STATE OF MINNESOTA

Health Professionals Services Program

1380 Energy Lane, Suite 202, St. Paul, MN 55018 – Phone: 651-642-0487 – Fax: 651-643-2163

FISCAL YEAR 2017 REPORT

Fiscal Year 2017: July 1, 2016 to June 30, 2017

Report Date: August 2017

CONTENTS

Gratitude: Special appreciation for assistance in the development of this report goes to Mark Chu of MN.iT, Ruth Martinez, Executive Director of the Minnesota Board of Medical Practice, Mark Stensgard, IT Consultant, and HPSP staff.

Questions or comments about this report should be directed to Monica Feider at 612-317-3060 or Monica.Feider@state.mn.us.

OVERVIEW

The Health Professionals Services Program (HPSP) is a program of the Minnesota health related licensing boards that provides monitoring services to health professionals with illnesses that may impact their ability to practice safely. HPSP promotes public safety in health care by implementing Participation Agreements that oversee the participants' illness management and professional practice, both of which are tied to patient safety. A Participation Agreement may include the participant's agreement to comply with continuing care recommendations, practice restrictions, random drug screening, work site monitoring, and support group participation. A summary of HPSP's primary functions are described below.

FUNCTIONS

1. Provide health professionals with services to determine if they have an illness that warrants monitoring:
   - Evaluate symptoms, treatment needs, immediate safety and potential risk to patients
   - Obtain substance, psychiatric, and/or medical histories along with social and occupational data
   - Determine practice limitations, if necessary
   - Secure records consistent with state and federal data practice regulations
   - Collaborate with medical consultants and community providers concerning treatment and monitoring that promotes public safety

2. Create and implement Participation Agreements:
   - Specify requirements for appropriate treatment and continuing care
   - Determine illness-specific and practice-related limitations or conditions

3. Monitor the continuing care and compliance of program participants:
   - Communicate monitoring procedures to treatment providers, supervisors and other collaborative parties
   - Review records and reports from treatment providers, supervisors, and other sources regarding the health professional's level of functioning and compliance with monitoring
   - Coordinate toxicology screening process
   - Intervene, as necessary, for non-compliance, inappropriate or inadequate treatment, or symptom exacerbation

4. Act as a resource for licensees, licensing boards, health care employers, practitioners, and medical communities.

Participant Exit Survey Comments

HPSP sends exit surveys to all participants who engaged in monitoring. Most participant comments about the benefits of monitoring related to drug screens, accountability and case manager support. The following is a sampling:

- *Monitoring/drug screens kept me thinking of the importance of compliance, which comes only from me and my sobriety.*
- *Structure. Reminders. Support and understanding.*
- *Case manager was kind, respectful and professional – did not feel judged or less of a human being.*
- *Work site monitor reports were a good thing.*

Participant comments about how HPSP can improve include:

- *Possibly be more visible to people who want help.*
- *More support for depression.*
- *On Saturdays, it was impossible to work days and get to collection site before it closed.*

All identifying information were removed from comments above.

PARTICIPATION

REFERRALS

Definitions of Referral Sources

HPSP's intake process is fairly consistent, regardless of how licensees are referred for monitoring. The program is responsible for evaluating the licensee's eligibility for services and whether they have an illness that warrants monitoring. When it is determined that a licensee has an illness that warrants monitoring, a Participation Agreement is developed and monitoring is initiated.

Licensees can be referred to HPSP in the following ways:

1. Self-Referrals

   Licensees refer themselves directly to the program. Licensees report themselves to HPSP at various points during an illness/recovery. Some call directly from a hospital or treatment center, while others call after they have been sent home from work for exhibiting illness-related behavior.

2. Third-Party Referrals

   Third party referrals come from persons concerned about a licensee's ability to practice safely by reason of illness. The most common third party referrals are from treatment providers and employers. The identity of all third party reporters is confidential. Reports by third parties are subject to immunity if the report is made in good faith.

3. Board Referrals

   Participating boards have three options for referring licensees to HPSP:

   - Determine Eligibility (Board Voluntary): The boards refer because there appears to be an illness to be monitored but a diagnosis is not known.

   - Follow-up to Diagnosis and Treatment (Board Voluntary): The board has determined that the licensee has an illness and refers the licensee to HPSP for monitoring of the illness.

   - Discipline (Board Discipline): The board has determined that there is an illness to monitor and refers the licensee to HPSP as part of a disciplinary measure (i.e.: Stipulation and Order). The Order may dictate monitoring requirements.

   For the purposes of this report, the two voluntary board referral sources (*Determine Eligibility* and *Follow-Up to Diagnosis and Treatment*) are combined.

> First Referral Source
> The term *first referral source* refers to the initial way practitioners are referred to HPSP. For example, a practitioner may self-report (first referral source) and while actively being monitored, HPSP may receive a report from their board, which is considered a *second referral source*. If the practitioner is discharged from HPSP and later is referred back to HPSP by a board without discipline, the first referral source for their second admission to the program would be *determine eligibility* or *follow-Up to diagnosis and treatment*.

Referrals by First Referral Source and Board

In fiscal year 2017 (July 1, 2016 to June 30, 2017), 460 health professionals were referred to HPSP. The table below shows the number of health professionals referred to HPSP by board and first referral source for the past four fiscal years.

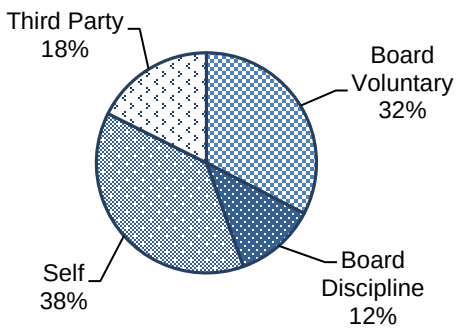
Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
Fiscal Year	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17
Board Voluntary	1	0	0	0	8	11	13	14	16	19	13	15	65	77	54	29	2	4	3	0	0	0	0	0
Board Discipline	0	0	0	0	3	1	1	0	2	0	0	0	5	0	2	3	0	1	2	1	0	0	0	0
Self	1	0	0	0	2	8	8	7	5	3	0	2	0	8	1	3	1	1	2	2	1	0	3	0
Third Party	0	0	0	0	5	3	6	9	0	0	1	0	7	6	2	1	1	0	0	0	0	0	0	0
SUM	2	0	0	0	18	23	28	30	23	22	14	17	77	91	59	36	4	6	7	3	1	0	3	0

Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
Fiscal Year	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17
Board Voluntary	9	5	8	10	2	1	3	0	12	12	9	13	43	30	51	48	1	0	0	0	3	9	2	1
Board Discipline	1	3	1	0	0	0	0	1	2	5	1	1	65	54	41	47	0	0	0	0	1	2	0	1
Self	7	8	3	11	4	1	2	3	30	21	33	20	93	97	97	102	0	0	0	0	10	4	3	8
Third Party	0	0	0	2	0	1	0	1	10	12	10	10	47	49	38	43	0	0	0	0	2	0	3	5
SUM	17	16	12	23	6	3	5	5	54	50	53	44	248	230	227	240	1	0	0	0	16	15	8	15

Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
Fiscal Year	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17
Board Voluntary	1	13	9	12	0	0	0	0	1	0	0	1	10	6	8	7	7	2	2	0	181	189	175	150
Board Discipline	1	0	0	0	0	0	1	0	1	1	1	0	0	3	0	1	0	1	2	0	81	71	52	55
Self	3	3	1	3	0	1	0	1	1	2	0	1	4	5	9	9	0	1	1	1	162	163	163	174
Third Party	0	0	1	1	0	0	0	0	2	4	0	3	1	3	1	6	2	1	0	0	77	79	62	81
SUM	5	16	11	16	0	1	1	1	5	7	1	5	15	17	18	23	9	5	5	1	501	502	452	460

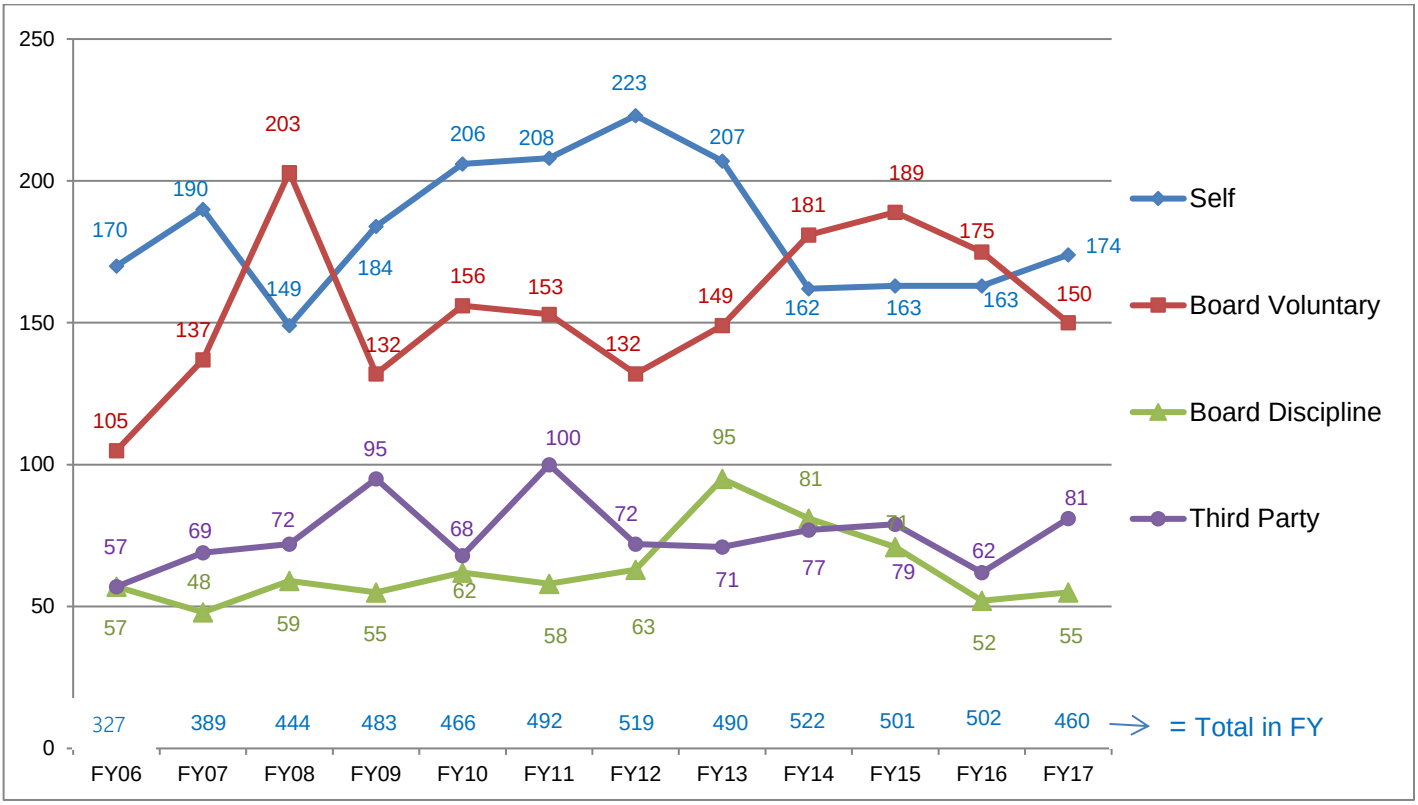
Referrals by First Referral Source

The chart below shows the percentage of referrals to HPSP by first referral source from July 1, 2016 to June 30, 2017:



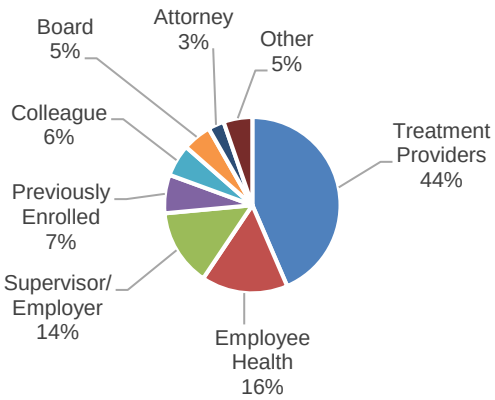
Referral Trends

The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2006 through fiscal year 2017. Self-referrals slightly increased and exceeded board voluntary referrals. Third party referrals also increased slightly. Self and third party referrals made up 56% of all referrals by first referral source to HPSP in fiscal year 2017.



Self-Referrals – How did licensees learn about HPSP?

Practitioners learn about HPSP from many sources. The following data shows how the 174 practitioners who self-referred to HPSP in fiscal year 2017 learned about the program:



The majority of people who self-referred in fiscal year 2017 learned about HPSP through their treatment providers. Treatment providers often include HPSP participation and compliance in continuing care planning. This reflects treatment providers' positive impression of the benefits of HPSP services.

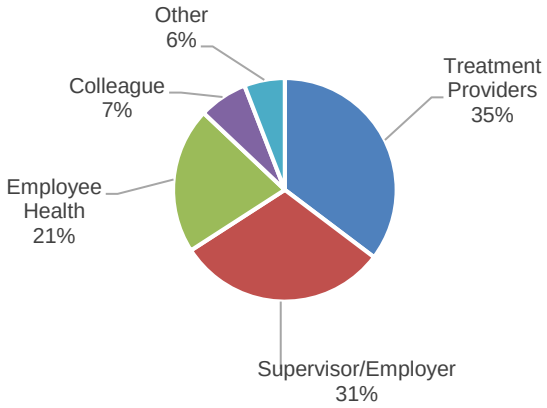
The majority of illnesses HPSP monitors are chronic illnesses which persist over one's lifespan with periods of remission and symptom exacerbation. Therefore, HPSP anticipates that more persons who had previously been enrolled will refer themselves back to the program.

Third Party Referrals – Who referred licensees to HPSP?

When HPSP receives a third party report about a licensee, the licensee typically receives a letter directing them to contact HPSP within ten days to follow-up on the report. In fiscal year 2017, HPSP decreased the timeframe in which licensees are required to contact the program from two weeks to ten days. In cases where immediate public safety is at risk, HPSP calls the licensee upon receipt of the report. If the licensee fails to contact HPSP in response to the report, HPSP closes the case as *no contact*. If the licensee fails to cooperate with the intake process, the licensee is discharged for *non-cooperation.* HPSP provides the licensee's board with a redacted copy of the third party report when HPSP discharges due to *no contact* or *non-cooperation.* Treatment providers not only tell their patients about HPSP (as seen in self-referrals), they are also the most common source of third party referrals.

Third Party Referent Information

The chart below shows the sources of fiscal year 2017 third party reports to HPSP:



Treatment providers are the most common source of third party referrals. However, work-related referrals represent 59% of referrals when supervisor/employer, employee health and colleagues are combined.

Fiscal Year 2017 Additional Referral Sources

The previous data showed how health practitioners were referred to HPSP in fiscal year 2017 by first referral source. The following data shows subsequent referral sources for the same admission:

First Referral Source	Second Referral Source
Self (#174)	• 19 Third Party • 10 Board Voluntary • 7 Board Disciplinary
Third Party (#81)	• 5 Self-Reports • 4 Third Party • 3 Board Voluntary
Board Voluntary (#150)	• 2 Board Disciplinary • 1 Third Party

Self and third party reports for the same person often arrive on the same day or week. Employers or treatment providers recommend licensees report to HPSP and follow-up by making third party reports.

DISCHARGES

Definitions of Discharge Categories:

When licensees are discharged from HPSP, the reason for the discharge is listed as one of the following:

1. Completion
   Program completion occurs when the licensee satisfactorily completes the terms of the Participation Agreement.

2. Non-Compliance*
   Participant violates the conditions of their Participation Agreement; the case manager closes case and files a report with licensee's board. Sub-categories of this include:
   - Non-Compliance – Diversion
   - Non-Compliance – Monitoring
   - Non-Compliance – Positive Screen
   - Non-Compliance – Problem Screens
   - Non-Compliance – Treatment

3. Voluntary Withdrawal*
   Participant chooses to withdraw from monitoring prior to completion of the Participation Agreement; the case manager closes the case and files a report with the licensee's board.

4. Ineligible Monitored*
   During the course of monitoring, it is determined that licensee is not eligible for program services as defined in statute; the case manager closes the case and files report with licensee's board. Sub-categories of this include:
   - Ineligible Monitored – Illness too severe
   - Ineligible Monitored – License suspended/revoked
   - Ineligible Monitored – License went inactive
   - Ineligible Monitored – Gave up license
   - Ineligible Monitored – Violation of practice act

5. Ineligible Not Monitored*
   At time of intake, it is determined that licensee is not eligible for program services as defined in statute; the case manager closes the case and files report with licensee's board. Subcategories of this include:
   - Ineligible Not Monitored – Illness too severe
   - Ineligible Not Monitored – License suspended/revoked
   - Ineligible Not Monitored – License went inactive
   - Ineligible Not Monitored – No active Minnesota license (not reported to board because not regulated in Minnesota)
   - Ineligible Not Monitored – Violation of practice act
   - Ineligible Not Monitored – Previously discharged to the board

6. No Contact*
   Initial report received by third party or board; licensee fails to contact HPSP; the case manager closes the case and files a report with licensee's board.

7. Non-Cooperation*
   Licensee cooperates initially, may sign Enrollment Form and/or releases, but then ceases to cooperate before the Participation Agreement is signed; the case manager closes case and files a report with licensee's board.

8. Non-Jurisdictional
   No diagnostic eligibility established; the case is closed.

**Discharge results in report to board and providing data.*

Discharges by Discharge Category and Board

The table below shows the number of persons discharged from HPSP by board and discharge category over the past four fiscal years.

Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
Fiscal Year	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17
Completion	0	0	1	0	6	5	2	3	3	5	3	3	7	6	6	8	0	0	0	2	0	0	0	2
Voluntary Withdraw	0	0	0	0	0	2	1	1	1	1	0	0	0	3	0	1	0	1	0	0	0	0	0	0
Non-Compliance	0	0	0	0	6	5	6	9	2	0	2	2	6	10	6	4	1	0	0	0	0	0	0	0
Deceased	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ineligible Monitored	0	0	0	0	0	0	1	2	3	1	0	0	2	0	1	0	1	0	1	0	0	0	0	0
Ineligible Not Monitored	0	0	0	0	1	0	1	3	0	0	0	0	1	2	1	1	0	0	0	0	0	0	0	0
No Contact	0	0	0	0	1	5	0	3	0	0	0	1	2	5	3	4	1	2	0	0	0	0	0	0
Non Cooperation	0	0	0	0	5	4	4	4	1	1	1	1	7	8	3	6	1	0	1	1	0	0	0	0
Non-Jurisdictional	2	0	0	0	1	3	3	3	14	16	10	13	55	58	39	19	1	1	2	1	0	0	1	0
SUM	14	15	16	0	20	25	18	28	24	24	16	20	80	92	59	43	5	4	4	4	0	0	1	2

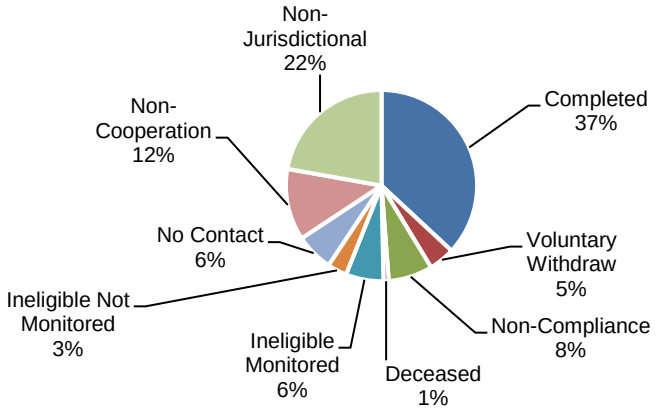
Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
Fiscal Year	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17
Completion	2	3	4	4	1	2	0	1	34	41	27	26	91	102	85	93	0	0	0	0	3	10	1	11
Voluntary Withdraw	1	2	2	1	0	0	0	0	5	1	2	0	18	15	15	13	0	0	0	0	0	1	0	1
Non-Compliance	3	1	3	0	0	0	0	0	1	0	0	0	74	50	39	12	0	0	0	0	4	2	3	2
Deceased	0	0	1	0	0	0	0	0	1	0	1	1	0	0	0	3	0	0	0	0	0	1	0	0
Ineligible Monitored	0	1	1	0	1	0	0	0	11	6	6	5	14	15	20	20	0	1	0	0	0	0	0	1
Ineligible Not Monitored	1	0	0	0	1	0	0	1	4	0	1	3	12	17	1	3	0	0	0	0	0	0	1	1
No Contact	1	1	1	5	0	0	0	0	1	3	2	3	11	12	11	11	0	0	0	0	3	4	1	1
Non Cooperation	2	4	3	2	1	1	3	0	2	4	1	2	22	26	24	32	0	0	0	0	2	1	2	3
Non-Jurisdictional	5	4	3	5	3	1	2	3	11	11	9	10	19	23	20	32	0	0	0	0	0	2	0	3
SUM	15	16	18	17	7	4	5	5	70	66	49	50	261	260	215	219	0	1	0	0	12	21	8	23

Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
Fiscal Year	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17	14	15	16	17
Completion	1	6	3	3	0	0	0	1	1	3	2	4	6	2	4	6	0	3	1	1	155	188	139	168
Voluntary Withdraw	0	1	0	1	0	0	0	0	0	0	1	0	2	0	2	2	0	0	0	0	27	27	23	20
Non-Compliance	2	2	0	2	0	0	0	0	2	2	0	0	2	1	2	3	1	1	0	0	104	74	61	34
Deceased	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2	2	2	4
Ineligible Monitored	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	1	0	1	0	33	24	33	29
Ineligible Not Monitored	0	0	0	0	0	0	0	0	0	0	0	1	1	2	1	1	2	0	0	1	23	21	6	15
No Contact	0	1	1	0	0	0	0	0	0	1	0	0	1	1	0	1	0	0	0	0	21	35	19	29
Non Cooperation	0	1	1	2	0	1	0	0	0	0	0	1	1	2	4	1	2	1	0	0	46	54	47	55
Non-Jurisdictional	2	7	4	5	0	0	0	0	0	1	0	0	1	6	0	6	3	1	1	1	117	134	94	101
SUM	5	18	9	13	0	1	0	1	3	7	3	6	15	14	15	21	9	6	3	3	528	559	424	455

Note: Discharge categories highlighted in blue represent categories of persons who did not engage in monitoring.

Discharges by Category

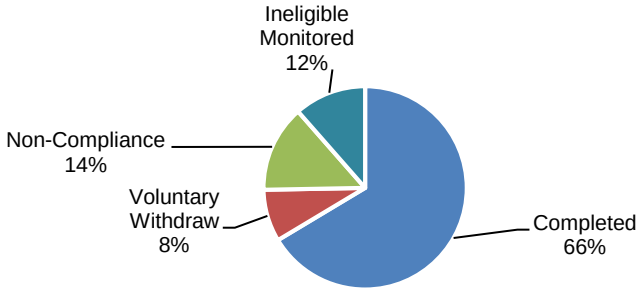
The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2017.



Of persons discharged in fiscal year 2017, 43% did not engage in monitoring, which is reflected in the table on the left (includes the categories of non-jurisdictional, non-cooperation, no contact, and ineligible-not monitored), which skews the overall completion rate to 33%. The most common reason that persons did not engage in monitoring is that HPSP did not identify an illness that warranted monitoring.

Discharges by Category for Those Monitored

The table below shows the discharge categories of persons who engaged in monitoring and were discharged from HPSP in fiscal year 2017.



The completion rate of 66% reflects only persons that engaged in monitoring.

Discharges Due to Ineligibility for Monitoring

Forty-five (45) health professionals were discharged in fiscal year 2017 because they were not eligible for program services; 29 were monitored and 16 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (29)

- 26 were discharged because their licenses were suspended, revoked, became inactive or they chose to give up their license;
- 2 were discharged because their illnesses were too severe to warrant continued monitoring; and
- 1 was discharged because of a practice act violation.

Not-monitored and discharged as ineligible (15)

- 7 were discharged because their license was suspended, revoked, became inactive or their application for licensure was not granted;
- 5 were discharged because of a practice act violation;
- 2 were discharged because their illnesses were too severe to warrant monitoring; and
- 1 was discharged because of a previous discharge to their board (board was still investigating prior HPSP discharge).

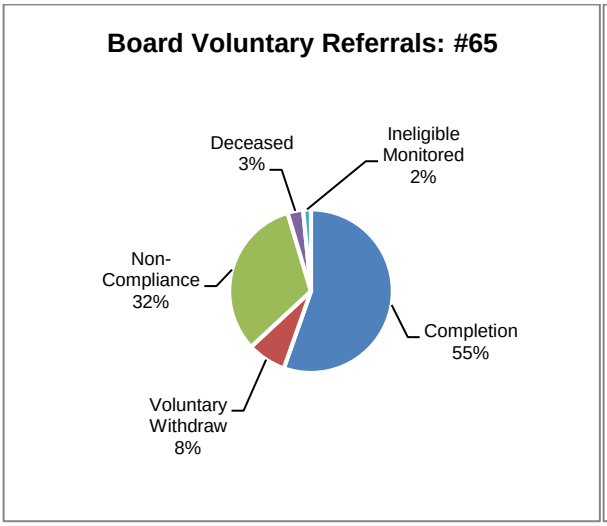
Discharges for Non-Compliance (34)

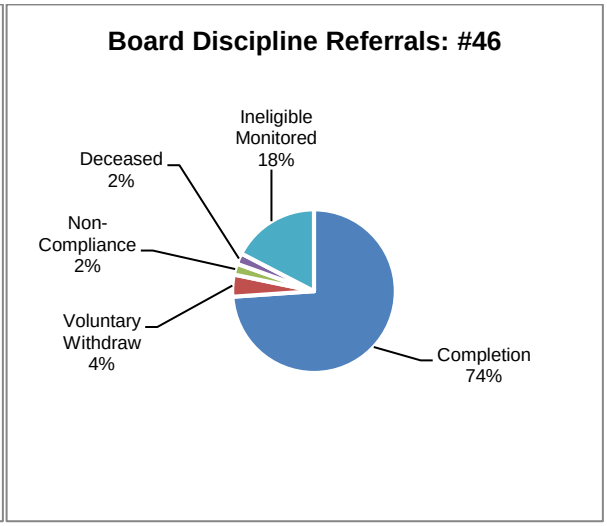
The sub-categories of the 34 persons discharged for non-compliance in fiscal year 2017 are as follows:

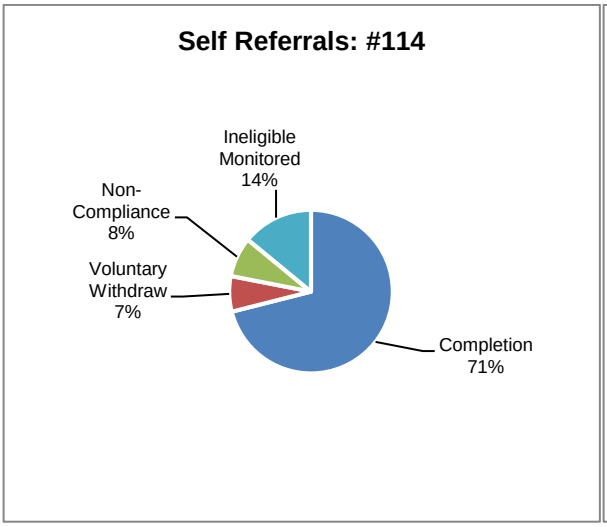
- 15 were discharged for non-compliance with Monitoring Plan (i.e. relapse and refusing evaluations);
- 15 were discharged for problem toxicology screen results (i.e. not providing screens as requested or providing dilute specimens); and
- 4 were discharged for non-compliance with treatment.

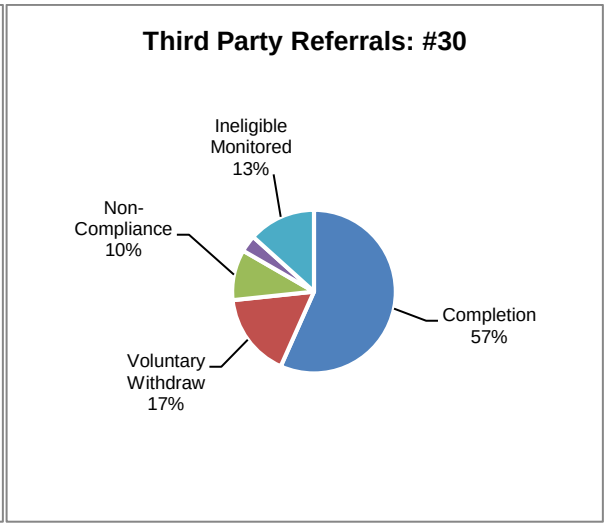
Discharges by First Referral Source for Those Monitored

The charts below show licensees monitored by first referral source and percent of discharge category in fiscal year 2017. The *completion* rate is highest among persons referred under a disciplinary order and lowest among those referred by third parties. The actual number of persons who self-referred and were discharged out-paced any other referral source.









Length of Monitoring

Successful Completion: In fiscal year 2017, the average length of monitoring of practitioners who successfully completed monitoring was two years and five months. The shortest length just under two months and the longest was six years and six months.

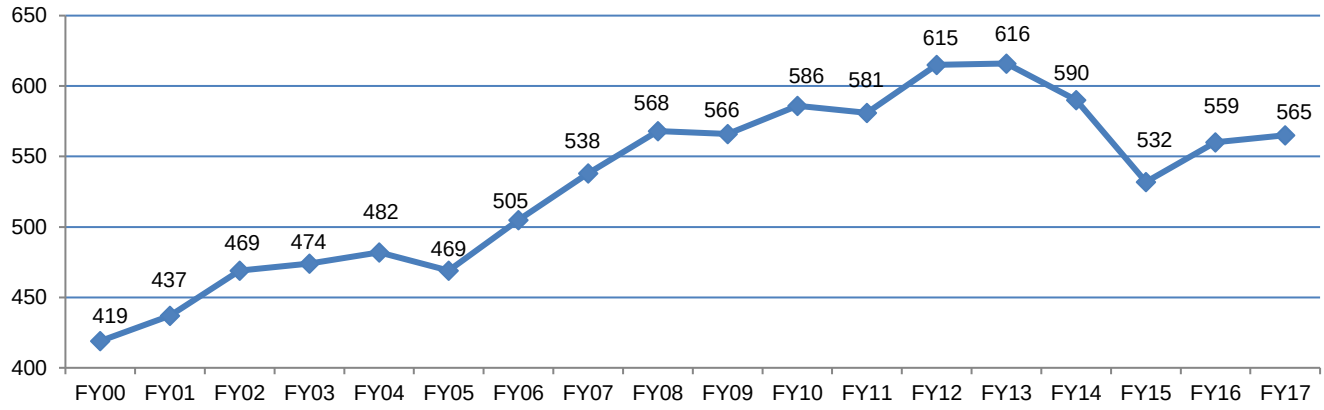
HPSP satisfactorily discharges persons based on the following protocols: (1) The individual is in sustained remission after a period of monitoring (usually the case for substance use disorders); (2) there is new information indicating the diagnosis has changed, or (3) the participant is deemed to be appropriately managing the illness after a period of monitoring (usually the case in chronic health or mental health illnesses).

Unsatisfactory Completion: In fiscal year 2017, the average length of monitoring for persons who were monitored but did not complete monitoring was just under twelve months (330 days). The shortest length was 11 days, and the longest was four years and three months. The majority, 63%, were discharged in the first year of monitoring, followed by 22% in the second year, 14% in the third year, and 1% in the fourth or greater years of monitoring.

CASELOAD

Open Cases at End of Fiscal Year

The following chart shows the number of open cases at the end of each of the last 18 fiscal years.



Rate of Participation by Board

The following table shows the number of persons regulated by each board, the number of persons active in HPSP on July 12, 2017, and the ratio of persons monitored by board per 1,000 regulated. The Number Active in HPSP represents persons in the enrollment phase as well as those with signed Participation Agreements. The Number Licensed or Regulated includes only individuals who are licensed or regulated by the board (some boards regulate facilities or agencies).

Board	Number Licensed or Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Licensed or Regulated
Board of Podiatric Medicine*	263	2	7.60
Board of Behavioral Health & Therapy	5,302	26	4.90
Board of Medical Practice**	23,523	84	3.57
Board of Nursing	129,418	329	2.54
Board of Physical Therapy	7,185	16	2.23
Board of Veterinary Medicine	2,977	5	1.67
Board of Social Work	14,938	24	1.61
Board of Psychology *	3,797	6	1.58
Board of Dentistry	17,531	23	1.31
Board of Dietetics and Nutrition Practice	1,817	2	1.10
Board of Pharmacy	20,742	18	0.87
Department of Health***	7,167	6	0.83
Board of Marriage and Family Therapy	2,571	2	0.78
Emergency Medical Services Regulatory Board	29,378	18	0.61
Board of Chiropractic Examiners *	9,486	4	0.42
Board of Optometry*	1,097	0	0
Board of Exam. of Nursing Home Admin.	866	0	0
Total	299,734	565	1.88 per 1,000

**Represents number regulated based on the Health-Related Licensing Board's Biennial Report, July 1, 2014 to June 30, 2016*
***Represents number regulated from the Boards' website on 7/17/18*
****Represents number regulated per data received July 2016*
All other data obtained from Board Office Managers from 7/18/17-7/20/17

Active Caseload by Board and Profession

The chart below shows the number of licensees active with HPSP on July 12, 2017 by Board and Profession. It includes persons in the enrollment phase as well as those with signed Participation Agreements.

Board		Number of Participants
Board of Behavioral Health & Therapy		26
	LPC	1
	LPCC	3
	LADC	22
Board of Chiropractic Examiners		4
Board of Dentistry		23
	Dental Assistants	7
	Dental Hygienists	6
	Dentists	10
Department of Health		6
	Occupational Therapists	5
	Occupational Therapy Assistant	1
Board of Dietetics and Nutrition Practice		2
Board of Exam. of Nursing Home Admin.		0
Emergency Medical Services Regulatory Board		12
	CMPA	1
	EMT1	9
	EMTP	7
Board of Marriage and Family Therapy		2
Board of Medical Practice		84
	Physician Assistant	7
	Physician	67
	Respiratory Care Practitioner	7
	Resident	3
Board of Nursing		329
	RN	268
	LPN	61
Board of Optometry		0
Board of Pharmacy		18
	Pharmacist	13
	Technician	5
Board of Physical Therapy		16
	Physical Therapist	11
	Physical Therapist Assistant	5
Board of Podiatric Medicine		2
Board of Psychology		6
Board of Social Work		24
	LGSW	11
	LICSW	6
	LISW	1
	LSW	6
Board of Veterinary Medicine		5
Total		565

Of the 565 active cases on July 12, 2017, 518 had signed Participation Agreements and 47 were in the enrollment process.

Nurses make up the greatest number of HPSP participants (58%).

ILLNESSES MONITORED

GENERAL ILLNESS DATA

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 14, 2017, there were 515 health professionals enrolled in HPSP with signed Participation Agreements. Many were monitored for more than one illness. The following data identifies the illnesses for which participants were being monitored.

Illness Category	Number of participants	Percent of 515 participants
Substance Use Disorders	436	85%
Psychiatric Disorders	365	71%
Medical Disorders	57	11%

Single and Co-occurring Illnesses	Number of participants	Percent of 515 participants
Substance Only	140	27%
Psychiatric Only	61	12%
Medical Only	6	1%
Substance and Psychiatric	257	50%
Substance and Medical	4	1%
Psychiatric and Medical	12	2%
Substance, Psychiatric & Medical	35	7%

Substance Use Disorders (SUD)	Number of participants with SUD: 436	Percent of 515 participants	Percent of 436 with a SUD
Alcohol	352	68%	81%
Prescription	125	24%	29%
Amphetamine	13	3%	3%
Barbiturate	3	<1%	<1%
Benzodiazepine	31	6%	7%
Opiate	99	19%	23%
Sedative/Hypnotic	11	2%	3%
Illicit	58	11%	13%
Cannabis	39	8%	9%
Cocaine	12	2%	3%
Heroin	6	1%	1%
Methamphetamine	13	3%	3%
Other	1	<1%	<1%
Over the Counter	1	<1%	<1%

It is common for persons to use more than one substance, oftentimes within the same class of substance. For example, of the 99 persons who used opiates, 50 used more than one type of opiate.

Psychiatric Disorders	Number of participants with psychiatric diagnosis: 365	Percent of 515 participants	Percent of 365 with a psychiatric diagnosis
Anxiety and/or Depression	328	63%	90%
Attention Deficit	24	5%	7%
Bipolar	40	8%	11%
PTSD	45	9%	12%
Eating Disorder	15	3%	4%
Other	22	4%	6%

Depression and/or anxiety often co-occur with other psychiatric disorders, such as post-traumatic stress and eating disorders.

Medical Disorders	Number of participants with medical disorders: 57
The majority of persons (>75%) monitored for a medical disorder have a pain-related condition (i.e. degenerative disc disease, fibromyalgia, migraines, chronic pain). Other medical conditions monitored include but are not limited to diabetes, neurological disorders, and seizure disorders. Some are monitored for more than one medical illness.	

DIVERSION OF CONTROLLED SUBSTANCES

HPSP Definition of Diversion

The HPSP working definition of diversion is *the inappropriate acquisition of controlled or other potentially abusable substances*. Note the term "diversion" is umbrella terminology in which stealing drugs from the work place is included. Methods of diversion vary greatly, as does the impact and potential impact on patients.

Monitoring Conditions

Standard monitoring conditions for work-related diversion include a minimum of twelve months of no access to, handling of, or responsibility for, controlled and mood altering substances at work. In some professions and work situations, access to drugs must be supervised after the restriction is lifted. The length of monitoring is also extended.

Prescription Drug Abuse and Diversion

On July 14, 2017, a total of 515 health professionals had signed Participation Agreements. Of the 515 health professionals with signed agreements, 125 (24%) were addicted to prescription medications. Of the 125 addicted to prescription medications, 77 (62%) engaged in diversion (15% of total engaged in monitoring). Of the 77 who engaged in diversion, 49 (63%) engaged in work-related diversion and 46 (60%) engaged in non-work related diversion. Also, 18 (23%) engaged in both work related and non-work related diversion.

Diversion by Board

The table below shows the number of participants with signed Participation Agreements on July 14, 2017, who diverted by Board and whether the diversion took place at work. Some participants diverted in more than one way. The data is based on participant self-report of diversion, employer report of diversion and Board data (i.e. data provided to HPSP by the Board via a disciplinary order).

Board	Number of persons who diverted by board	Diversion took place at work	Diversion did not take place at work	Percent in HPSP by board
Nursing	49	31*	34*	15%
Pharmacy	8	8**	1**	44%
Medical Practice	8	6	3	10%
Dentistry	3	2	1	13%
Physical Therapy	3	0	3	19%
Other Boards	6***	2	4	8%***
Totals	77	49	46	15% total

**Represents 16 persons regulated by the Board of Nursing engaged in work and non-work related diversion.*
***Represents 1 person regulated by the Board of Pharmacy engaged in work and non-work related diversion.*
****Represents 6 persons regulated by the Board of Behavioral Health and Therapy (2), the Department of Health (1), the Emergency Services Regulatory Board (1), the Board of Social Work (1) and the Board of Veterinary Medicine (1).*

Methods of Diversion

The tables below shows more specific data about the methods of diversion among the 77 who diverted (some used more than one method of diversion, which is shown in the data).

Diversion took place at work	49 participants
Took from inventory	20
Took from waste	19
Withdrew more than patient needed and kept extra for self	9
Wrote prescription for patient and filled for self	4
Other	7

Diversion did not take place at work (53%)	46 participants
Took from family or friends	41
Ordering off the internet	3
Wrote prescription for self	2
Wrote prescription for fake patient	1
Other	3

Note: HPSP does not currently track participants who buy medications from illegitimate sources.

Some of the other forms of diversion included substituting medications, taking medications that patients brought to the hospital, and altering prescriptions. Persons who engaged in substitution of medications and falsifying prescriptions were referred to HPSP by their Boards or reported to their Board per HPSP statutory reporting requirements.

Referral Sources of Persons who Diverted by First Referral Source:

The referral sources of HPSP participants who diverted medications include are described below:

- 39 (51%) self-referred (12 were later Board referred, 10 with discipline and 2 without discipline)
- 30 (39%) were board referred with discipline
- 4 (5%) were board referred without discipline (voluntary)
- 4 (5%) were third party referred

Trends

Diversion at Work

Access to controlled substances is a risk factor for diverting the drugs. This is evidenced by the rate of diversion among professions. For example, pharmacists have the greatest access to controlled substances and the highest rate of diversion among HPSP participants.

Diversion from Other Sources

The most common form of non-work-related diversion is taking (or receiving) medications from family members or friends, which is increasing across health professions. This demonstrates the need for greater education for patients who are prescribed controlled substances regarding risks associated with sharing medications and proper disposal of unused medications.

BUDGET

HPSP is committed to providing quality services that contribute to public safety in health care in the most cost effective manner possible. HPSP appreciates the boards' recognition that adequate funding is essential to HPSP's success.

FUNDING

The health licensing boards and the Department of Health fund HPSP. Each board pays an annual $1,000 fee and a pro-rata share of program expenses to HPSP based on the number of the board's participants in the program at the end of each month. No additional fees are collected by HPSP for program participation from licensees.

HPSP sought additional funding in the 2018-2019 biennium for database enhancements and to address inflation in salaries, benefits, rent and other expenses. Both were granted.

EXPENSES

HPSP's operating budget in fiscal year 2017 was $864,000, increased to $903,000 after moving $39,000 of unspent money forward from fiscal year 2016 to fiscal year 2017. The majority of savings came from salary savings.

Similar to the health licensing boards, the majority of HPSP's expenses are directed toward salaries and benefits (77%). The next largest expense was rent. HPSP utilized additional salary savings during fiscal year 2017 to purchase updated equipment and furniture for specific work areas. HPSP stayed within its spending authority and retained $50,000 for database upgrades.

Rent Projections

HPSP office space is located at Energy Park Place, 1380 Energy Lane, Suite 202, St. Paul, Minnesota and consists of 2,279 square feet. HPSP's lease will expire on January 31, 2018. The Minnesota Department of Administration will negotiate HPSP's updated lease.

Lease Period	Annual Payment
7/1/16 to 6/30/17	$36,283.20
7/1/17 to 1/31/18	$21,150.75*

*Represents 6 months of rent. so HPSP's lease timeframe will be consistent with the Health Licensing Boards.

HIGHLIGHTS

STRATEGIC PLANNING

Documents Updated

HPSP focused on improving forms, authorizations, letters and most importantly, the Participation Agreement (contract) that participants sign. It is anticipated that participants will find the new letters and forms easier to understand.

Outreach

HPSP staff presented to 15 different stakeholder groups (i.e. schools, professional associations, employers); interfacing with over 500 individuals in fiscal year 2017. This exceeded fiscal year 2016 numbers by an estimated 111 contacts.

As the boards and HPSP work together to protect the public, HPSP thanks the Boards of Dentistry and Nursing for including information about HPSP in board newsletters. Some other boards include information about HPSP in renewal packets. Additionally, HPSP offers each board the opportunity to have HPSP present to their board annually. This promotes board member understanding of HPSP services.

Program Committee

A sub-committee of the Program Committee met to review whether the Program Committee's role warranted change. After several meetings and robust discussions, the sub-committee brought a recommendation to the full Program Committee for review. The Program Committee voted to retain its current structure and roles.

The Program Committee voted unanimously to accept HPSP's proposal for a new Participation Agreement template.

Advisory Committee

HPSP worked with the Advisory Committee to identify opportunities for outreach and education. Advisory Committee members took an active role in providing information to their membership and professional schools about professional support groups, addiction and HPSP. HPSP had the opportunity to present to several groups in collaboration with Advisory Committee members.

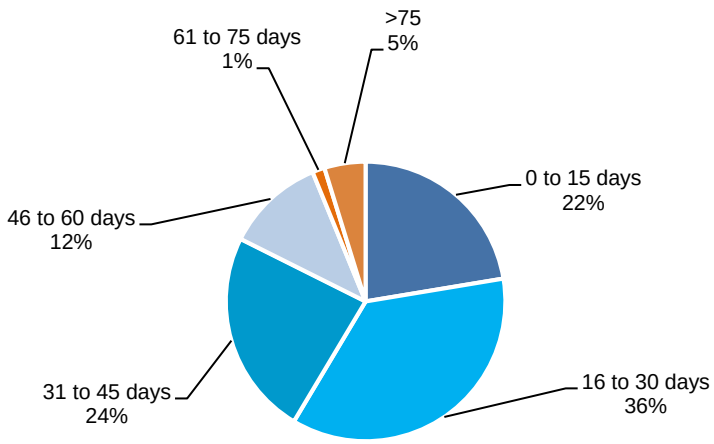
HPSP staff collaborated with the Advisory Committee to compare HPSP's work site monitor report form to forms used in other states. The form was modified based on input from the Advisory Committee.

PARTICIPATION AGREEMENTS

HPSP strives to have Participation Agreements signed within 60 days of participant contact with the program. Despite the timeframe allowed for participants to sign Participation Agreements, an intervention takes place during the initial intake interview, which protects the public.

In fiscal year 2017, 210 Participation Agreements were signed. Of these, 94% were signed within 60 days of the individual's contact with the program. The average timeframe was 31 days. Delays in obtaining appropriate assessments was the most common factor causing the timeframe to exceed 60 days. More specifically, assessments by neuropsychologists, neurologists, and pain management physicians are challenging to schedule in a timely manner. The chart below shows the number of days between the dates licensees contacted the program and the dates their Participation Agreements were signed.

Days from Participant Contact to Date Participation Agreement Signed



PROGRAM COMMITTEE GOALS

In 1999, the Program Committee worked with a consultant to develop five goals to outline the Committee's responsibilities. These goals have remained consistent since that time. HPSP staff is committed to meeting these goals. Many quantifiable measures of how HPSP is addressing the goals are listed earlier in this document. Additional examples are listed below.

GOAL 1: ENSURE THE PUBLIC IS PROTECTED

HPSP's protection of the public is multifaceted. Some of the examples listed below will be quantified in future reports.

- HPSP works collaboratively with board staff to ensure monitoring is consistent with board expectations, national norms and available science
- Self and third party reporting of illness made up 56% of referrals in fiscal year 2017 (this is up 6% from fiscal year 2016)
- HPSP implements practice restrictions when appropriate
- HPSP refers health professionals for appropriate assessments and evaluations
- HPSP requires participants to follow their treatment recommendations
- HPSP tracks participants' compliance with treatment
- HPSP intervenes when participants have exacerbations of symptoms
- HPSP serves as a liaison between employers and treatment providers
- HPSP reports health professionals who are not compliant with monitoring to their licensing boards
- HPSP educates employers and the medical community about professional impairment
- HPSP encourages early intervention through its outreach and reputation

GOAL 2: ENSURE INDIVIDUAL CLIENTS ARE TREATED WITH RESPECT

Showing respect in a complex interaction is essential when providing any type of service. Beyond HPSP's day-to-day involvement with participants, the following HPSP procedures and activities demonstrate respect for clients:

- Maintaining a simple process for reporting to the program
- Developing and utilizing monitoring guidelines that are based on research and national norms
- Providing a consistent service to all health professionals
- Maintaining motivated, competent staff who are proficient in substance and psychiatric disorders as well as case management
- Collecting and reviewing feedback from participants on a regular basis
- Incorporating participant feedback as deemed appropriate
- Finding accessible collection sites for participants and posting them on our website
- Maintaining a user-friendly website that includes participant, treatment provider and work site monitor information and forms

GOAL 3: ENSURE THE PROGRAM IS WELL MANAGED

Identifying how HPSP is well managed includes the above items in addition to a broad range of actions, including:

- HPSP collaborates with board staff and seeks input regarding the monitoring process and guidelines
- HPSP holds quarterly meetings with board staff to review program processes and board concerns
- HPSP is staffed with competent employees who are invested in the program's mission
- The program manager hires competent case managers who provide quality intake, case management monitoring services
- The program manager performs annual performance reviews of employees
- The program manager surveys executive directors annually to obtain input on program services
- The program manager submits monthly billing reports to the Administrative Services Unit on a timely basis
- The program manager meets with the Administering Board Executive Director and the Administrative Services Unit's Chief Financial Officer to review spending on a regular basis
- The program manager follows all state requirements for hiring and managing personnel
- The program manager ensures all staff review relevant state polices upon hire and in even numbered years (i.e. data practices, code of ethics, respectful workplace, electronic communications and others)
- The program manager reviews policy and other issues with the Administering Board Executive Director as needed
- The program manager seeks legal advice when needed
- HPSP is recognized nationally as having a quality program
- HPSP utilizes highly specialized consultants to assist in developing monitoring plan conditions for complex cases

GOAL 4: ENSURE THE PROGRAM IS FINANCIALLY SECURE

The funding source of HPSP is defined in statute and is established by the Legislature on a biennial basis. HPSP has sought increases when deemed necessary to address program growth and needs. For example, HPSP requested increases for the 2018-2019 biennium to support improving technology, which will result in more efficient services and the ability to sustain current staffing levels.

HPSP consistently spends within its allotted budget. HPSP has regular budget meetings with the Administrative Services Unit Chief Financial Officer and the Administering Board Executive Director to track spending.

The majority of HPSP costs are related to staffing. All expenses are tracked and reconciled with reports from the Administrative Services Unit. The Administrative Services Unit also performs audits.

GOAL 5: ENSURE THE PROGRAM IS OPERATING CONSISTENT WITH ITS STATUTE

HPSP understands and appreciates the benefits and constraints of its enabling legislation. HPSP consistently operates within the parameters of its enabling legislation. HPSP utilizes the Office of the Attorney General as legal questions arise regarding the program's authority.

In fiscal year 2017, HPSP utilized the Office of the Attorney General to improve several documents, including the Participation Agreement, Tennessen Warning, and Authorizations.

SUMMARY

HPSP is committed to protecting the public by providing monitoring services to regulated health professionals whose illnesses may impact their ability to practice safely. Monitoring is multifaceted and focuses on reviewing the professional's illness management and professional practice. To this end, HPSP obtains reports from participants' work site monitors, treatment providers and other sources.

HPSP is also committed to providing services in an effective and efficient manner that supports participant cooperation and success, as well as board satisfaction. HPSP accomplishes this by seeking input from a variety of sources; including participants, boards and professional associations; as well as by keeping current on monitoring programs in other states and on national developments in healthcare, impairment and recovery.

As a program of the Minnesota Health Related Licensing Boards, HPSP benefits from collaborating with regulators in an ongoing assessment of program effectiveness, communications, and monitoring processes to assure public protection and board satisfaction.

COMMITTEE MEMBERS AND STAFF

PROGRAM COMMITTEE MEMBERS

The Program Committee consists of one member from each health licensing board. By law, the Program Committee provides HPSP with guidance to ensure the direction of HPSP is in accord with its statutory authority. In 1997, the Program Committee established the following five goals to meet this responsibility:

1. The public is protected;
2. Individual clients are treated with respect;
3. The program is well-managed;
4. The program is financially secure; and
5. The program is operating consistent with its statute.

Board	Member Name	Term Expires
Behavioral Health and Therapy	Yvonne Hundshamer	1/1/2018
Chiropractic Examiners	Nestor Riano	1/1/2018
Dentistry	Bridgett Anderson	1/1/2018
Department of Health	Catherine Lloyd	1/1/2018
Dietetics and Nutritionists	Margaret Schreiner	1/1/2018
Emergency Medical Services	Matthew Simpson	1/1/2018
Marriage and Family Therapy	Kathryn Graves	1/1/2018
Medical Practice	Allen Rasmussen	1/1/2018
Nursing	Christine Norton	1/1/2018
Nursing Home Administrators	Randy Snyder	1/1/2018
Optometry	Michelle Falk	1/1/2018
Pharmacy	Joseph Stanek (through 6/12/17) James Bialke (effective 6/13/17)	1/1/2018
Physical Therapy	Kathy Polhamus, Vice Chair	1/1/2018
Podiatric Medicine	Margaret Schreiner	1/1/2018
Psychology	Angelina Barnes (through 4/4/17) Samuel Sands (effective 7/19/17)	1/1/2018
Social Work	Rosemary Kassekert (through 7/17/17)	1/1/2018
Veterinary Medicine	Julia Wilson	1/1/2018

ADMINISTERING BOARD

HPSP is not an independent State agency. By statute, the Program Committee designates one of the health licensing boards to administer the program. The Board of Medical Practice is serving as HPSP's Administering Board. HPSP is grateful to the Board of Medical Practice for accepting the responsibility to serve as HPSP's Administering Board.

ADVISORY COMMITTEE MEMBERS

The Advisory Committee consists of one person appointed by various health-related professional associations and two public members appointed by the Governor. The Advisory Committee established the following goals:

1. Promote early intervention, diagnosis, treatment and monitoring for potentially impaired health professionals;
2. Provide expertise to HPSP staff and Program Committee; and
3. Act as a liaison with membership.

Professional Association	Member	Term Expires
MN Pharmacists Assoc.	Jim Alexander	1/1/2018
MN Health Systems Pharmacists	S. Bruce Benson	1/1/2018
MN Assoc. of Social Workers	Pam Berkwitz	1/1/2018
MN Veterinary Assoc.	Marcia Brower	1/1/2018
MN Psychological Assoc.	Lois Cochrane-Schlutter	1/1/2018
MN Dental Assoc.	Stephen Gulbrandsen, Chair	1/1/2018
MN Nurses Assoc.	Jody Haggy	1/1/2018
MN Assoc. of Marriage &Fam. Therapy	Eric Hansen	1/1/2018
MN Ambulance Assoc.	Megan Hartigan (Debbie Gillquist alt)	1/1/2018
MN Chiropractic Assoc.	Rick Heuffmeier	1/1/2018
Public Member	Abdiaziz Hirsi	1/1/2018
MN Academy of Physician Assist.	Tracy Keizer	1/1/2018
MN Medical Assoc.	Teresa Knoedler	1/1/2018
MN Academy of Nutrition and Dietetics	Sheryl Lundquist	1/1/2018
MN Nurse Peer Support Group	Marie Manthey	1/1/2018
Physicians Serving Physicians	Jeff Morgan	1/1/2018
Ad Hoc Member	Rose Nelson	1/1/2018
MN Occupational Therapy Assoc.	Karen Sames	1/1/2018
MN Organization of Registered Nurses	Joseph Twitchell	1/1/2018
MN LPNA/AFSCME	Lisa Weed	1/1/2018

HPSP STAFF

Staff Person	Position
Monica Feider, MSW, LICSW	Program Manager
Tracy Erfourth, BA	Case Manager
Marilyn Miller, MS, LICSW	Case Manager
Audrey Grossman, MA, LADC	Case Manager
Kurt Roberts, EdD, LADC	Case Manager
Kimberly Zillmer, BA, LADC	Case Manager
Daisy Chavez	Case Manager Assistant
Sheryl Jones	Office Manager