

STATE OF MINNESOTA

Health Professionals Services Program

Biennial Report

Fiscal Year July 1, 2000 to June 30, 2002

I. General Information

Minnesota Statutes, section 214.31 to 214.37 charges the Health Professionals Services Program (HPSP) with the responsibility to *"protect the public from persons regulated by the [health licensing] boards [and the Emergency Medical Services Regulatory Board and the Dept. of Health] who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals or any other material, or as a result of any mental, physical or psychological condition."*

A. HPSP Mission and Major Functions

1. Mission:

The mission of the Health Professionals Services Program is to enhance public safety in health care. Its goals are to promote early intervention, diagnosis and treatment for health professionals and to provide them with monitoring services as an alternative to board discipline.

2. Functions:

- a. **Provide health professionals with intake and assessment services to determine if they have an illness that warrants monitoring:**
 - Evaluate symptoms, treatment needs, immediate safety and potential risk to patients;
 - Obtain chemical, mental and physical histories along with social, and occupational data;
 - Determine practice limitations, if necessary;
 - Secure records consistent with state and federal data practice regulations; and
 - Collaborate with medical consultants and community providers concerning treatment.
- b. **Create and implement monitoring contracts:**
 - Specify requirements for appropriate treatment and continuing care; and
 - Determine illness-specific and practice-related limitations or conditions.
- c. **Monitor the continuing care and compliance of health program participants:**
 - Communicate monitoring procedures to treatment providers, work site supervisors and other collaborative parties;
 - Review records and reports from treatment providers, work site supervisors and other sources regarding the health professional's level of functioning and compliance with monitoring;
 - Coordinate toxicology screening process; and
 - Intervene, as necessary, for non-compliance, inappropriate treatment, or symptom exacerbation.
- d. **Consult with licensees, licensing boards, health employers, practitioners, and medical communities:**
 - Provide information and set standards for early intervention and monitoring of impaired professionals.
 - Refer inquiries to appropriate government or community resources.
 - Provide outreach services to hospitals, clinics, and professional associations.
 - Conduct research on professional impairment, appropriate care, and potential for harm.
 - Consult with health-licensing boards on illness related issues.
- e. **Eliminate the duplication of monitoring functions by health licensing boards:**
 - Offer a single point of contact for health professionals, employers, boards and the public regarding impaired health professionals.
 - Promote streamlined and efficient reporting of impaired professionals.
 - Combine expertise in a central location.
 - Relate clear understanding of professional reporting obligations.

B. Major Activities During Biennium

HPSP provided services to more health professionals than ever before in the program's history. The impact of this is described below.

HPSP established outreach strategies that lead to a 58% increase in the number of self and third party referrals over the last biennium.

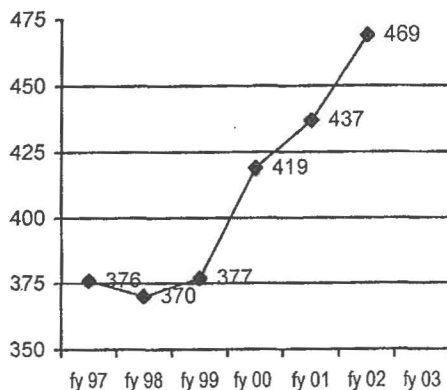
HPSP continued to implement quality improvement initiatives. These included but are not limited to improving the toxicology screening process and increasing utilization of the computerized database to promote efficiency and effectiveness.

C. Emerging Issues - Program Growth and Cost

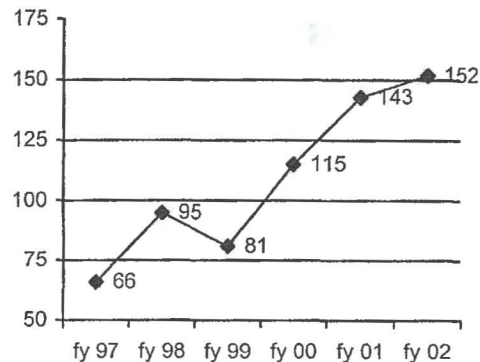
When HPSP started in August of 1994, five licensing boards participated in the program. Today all fourteen health-licensing boards participate, as well as the Emergency Medical Services Regulatory Board and three programs administered by the Department of Health. This totals nearly 180,000 persons eligible for program services.

The number of health professionals enrolling in HPSP continues to grow. For example, from fiscal year 1999 to 2002, the number of active cases grew from 377 to 469, an increase of 24%. This growth is in part due to the increase 50% increase in the numbers of persons self-referring to the program from 1999 to 2002. The following graphs depict the increases in HPSP's caseload and self-referral to the program:

Caseload by Fiscal Year:



Self Referrals by Fiscal Year:



When HPSP was conceived, it was not anticipated that health professionals would seek help and report themselves to the program at the current rate. While this is viewed as a positive response to program services, which enhances public safety in health care, participating boards are bearing the increased cost. Program growth puts financial stress on boards, which in turn, impacts the program.

Program resources need to be consistent with the rate of program growth. The current rate of growth threatens the ability of the program to provide quality services to health professionals who may be unable to practice safely. In response to this, a budget has been developed that outlines the need for additional staff (1 case manager and changing the .36 student worker position to a full-time support staff position). Even with those increased proposed staffing hours, case loads would remain consistent with national standards.

II. Board Members, Staff and Budget

A. Composition of Committees

Program Committee

The Program Committee consists of one representative of each participating board. The Program Committee provides direction and assures the participating boards that HPSP is operating effectively and efficiently to achieve the purposes outlined in statute. Its goals are to ensure that the public is protected, clients are treated with respect, the program is well-managed, financially secure and operating consistently within the statute. The committee designates one of the health-related boards to act as an Administering Board to provide administrative support to HPSP.

Current Program Committee Members:

- Steven Altchuler, Board of Medical Practice
- Tony Bibus, Board Social Work
- Robert Butler, Board Marriage and Family Therapy
- Linda Dieleman, Board of Dietetics & Nutrition.
- Vernon Kassekert, Board of Pharmacy
- Rosemary Kassekert, Board of Chiropractic Examiners
- Therese McDevitt, Board of Physical Therapy
- Laurie Michelson, Board of Optometry
- Sharilyn Moore, Board of Podiatric Medicine
- Susan Osman, Board of Veterinary Medicine
- James Peterson, Board of Psychology
- Freeman Rosenblum, Board of Dentistry
- Richard Sizer, Nursing Home Admin. Board
- Gary Wingrove, Emergency Medical Services
- Susan Winkelmann, Dept. of Health
- Susan Ward, Board of Nursing

Advisory Committee

The Advisory Committee is required by statute to advise the Program Committee and the Program Manager. The Advisory Committee consists of one person appointed by each professional association by any means acceptable to them as identified in (Minn. Stat., section 214.32 subd. 1 (c) (1).)

Current Advisory Committee Members:

- Jim Alexander, MN Pharmacists Assoc.
- Gail Arnold, MN Academy of Physician Assistant's
- Bruce Benson, MN Society of Health-System Pharmacists
- Bernard Belling, MN Psychological Assoc.
- Peter Cannon, MN Dental Assoc.
- Bernadine Engeldorf, MN Nurses Assoc.
- Randy Herman, American Assoc. of Social Work Education
- Michael Koopmeiners, Physicians Serving Physicians
- William Kuglar, MN Podiatric Medical Assoc.
- Clare Larkin, MN Dental Hygienists Assoc.
- Nancy Malmon, Public Member
- Jackie Morehead, MN Physical Therapy Assoc.
- Rose Nelson, MN LPN Assoc.
- Steve Polei, MN Medical Assoc.
- Deb Sidd, MN Society for Respiratory Care
- Debra Skees, MN Respiratory Care Assoc.
- Scott Wells, MN Veterinary Assoc.

Board Staff and HPSP Staff Work Group

Each board designates one or more representatives to meet regularly with program staff as part of a work group to discuss issues relating to HPSP policies, procedures and activities. The Program Manager solicits agenda items from all the members of the work group. Board representatives communicate the interests and concerns of their boards to HPSP staff as well as obtain information to enhance the operations of HPSP consistent with statute.

B. Employees

HPSP is currently staffed with 5.5 full time employees:

- 1 Program Manager
- 4 Case Managers
- 2 Support Staff

C. Receipts and Disbursements

HPSP is a service program and does not generate revenue. HPSP is funded by the health licensing boards, whose income is generated through licensing fees and by the EMSRB and the Dept. of Health, both of which receive general fund dollars. Each board pays an annual \$1,000 participation fee and a pro rata share of program expenses based on the number of licensees they have in the program:

Dollars in Thousands

| | FY 2001 | FY 2002 |
|--|---------|---------|
| Total Direct Costs: | 360 | 426 |
| Statewide Indirect: | 0 | 8 |
| Total Indirect Costs: | | 8 |
| Total Direct & Indirect Costs: | 360 | 426 |
| Total Revenue: | | |
| Surplus (Shortfall): | 19 | 17 |
| A Cumulated Ending Surplus (Shortfall) or Carry forward: | | 1 |

HPSP's budget is broken down as follows:

- 76% -Salaries
- 8% - Professional Technical Contracts
- 5% - Other Operational Costs
- 4% - Rent/Lease
- 4% - Statewide Indirect Costs
- 3% - Attorney General

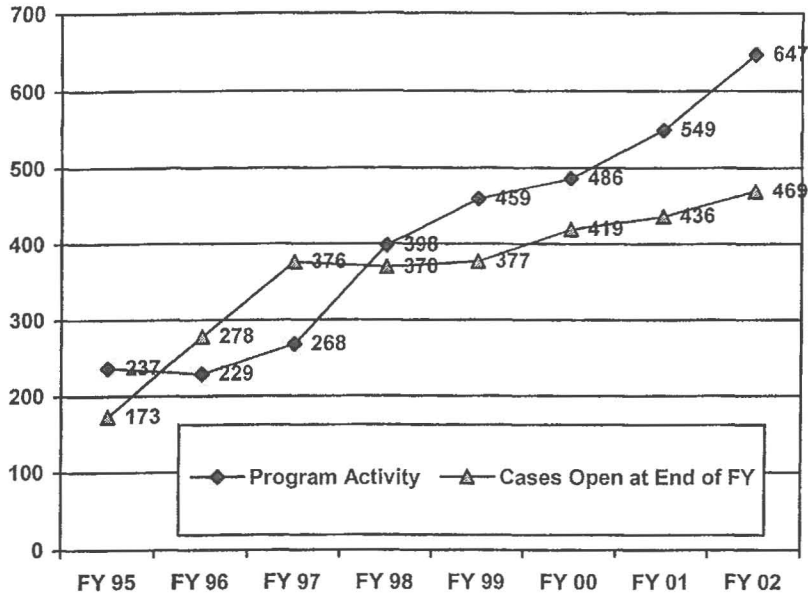
III. Caseload - Referrals and Discharges by Board and Fiscal Year

| FY Joined | BOARD | 95 | | | 96 | | | 97 | | | 98 | | | 99 | | | 00 | | | 01 | | | 02 | | |
|-----------|--------------|------------|-----------|-------------------|------------|-----------|-------------------|------------|-----------|-------------------|------------|------------|-------------------|------------|------------|-------------------|------------|------------|-------------------|------------|------------|-------------------|------------|------------|-------------------|
| | | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY | Opened | Closed | Open at End of FY |
| 01 | BENHA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 1 |
| 96 | Chiropractic | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 1 | 3 | 3 | 1 | 5 | 3 | 3 | 5 | 3 | 3 | 5 | 5 | 4 | 6 | 14 | 9 | 11 |
| 94 | Dentistry | 1 | 0 | 1 | 3 | 0 | 4 | 6 | 1 | 9 | 4 | 6 | 7 | 6 | 6 | 7 | 7 | 1 | 13 | 5 | 5 | 13 | 16 | 12 | 17 |
| 02 | Dept. Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 2 | 4 |
| 02 | Diet & N | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 2 | 1 |
| 01 | EMS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 3 | 2 | 6 | 4 | 4 |
| 94 | Medical | 87 | 6 | 81 | 63 | 28 | 116 | 57 | 30 | 143 | 43 | 67 | 119 | 47 | 57 | 109 | 68 | 70 | 107 | 46 | 52 | 101 | 88 | 80 | 109 |
| 95 | MFT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 94 | Nursing | 108 | 24 | 84 | 97 | 34 | 147 | 107 | 48 | 206 | 126 | 118 | 214 | 148 | 142 | 220 | 165 | 137 | 248 | 196 | 175 | 269 | 174 | 168 | 275 |
| 01 | Optometry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 1 | 2 |
| 94 | Pharmacy | 9 | 2 | 7 | 4 | 0 | 11 | 8 | 5 | 14 | 10 | 8 | 16 | 12 | 10 | 18 | 10 | 2 | 26 | 10 | 10 | 26 | 8 | 14 | 20 |
| 94 | Phys. Ther. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 3 | 1 | 3 | 1 | 0 | 4 | 4 | 2 | 6 | 6 | 5 | 7 |
| 94 | Podiatry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 3 | 1 | 1 | 3 | 0 | 1 | 2 | 1 | 2 | 1 | 0 | 1 | 0 |
| 02 | Psychology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 2 | 3 |
| 97 | Social Work | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 6 | 2 | 5 | 10 | 5 | 10 | 9 | 7 | 12 | 7 | 10 | 9 | 11 | 7 | 14 |
| 99 | Veterinary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 1 | 2 | 1 | 1 | 2 | 1 | 2 | 1 | 1 | 0 | 2 |
| | TOTAL | 205 | 32 | 173 | 167 | 62 | 278 | 183 | 85 | 376 | 196 | 202 | 370 | 233 | 226 | 377 | 264 | 222 | 419 | 283 | 266 | 436 | 340 | 307 | 469 |

--Opened = Number of cases opened within FY -- Closed = Number of cases closed within FY--
--Open at End of FY = Number of cases open at end of FY--

IV. Trend Data

A. Program Activity and Caseload Size by Fiscal Year

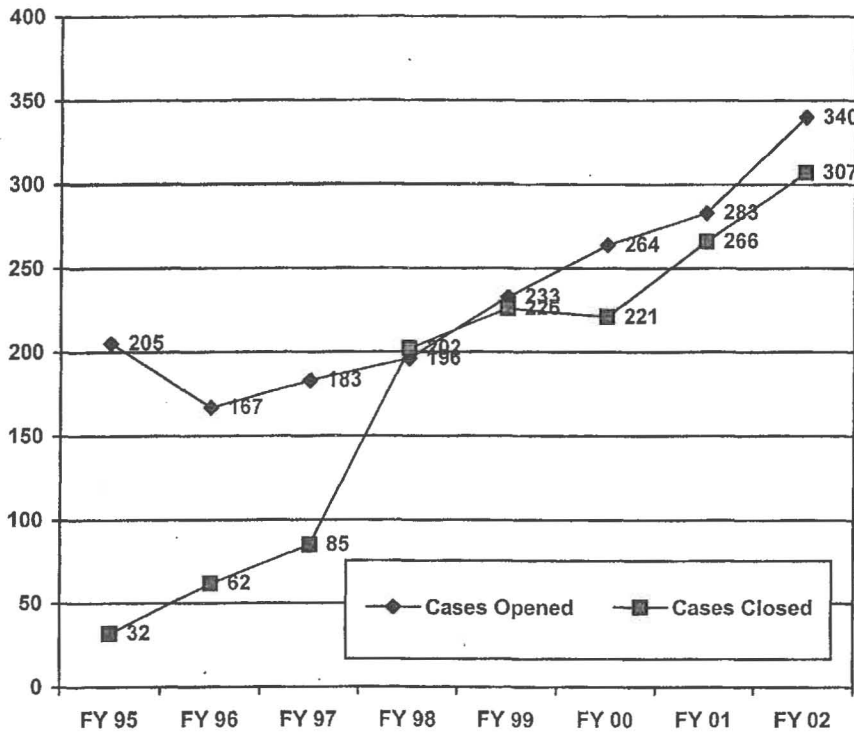


Interpretation:

- The number of health professionals enrolled in HPSP is at an all-time high.
- The majority of case management time is spent on opening and closing cases, thus the increase in program activity correlates to the program's increasing workload.

Program Activity is the sum of opened and closed cases. Because case managers tend to do the vast majority of work when opening and closing cases, caseload size is not an accurate representation of case management workload.

B. Opened and Closed Cases by Fiscal Year



Interpretation:

The number of health professionals entering HPSP is growing at a faster rate than those being discharged, causing the program's caseload to continue to grow.