

STATE OF MINNESOTA

Health Professionals Services Program

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FISCAL YEAR 2016 REPORT

Fiscal Year 2016: July 1, 2015 to June 30, 2016
Report Date: August 2016

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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 monitoring plans that oversee the participants' illness management and professional practice, both of which are tied to patient safety. A monitoring plan 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 monitoring contracts:**
 - 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

- *The whole program/process kept me very accountable.*
- *I would not have been as successful without urine tox screens early in recovery.*
- *Overall I can't say enough how thankful I am for what HPSP has done for me and my life. I have never been so confident in my sobriety.*
- *The entire program has clearly been a great benefit for me.*
- *HPSP gave me confidence and "protection." It gave me a way to display and prove or proof of competency and safety*

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 and Monitoring Plan are 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 when they are at various points in their 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 also subject to immunity if they are 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.
- **Action** (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 Board 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, we 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 third party, the first referral source for their second admission to the program would be a *third party referral*.

Referrals by First Referral Source and Board

In fiscal year 2016 (July 1, 2015 to June 30, 2016), 452 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.

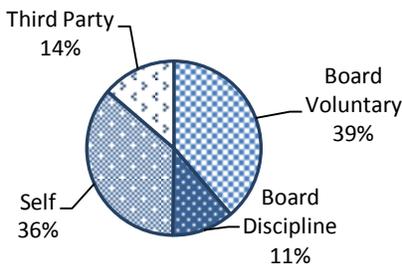
Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Board Voluntary	0	1	0	0	12	8	11	13	15	16	19	13	46	65	77	54	1	2	4	3	1	0	0	0
Board Discipline	0	0	0	0	2	3	1	1	2	2	0	0	5	5	0	2	1	0	1	2	0	0	0	0
Self	1	1	0	0	6	2	8	8	3	5	3	0	3	0	8	1	1	1	1	2	0	1	0	3
Third Party	0	0	0	0	5	5	3	6	0	0	0	1	1	7	6	2	0	1	0	0	1	0	0	0
SUM	1	2	0	0	25	18	23	28	20	23	22	14	55	77	91	59	3	4	6	7	2	1	0	3

Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Board Voluntary	14	9	5	8	2	2	1	3	11	12	12	9	37	43	30	51	0	1	0	0	0	3	9	2
Board Discipline	1	1	3	1	0	0	0	0	5	2	5	1	73	65	54	41	0	0	0	0	3	1	2	0
Self	5	7	8	3	1	4	1	2	47	30	21	33	122	93	97	97	0	0	0	0	7	10	4	3
Third Party	0	0	0	0	0	0	1	0	9	10	12	10	46	47	49	38	0	0	0	0	4	2	0	3
SUM	20	17	16	12	3	6	3	5	72	54	50	53	278	248	230	227	0	1	0	0	14	16	15	8

Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Fiscal Year	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Board Voluntary	4	1	13	9	0	0	0	0	1	1	0	0	2	10	6	8	3	7	2	2	149	181	189	175
Board Discipline	2	1	0	0	0	0	0	1	0	1	1	1	0	0	3	0	1	0	1	2	95	81	71	52
Self	1	3	3	1	0	0	1	0	3	1	2	0	6	4	5	9	1	0	1	1	207	162	163	163
Third Party	1	0	0	1	0	0	0	0	2	2	4	0	2	1	3	1	0	2	1	0	71	77	79	62
SUM	8	5	16	11	0	0	1	1	6	5	7	1	10	15	17	18	5	9	5	5	522	501	502	452

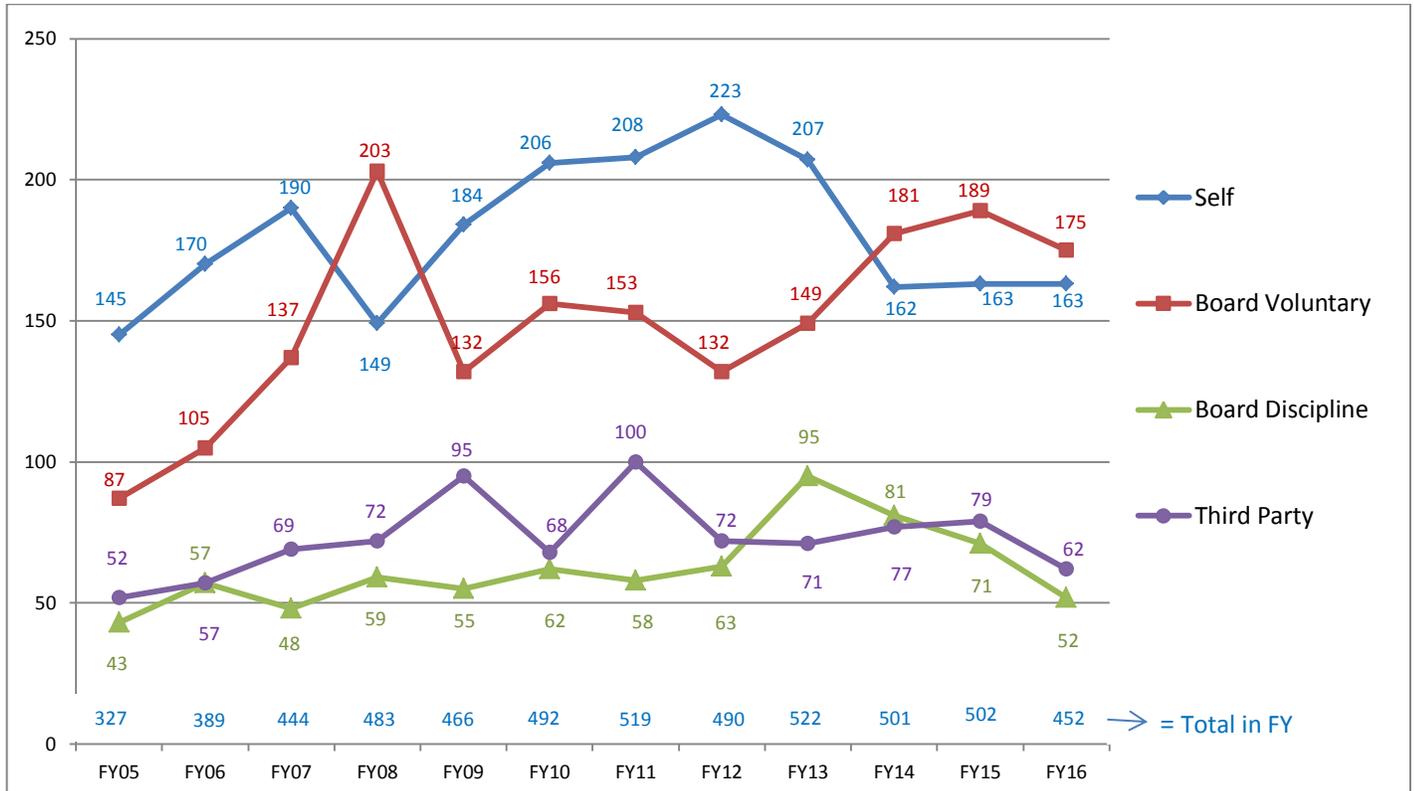
Referrals by First Referral Source

The chart below shows the percentage of referrals to HPSP by first referral source from July 1, 2015 to June 30, 2016:



Referral Trends

The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2005 through fiscal year 2016. Board disciplinary referrals shot up in 2013 by 51% and have steadily decreased since then. Self-referrals remain lower than expected based on the trajectory from 2008 to 2012. Third party referrals also declined, resulting in the fewest number of referrals since 2007. This is the third consecutive year since 2008 that board voluntary referrals exceeded self-referrals.



Self-Referrals – How Did They Learn About HPSP?

Practitioners learn about HPSP from multiple sources. The following data shows how the 163 practitioners who self-referred to HPSP in fiscal year 2016 learned about the program:

- 43% Treatment providers/programs
- 17% Employee health services
- 12% Supervisors
- 9% Previously referred
- 6% Board
- 4% Colleagues
- 9% Other (includes union, HPSP website or brochure, attorney, sponsor and other sources)

As the program ages, we anticipate seeing more people self-report who had previously been enrolled in the program. The large number of persons who learned about HPSP by their treatment providers/programs is congruent with what we see with continuing care planning. Treatment programs encourage patients to contact HPSP to improve their compliance with recovery activities and improves their likelihood for long-term recovery which in turn, helps protect the public.

Third Party Referrals

When HPSP receives a third party report about a licensee, we typically send the licensee a letter and direct them to contact us within two weeks to follow-up on the report. In cases where immediate public safety is at risk, we call the licensee upon receipt of the report. If the licensee fails to contact HPSP in response to the report, they are discharged as *no contact*. If the licensee fails to cooperate with the intake process, they are discharged as *non-cooperative*. 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.

In fiscal year 2016, HPSP third party reports came from the following:

- 42% Treatment Providers
- 19% Supervisors
- 15% Colleagues
- 11% Employee Health
- 8% Family or Friends
- 5% Other

Fiscal Year 2016 Additional Referral Sources

The previous data showed how health practitioners were referred to HPSP in fiscal year 2016 by first referral source. The following data shows subsequent referral sources:

First Referral Source	Second Referral Source	Third Referral Source
Self (#163)	8 Third Party	2 Board Disciplinary
Third Party (#62)	1 Board Disciplinary	
Board Voluntary (#174)	7 Board Disciplinary	

Note: Second and third referral sources are for a single admission into the program. (See page 2 for definitions)

Re-Referrals

Of the 452 persons referred to HPSP between July 1, 2015 and June 30, 2016, 117 (26%) had previously participated in the program. Seventy percent of persons re-referred to HPSP were referred by their licensing boards. Their referral sources for entry to the program are described below:

- Board Voluntary: 48 or 11% of referrals
- Board Discipline: 34 or 8% of referrals
- Self-referrals: 25 or 6% of referrals
- Third Party Referrals: 10 or 2% of referrals

Self-Re-Referrals

Self-re-referrals to HPSP are permitted only under the following circumstances: (1) the participant previously successfully completed HPSP; (2) if discharged to the board, the case was dismissed by the board; or (3) HPSP determined there was no jurisdiction (no illness) in the previous admission.

In fiscal year 2016, the average length between prior discharge and self-re-referral was six years. The shortest time-frame was 11 months and the longest was just short of 18 years. The table below shows the timeframe from prior discharge and self-re-referral to HPSP:

Time between prior discharge and self-re-referral	Number of Participants
<1 to 3 years	6
>3 to 6 years	9
>6 to 9 years	4
>9 to 12 years	3
>12 to 18 years	3

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 and Monitoring Plan.

2. Non-Compliance*

Participant violates the conditions of their Participation Agreement/Monitoring Plan; 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 and Monitoring Plan; the case manager closes 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
- 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

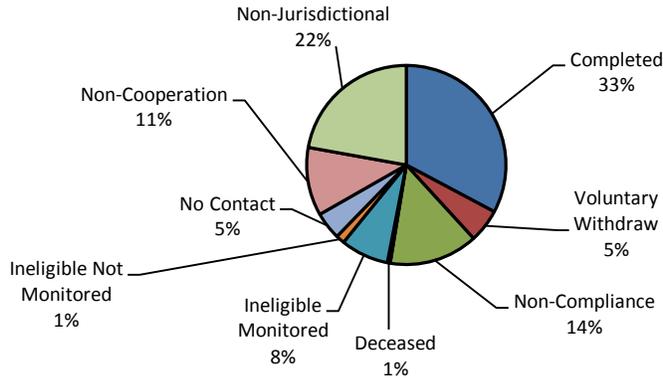
The table below shows the number of persons discharged from HPSP by board and discharge category over the past four fiscal years.

Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Completion	0	0	0	1	2	6	5	2	2	3	5	3	6	7	6	6	1	0	0	0	0	0	0	0
Voluntary Withdraw	0	0	0	0	0	0	2	1	0	1	1	0	2	0	3	0	1	0	1	0	0	0	0	0
Non-Compliance	0	0	0	0	7	6	5	6	3	2	0	2	7	6	10	6	0	1	0	0	0	0	0	0
Deceased	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Ineligible Monitored	0	0	0	0	1	0	0	1	0	3	1	0	0	2	0	1	0	1	0	1	0	0	0	0
Ineligible Not Monitored	0	0	0	0	1	1	0	1	0	0	0	0	1	1	2	1	0	0	0	0	0	0	0	0
No Contact	0	0	0	0	3	1	5	0	1	0	0	0	0	2	5	3	0	1	2	0	1	0	0	0
Non Cooperation	0	0	0	0	5	5	4	4	3	1	1	1	5	7	8	3	0	1	0	1	0	0	0	0
Non-Jurisdictional	0	2	0	0	4	1	3	3	10	14	16	10	34	55	58	39	0	1	1	2	0	0	0	1
SUM	0	2	0	1	23	20	25	18	19	24	24	16	55	80	92	59	2	5	4	4	1	0	0	1
Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Completion	2	2	3	4	1	1	2	0	34	34	41	27	100	91	102	85	0	0	0	0	6	3	10	1
Voluntary Withdraw	1	1	2	2	0	0	0	0	1	5	1	2	28	18	15	15	0	0	0	0	1	0	1	0
Non-Compliance	3	3	1	3	1	0	0	0	0	1	0	0	68	74	50	39	0	0	0	0	3	4	2	3
Deceased	0	0	0	1	0	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	1	0
Ineligible Monitored	1	0	1	1	0	1	0	0	11	11	6	6	17	14	15	20	0	0	1	0	0	0	0	0
Ineligible Not Monitored	0	1	0	0	0	1	0	0	1	4	0	1	20	12	17	1	0	0	0	0	0	0	0	1
No Contact	1	1	1	1	0	0	0	0	1	1	3	2	7	11	12	11	0	0	0	0	1	3	4	1
Non Cooperation	4	2	4	3	0	1	1	3	6	2	4	1	24	22	26	24	0	0	0	0	3	2	1	2
Non-Jurisdictional	3	5	4	3	2	3	1	2	14	11	11	9	30	19	23	20	0	0	0	0	2	0	2	0
SUM	15	15	16	18	4	7	4	5	68	70	66	49	295	261	260	215	0	0	1	0	16	12	21	8
Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16	13	14	15	16
Completion	3	1	6	3	0	0	0	0	2	1	3	2	3	6	2	4	0	0	3	1	162	155	188	139
Voluntary Withdraw	0	0	1	0	0	0	0	0	0	0	0	1	0	2	0	2	0	0	0	0	34	27	27	23
Non-Compliance	1	2	2	0	0	0	0	0	0	2	2	0	0	2	1	2	1	1	1	0	94	104	74	61
Deceased	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2	2	2
Ineligible Monitored	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2	0	1	0	1	33	33	24	33
Ineligible Not Monitored	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	1	0	2	0	0	24	23	21	6
No Contact	0	0	1	1	0	0	0	0	0	0	1	0	0	1	1	0	1	0	0	0	16	21	35	19
Non Cooperation	0	0	1	1	0	0	1	0	0	0	0	0	3	1	2	4	1	2	1	0	54	46	54	47
Non-Jurisdictional	4	2	7	4	0	0	0	0	1	0	1	0	0	1	6	0	0	3	1	1	104	117	134	94
SUM	10	5	18	9	0	0	1	0	3	3	7	3	8	15	14	15	3	9	6	3	522	528	559	424

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

Discharges by Category

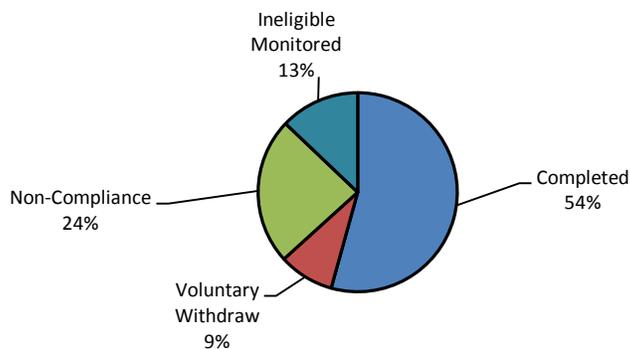
The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2016.



Of persons discharged in fiscal year 2016, 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 33%.

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 2016.



The completion rate of 54% reflects only persons that engaged in monitoring.

Discharges Due to Ineligibility for Monitoring

Thirty-nine (39) health professionals were discharged in fiscal year 2016 because they were not eligible for program services; 33 were monitored and 6 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (33)

- 26 were discharged because their licenses were suspended, revoked, or changed to inactive status;
- 5 were discharged because their illnesses were too severe to warrant continued monitoring; and
- 2 were discharged because they violated their practice act.

Not-monitored and discharged as ineligible (6)

- 3 were discharged because their license was suspended, revoked or inactive;
- 2 were discharged because their illnesses were too severe to warrant monitoring; and
- 1 was discharged due to practice act violations.

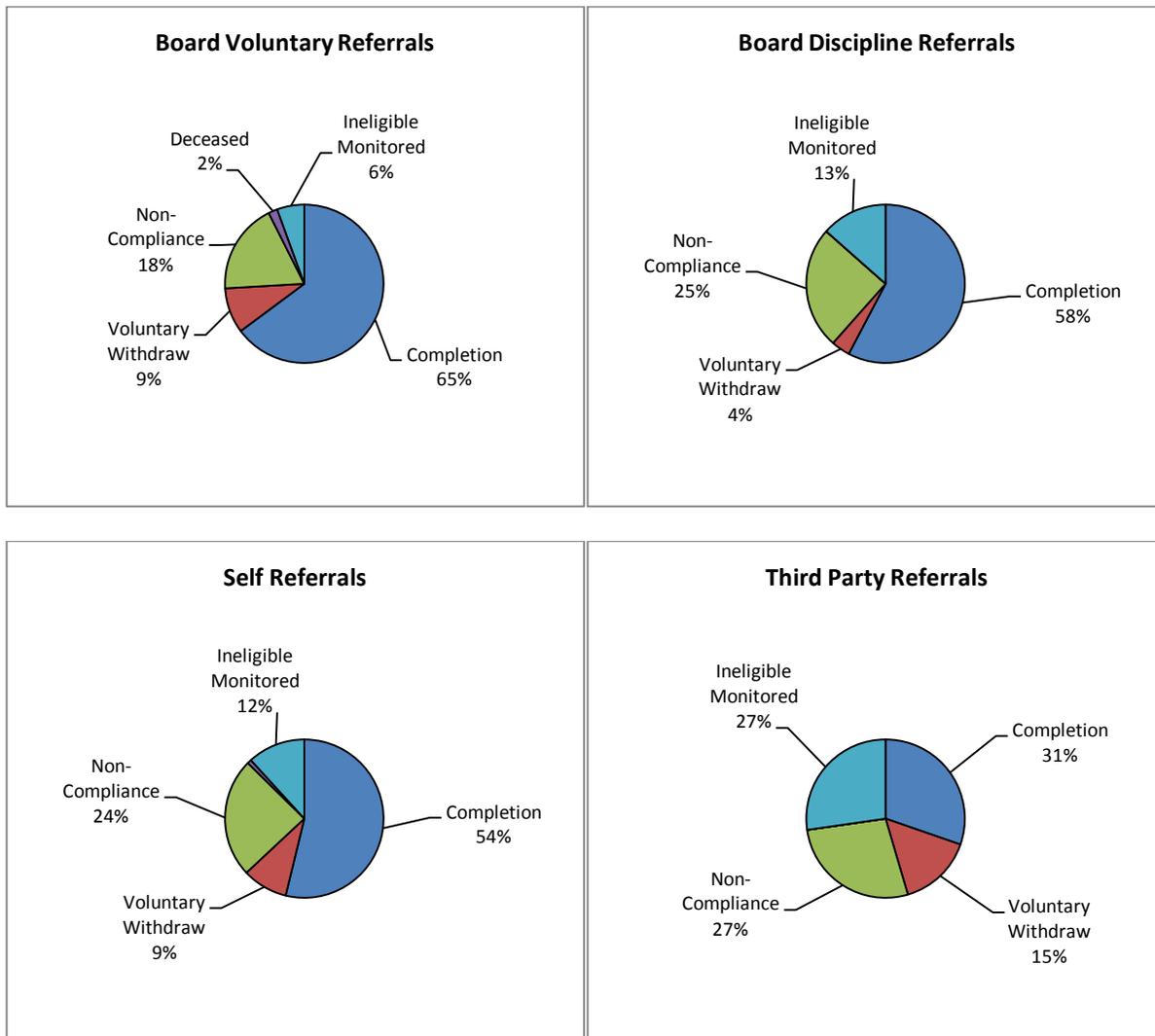
Discharges for Non-Compliance (61)

The sub-categories of the 61 persons discharged for non-compliance in fiscal year 2016 are as follows:

- 23 were discharged for non-compliance with Monitoring Plan (i.e. relapse and refusing evaluations);
- 19 were discharged for problem toxicology screen results (i.e. not providing as requested or dilute);
- 16 were discharged for positive screens; and
- 3 were discharged for non-compliance with treatment.

Discharges by Referral Source for Those Monitored

The charts below show the percentages of licensees monitored by first referral source and discharge category in fiscal year 2016. The *completion* rate is highest among board referred licensees and lowest among those referred by third parties. Third party referents had a significantly higher rate of *ineligible* discharges than other referral sources.



Length of Monitoring

Successful Completion: In fiscal year 2016, the average length of monitoring of practitioners who successfully completed monitoring was two years and eight months. The shortest length was shy of nine months and the longest was six years and ten months.

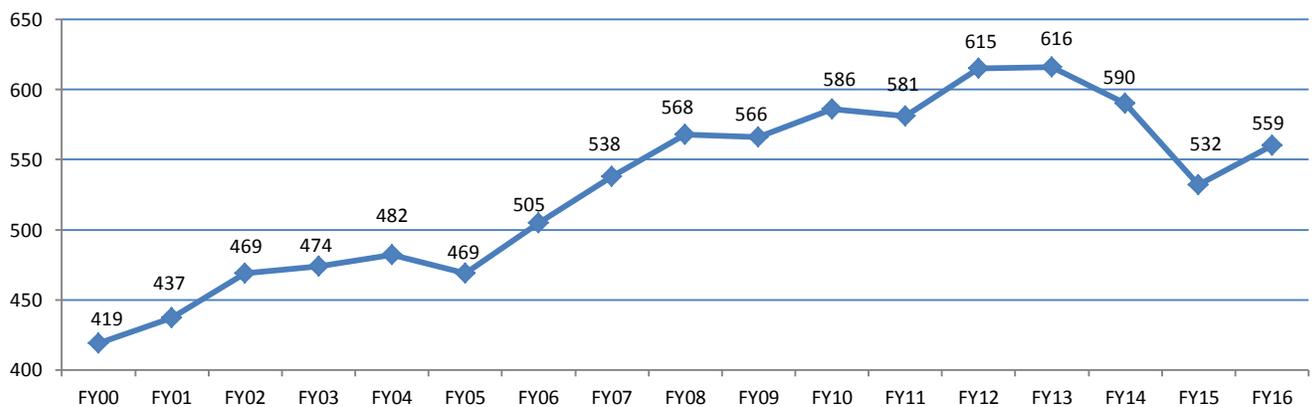
HPSP satisfactorily discharges persons based on the following protocols: (1) The individual is in sustained remission after a period of monitoring (usually the case for substance use disorders); (2) there is new information indicating the diagnosis has changed, or (3) the participant is deemed to be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

Unsatisfactory Completion: In fiscal year 2016, the average length of monitoring for persons who were monitored but did not complete monitoring was just over twelve months (367 days). The shortest length was 27 days, and the longest was five years and nine months. The majority, 65%, were discharged in the first year of monitoring, followed by 22% in the second year, 8% in the third year, and 5% 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 17 fiscal years. While HPSP's caseload decreased in fiscal years 2014-2015, it started rebounding in fiscal year 2016.



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, 2016, 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	4,619	23	4.98
Board of Podiatric Medicine***	256	1	3.91
Board of Medical Practice	29,919	90	3.01
Board of Chiropractic Examiners	3,044	8	2.63
Board of Nursing	124,732	306	2.45
Board of Dietetics and Nutrition Practice***	1,735	4	2.31
Board of Physical Therapy	6,849	13	1.90
Board of Veterinary Medicine	3,822	7	1.83
Board of Psychology	3,850	7	1.82
Board of Dentistry	17,313	29	1.68
Board of Social Work	14,429	20	1.39
Board of Pharmacy*	16,718	23	1.38
Department of Health**	7,167	7	0.98
Board of Marriage and Family Therapy	2,417	2	0.83
Emergency Medical Services Regulatory Board	29,405	12	0.41
Board of Optometry	1,084	0	0
Board of Exam. of Nursing Home Admin.	837	0	0
Total	268,196	552	2.06

The data for the Number Licensed or Regulated were gathered from Board websites or office managers from June to July 2016 unless otherwise noted.

*Pharmacy licensee number is based on number of pharmacists and pharmacy techs that live in Minnesota.

** Does not include unlicensed complementary and alternative health care practitioners (CAP). CAPs are subject to investigation and discipline but because they are not licensed, they are not required to register. The Dept. of Health estimates over 3,000 CAPs.

***Based on number licensed per last year's report.

Active Caseload by Board and Profession

The chart below shows the number of licensees active with HPSP on July 12, 2016 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	23
LPC	2
LADC	21
Board of Chiropractic Examiners	8
Board of Dentistry	29
Dental Assistants	11
Dental Hygienists	8
Dentists	10
Department of Health	7
Occupational Therapists	6
Hearing Instrument Dispensers	1
Board of Dietetics and Nutrition Practice	4
Board of Exam. of Nursing Home Admin.	0
Emergency Medical Services Regulatory Board	12
EMR	0
EMT1	4
EMTN	2
EMTP	6
Board of Marriage and Family Therapy	2
Board of Medical Practice	90
Physician Assistant	6
Physician	78
Respiratory Care Practitioner	5
Resident	1
Board of Nursing	306
RN	252
LPN	54
Board of Optometry	0
Board of Pharmacy	23
Intern	1
Pharmacist	18
Technician	4
Board of Physical Therapy	13
Physical Therapist	9
Physical Therapist Assistant	4
Board of Podiatric Medicine	1
Board of Psychology	7
Board of Social Work	20
LGSW	8
LICSW	4
LISW	2
LSW	6
Board of Veterinary Medicine	7
Total	552

Of the 552 active cases on July 12, 2016, 503 had signed Participation Agreements and 49 were in the enrollment process.

Registered Nurses make up the greatest number of HPSP participants (46%), which is consistent with the fact that there are more Registered Nurses licensed than any other profession eligible for HPSP services.

ILLNESSES MONITORED

General Illness Data:

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 19, 2016, there were 496 health professionals enrolled in HPSP with signed Participation Agreements. Many were monitored for more than one illness. The following data identify the illnesses for which they are being monitored.

Illness Category	Number of participants	Percent of 496 participants
Substance Use Disorders	404	81%
Psychiatric Disorders	346	70%
Medical Disorders	68	14%

We have seen a steady increase in the number of participants monitored for psychiatric disorders. In fiscal year 2007, 51% of participants were monitored for psychiatric disorders compared to 70% this fiscal year.

Comorbid Disorders	Number of participants	Percent of 496 participants
Substance and Psychiatric	226	46%
Substance and Medical	8	2%
Psychiatric and Medical	14	3%
Substance, Psychiatric & Medical	38	8%

Substance Use Disorders (SUD)	Number of participants with SUD: 404	Percent of 496 participants	Percent of 404 with a SUD
Alcohol	317	64%	78%
Prescription	123	25%	31%
Amphetamine	10	2%	3%
Barbiturate	5	1%	1%
Benzodiazepine	35	7%	9%
Opiate	98	20%	24%
Sedative/Hypnotic	14	3%	4%
Illicit	46	9%	12%
Cannabis	25	5%	6%
Cocaine	8	2%	2%
Heroin	4	1%	1%
Methamphetamine	15	3%	4%
Other (OTC)	3	<1%	1%

Many participants used more than one substance.

Psychiatric Disorders	Number of participants with a psychiatric: 346	Percent of 496 participants	Percent of 346 with a psychiatric
Anxiety and/or Depression	292	59%	84%
Attention Deficit	18	4%	5%
Bipolar	35	7%	10%
PTSD	35	7%	10%
Eating Disorder	16	3%	5%
Other	23	5%	7%

It is not uncommon for participants to be monitored for more than one psychiatric disorder.

Medical Disorders	Number of participants with medical disorders: 68
The majority of persons (>82%) 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, chronic fatigue, and seizure disorders. Some are monitored for more than one medical illness.	

Gastric Bypass

Gastric bypass surgery can have unintended consequences that patients are not consistently educated about. Several studies have shown an increase in alcohol use disorders among persons who have had bariatric surgery.

Adults who had a common bariatric surgery to lose weight had a significantly higher risk of alcohol use disorders (AUD) two years after surgery, according to a study by a National Institutes of Health research consortium.

<https://www.nih.gov/news-events/news-releases/weight-loss-surgery-increases-alcohol-use-disorders-over-time>

On July 12, 2016, 7% (37) of participants with signed Participation Agreements had a history of having gastric bypass surgery.

- 84% (31) had an alcohol use disorder (9 with co-occurring prescription medication use disorder)
- 73% (27) had depression and/or anxiety
- 35% (13) had a prescription medication use disorder (4 without a co-occurring alcohol use disorder)
- 14% (5) had other psychiatric disorders (3 of which were co-occurring with anxiety and/or depression)
- 11% (4) had medical disorders

One might expect health care practitioners to have greater information about gastric bypass surgery, which may lead to higher utilization of the surgery than that of the general population. The professions of those who had the surgery include:

- 28 Nurses (20 RNs and 8 LPNs)
- 2 Alcohol and Drug Counselors
- 2 Psychologists
- 2 Social Workers
- 1 Dental Assistant
- 1 Physician
- 1 Reparatory Care Practitioner

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

Our 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 19, 2016, a total of 496 health professionals had signed participation agreements. Of the 496 health professionals with signed agreements, 123 (25%) were addicted to prescription medication. Of the 123 addicted to prescription medications, 86 (70%) engaged in diversion.

Diversion by Board

The table below shows the number of participants with signed Participation Agreements on July 19, 2016, 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 being monitored by board
Nursing	50	33	30	50/275 =18%
Pharmacy	12	11	3	12/20=60%
Medical Practice	11	9	6	11/85=13%
Other boards	13*	6**	7***	13/47=28%*
Totals	86	59	46	-

* (Represents persons regulated by the Boards of Dentistry (3), Behavioral Health and Therapy (2), Emergency Medical Services (2), Physical Therapy (3), Podiatric Medicine(1), and Veterinary Medicine (2).

** Represents persons regulated by the Boards of Dentistry (2), Emergency Services (1), Podiatric Medicine (1), and Veterinary Medicine (2)

*** Represents persons regulated by the Boards of Behavioral Health and Therapy (2), Dentistry (1), Emergency Medical Services (1), and Physical Therapy (3)

Methods of Diversion

The tables below shows more specific data about how 86 health professionals engaged in diversion.

Diversion took place at work (69%)	59 total participants
Took from inventory	23
Took from waste	23
Withdrew more than patient needed and kept extra for self	6
Wrote prescription for patient and filled for self	7
Other	10

Diversion did not take place at work (53%)	46 total participants
Took from family or friends	42
Ordering off the internet	4
Wrote prescription for self	3
Wrote prescription for fake patient	1
Other	2

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

Other forms of diversion included substituting medications, taking medications that patients brought to the hospital, writing a prescription for a patient and splitting it with them, ordering medications for the clinic and taking them for personal use and other methods. Persons who engaged in substitution of medications and falsifying prescriptions were referred to HPSP by their Boards as part of disciplinary actions.

Referral Sources of Persons who Diverted by First Referral Source:

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

- 54% self-referred
- 37% were board referred with discipline
- 6% were third party referred
- 3% were board referred without discipline (voluntary)

Trends

Diversion at Work

As seen in previous years, health care practitioners with the greatest access to controlled substances are more likely to divert substances than those in professions with limited or no access. In this fiscal year all diversion that occurred in the work setting was done by persons with access to controlled substances in the work setting. Pharmacists represent less than 3% of HPSP participants but 14% of diversion cases compared to nurses who represent 55% of HPSP participants and 58% of diversion cases.

Diversion from Other Sources

The most common form of non-work-related diversion is taking (or receiving) medications from family members or friends. We are seeing this increase 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 participants they have in the program at the end of each month. No additional fees are collected by HPSP for program participation from licensees.

EXPENSES

HPSP's operating budget in fiscal year 2016 was \$850,000. Spending was within projected levels. Ninety percent of HPSP's budget was directed to staffing (salaries/benefits). The next greatest cost was rent, which made up just shy of 5% of expenses. The remaining 5% was directed toward all other operating costs, including but not limited to information technology (IT) services (MN.IT), consulting services (IT and a psychiatrists/addictionologist, and supplies. HPSP stayed well within its spending authority and anticipates carrying over roughly \$21,000 to fiscal year 2017.

HPSP's fiscal year 2017 budget is \$864,000. As noted above, HPSP will carry over roughly \$21,000 to fiscal year 2017, which will increase the budget to \$885,000. This will help address increases in staffing costs of approximately \$31,000.

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. The lease agreement is in effect for two and one half years at the following rates:

Lease Period	Annual Payment
7/1/15 to 6/30/16	\$35,837.40
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

In fiscal year 2016, HPSP remained focused on the strategic goals established in fiscal year 2014 and 2015. The goals were developed through a strategic planning process facilitated by the Minnesota Department of Administration's Management, Analysis and Development (MAD) department that included stakeholders from the health licensing boards. Some goals have been completed while others remain a work in progress. HPSP staff will review the progress made with each goal and work on identifying new goals. An update of HPSP's strategic planning progress is in separate document.

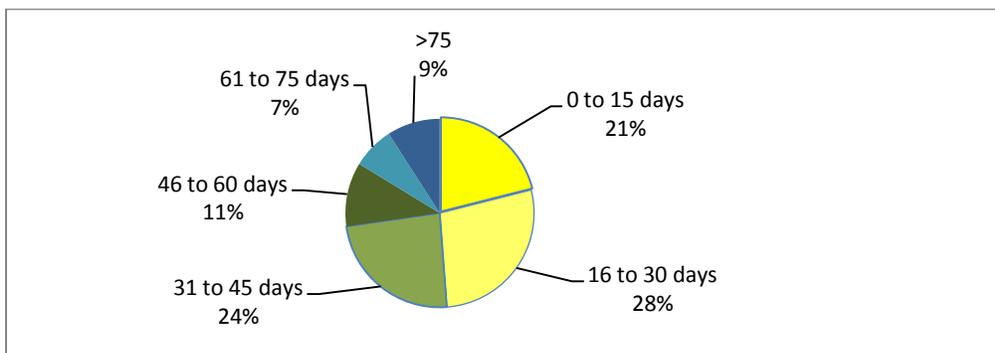
PARTICIPATION AGREEMENTS

HPSP strives to have Participation Agreements signed within 60 days of participant contact with the program. However, when participants are in the intake process prior to a signed Participation Agreement, an intervention has been initiated that protects the public when warranted.

In fiscal year 2016, 203 participation agreements were signed. Of these, 93% were signed within 60 days following the individual's contact with the program. The average timeframe was 33 days. Factors contributing to signed agreements exceeding 60 days were commonly related to the need for specialized assessments (i.e. pain management, neuropsychological), as well as delays in obtaining medical records. Participant cooperation with the intake process was a less frequently cited reason for the delay in the signing of Participation Agreements.

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 50% of referrals in 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 an exacerbation 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 is a complex interaction when providing any type of service. Beyond our 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 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 and 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 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 policies 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 very effective 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. 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.

HPSP will be seeking additional funding in the upcoming biennium to address technological needs, which will improve quarterly reporting efficiencies.

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.

SUMMARY

HPSP is committed to protecting the Minnesota public by providing monitoring services that include the monitoring of professional performance and illness management. HPSP does this by seeking feedback from participants' work site monitors, treatment providers and other sources. HPSP is also committed to providing services in an effective and efficient manner. This is done 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 has the benefit of collaborating with regulators in an ongoing assessment of the effectiveness of program communications and monitoring processes to assure public protection. HPSP and the Boards interact closely to carry out the shared goal of public protection.

COMMITTEE MEMBERS AND STAFF LIST

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	1/1/2017
Chiropractic Examiners	Nestor Riano	1/1/2017
Dentistry	Bridgett Anderson	1/1/2017
Department of Health	Catherine Lloyd	1/1/2017
Dietetics and Nutritionists	Margaret Schreiner	1/1/2017
Emergency Medical Services	Matthew Simpson	1/1/2017
Marriage and Family Therapy	Kathryn Graves	1/1/2017
Medical Practice	Allen Rasmussen	1/1/2017
Nursing	Christine Norton	1/1/2017
Nursing Home Administrators	Randy Snyder	1/1/2017
Optometry	Michelle Falk	1/1/2017
Pharmacy	Joseph Stanek	1/1/2017
Physical Therapy	Kathy Polhamus, Vice Chair	1/1/2017
Podiatric Medicine	Margaret Schreiner	1/1/2017
Psychology	Angelina Barnes	1/1/2017
Social Work	Rosemary Kassekert	1/1/2017
Veterinary Medicine	Julia Wilson	1/1/2017

ADMINISTERING BOARD

HPSP is not an independent State agency. By statute, one of the health licensing boards must be designated by the Program Committee to administer the program. Marshall Shragg, throughout his tenure at the Board of Dentistry and later at the Board of Physical Therapy, served as the Executive Director of HPSP's Administering Board.

The HPSP staff would like to thank Marshall for acting as the Executive Director of HPSP's Administering Board since June 2008. Throughout that time, Mr. Shragg provided HPSP with sound, positive, thoughtful and pragmatic leadership. He was an exceptional advocate for the program and its mission. Mr. Shragg will be leaving the health licensing boards in the fall of 2016, at which time the Program Committee will direct a Board to administer the program.

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
Public Member	Sadiq Abdirahman	1/1/2017
MN Pharmacists Assoc.	Jim Alexander	1/1/2017
MN Health Systems Pharmacists	S. Bruce Benson	1/1/2017
MN Assoc. of Social Workers	Pam Berkwitz	1/1/2017
MN Veterinary Assoc.	Marcia Brower	1/1/2017
MN Psychological Assoc.	Lois Cochrane-Schlutter	1/1/2017
MN Dental Assoc.	Stephen Gulbrandsen, Chair	1/1/2017
MN Nurses Assoc.	Jody Haggy	1/1/2017
MN Assoc. of Marriage & Fam. Therapy	Eric Hansen	1/1/2017
MN Ambulance Assoc.	Megan Hartigan (Debbie Gillquist alt)	1/1/2017
MN Chiropractic Assoc.	Rick Heuffmeier	1/1/2017
Public Member	Abdiaziz Hirsi	1/1/2017
MN Academy of Physician Assist.	Tracy Keizer	1/1/2017
MN Medical Assoc.	Teresa Knoedler	1/1/2017
MN Academy of Nutrition and Dietetics	Sheryl Lundquist	1/1/2017
MN Nurse Peer Support Group	Marie Manthey	1/1/2017
Physicians Serving Physicians	Jeff Morgan	1/1/2017
Ad Hoc Member	Rose Nelson	1/1/2017
MN Occupational Therapy Assoc.	Karen Sames	1/1/2017
MN Organization of Registered Nurses	Joseph Twitchell	1/1/2017
MN LPNA/AFSCME	Lisa Weed	1/1/2017

HPSP STAFF

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