MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

FISCAL YEAR 2018 REPORT

July 1, 2017 to June 30, 2018
Report Date: August 2018

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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.*

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OVERVIEW

MISSION

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.

FUNCTIONS

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. HPSP's primary functions are described below.

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 practices 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, medical communities, and state policy makers.**

Participant Exit Survey Comments

Most comments about how HPSP was helpful were related to accountability and drug screening:

- HPSP kept me accountable and provided me with a three year firm foundation of sobriety to grow upon. In early recovery the accountability and monitoring part of the program was essential….
- It was helpful to have many layers of accountability. I requested help from others to complete requirements of the monitoring program, which helped me open up and be honest about my addiction.
- [HPSP] Helped keep me on track and accountable from start to finish. The most beneficial part of the program was urine screens to make sure I stayed sober.
- In the beginning when things were in a fragile state of recovery, it was so beneficial to have the support of the monitoring of this agency until and to get to the point of improved physical, mental and spiritual strength.

Comments about how HPSP could improve were related to the length of monitoring and toxicology screening:

- I wish the program wasn't so long.
- The cost of urine screens and the cost of lab bills was too much.
- Make more allowances for participants' lives and life events.
- More flexibility with tox screens.

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 symptoms.

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 that warrants monitoring 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 assessment of the need 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 action (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 2018 (July 1, 2017 to June 30, 2018), 423 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 ▸ Referral Source ▾	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18
Board Voluntary	0	0	0	3	11	13	14	15	19	13	15	7	77	54	28	22	4	3	0	0	0	0	0	0
Board Discipline	0	0	0	0	1	1	0	0	0	0	0	2	0	2	4	6	1	2	1	0	0	0	0	0
Self	0	0	0	0	8	8	7	6	3	0	2	0	8	1	3	5	1	2	2	0	0	3	0	0
Third Party	0	0	0	0	3	6	9	8	0	1	0	0	6	2	1	3	0	0	0	0	0	0	0	0
SUM	0	0	0	3	23	28	30	29	22	14	17	9	91	59	36	36	6	7	3	0	0	3	0	0

Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Occupational Therapy*				Optometry			
Fiscal Year ▸ Referral Source ▾	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18
Board Voluntary	5	8	10	17	1	3	0	0	12	9	13	16	30	51	48	28	-	-	-	0	0	0	0	0
Board Discipline	3	1	0	0	0	0	1	0	5	1	1	1	54	41	47	34	-	-	-	0	0	0	0	0
Self	8	3	11	6	1	2	3	1	21	33	20	32	97	97	102	82	-	-	-	2	0	0	0	0
Third Party	0	0	2	3	1	0	1	2	12	10	10	15	49	39	43	46	-	-	-	0	0	0	0	1
SUM	16	12	23	26	3	5	5	3	50	53	44	64	230	228	240	190	-	-	-	2	0	0	0	1

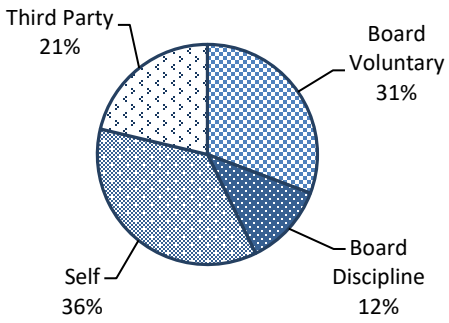
Board	Pharmacy				Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine			
Fiscal Year ▸ Referral Source ▾	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18
Board Voluntary	9	2	1	4	13	9	12	10	0	0	0	2	0	0	1	3	6	8	7	1	2	2	0	2
Board Discipline	2	0	1	2	0	0	0	0	0	1	0	0	1	1	0	0	3	0	1	5	1	2	0	1
Self	4	3	8	6	3	1	3	2	1	0	2	0	2	0	1	2	5	9	9	7	1	1	1	1
Third Party	0	3	5	3	0	1	1	0	0	0	0	0	4	0	3	4	3	2	6	5	1	0	0	0
SUM	15	8	15	15	16	11	16	12	1	1	2	2	7	1	5	9	17	19	23	18	5	5	1	4

Totals by Fiscal Year ▸ and Referral Source ▾	15	16	17	18
Board Voluntary	189	175	149	130
Board Discipline	71	52	56	51
Self	163	163	174	152
Third Party	79	64	81	90
Sum	502	454	460	423

*Prior to January 2018, Occupational Therapists (OTs) and Occupational Therapy Assistants (OTAs) were regulated by the Department of Health. In January 2018 the Board of Occupational Therapy was created. Therefore, data regarding OTs and OTAs in years prior to 2018 is reflected in the Department of Health's data.

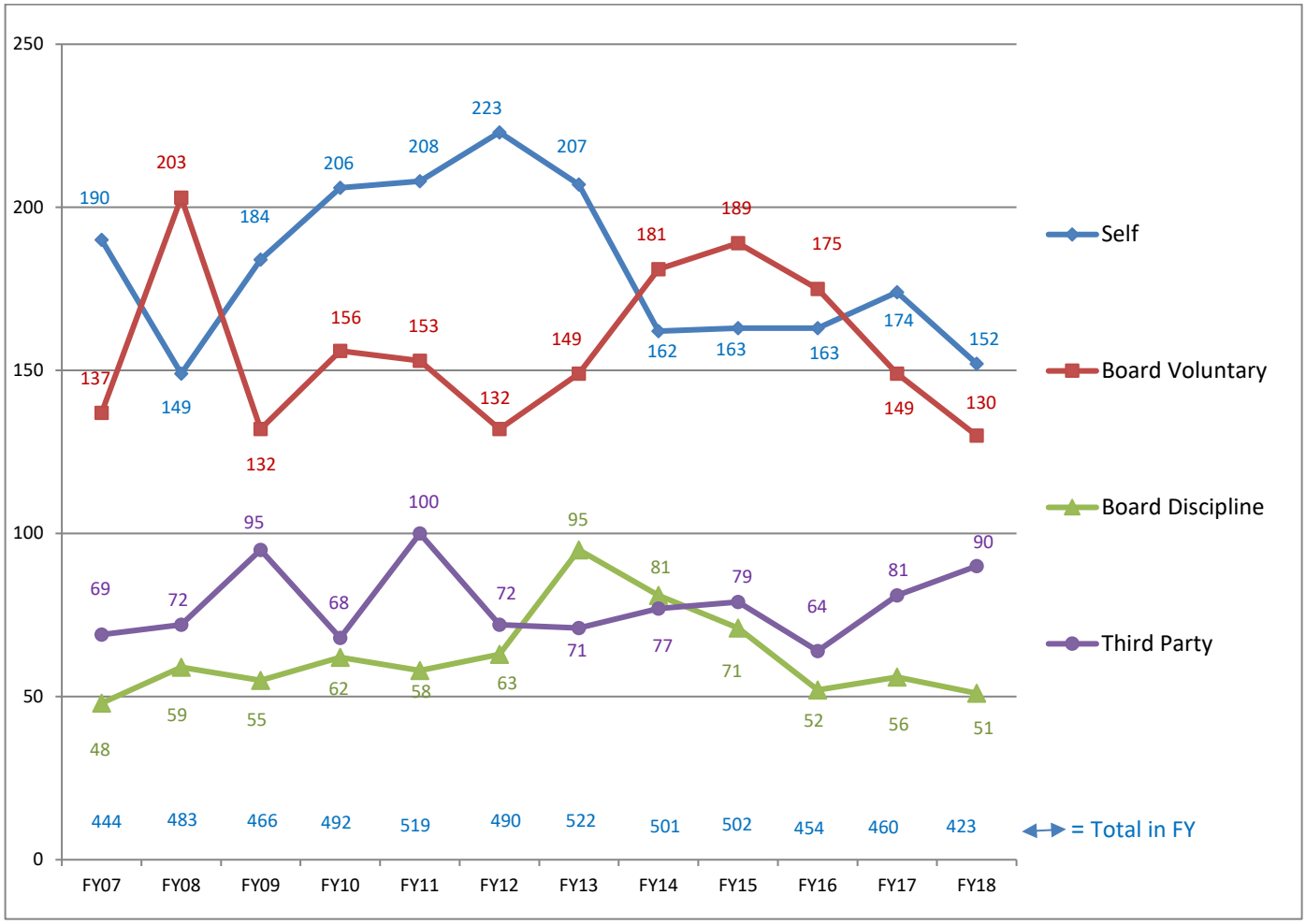
Referrals by First Referral Source

The chart below shows the percentage of referrals to HPSP by first referral source from July 1, 2017 to June 30, 2018:



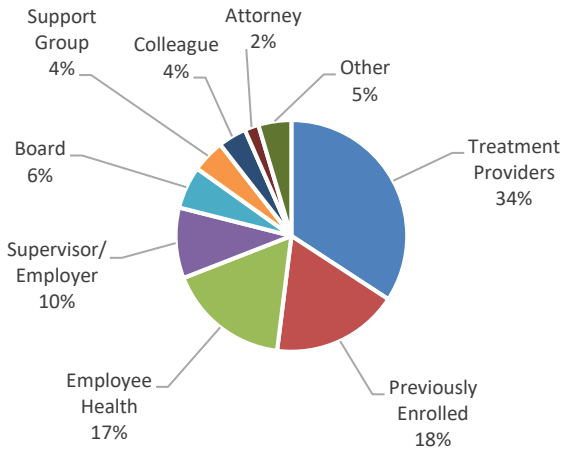
Referral Trends

The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2007 through fiscal year 2018. In fiscal year 2018, third party referrals was the only referral source that saw an increase. All other referral sources decreased from fiscal year 2017. It has been ten years since self-referrals were lower than those in fiscal year 2018.



Self-Referrals – How did licensees learn about HPSP?

The chart below shows how the 152 practitioners who self-referred to HPSP in fiscal year 2018 learned about the program:



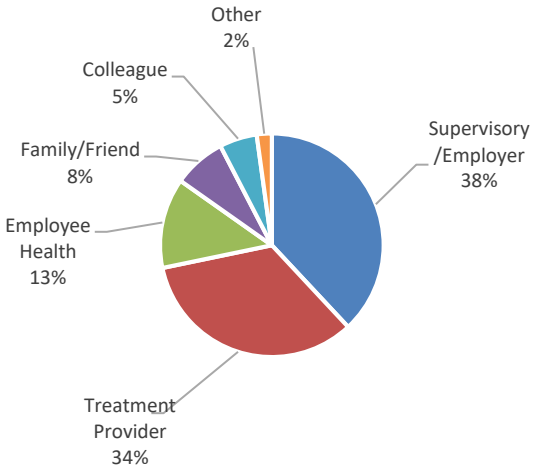
Health care practitioners learn about HPSP from many different sources. Thirty-four percent of those who self-referred in fiscal year 2018 learned about HPSP from their treatment providers.

The illnesses HPSP monitors are often chronic illnesses that may exacerbate and remit over one's lifespan. Because of this, HPSP is seeing increasing numbers of persons referring themselves back to the program.

Third Party Referrals – Who refers 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 cases where immediate public safety is at risk, HPSP calls the licensee upon receipt of the report. If the licensee does not follow-up on the initial letter, HPSP sends a follow-up letter requesting contact and return of enrollment materials within seven days. If the licensee does not contact HPSP after the second deadline, HPSP closes the case as *no contact* and files a report with the Board. If the licensee fails to cooperate with the intake process (i.e. will not obtain requested evaluations or does not sign authorizations), 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.*

The chart below shows the sources of fiscal year 2018 third party reports to HPSP:



Most health professionals enrolling in HPSP report that their illness did not impact their practice. However, 56% of third party referrals came from work related sources (supervisor, employer, employee health and colleagues). Often times, as monitoring progresses, licensees develop insight and are able to identify how their illness impacted their practice.

Fiscal Year 2018 Additional Referral Sources

The previous data showed how health practitioners were referred to HPSP in fiscal year 2018 by first referral source. The following data shows subsequent referral sources for the same admission:

First Referral Source	Second Referral Source
Self (#152)	• 11 third party • 10 Board voluntary • 3 Board discipline
Third Party (#90)	• 4 Self-reports • 1 Board discipline
Board Voluntary (#130)	• 1 Board discipline • 1 Third party

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

Fiscal Year 2018 Re-Referrals

Of the 423 referrals to HPSP in fiscal year 2018, 123 (29%) were individuals who had previously been referred to and discharged from HPSP; some within the same fiscal year and some years earlier. Of the 123, 44 engaged in monitoring and completed the terms of their Participation Agreements and 43 did not complete monitoring. An additional 36 did not engage in monitoring.

Of persons referred to HPSP in fiscal year 2018, who had previously been referred:

- 90% of persons referred with disciplinary action had previously been referred to the program
- 35% of persons referred by their board without discipline had previously been referred to the program
- 22% of persons who self-referred had previously been referred to the program
- 14% of persons referred by a third party had previously been referred to the program

Referral Source	Average time from prior file closed to re-referral date	Date Range
Board Disciplinary Referrals (31)		
Previously Completed (1)	20 years	20 years
Previously Monitored - Did Not Complete (22)	3 years	1 month to 16 years
Previously Referred - Not Monitored (8)	2 years	4 months to 5 years
Board Voluntary Referrals (46)		
Previously Completed (5)	5 years	3 year to 9 years
Previously Monitored - Did Not Complete (17)	1 year	2 months to 3 years
Previously Referred - Not Monitored (24)	1 year	9 days to 6 years
Self-Referrals (33)		
Previously Completed (29)	4.5 years	3 months to 14 years
Previously Monitored - Did Not Complete (2)	5 years	4 years to 6 years
Previously Referred - Not Monitored (2)	6 years	5 years to 7 years
Third Party Referrals (13)		
Previously Completed (9)	6 years	5 months to 17 years
Previously Monitored - Did Not Complete (2)	32 months	2 months to 42 months
Previously Referred - Not Monitored (2)	3 months	2 months to 4 months

About the above data: Years and months were rounded up or down to closest whole number in most of the above data.

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 becomes inactive
   - Ineligible Monitored – License relinquished
   - 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 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 with copy of file.*

Discharges by Discharge Category and Board

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

Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
Fiscal Year ▸ Discharge Category ▾	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18
Completion	0	1	0	0	5	2	3	5	5	3	3	3	6	6	8	8	0	0	2	1	0	0	2	0
Voluntary Withdraw	0	0	0	0	2	1	1	3	1	0	0	0	3	0	1	2	1	0	0	0	0	0	0	0
Non-Compliance	0	0	0	1	5	6	9	4	0	2	2	0	10	6	4	3	0	0	0	0	0	0	0	0
Deceased	0	0	0	0	1	0	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	1	2	0	1	0	0	0	0	1	0	0	0	1	0	1	0	0	0	0
Ineligible Not Monitored	0	0	0	0	0	1	3	0	0	0	0	0	2	1	1	0	0	0	0	0	0	0	0	0
No Contact	0	0	0	0	5	0	3	5	0	0	1	0	5	3	4	5	2	0	0	0	0	0	0	0
Non Cooperation	0	0	0	0	4	4	4	10	1	1	1	2	8	3	6	6	0	1	1	0	0	0	0	0
Non-Jurisdictional	0	0	0	1	3	3	3	1	16	10	13	5	58	39	19	12	1	2	1	0	0	1	0	0
SUM	0	1	0	2	25	18	28	28	24	16	20	10	92	59	43	36	4	4	4	2	0	1	2	0

Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Occupational Therapy*				Optometry			
Fiscal Year ▸ Discharge Category ▾	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18
Completion	3	4	4	4	2	0	1	1	41	27	26	21	102	85	93	88	-	-	-	0	0	0	0	0
Voluntary Withdraw	2	2	1	2	0	0	0	1	1	2	0	0	15	15	13	16	-	-	-	0	0	0	0	0
Non-Compliance	1	3	0	1	0	0	0	0	0	0	0	1	50	39	12	27	-	-	-	0	0	0	0	0
Deceased	0	1	0	0	0	0	0	0	0	1	1	0	0	0	3	0	-	-	-	0	0	0	0	0
Ineligible Monitored	1	1	0	0	0	0	0	0	6	6	5	8	15	20	20	21	-	-	-	0	1	0	0	0
Ineligible Not Monitored	0	0	0	0	0	0	1	0	0	1	3	5	17	1	3	3	-	-	-	1	0	0	0	0
No Contact	1	1	5	5	0	0	0	0	3	2	3	1	12	11	11	7	-	-	-	0	0	0	0	0
Non Cooperation	4	3	2	4	1	3	0	0	4	1	2	4	26	24	32	18	-	-	-	0	0	0	0	0
Non-Jurisdictional	4	3	5	11	1	2	3	0	11	9	10	8	23	20	32	22	-	-	-	0	0	0	0	1
SUM	16	18	17	27	4	5	5	2	66	49	50	48	260	215	219	202	-	-	-	1	1	0	0	1

Board	Pharmacy				Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine			
Fiscal Year ▸ Discharge Category ▾	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18	15	16	17	18
Completion	10	1	11	4	6	3	3	3	0	0	1	0	3	2	4	1	2	4	6	5	3	1	1	4
Voluntary Withdraw	1	0	1	0	1	0	1	1	0	0	0	0	0	1	0	1	0	2	2	0	0	0	0	0
Non-Compliance	2	3	2	3	2	0	2	3	0	0	0	0	2	0	0	2	1	2	3	2	1	0	0	0
Deceased	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ineligible Monitored	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	1	2	0	1	0	0
Ineligible Not Monitored	0	1	1	1	0	0	0	0	0	0	0	0	0	0	1	0	2	1	1	1	0	0	1	0
No Contact	4	1	1	1	1	1	0	0	0	0	0	0	1	0	0	1	1	0	1	1	0	0	0	0
Non Cooperation	1	2	3	1	1	1	2	0	1	0	0	0	0	0	1	0	2	4	1	5	1	0	0	0
Non-Jurisdictional	2	0	3	3	7	4	5	9	0	0	0	3	1	0	0	2	6	0	6	0	1	1	1	1
Sum	21	8	23	14	18	9	13	17	1	0	1	3	7	3	6	7	14	15	21	16	6	3	3	5

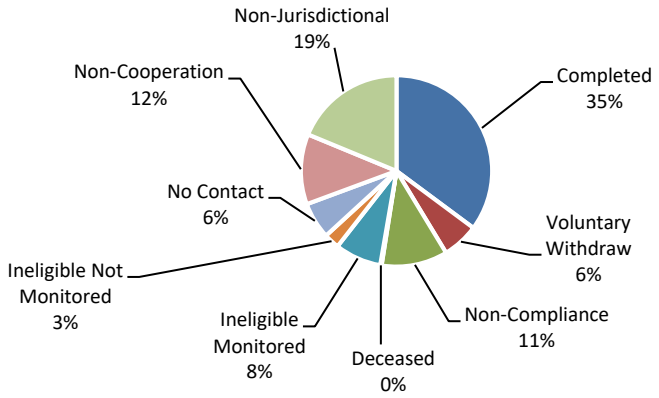
*As described in the referral section, the OTs and OTAs were regulated by the Department of Health until January 2018, when the Board of Occupational Therapy was created. OT and OTA data prior to 2018 is included in the Department of Health's data.

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

Totals by Fiscal Year ▸ And Discharge Category ▾	15	16	17	18
Completion	188	139	168	148
Voluntary Withdraw	27	23	20	26
Non-Compliance	74	61	34	47
Deceased	2	2	4	1
Ineligible Monitored	24	33	29	33
Ineligible Not Monitored	21	6	15	11
No Contact	35	19	29	26
Non Cooperation	54	47	55	50
Non-Jurisdictional	134	94	101	79
SUM	559	424	472	421

Discharges by Category

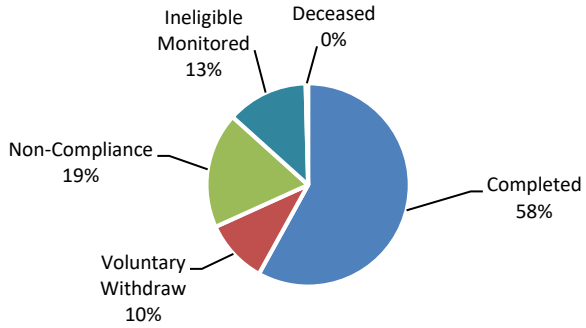
The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2018.



Of persons discharged in fiscal year 2018, 39% 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 35%. The most common reason for not engaging 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 2018.



The completion rate of 58% reflects only persons that engaged in monitoring.

Discharges Due to Ineligibility for Monitoring

Forty-four (44) health professionals were discharged in fiscal year 2018 because they were not eligible for program services; 33 were monitored and 11 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (33)

- 30 – ineligible due to license suspension, revocation, expired or given up
- 3 – ineligible due to severity of illness

Not-monitored and discharged as ineligible (11)

- 7 – ineligible due to license being suspended, revoked, inactive or not being licensed in Minnesota
- 2 – ineligible due to violation of practice act
- 2 – ineligible due to prior discharge to board

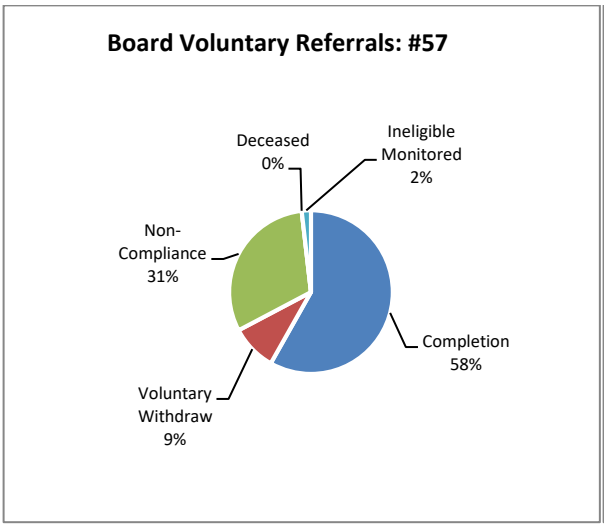
Discharges for Non-Compliance (47)

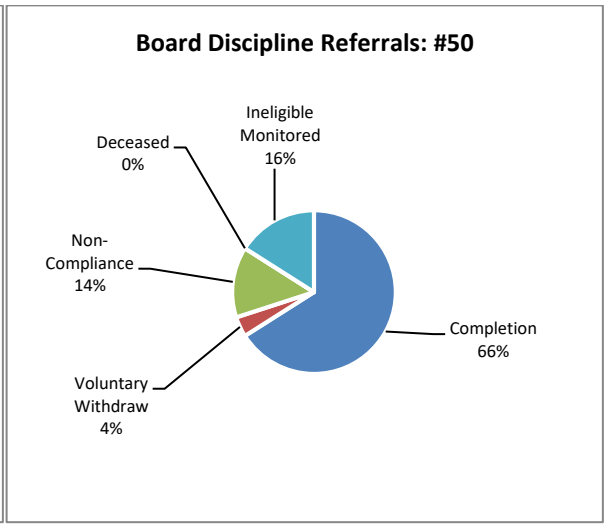
Forty-seven (47) health professionals were discharged in fiscal year 2018 due to non-compliance with their Participation Agreements. More detailed information regarding the type of non-compliance is listed below:

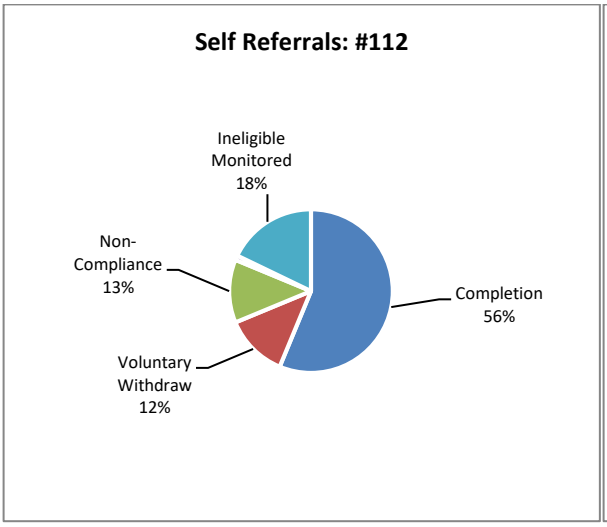
- 20 – non-compliance related to problem screens
- 16 – non-compliance with Participation Agreement
- 4 – non-compliance related to positive screen
- 4 – non-compliance related to treatment
- 3 – non-compliance related to diversion

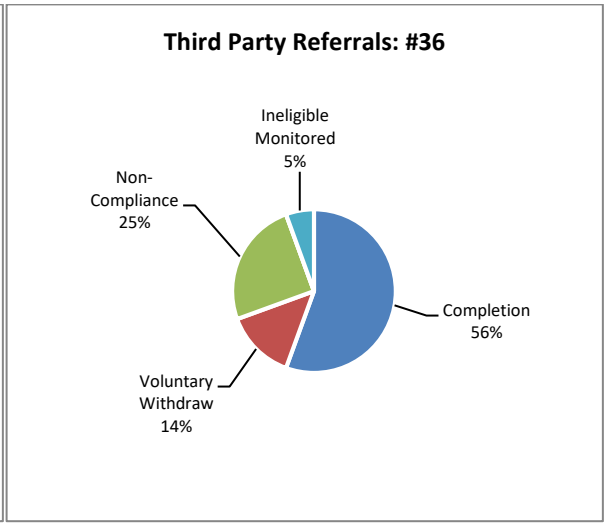
Discharges Category and First Referral Source for Those Monitored

The charts below provide data about licensees who engaged in monitoring and where discharged from HPSP in fiscal year 2018 based on first referral source and discharge category. Over the past two years, persons referred as part of a disciplinary order completed monitoring at the highest rate.









Length of Monitoring

Successful Completion: In fiscal year 2018, the average length of monitoring of practitioners who successfully completed monitoring was two years and six months. The shortest length was 31 days and the longest was five years and six months.

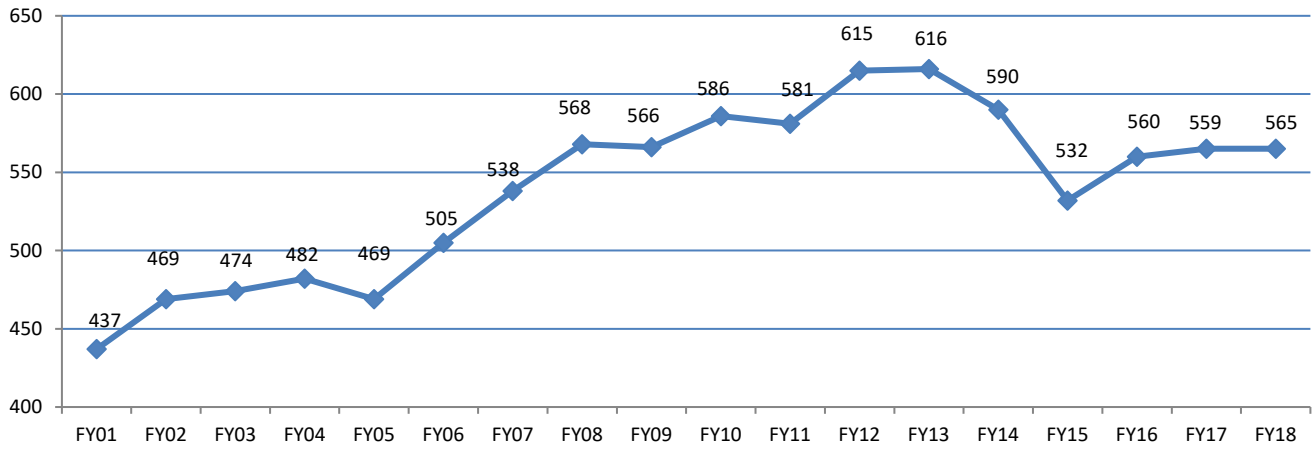
HPSP satisfactorily discharges persons based on the following: (1) The individual is in sustained remission after a period of monitoring (usually the case for substance use disorders); (2) there is new information indicating the diagnosis has changed; or (3) the participant is deemed to be appropriately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

Unsatisfactory Completion: In fiscal year 2018, the average length of monitoring for persons who were monitored but did not complete monitoring was one year. The shortest length was 7 days, and the longest was seven years and ten months. The majority, 66%, were discharged in the first year of monitoring, followed by 21% in the second year, 9% in the third year, and the remaining four percent were discharged beyond three 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.



Estimated Rate of Participation by Board

The following table shows the number of persons regulated by each board in early July, 2018, the number of persons active in HPSP on July 2, 2018, 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.

Board	Number Licensed or Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Licensed or Regulated
Board of Behavioral Health & Therapy	5,977	26	4.4
Board of Podiatric Medicine	248	1	4.0
Board of Medical Practice	30,960	102	3.3
Board of Nursing	130,075*	312	2.4
Board of Psychology	3,775	8	2.1
Board of Social Work	15,347	26	1.7
Board of Physical Therapy	7,443	11	1.5
Board of Dentistry	17,487	25	1.5
Board of Veterinary Medicine	3,007	4	1.4
Board of Chiropractic Examiners	3,142	4	1.3
Board of Exam. of Nursing Home Admin.	842	1	0.12
Board of Marriage and Family Therapy	2,685	3	1.1
Board of Dietetics and Nutrition Practice	1,910	2	1.0
Board of Occupational Therapy	5,167	5	.97
Board of Pharmacy	21,000	18	.86
Emergency Medical Services Regulatory Board	28,210	17	.60
Department of Health	4,170	0	0
Board of Optometry	1,146	0	0
Total	261,767	565	2.2

About the data:

- The number of persons actively enrolled with HPSP changes from day to day. The numbers reflect a snapshot of active participation in HPSP on July 2, 2018.
- The number licensed or regulated by board is a snapshot of the number licensed or regulated on the day the data was provided to HPSP (within first two weeks of July 2018).
- The number licensed or regulated includes only individuals who are licensed or regulated – not regulated firms, facilities or agencies.
- Many persons who are licensed in Minnesota choose to keep their Minnesota license active even when they are not working or are working and living in another state.

*As of July 9, 2018, there were a total of 131,099 RNs and LPNs with current (active) licensure. Of those, 109,539 were RNs and 32,560 were LPNs. Of the 109,539 RNs, 1,024 also held an LPN license. Therefore, on July 9, 2018, there are 130,075 nurses licensed in Minnesota.

Active Caseload by Board and Profession

The chart below shows the number of licensees actively enrolled with HPSP on July 2, 2018, by Board and Profession. It includes persons who are in the enrollment phase as well as those with signed Participation Agreements.

Board		Number of Participants
Board of Behavioral Health & Therapy		26
	LPC	2
	LPCC	5
	LADC	19
Board of Chiropractic Examiners		4
Board of Dentistry		25
	Dental Assistants	8
	Dental Hygienists	4
	Dentists	13
Department of Health		0
Board of Dietetics and Nutrition Practice		2
Board of Exam. of Nursing Home Admin.		1
Emergency Medical Services Regulatory Board		17
	CMPA	1
	EMR	2
	EMT	10
	EMTP	4
Board of Marriage and Family Therapy		3
Board of Medical Practice		102
	Physician Assistant	7
	Physician	80
	Respiratory Care Practitioner	9
	Resident	6
Board of Nursing		312
	RN	259
	LPN	53
Board of Occupational Therapy		5
Board of Optometry		0
Board of Pharmacy		18
	Pharmacist	13
	Technician	5
Board of Physical Therapy		11
	Physical Therapist	10
	Physical Therapist Assistant	1
Board of Podiatric Medicine		1
Board of Psychology		8
Board of Social Work		26
	LGSW	7
	LICSW	13
	LISW	1
	LSW	5
Board of Veterinary Medicine		4
Total		565

Of the 565 active cases on July 2, 2018, 518 had signed Participation Agreements and 47 were in the intake process.

Nurses represent the largest percentage of licensees both eligible for and participating in HPSP (55%).

ILLNESSES MONITORED

GENERAL ILLNESS DATA

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 11, 2018, there were 516 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 516 participants
Substance Use Disorders	439	85%
Psychiatric Disorders	350	68%
Medical Disorders	64	12%

Single and Co-occurring Illnesses	Number of participants	Percent of 516 participants
Substance Only	151	29%
Psychiatric Only	58	11%
Medical Only	8	2%
Substance and Psychiatric	243	47%
Substance and Medical	7	1%
Psychiatric and Medical	11	2%
Substance, Psychiatric & Medical	38	7%

Substance Use Disorders (SUD)	Number of participants with SUD: 439	Percent of 439 participants with a SUD	Percent of 516 active participants
Alcohol	358	82%	69%
Prescription	118	27%	23%
Amphetamine	14	3%	3%
Barbiturate	3	1%	1%
Benzodiazepine	27	6%	5%
Opiate	97	22%	19%
Sedative/Hypnotic	11	3%	2%
Illicit	57	13%	11%
Cannabis	31	7%	6%
Cocaine	17	4%	3%
Heroin	5	1%	1%
Methamphetamine	17	4%	3%

Psychiatric Disorders	Number of participants with psychiatric illness: 350	Percent of 350 participants with a psychiatric illness	Percent of 516 active participants
Anxiety and/or Depression	303	87%	59%
Attention Deficit Disorder	28	8%	5%
Bipolar Disorder	30	9%	6%
Eating Disorder	10	3%	2%
Gambling Addiction	5	1%	1%
Post-Traumatic Stress Disorder	46	13%	9%
Other	17	5%	3%

Medical Disorders	Number of participants with medical disorders: 64 - 12%. Sixty-one percent of those with medical disorders included a pain-related condition (i.e. degenerative disc disease, migraines, fibromyalgia).

It is common for persons to use more than one substance, both within the same substance category and across categories.

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

Psychiatric conditions also co-occur with substance and medical disorders.

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 11, 2018, a total of 516 health professionals had signed participation agreements. Of the 516 health professionals with signed agreements, 118 (23%) were addicted to prescription medications. Of the 118 addicted to prescription medications, sixty-five (55%) engaged in diversion.

Diversion by Board

The table below shows the number of participants with signed Participation Agreements on July 11, 2018, who diverted medications 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 of HPSP's diversion cases**	Percent of board's participants who diverted ***
Nursing	42	26	31	65%	13%
Medical Practice	7	4	4	11%	7%
Pharmacy	5	5	0	8%	28%
Dentistry	3	2	1	5%	12%
Behavioral Health and Therapy	3	0	3	5%	12%
Other Boards *	5	1	4	8%	10%
Totals	65	38 (58%)	43 (66%)		

**Represents five persons regulated by four boards: Physical Therapy (1), Psychology (1), Social Work (2), and Veterinary Medicine (1).*
***Represents the number of participants who diverted by board divided by total who diverted*
****Represents the number of participants who diverted by board divided by the number active in HPSP by board on 7/2/18*

Methods of Diversion

The tables below shows more specific data about the methods of diversion among the 65 who diverted (some used more than one method of diversion, which is shown in the data).

Work-related diversion (58%)	38
Took from inventory	18
Took from waste	15
Withdrew more than patient needed and kept extra for self	9
Wrote prescription for patient and filled for self	5
Other	5

Non-work-related diversion (65%)	42
Took from family or friends	38
Ordering off the internet	3
Wrote prescription for self	3
Wrote prescription for fake patient	3
Other	2

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

Referral Sources of Persons who Diverted by First Referral Source:

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

- 32 (49%) self-referred
  - 6 were later board referred with discipline – the average timeframe between self-referral and board disciplinary referral was 403 days
  - 3 were later board referred without discipline – the average timeframe between self-referral and board voluntary referral was 201 days
- 26 (40%) were board voluntary referrals
- 5 (8%) were board referred without discipline (voluntary)
- 2 (3%) was referred by a third party

Trends

It cannot be overstated that access to controlled substances is a risk factor for diverting drugs from the workplace. This is evidenced by the rate of diversion by board. Persons regulated by the Board of Pharmacy have the greatest access to controlled substances among all of the professions monitored by HPSP. While persons regulated by the Board of Pharmacy comprise 8% of diversion cases, they make up 28% of the Board of Pharmacy's participants, which is greater than any other board. Conversely, persons regulated by the Board of Nursing comprise 65% of diversion cases, but only 13% of the board's participants diverted.

The table below shows the number of health professionals who diverted medications, the general source of diversion and the number addicted to prescription medications over the past five years.

Diversion and Addiction to Controlled Substances by Fiscal Year				
Fiscal Year	Number that diverted	Work-related diversion	Non-work-related diversion	Number addicted to prescription medications
2014	111	82	52	144
2015	64	47	36	117
2016	86	59	46	123
2017	77	49	46	125
2018	65	38	42	118

The table on the left shows:

- HPSP is monitoring fewer people with addictions to prescription medications than in prior years
- HPSP is monitoring fewer people who have diverted medications than in prior years
- It is not uncommon for persons to divert medications from more than one source

About the above data: Some individuals identified in the above table may duplicate from one year to another.

BUDGET

HPSP is committed to providing cost-effective quality monitoring services that contribute to public safety in health care. 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's administering board 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. Licensees are responsible for paying for costs associated with evaluations, treatment and toxicology screens (if warranted).

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.

HPSP's base budget for the fiscal years 2018-2019 biennium is $1,848,000. HPSP's appropriation for fiscal year 2018 is $955,000 and $964,000 in fiscal year 2019. The additional appropriations were specifically granted to make technological improvements.

EXPENSES

Similar to the health licensing boards, the majority of HPSP's expenses are directed toward salaries and benefits (77%). The next largest expense is rent. HPSP is spending within its appropriation. Unspent appropriations for fiscal year 2018 will be carried forward to fiscal year 2019 and directed primarily at database enhancements.

In December 2017, the Department of Administration extended HPSP's lease agreement. The new rates are listed in the chart below:

Timeframe	Cost
FY 2018 (2/1/18 to 6/30/18)	$16,265.00
FY 2019 (7/1/18 to 6/30/19)	$39,961.20
FY 2020 (7/19 to 6/30/20)	$40,043.78
FY 2021 (7/1/20 to 6/30/21)	$40,779.38
FY 2022 (7/1/20 to 6/30/22)	$41,524.33
FY 2023 (7/1/22 to 1/31/23)	$24,480.33

HIGHLIGHTS

DATABASE ENHANCEMENTS

HPSP has two database enhancements underway. The first will enable the automatic submission of over 13,000 toxicology screen results in the HPSP Case Management System (CMS) database in real time annually. This project is in the testing phase. It is anticipated that testing will be completed by the end of September and will be fully implemented in October 2018. This project will save staff time from manually entering and filing screen results.

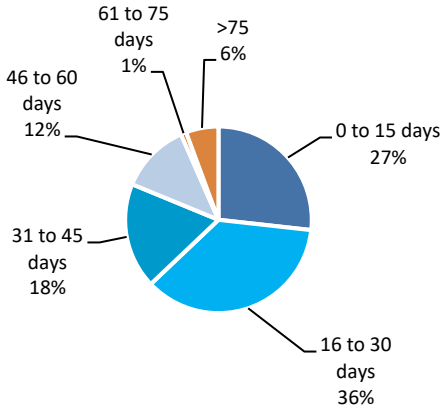
The second enhancement is electronic submission of reports to HPSP's CMS database from a newly developed website. Each work site monitor, treatment provider and participant will receive a unique security code issued by the system for logging into the online portal to submit reports. This will enable work site monitors, treatment providers, and participants to electronically enter quarterly compliance reports. Case managers will review the electronic reports prior to authorizing electronic loading into the CMS database. A testing phase with specific providers and work site monitors will take place prior to implementation. The enhancement will increase HPSP efficiency by reducing staff time spent entering paper reports. This feature will also enable work site monitors, treatment providers and participants to efficiently upload PDF documents.

PARTICIPATION AGREEMENTS

HPSP strives to complete the intake process, and when monitoring is deemed appropriate, to have practitioners sign Participation Agreements within 60 days from contacting the program. It is important to recognize that the case manager's initial contact with a practitioner is the first step in the assessment and intervention phase of the intake, which promotes public protection. It is not uncommon for case managers to ask practitioners to refrain from practice until it can be determined whether they are safe to return to practice.

In fiscal year 2018, 213 Participation Agreements were signed. Of these, 93% were signed within 60 days of the individual's contact with the program. The average timeframe was 31 days. Delays in obtaining assessments from neuropsychologists, neurologists, and pain management physicians continue to be the greatest barriers to having agreements signed within 60 days.

The chart below shows the number of days between the dates licensees initially contacted the program and the dates on which Participation Agreements were signed.



OUTREACH

HPSP staff presented to 10 different stakeholder groups (i.e. schools, professional associations, employers), which provided the opportunity to interface with over 671 individuals in fiscal year 2018. In addition, the Board of Pharmacy included information about HPSP in its newsletter.

The boards and HPSP work together to protect the public. HPSP appreciates visibility on board websites and in board newsletters to promote program awareness. Several boards include an HPSP brochure in their renewal packets. Additionally, HPSP offers each board the opportunity to have HPSP present to the board annually. This promotes board member understanding of HPSP services.

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 its goals are outlined throughout this document. Additional examples are listed below.

GOAL 1: ENSURE THE PUBLIC IS PROTECTED

HPSP's protection of the public is multifaceted.

- HPSP works collaboratively with board staff to ensure monitoring is consistent with board expectations, national norms established by the American Society of Addiction Medicine, the National Council of State Boards of Nursing, the Federation of State Medical Boards, the Federation of State Physician Health Programs and emerging science.
- Self and third party reporting of illness made up 57% of referrals in fiscal year 2018
- HPSP implements practice restrictions when appropriate
- HPSP refers health professionals for appropriate assessments and evaluations
- HPSP requires participants to follow 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 Participation Agreements to their licensing boards
- HPSP educates employers and the medical community about professional impairment
- HPSP encourages early intervention through its outreach

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 standards
- 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 the HPSP website (updated approximately monthly)
- Maintaining a user-friendly website that includes participant, treatment provider and work site monitor information and forms
- Expanding electronic options for submitting quarterly compliance reports
- Maintaining competent staff and promoting staff development

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 completes the Department of Management and Budget's (MMB) Internal Control Self-Assessment tool annually to identify program strengths and vulnerabilities
- HPSP follows all MMB human resource, budget and financial management procedures
- HPSP utilizes MN.IT for computer security, database development, and other electronic technology (i.e. phones, printers, email)
- HPSP is staffed with competent employees who are invested in the program's mission
- The program manager assures that case managers provide quality intake and case management monitoring services
- The program manager performs annual performance reviews of employees and undergoes a performance evaluation by the administering board
- 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 sends board executive directors monthly referral, discharge and cost allocation reports
- 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 ensures that all staff review relevant state policies upon hire and annually (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 from the Office of the Attorney General when needed
- HPSP is recognized nationally as a quality program
- HPSP utilizes specialized consultants to assist in developing the terms of Participation Agreements in complex situations

GOAL 4: ENSURE THE PROGRAM IS FINANCIALLY SECURE

The funding source of HPSP is defined in statute and is appropriated by the Legislature on a biennial basis. HPSP has sought funding increases when deemed necessary to address program growth and needs. For example, HPSP requested increases for the 2018-2019 biennium to support technological advancements, 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.

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	Carrie Lindberg	1/1/2019
Chiropractic Examiners	Nestor Riano	1/1/2019
Dentistry	Ruth Dahl	1/1/2019
Department of Health	Barbara Damchik-Dykes	1/1/2019
Dietetics and Nutritionists	Margaret Schreiner	1/1/2019
Emergency Medical Services	Matthew Simpson	1/1/2019
Marriage and Family Therapy	Jennifer Mohlenhoff	1/1/2019
Medical Practice	Allen Rasmussen	1/1/2019
Nursing	Christine Norton	1/1/2019
Nursing Home Administrators	Randy Snyder	1/1/2019
Occupational Therapy	Laura McGrath	1/1/2019
Optometry	Randy Snyder	1/1/2019
Pharmacy	James Bialke	1/1/2019
Physical Therapy	Kathy Polhamus, Vice Chair	1/1/2019
Podiatric Medicine	Margaret Schreiner	1/1/2019
Psychology	Samuel Sands	1/1/2019
Social Work	Laura McGrath	1/1/2019
Veterinary Medicine	Jody Groat	1/1/2019

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 currently serves 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	1/1/2020
MN Health Systems Pharmacists	S. Bruce Benson	1/1/2020
MN Assoc. of Social Workers	Pam Berkwitz	1/1/2020
MN Medical Association	Becca Branum (Alt: Janet Silversmith)	1/1/2020
MN Veterinary Assoc.	Marcia Brower	1/1/2020
MN Psychological Assoc.	Lois Cochrane-Schlutter	1/1/2020
MN Dental Assoc.	Stephen Gulbrandsen, Vice Chair	1/1/2020
MN Nurses Assoc.	Jody Haggy	1/1/2020
MN Assoc. of Marriage &Fam. Therapy	Eric Hansen	1/1/2020
MN Ambulance Assoc.	Megan Hartigan (Debbie Gillquist alt)	1/1/2020
Public Member	Abdiaziz Hirsi	1/1/2020
MN Academy of Physician Assist.	Tracy Keizer	1/1/2020
MN Nurse Peer Support Group	Linda Halcon	1/1/2020
Physicians Serving Physicians	Jeff Morgan	1/1/2020
Ad Hoc Member	Rose Nelson	1/1/2020
MN Academy of Nutrition and Dietetics	Andrew Pfaff	1/1/2020
MN Podiatric Medicine Assoc.	Kari Prescott	1/1/2020
MN Occupational Therapy Assoc.	Karen Sames	1/1/2020
MN Organization of Registered Nurses	Joseph Twitchell	1/1/2020
MN LPNA/AFSCME	Lisa Weed	1/1/2020

HPSP STAFF

Staff Person	Position
Monica Feider, MSW, LICSW	Program Manager
Tracy Erfourth, BA	Case Manager
Marilyn Miller, MS, LICSW	Case Manager
Bettina Oppenheimer, LADC	Case Manager
Kurt Roberts, EdD, LADC	Case Manager
Kimberly Zillmer, BA, LADC	Case Manager
Charlotte Duke	Case Aide
Alicia Gonzales	Student Worker