Health Professionals Services Program

Biennial Report

Fiscal Year July 1, 1998 to June 30, 2000

I. General Information

A. Program Mission and Major Functions

HPSP Mission

The mission of the Health Professionals Services Program (HPSP) is to maintain public safety through intervention, assessment and monitoring of regulated health professionals who may be unable to practice with reasonable skill and safety due to mental illness, substance abuse, or physical conditions.

HPSP Functions

Provide intake and assessment services for health professionals who may be impaired due to illness.

- Evaluate symptoms and treatment needs of participants.
- Obtain chemical, mental and physical histories along with social, family, and occupational data from participants.
- Assess immediate safety and potential risk to patients. Determine practice limitations, if necessary.
- Secure records consistent with state and federal data practice regulations.
- Collaborate with medical consultants and community providers concerning the treatment needs of participants.

Design and implement monitoring contracts for health professionals who may be impaired due to illness.

- Specify requirements for appropriate care.
- Determine illness specific and practice-related terms and conditions.
- Review and negotiate monitoring terms.
- Assist participants with compliance protocols.

Monitor the continuing care and compliance of health professionals who may be impaired due to illness.

- Communicate monitoring procedures to treating professionals, work site supervisors and other collaborative parties.
- Develop and maintain positive working relationships with community providers, employers, and licensing boards.
- Review records and reports from treating professionals, work site supervisors and other sources regarding the level of functioning and compliance of participants.
- Coordinate random toxicology screening process.
- Intervene, as necessary, for non-compliance, inappropriate treatment, or exacerbation of symptoms.

Consult with licensees, licensing boards, health employers, practitioners, and medical communities.

- Provide information and set standards for early intervention and monitoring of impaired professionals.
- Refer inquiries to appropriate government or community resources.
- Provide outreach services to hospitals, clinics, and professional associations.
- Conduct research on professional impairment, appropriate care, and potential for harm.
- Consult with health-licensing boards on illness related issues.

Eliminate the duplication of monitoring functions by health licensing boards

- Offer a single point of contact for health professionals, employers, boards and the public to reach regarding impaired health professionals.
- Promote streamlined and efficient reporting of impaired professionals.
- Combine expertise in a central location.
- Relate clear understanding of professional reporting obligations.

B. Major Activities During Biennium

- Outreach activities were expanded to promote early intervention, treatment and monitoring for health professionals. These efforts increased the number or participants (52%) who either reported themselves or were referred to the program by a colleague or employer.
- The HPSP Program Manual was updated with specific monitoring standards and reporting guidelines to maintain consistent, high quality services.
- A new toxicology screening system was developed to provide better access, convenience, and more accountability.
- Regular meetings were initiated with board staff and other program constituents to promote better communication.
- Quality assessment tools were developed and implemented, which precipitated quality improvement initiatives.
- Computerized database has been utilized to support staff in a variety of areas, increasing staff efficiency and effectiveness.

C. Emerging Issues

When HPSP began in August of 1994, five licensing boards participated in the program. Today, twelve boards participate with over 160,000 licensees eligible for program services. New legislation mandates all health licensing boards to participate in HPSP or a similar program by July 2001. All of the fifteen health-licensing boards intend to participate in HPSP. The increase in participating boards will expand the number of eligible licensees to over 180,000.

The demand for HPSP services has been growing statewide. The number of active cases grew from 377 in FY 1999 to 420 in FY 2000. Program growth is due to expanded outreach and deeper market penetration. Treatment programs and health providers are making more referrals, as well as, encouraging impaired professionals to report themselves to HPSP.

Resources and staffing levels have not risen to match the growth of HPSP. The current rate of growth and expected demand threatens the ability of the program to provide quality services to impaired professionals in Minnesota. The HPSP Program Committee and Advisory Committee plan to work jointly to address these issues.

HPSP is funded by the health licensing boards whose revenue is generated from licensing fees. When HPSP was developed, it was not anticipated that health professionals would seek help and report themselves to the program at the current rate. While this is viewed as a positive response to program services, which enhances public safety, participating boards are bearing the increased cost. Program growth puts financial stress on boards, which in turn, impacts the program. There are many issues related to funding that need to be addressed:

- Should boards be responsible for the cost of participants they don't refer to the program?
- Should licensees be charged for participation? What if they are not working? Would LPN's be charged at the same rate as physicians?
- Will the increasing cost to boards cause licensing fees to increase and is this fair to licensees who do not utilize the program?
- Will boards not refer licensees to the program as a means to keep their costs down and will this negatively impact public safety? Will this cause more licensees to go through the public disciplinary process?
- Will boards discontinue participation in the program secondary to increased cost?
- Will the program be able to provide quality monitoring services if staffing is not able to meet growth rate?

HPSP's Program and Advisory Committees will address these and other related issues over the next biennium.

II. Board Members, Staff and Budget

A. Composition of Committees

Program Committee

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

Current Program Committee Members:

- Steven Altchuler, Board of Medical Practice
- Tony Bibus, Board Social Work
- Robert Butler, Board Marriage and Family Therapy
- Henry Capiz, Board of Pharmacy
- Meg Glattly, Board of Veterinary Medicine
- Susan Hennessy, Board of Nursing
- Rosemary Kassekert, Board of Chiropractic Examiners
- Stephanie Lunning, Board of Physical Therapy
- Laurie Michelson, Board of Optometry
- Sharilyn Moore, Board of Podiatric Medicine
- Gary Winegrove, Emergency Medical Services Regulatory Board
- Freeman Rosenblum, Board of Dentistry

Advisory Committee

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

Current Advisory Committee Members:

- Jim Alexander, MN Pharmacists Assoc.
- Kathryn Andrews, MN Nurses Assoc.
- Gail Arnold, MN Academy of Physician Assistant's
- Bruce Benson, MN Society of Health-System Pharmacists
- Peter Cannon, MN Dental Assoc.
- Mike Erkel, MN Academy of Physician Assistants
- Randy Herman, American Assoc. of Social Work Education
- William Kuglar, MN Podiatric Medical Assoc.
- Clare Larkin, MN Dental Hygienists Assoc.
- Nancy Malmon, Public Member
- Jackie Morehead, MN Physicial Therapy Assoc.
- Rose Nelson, MN LPN Assoc.
- Thomas Peyla, MN Medical Assoc.
- Richard Sizer, Public Member
- Debra Skees, MN Respitory Care Assoc.
- Scott Wells, MN Veterinary Assoc.

Board Staff and HPSP Staff Work Group

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

B. Employees

HPSP is currently staffed with 5.5 full time employees:

- .4 Program Manager
- 3.6 Case Managers
- 1.5 Support Staff

C. Receipts and Disbursements

HPSP does not generate revenue. The health licensing boards fund the program with money they receive from licensing fees. Each participating board's share of operating costs is the sum of an annual participation fee ($1,000) and a prorated share of program expenses.

Dollars in Thousands

	FY 1999	FY 2000
Total Direct Costs:	328	363
Statewide Indirect:	0	8
Total Indirect Costs:		8
Total Direct & Indirect Costs:	328	371
Total Revenue:		
Surplus (Shortfall):	0	4
A Cumulated Ending Surplus (Shortfall) or Carry forward:		1

HPSP's budget is broken down as follows:

- 81% -Salaries
- 5% - Professional Technical Contracts
- 5% - Rent/Lease
- 2% - Communication
- 2% - Attorney General
- 5% - Other Costs

III. Caseload - Referrals and Discharges

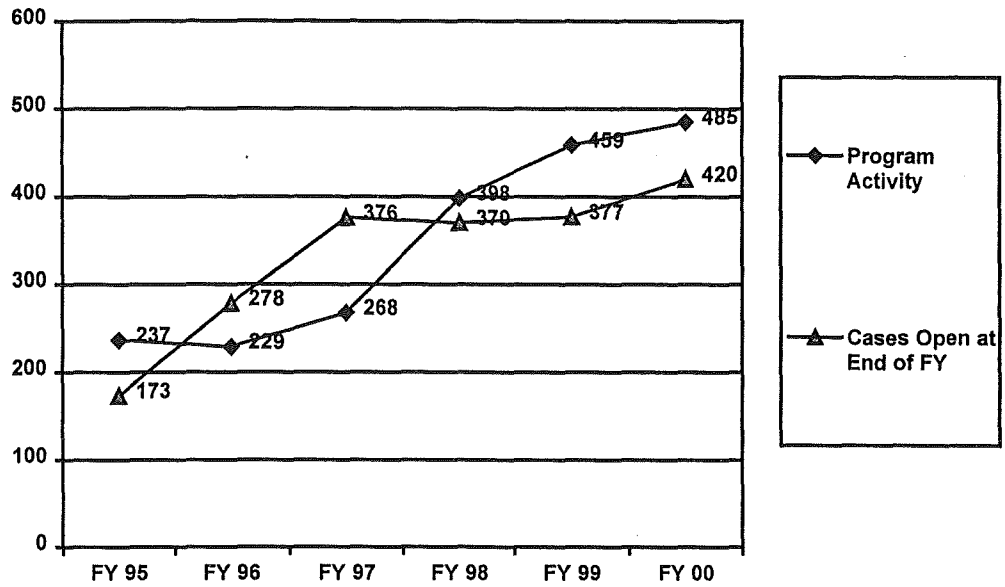
Board & Date Joined		FY 1995			FY 1996			FY 1997			FY 1998			FY 1999			FY 2000		TOTALS		
FY	Board	Opened	Closed	Open at End of FY	Opened	Closed	Open at End of FY	Opened	Closed	Open at End of FY	Opened	Closed	Open at End of FY	Opened	Closed	Open at End of FY	Opened	Closed	Open at End of FY	Total Opened	Total Closed
94	Dentistry	1	0	1	3	0	4	6	1	9	4	6	7	6	6	7	7	1	13	27	14
	Medical Practice	87	6	81	63	28	116	57	30	143	43	67	119	48	57	110	68	70	108	366	258
	Nursing	108	24	84	97	34	147	107	48	206	126	118	214	148	142	220	165	136	249	749	502
	Physical Therapy*	0	0	0	0	0	0	0	0	0	1	0	1	2	1	2	1	0	3	4	1
	Pharmacy	9	2	7	4	0	11	8	5	14	10	8	16	12	10	18	10	2	26	53	27
	Podiatry	0	0	0	0	0	0	0	0	0	3	0	3	1	1	3	0	1	2	4	2
95	Marriage & Family	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
96	Chiropractic	0	0	0	0	0	0	4	1	3	3	1	5	3	3	5	3	3	5	13	8
97	Social Work	0	0	0	0	0	0	1	0	1	6	2	5	10	5	10	9	7	12	26	14
99	Veterinary Medicine	0	0	0	0	0	0	0	0	0	0	0	0	3	1	2	1	1	2	4	2
01	Emergency Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Optometry	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
02	Dietetics & Nut.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nursing Home Adm.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Psychology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL	205	32	173	167	62	278	183	85	376	196	202	370	233	226	377	264	221	420	1246	828

Physical Therapy had been under the Board of Medical Practice until FY 2001

- **Open = Number of cases opened within fiscal year**
- **Closed = Number of cases closed in fiscal year**
- **Open at End of FY = Number of cases open at end of fiscal year**

IV. Trend Data

A. Program Activity and Caseload Size by Fiscal Year



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

B. Opened and Closed Cases by Fiscal Year