



THE REPORT

March 2025

Message From the Board of Medicine:

What Comes Of A Complaint To The Board?

Jared Morton, MD
Board Member

*Public Protection
through fair and
impartial application
and enforcement of
practice acts*



At times, questions arise regarding official complaints to the Idaho Board of Medicine and the subsequent process of discipline review. Any individual or organization can lodge a complaint against a licensee of the Board relating to quality of care, unethical conduct, practicing without a valid license, HIPAA violations, provider impairment, inappropriate prescribing practices, or other sundry topics of potential concern. The Idaho Division of Occupational and Professional Licenses is responsible for the investigation of all complaints. In 2023, there were 234 complaints made to the Board of Medicine. Upon ascertaining that the complaint falls under the purview of the Board of Medicine, an initial legal review and screening for a possible violation of the [Medical Practice Act](#) occurs. All complaints are scrutinized, thoroughly evaluated, and kept confidential throughout the course of the investigation as per Idaho Code ([§74-106](#) (9) & (11)).

If there is potential merit to the complaint, special investigators then open the case under the direction of the Board. They may reach out to the author of the complaint and the licensee for additional insight and clarification while also obtaining pertinent medical records

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and preparing the case for the members of the Board and the various subcommittees appointed by the Board. If no violation is found, the case will be closed, and the licensee will be notified accordingly. When the complaint is verified and a potential violation of the Medical Practice Act is suspected, the members of the Committee of Professional Discipline (COPD), who are appointed by the Board, will review the case and make specific recommendations to the Board if the complaint involves a physician. As per Idaho Statute [54-1806A](#), the COPD has no authority to impose sanctions, limitations, or conditions on licenses issued and is authorized only to make recommendations to the Board. The COPD provides a critical initial review of the investigator's findings and helps provide another layer of peer review to all complaints that reach this stage of investigation. Other advisory committees such as the Allied Health Advisory Board (AHAB) and the Physician Assistant Advisory Committee (PAAC) perform similar tasks given their respective licenses. These committees also review disciplinary cases and send recommendations to the Board of Medicine. At times, outside input from equitable peers is needed and is obtained confidentially and at the request of the Board.

When a provider's actions are felt to have violated the Medical Practice Act, and after receiving the COPD or subspecialty board/committee recommendations, the Board of Medicine can take action on that provider and his/her license to not only help educate but also prevent future problems and protect future patients depending on the specific case. Most complaints do not warrant any disciplinary action and the outcomes remain confidential.

Various outcomes on violations of the Medical Practice Act are possible. Some cases warrant no formal action, the licensee is notified, and information remains on file for future monitoring. Other cases lead to private action against the licensee such as an Agreement in Lieu of Discipline, which are binding on the licensee, but are kept confidential.

When public action is needed, the outcomes may involve a public reprimand, a letter of concern, possible restrictions on the provider's license, or even a suspension/revocation of the license. At all times, significant deliberation from both the medical and non-medical members of the Board, along with legal input from both inside and outside counsel, is obtained during an investigation.

Complainants (those submitting their concerns to the Board) are not a party to the investigation or any resulting disciplinary proceedings. As a result, complainants are not entitled to case updates or access to investigative records, which are exempt from public disclosure pursuant to Idaho Code sections [67-2615\(1\)](#) and [74-106\(9\)](#). In the event formal disciplinary action is taken by the respective Board, such action will be set forth in a written order of that Board, which becomes a public record that is available online at dopl.idaho.gov.

Information About Idaho's Licensed and Registered Naturopathic Providers

Naturopathic Medical Doctor (NMD):

Definition: Naturopathic medical doctor means a person authorized and licensed to practice naturopathic medicine under [Title 54, Chapter 51](#) of Idaho Code.

Under Idaho Code §[54-5106](#) Qualifications for Licensure:

To be eligible for a license to practice as a naturopathic medical doctor in the state of Idaho, the applicant shall submit an application, pay the fee, and fulfill the following requirements:

- (1) The applicant must be a graduate of an approved naturopathic medical program as defined in this [chapter](#);
- (2) The applicant must provide proof of having received a passing grade on the naturopathic physician's licensing examinations administered by the approved national board of naturopathic examiners;
- (3) The board may require an applicant to be personally interviewed by the board, the allied health advisory board, or by a designated committee of the board.
Such an interview shall be limited to a review of the applicant's qualifications and professional credentials; and
- (4) The application shall require a fingerprint-based criminal history check in accordance with section [67-9411A](#), Idaho Code.

Regulating Board: A Naturopathic Medical Doctor (NMD) is regulated by the Board of Medicine.



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Licensed Naturopathic Doctor (LND):

Definition: A licensed naturopathic doctor means an individual licensed as a medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of chiropractic, doctor of dental medicine, or doctor of nursing practice who has obtained an approved naturopathic doctoral degree, as set for in rule, and who voluntarily elects to seek and receives licensure under [Title 54, Chapter 59](#) of Idaho code to practice naturopathic health care in Idaho.

The Legislature, during the 2024 session, amended the qualifications for licensure as a **naturopathic doctor** in Idaho Code § [54-5905](#). Under that amended statute, an applicant must:

1. Possess a current, valid, and unrestricted license in any state, district, or territory of the United States in any of the following professions:

1. Medical doctor or doctor of osteopathy;
2. Podiatrist;
3. Dentist;
4. Chiropractor with an accredited doctoral degree in chiropractic medicine; or
5. Nurse, with a level of training and education equivalent to an advanced practice registered nurse and has a doctorate degree in nursing.

2. Obtain a certificate of completion of a naturopathic doctor curriculum of at least 160 hours from an institution accredited by an accreditation agency approved by the United States Department of Education.

3. Have not pled guilty to or been convicted of a crime that is deemed relevant in accordance with section [67-9411](#)(1), Idaho Code, unless such applicant demonstrates that he has been sufficiently rehabilitated to warrant the public trust: and

4. Complete one (or more) of the following:

- A. At least four (4) years of experience in the practice of naturopathic health care in Idaho that is acceptable to the board; provided, however, a practitioner who has at least two (2) years of naturopathic health care experience that is acceptable to the board and that occurred on or before July 1, 2024, shall satisfy the requirements of this paragraph;



- B. Passes an Idaho state examination proving minimum competency and skills, to be developed and approved by the board by rule and the American naturopathic medical certification board pursuant to this chapter; or
- C. Passes any national board examination that certifies the individual has achieved minimum competency and skills in the practice of naturopathic health care as approved by the board by rule.

Regulating Board: A licensed naturopathic doctor (LND) is regulated by the Board of Naturopathic Health Care, which was established by the Idaho legislature in 2022. The LND is not regulated by the Board of Medicine.

Registered Naturopath:

Naturopaths who are not licensed naturopathic doctors may, but shall not be required to, obtain registration under the provisions of this chapter (Title 54, Chapter 59) and pursuant to the rules of the board

Scope:

The scope of practice for a registered naturopath under this chapter shall be limited to practices permitted pursuant to section [54-1804\(1\)\(I\)](#), Idaho Code.

54-1804. UNLICENSED PRACTICE — PENALTIES AND REMEDIES RELATING TO UNLICENSED PRACTICE. (1) Under the circumstances described and subject in each case to limitations stated, the following persons, though not holding a license to practice medicine in this state, may engage in activities included in the practice of medicine:

- (I) A person who administers treatment or provides advice regarding the human body and its functions and who:
 - (i) Does not use legend drugs or prescription drugs in such practice;
 - (ii) Uses natural elements such as air, heat, water and light;
 - (iii) Uses only class I or class II nonprescription, approved, medical devices as defined in section 513 of the federal food, drug and cosmetic act;
 - (iv) Uses only vitamins, minerals, herbs, natural food products and their extracts, and nutritional supplements;
 - (v) Does not perform surgery: and who:
 - (vi) Requires each person receiving services to sign a declaration of informed consent that includes an

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overview of the health care provider's education which states that the health care provider is not an "M.D." or "D.O." and is not licensed under the provisions of this chapter.

Regulating Board: A registered naturopath is regulated by the Board of Naturopathic Health Care.

To view or print a one page table summarizing the above information and the authority related to medications, go to the Idaho Board of Pharmacy [website](#) , under Board News select the topic entitled [Medication Authority ID Naturopaths](#) or to go directly to the pdf click [here](#).



Chronic Opioid Use and Its Societal Impact

Christian G. Zimmerman, M.D., MBA

Board Member

Prologue: *The pervasive, enduring, and irremediable issue of chronic opioid use poses significant challenges to society, impacting public health, economics, and societal norms. The opioid crisis, driven by both prescription and illicit opioids, has resulted in devastating consequences for communities and individuals. **Chronic Opioid** use often begins with legitimate pain management but can lead to dependence and addiction, altering the course of life and burdening healthcare systems. The escalation of opioid misuse has contributed to a rise in overdose deaths, with public health agencies struggling to mitigate the crisis through prevention, treatment, and harm reduction strategies.*

This article explores the ramifications of this omnipresent malady, its statistical impact, and the associated cost control by providers, citizens, and legislators alike.

Opioid overdose deaths remain high in this country despite enhanced levels of education, awareness, and interventional methods by both Federal and State organizations.

Nearly 108,000 people died from drug overdose in 2022, and approximately 82,000 of those deaths involved opioids (about 76%).

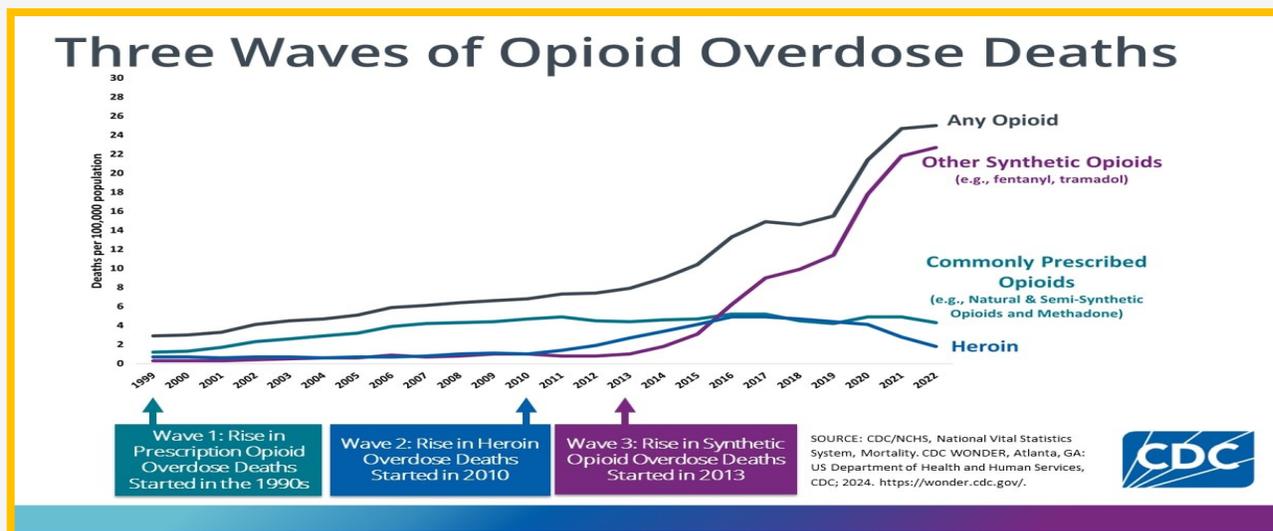
The number of people who died from an opioid overdose in 2022 was 10 times the number in 1999; however, opioid overdose death rates were relatively stable from 2021 to 2022. Death rates involving various types of opioids are changing differently.

*From 2021-2022: The rate of overdose deaths involving synthetic opioids other than methadone (primarily illegally made fentanyl and fentanyl analogs) **increased** by approximately 4%. The rate of overdose deaths involving heroin **decreased** by 36%. The rate of overdose deaths involving prescription opioids **decreased** by approximately 12%. ⁽¹⁾*

The rise in opioid overdose deaths is shown in three successive incursions.

From 1999-2023, nearly 830,000 people died from an opioid overdose.⁽²⁾ This number includes overdose deaths involving prescription and illegal opioids.

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https://stacks.cdc.gov/view/cdc/119116/cdc_119116_DS1.pdf

The rise in opioid overdose deaths can be outlined in *three* distinct patterns. The first surge began with an increased prescribing of opioids in the 1990s. Overdose deaths involving prescription opioids increased starting around 1999 but have declined in recent years with both societal awareness and education. **This increase in deaths coincided with the deliberate intentness toward pain as a vital sign and not a symptom.** The second uptick began in 2010 with rapid increases in overdose deaths involving heroin and its derivatives. In recent years, heroin overdose deaths have been declining as trends and availability of synthetic opioid analogs have displaced and surpassed other illicit compounds. The third surge began in 2013, with substantial increases in overdose deaths involving the flood of synthetic opioids, particularly those involving illegally made fentanyl combined with other chemicals. Synthetics have saturated the illegal drug markets, being a 31% greater seizure amount at the US Border in 2024.⁽³⁾ Synthetics are often found in powder form, pressed into counterfeit pills, or mixed into other drugs. More recently, non-opioid sedatives, such as xylazine, have been found mixed into fentanyl implanted medications.

In the current landscape, many opioid overdose deaths also involve other drugs. In 2022, among a subset of state boundaries, 43% of drug overdose deaths involved opioids, stimulants, or both.

Approximately 47,000 persons in the United States died from an opioid-involved overdose in 2018, and greater than 5 million people met the diagnostic criteria for an opioid use disorder in 2017. The economic cost of the U.S. opioid epidemic in 2017-2022 was estimated at \$1021 billion. The CDC used national-level cost estimates to calculate the state-level *economic cost* of opioid use disorder and fatal opioid overdose during 2017.^(4,5) The (cases and) costs of state-level opioid use disorder and fatal opioid overdose per capita were calculated for each of the 38 states and the District of Columbia (DC). Combined costs of opioid use disorder and fatal opioid overdose varied substantially, ranging from \$985 million in

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Wyoming to \$72,583 million in Ohio. Per capita combined costs also varied considerably from state to state, ranging from \$1,204 in Hawaii to \$7,247 in West Virginia. States with high per capita combined costs were mainly in two regions: Ohio Valley and New England.

Estimated case counts of state-level opioid use disorder were extracted from the National Survey on Drug Use and Health (NSDUH) 2-Year Restricted-Use Data Analysis System (2016–2017) provided by the Substance Abuse and Mental Health Services Administration. ⁽⁵⁾ NSDUH is a nationally representative sample of the U.S. civilian noninstitutionalized population aged ≥ 12 years. Cases of opioid use disorder were identified by using questions on opioid abuse or dependence during the past year. Case counts of state-level fatal opioid overdose and population estimates in 2017 were extracted from the CDC's WONDER database. Cases of fatal opioid overdose were identified using *International Classification of Diseases, Tenth Revision*. The underlying cause-of-death codes in this report are limited to DC and the 38 states that met the requirement that at least one specific drug is named on the death certificate. ⁽⁶⁾

The cost per opioid use disorder case (\$221,219) was derived by dividing the total U.S. cost of opioid use disorder (\$470,975 million) during 2017 by the number of opioid use disorder cases in the same year (2.129 million). The cost per case of fatal opioid overdose (\$11.548 million) was derived by dividing the total cost of fatal opioid overdose (\$549,691 million) by the number of fatal opioid overdose cases (47,600).

The state-level cost of opioid use disorder was calculated by multiplying the U.S. cost of opioid use disorder per case by the number of cases of opioid use disorder in each state.

To facilitate comparison across states, the CDC divided state-level combined costs of opioid use disorder and fatal opioid overdose by state population to generate per capita costs. The 38 states and DC were ranked by per capita combined costs. Cost components of opioid use disorder and fatal opioid overdose include the costs of health care, substance use treatment, criminal justice, lost productivity, reduced quality of life, and the value of statistical life lost. These components were calculated by multiplying the number of state cases of opioid use disorder or fatal opioid overdose by national cost estimates per case for each component. ⁽¹⁾

The cases of opioid use disorder and fatal opioid overdose varied substantially among states. Three adjacent states in the Ohio Valley (West Virginia, Ohio, and Kentucky) had the first, second, and fourth highest per capita combined costs. Per capita costs of fatal opioid overdose were highest in West Virginia and Ohio. Per capita combined costs in New England states were among the eight highest: New Hampshire, Massachusetts, Maine, and Connecticut. ^(1,2)

Reduced quality of life was the largest component of the cost of opioid use disorder, and the value of statistical life lost was the largest component of the cost of fatal opioid overdose. Together, these two components accounted for approximately 84% of combined costs, followed by lost productivity.

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Epilogue

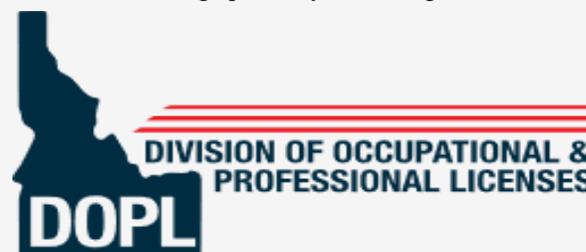
The opioid overdose epidemic has had a substantial economic impact on the United States since 2017. Individual states differed widely in overall and per capita economic cost. Per capita, combined costs of opioid use disorder and fatal opioid overdose were highest in states in the Ohio Valley and New England regions. Three states in New England had some of the highest per capita combined costs in 2017. However, previous reports have shown that these states had low per capita lifetime medical and work-loss costs from all fatal injuries (including opioid overdose) in 2014. Further investigation is needed to ascertain why states that have relatively low costs for other types of injuries have relatively high costs related to opioid use disorder and fatal overdose.

Several effective strategies have been identified to improve opioid prescribing consistently with clinical guidelines, treat opioid use disorder, and prevent fatal overdose. Pain clinic laws and combined implementation of mandated provider review of state-run prescription drug monitoring program data have reduced the amounts of opioids prescribed and, in effect, prescription opioid overdose death rates. Treatment with Food and Drug Administration–approved medications (methadone, buprenorphine, or naltrexone) are the most effective form of treatment for opioid use disorder. Overdose education and nasal naloxone distribution programs have reduced opioid overdose mortality rates nationwide. Yet the permissiveness of these remedies begs the discussion of allowances and furthering/substantiation of an already growing pandemic.

References

1. Wolff, J, Gitukui, S, O'Brien, M, Mital, S., Noonan, RK. [The Overdose Response Strategy: Reducing Drug Overdose Deaths Through Strategic Partnership Between Public Health and Public Safety](#). *Journal of Public Health Management and Practice*. 28(Supplement 6):S359-S366, November/December 2022.
2. <https://www.cdc.gov/nchs/products/databriefs/db522.htm>
3. [A scoping review of law enforcement drug seizures and overdose mortality in the United States - ScienceDirect](#)
4. <https://wisqars.cdc.gov/help/economic-cost-of-opioid-use-disorder-and-fatal-overdose>
5. <https://library.samhsa.gov/sites/default/files/pep23-07-00-001.pdf>
6. <https://cdc.gov/nchs/nvss/manuals/2018/2a-sectioni-2018.htm>

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Idaho Medicaid and Benzodiazepine Utilization

Idaho Medicaid Aims to Improve Safety through Benzodiazepine Utilization Management

- **New benzodiazepine prescriptions limited to 2 weeks.**
- **All alprazolam prescriptions require prior authorization.**

Benzodiazepine (BZD) use can lead to physical dependence, overdose and death; cognitive decline; falls and fractures; and multiple negative psychological effects. BZDs are only rarely indicated in the treatment of behavioral health conditions and sometimes, such as in PTSD, can even make symptoms worse. That said and despite their risks, BZD utilization in Idaho and around the country remains high. To decrease overreliance on BZDs, Idaho Medicaid is now¹ limiting new fills to two (2) weeks and prior authorizing higher risk BZDs, including alprazolam. In the near future, all BZD prescriptions will require prior authorization.

Keyways to Improve BZD Safety:

- **Use BZDs sparingly – the lowest dose for the shortest time.** Even two weeks of BZDs can lead to tolerance, dependence, and adverse effects.
- **Set clear expectations.** Discuss risks, stopping parameters, and a discontinuation plan when first starting a BZD (keeping in mind that dependence may develop even after a few weeks of daily use and a taper may be needed).
- **Obtain a second opinion.** Consult psychiatry early and often. Consider bringing cases to [Project ECHO Idaho](#)'s Behavioral Health in Primary Care series.
- **Limit prescribers.** One prescriber should ideally be responsible for all controlled substance prescribing. If this is not possible, coordinate closely with other prescribers.
- **Drug test sometimes.** Urine drug testing should be done intermittently to confirm adherence. Quantitative (confirmatory) urine drug testing is typically needed to identify most BZDs.
- **Dispose of unused BZDs.** Require return of unused BZDs for new prescriptions. Many pharmacies have [drug disposals](#).

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Idaho Medicaid Support:

- **Emergency Fills:** If you have a prior authorization pending and your patient needs their medication urgently, the pharmacy can fill a 72-hour emergency supply. The override codes for billing a 72-hour emergency supply at the pharmacy are:
 - o Reason for Service code: TP (Payer/processor questions)
 - o Professional Service code: MR (Medication review)
 - o Result for Service code: 1F (Filled, with a different quantity)
- **Tapering & Discontinuation:** Taper planning should be individualized and typically slow and gradual. In many cases, decreasing the dose by one tablet per month is appropriate. Idaho Medicaid’s pharmacists can help structure taper plans. Consider reviewing the following resources:
 - ◇ [VAMC: Re-evaluating the Use of Benzodiazepines](#)
 - ◇ [Benzodiazepine Information Coalition: Ashton Manual](#)
 - ◇ [Effective Treatments for PTSD: Helping Patients Taper from Benzodiazepines](#)
 - ◇ [Project ECHO Idaho](#)

For more information about Idaho Medicaid’s pharmacy benefit, including the most recent Preferred Drug List, visit <https://medicaidpharmacy.idaho.gov>.

For questions about Prior Authorizations, call 1-866-827-9967 , Mon-Fri, 8am-5pm MST.

For support with benzodiazepine or opioid tapering, please reach out to the Idaho Department of Health & Welfare’s Opioid and Benzodiazepine Safety Pharmacists², Elaine Ladd and Amy McHenry.

Elaine Ladd, PharmD
208-364-1829
elaine.ladd@dhw.idaho.gov

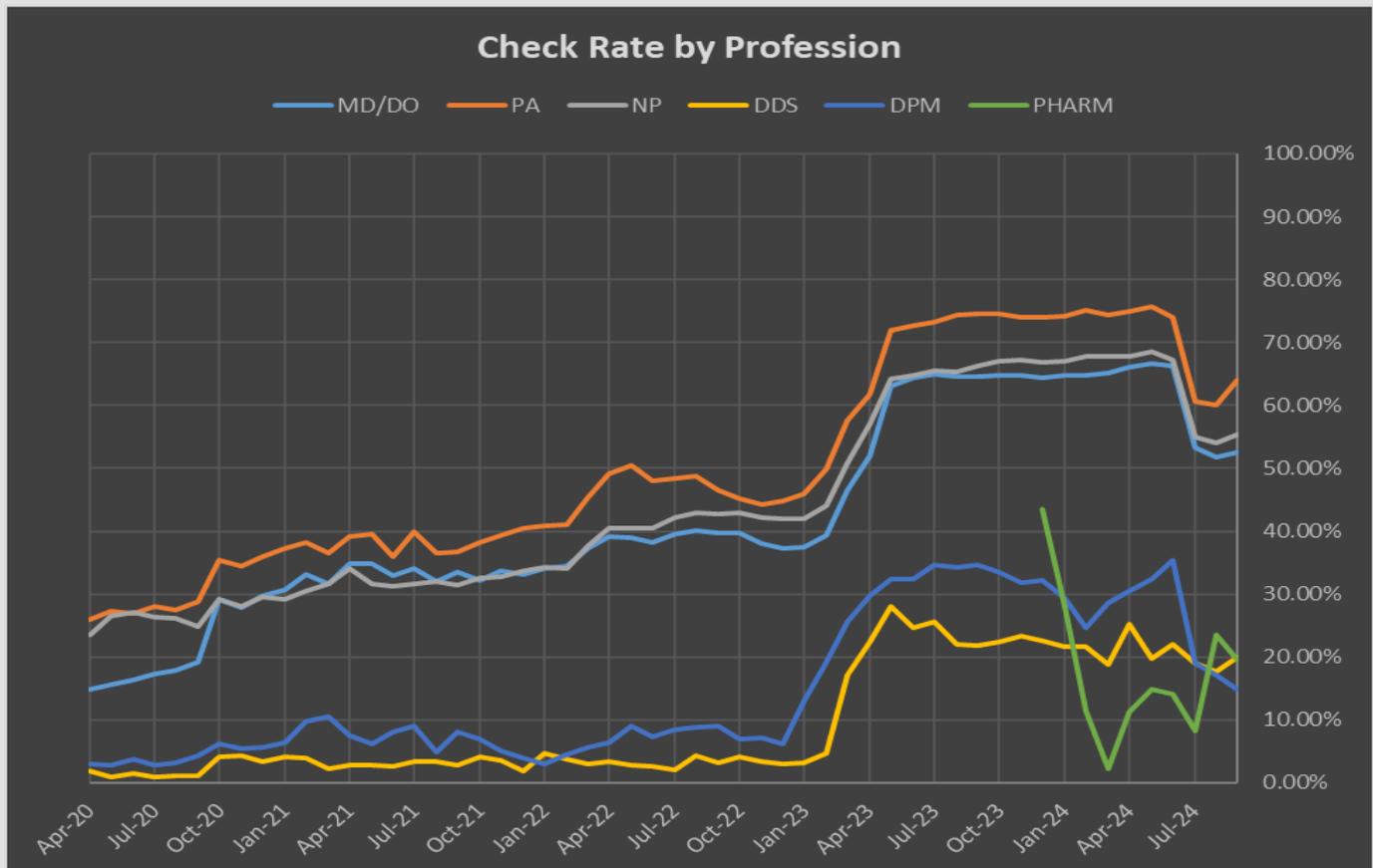
Amy McHenry, RPh
208-364-1829
amy.mchenry@dhw.idaho.gov

1. BZD-naive rule limiting the first fill to 14 days went into effect in September of 2024. Alprazolam effectively noted as a non-preferred agent in the Medicaid system went into effect in October 2024 (previously it has been listed as a non-preferred agent for years but there wasn't the manpower to activate it in the Medicaid system and take on the additional PA work related to it).

2. The Idaho Department of Health & Welfare Division of Public Health Drug Overdose Prevention Program (DOPP) is using their CDC Overdose Data to Action in States (OD2A-S) grant to facilitate a unique partnership with the Division of Medicaid pharmacy program to use the prior authorization process to educate and support providers in Idaho to make safer decisions when prescribing opioids and BZDs and ultimately reduce reliance on long-term opioid and BZD therapy.

Mandatory Prescription Drug Monitoring Program (PDMP) Prescriber Checking

Per Idaho Code [§37-2722](#) (f) Prior to issuing to a patient a prescription for outpatient use for an opioid analgesic or benzodiazepine listed in schedule II, III, or IV, the prescriber or the prescriber's delegate shall review the patient's prescription drug history for the preceding twelve (12) months from the prescription drug monitoring program and evaluate the data for indicators of prescription drug diversion or misuse.



(DOPL, 2025)

Want to Improve Your Check Rate?

One way to improve your check rate is to verify that your delegate list is up to date. The following link is a guide on how to review delegates:

<https://pmpawarxe.zendesk.com/hc/en-us/articles/27383265489427-Approving-Removing-Delegates>

Once your delegate list is up to date, you will get credit for your delegates when they check the PDMP. Updating your delegate list will also remove those who are no longer authorized delegates. As a supervisor you are responsible for activities your delegate(s) perform within the PDMP system.

Health Professionals RECOVERY Program (HPRP)

formerly Physician Recovery Network

The goal of the Health Professionals Recovery Program is to assist health professionals and their families in identifying substance use disorders that may be a potential threat to the individual or their loved ones. The program aims to lessen the negative impacts on the individual and their career.

Research shows that disciplinary actions don't necessarily intervene in the progression of addiction. However, individualized alcohol or substance use disorder treatment can be an effective method for medical professionals and society at large.

Are you ready to make changes?

Do you feel that yourself or someone you know is going down the wrong path?

Do you know someone in the medical community struggling who needs help?

You can choose the direction you are headed and get help addressing substance use or mental health. For further information about this program contact Katie Stuart.

Katie Stuart, CIP

Website: dopl.idaho.gov/health-professionals-recovery-program

Phone: (208) 577-2489

Email: Katie.Stuart@dopl.idaho.gov

2025 Board Meeting Schedules

Board of Medicine

- 5/22/2025
- 8/28/2025
- 11/13/2025

Physician Assistant Advisory Committee

- 4/15/2025
- 7/23/2025
- 10/21/2025

Allied Health Advisory Board

- 4/16/2025
- 7/30/2025
- 10/08/2025

Committee on Professional Discipline

- 4/24/2025
- 7/31/2025
- 10/16/2025

Maternal Mortality Review Committee

- 5/02/2025
- 6/13/2025
- 9/12/2025
- 11/07/2025

All Meetings will be held at:

11341 W Chinden Blvd.

Building 4

Boise, ID 83714

Room: TBD

For meeting updates visit:

[Home - DOPL \(idaho.gov\)](https://www.idaho.gov/DOPL)



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