employees comb through those records to determine if doctors and nurses are following safety protocols.

In mid-2010, just 15 percent of the nation's acute-care hospitals had electronic health records, according to the American Hospital Association. That number is expected to grow, as the government has allocated billions of dollars to help hospitals and physicians invest in electronic records. Georgetown and Inova Fairfax are both in various stages of rolling out electronic-records systems, which they hope to complete in 2012. Suburban and Shady Grove installed systems in 2011.

Holy Cross, a member of Trinity Health, spent about \$6 million on its electronic-records system, which went live in September 2008.

Lisa Shah, a Holy Cross doctor, describes the system as an "in your face" checklist that can be helpful when a doctor is dealing with fatigue and has multiple tasks to perform. The computer guides doctors through steps to follow, so Dr. Shah doesn't have to rely on her memory.

The 2010 health-care-reform law is prodding hospitals to move faster on all of these patient-safety efforts. Beginning in October, hospitals will be reimbursed for how well they take care of Medicare patients. If a hospital doesn't show improvement on patient safety, it could lose lots of Medicare money.

The law also provides for about \$1 billion to help hospitals with safety efforts and requires hospitals to provide more patient-safety data to the public.

The current lack of transparency makes it hard for people to figure out which of their local hospitals is safest. The District of Columbia reports on injuries occurring in the city's hospitals, for example, but doesn't say at which hospital the problems occurred. The DC Department of Health reported that between 2009 and 2010 there were at least 310 serious injuries in the city's hospitals, down from 706 in 2008. But those figures may not include all injuries, because it's not clear whether all hospitals reported all mistakes, as doing so is voluntary. In Maryland, there were about 56,000 preventable complications involving hospital patients between July 2010 and July 2011. Virginia doesn't detail medical errors.

The only comprehensive source of data on hospital safety is the Medicare Hospital Compare Web site, and that information lags by about a year and mostly captures care of those age 65 and older.

In October, Hospital Compare began reporting hospital infection data for Medicare patients. In January, the site began reporting on central-line infections in the broader population. More data on other types of infections will be available in 2013.

Anne-Marie Audet, vice president of health-system quality and efficiency at the nonprofit Commonwealth Fund, says the more patient-safety information is public, the better it is for everyone because it will prod hospitals to compete with one another on safety.

"Hospitals are doing a lot of harm by omission," says Paul Levy, former CEO of Beth Israel Deaconess Medical Center in Boston and author of the blog *Not Running a Hospital*. "Measure your data and post it for the world to see. Hospitals are worried the public won't properly judge their performance, but I think that people will say, 'I'd rather go to a hospital that is trying hard rather than one that won't publish their numbers.'"



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January 30, 2012

Ear Doctors Performing Face-Lifts? It Happens

By KATE MURPHY

After moving from New York to Los Angeles in 2010 to take a job with a financial services firm, Joan, now 59, believed she needed to freshen her look. So she got a face-lift and tummy tuck from a board-certified doctor in Beverly Hills.

What she did not realize was that his certification was in otolaryngology — ear, nose and throat — not plastic surgery. The outcome was less than ideal: thick scars on her temples and a wavy abdomen.

“I had to use all my savings to get a real plastic surgeon to fix what he did to me,” said Joan, who asked that her last name be withheld to protect her privacy. “I have an M.B.A. I’m not stupid. But when the doctor has a nice clinic and all those diplomas and certifications on the wall, you think he knows what he’s doing.”

With declining insurance reimbursements, more doctors, regardless of specialty, are expanding their practices to include lucrative cosmetic procedures paid for out of pocket by patients. It’s now common to find gynecologists offering breast augmentation, ophthalmologists doing liposuction, even family practice physicians giving Botox injections.

The result, according to certified plastic surgeons, is an increasing number of dissatisfied, even disfigured, patients.

“The public needs to be protected from doctors who are not upfront about what board certifications they have,” said Dr. Malcolm Z. Roth, chief of plastic surgery at the Albany Medical Center in Albany and president of the American Society of Plastic Surgeons.

Members of the society claim there has been a surge in patients requesting revisionary surgery — operations to undo damage caused by botched procedures. “I’m seeing cases like this on a weekly basis now, when a few years ago I hardly saw any,” said Dr. Patti Flint, a plastic surgeon in Mesa, Ariz.

But many of these new alternate practitioners say that traditional plastic surgeons are simply trying to protect their lucrative trade. "For a certain group to wage a turf battle and say for financial reasons that they are the only ones who can safely perform cosmetic procedures is hypocritical and grossly untrue," said Dr. Angelo Cuzalina, the president of the rival American Academy of Cosmetic Surgery, composed primarily of doctors who are not board-certified plastic surgeons.

About 80 percent of licensed doctors get a specialty certification by one of 24 boards approved by the American Board of Medical Specialties. This requires a minimum three-year residency in the chosen area of concentration, plus extensive oral and written exams.

There are no laws in the United States that require doctors to practice only within the specialty fields in which they were trained. Dr. Cuzalina, for example, was first board-certified as an oral and maxillofacial surgeon and then completed a yearlong fellowship at a cosmetic surgery clinic.

"With my experience, I don't think of myself as an oral surgeon anymore," he said.

Only Texas, California, Louisiana and Florida mandate that doctors be specific in their advertising about which specialty board certifications they have. Elsewhere they may say just that they are "board-certified."

No one knows how many doctors are practicing outside their specialty; they don't have to report to any oversight authority that they are doing so. And doctors performing cosmetic procedures are not required to report complications.

Still, the unregulated nature of cosmetic surgery is raising concern. Michael Freedland, a medical malpractice lawyer in Weston, Fla., said that since 2008 he had seen a steady rise in the number of patients incapacitated or even fatally injured by cosmetic surgery performed by unqualified doctors.

"Not only are the doctors not properly trained in plastic surgery, but they are also operating in facilities, like tanning salons and med spas, that are not equipped to handle a medical emergency," he said. "The best they can do for you if things go wrong is call 911, and sometimes they don't even do that."

State medical authorities don't tally deaths or injuries by the type of doctor involved. In any event, many plastic surgery patients are, like Joan, too embarrassed to file formal complaints.

“A doctor may be good and well trained in his or her specialty, but it takes more than a weekend seminar to achieve mastery in plastic surgery,” said Dr. Joel Aronowitz, a plastic surgeon in Los Angeles who is also a clinical assistant professor at the University of Southern California.

He noted that aspiring cosmetic surgeons may attend weekend continuing medical education courses, some held aboard cruise ships, in which they are taught to perform Botox and filler injections, liposuction and breast augmentation. The courses are often taught by physicians who themselves are not certified by the American Board of Plastic Surgery, he said.

Many such physicians claim certification by boards that have names similar to the American Board of Plastic Surgery but are not endorsed by the American Board of Medical Specialties. “They have lower requirements and are not as rigorous,” Dr. Aronowitz said. “There’s a reason they are not recognized boards.”

Dr. Cuzalina said that lobbying by plastic surgeons prevented groups like his from joining the medical specialties board.

Dr. John Santa, an internist and director of Consumer Reports’ Health Ratings Center, which rates hospitals and gives advice on choosing doctors, advised that prospective patients check state medical boards for any disciplinary actions, and also to see whether a doctor has full operating, privileges at a given hospital.

“Above all, I think common sense is in order,” he said. “I would be suspicious of anyone who is operating way outside his or her specialty area, and always get a second opinion.

“When there’s no insurance involved,” he added, “it’s really the Wild West and there’s no sheriff in town.”

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