STATE OF MINNESOTA

BOARD OF DENTISTRY

REPORT to the SUNSET COMMISSION 2011

Report to the Legislature in Compliance with Minnesota Statutes Section 3D.06

December 8, 2011

Includes:

PART I: The Minnesota Board of Dentistry

PART II: The Health Professional Services Program (HPSP)

PART I: Agency Contact Information

Marshall Shragg, MPH
Executive Director
Minnesota Board of Dentistry
2829 University Avenue SE, Suite 450
Minneapolis, MN 55414
612-617-2250 (main)
612-617-2260 (fax)
dentalboard@state.mn.us

PART II: Department Contact Information

Monica Feider, MSW, LICSW
Program Manager
Health Professionals Services Program (HPSP)
1380 Energy Lane, Suite 202
St Paul, MN 55108
651-641-0487 (main)
651-643-2163 (fax)
www.hpsp.state.mn.us

BACKGROUND

The **Minnesota Board of Dentistry** is among the state agencies being evaluated in the first round of reviews by the Minnesota Sunset Commission. As an independent state agency initially established in 1883 and as one of the Health Related Boards who share common resources, we strive to fulfill our mission of protecting the public in an open and efficient manner.

The **Health Professionals Services Program (HPSP)** was established in 1994 to provide monitoring services for licensees of all of the Health Related Boards. Because it was not established as an independent agency, but as a program of the Boards, one of the Health Related Boards must act as HPSP's Administering Board for oversight and budgeting. The Minnesota Board of Dentistry has had that responsibility since 2007, and so incorporates the HPSP sunset review into this report.

The report is set up in two sections: **Part I** addresses the Minnesota Board of Dentistry, and **Part II** addresses HPSP. The report is available on the Board's website in electronic form, which includes hyperlinks for direct access to documents referenced throughout the report.

HEALTH REGULATORY BOARDS

Each of the independent health licensing boards consists of members appointed by the Governor. The principal staff person for each board is the Executive Director. Each Board is charged with the regulation of particular health professions specified by statute. Each Board is governed by its own Practice Act. Certain statutory requirements apply to all Boards; these are specified in Chapter 214. The Emergency Medical Services Regulatory Board, although not statutorily defined as a health licensing Board, is housed with the Boards and cooperates with them on administrative, policy, and financial matters. Similarly, the Board of Barber Examiners and Board of Cosmetologist Examiners, though not statutorily designated as health licensing Board, are housed with the Boards and cooperate with them on administrative, policy and financial matters. The health regulatory Boards which are housed in the same building are funded by licensing fees, as opposed to general state funds.

REPORT COSTS

Per MS§ 3.197, the Board is required to inform the public of the cost of preparing a report to the Legislature. For this report to the Sunset Commission, the approximate costs were as follows:

Board of Dentistry: $5,500

Health Professional Services Program: $2,000

Total report costs: $7,500

PART I: MINNESOTA BOARD OF DENTISTRY

Table of Contents

Introduction

Minnesota Board of Dentistry

The Board of Dentistry is the independent State agency charged with *protecting the public* regarding dental services provided in the State. The Board's mission is "to ensure that Minnesota citizens receive quality dental care from competent dental health care professionals." The Board accomplishes its mission through services that include: establishing the educational and examination and other qualification standards for **initial licensure** as dentists, dental hygienists, dental therapists, and dental assistants; determining requirements for **license renewal**, such as professional development (continuing education); accepting, investigating, and **resolving complaints** regarding licensed dental professionals; tracking **compliance** of those licensees who are under corrective or disciplinary action of the Board; registering **professional firms**; disseminating **public information**; and engaging in **policy initiatives** to ensure that related statutes and rules that protect the public through regulating dental professions remain relevant.

Major activities recently engaged in by the Board of Dentistry have included:

- operationalizing the recommendations from its strategic plan, the framework for providing improved services to the public and to licensees
- maintaining a comprehensive web site that provides on-demand public information. The web site (www.dentalboard.state.mn.us) now offers on-line renewals, license verification, address changes, and other interactive features
- contracting to develop and administer both the Jurisprudence Exam and the State Dental Assisting Licensure Exam in secure testing facilities
- establishing program requirements for instruction and developing clinical examinations for Dental Therapists and Advanced Dental Therapists, the *first* such mid-level dental providers in the country
- ensuring access to dental health services for all Minnesota citizens remains an issue that the Board is exploring ways to address. The Board has been working with many government organizations, community groups and professional associations to address access from a regulatory perspective.

Executive Summary

Core functions of the Board are established to protect the public by ensuring that dental professionals comply with the Board's rules and practice in a professional, legal, and ethical manner. The Board's core functions are:

- Establishing minimum standards for initial licensure (education, testing, etc)
- Ensuring that those who are awarded a professional dental credential by the Board continue to meet established standards throughout their careers
- Identifying those who fail to maintain the minimum standards necessary to render quality care safely to patients
- Responding to complaints and taking timely and appropriate disciplinary or corrective actions when warranted
- Providing accurate and current information to the public to enable them to make informed decisions about their dental health care

The Board of Dentistry's mission is "to ensure that Minnesota citizens receive quality dental care from competent dental health care professionals." The Board accomplishes its mission through services that include:

- establishing the educational and examination and other qualification standards for **initial licensure** as dentists, dental hygienists, dental therapists, and dental assistants;
- determining requirements for **license renewal**, such as professional development (continuing education);
- accepting, investigating, and **resolving complaints** regarding licensed dental professionals;
- tracking **compliance** of those licensees who are under corrective or disciplinary action of the Board;
- registering **professional firms**;
- disseminating **public information**; and
- engaging in **policy initiatives** to ensure that related statutes and rules that protect the public through regulating dental professions remain relevant.

The Minnesota Board of Dentistry regulates 16,715 licensees with 10 staff members at an annual budget (FY12, direct and indirect) of $1,571,051. This calculates to the following measures:

1,672 licensees per staff member (national average: 1,448/staff)

$ 93.99 per licensee per year (national average: $140.01/licensee)

☑ As indicated, the *Minnesota* Board of Dentistry functions with fewer staff proportionate to the number of dental professionals regulated, and at a lower cost per licensee, than most other states.

Minnesota Board of Dentistry Annual At-A-Glance

Licensing

- Nearly 17,000 dental professionals licensed
- 3,988 Dentists
- 0 Dental Therapists (first licenses issued Aug 2011)
- 5,179 Dental Hygienists
- 7,098 Licensed Dental Assistants
- 25 Guest Licenses (dentists, hygienists, assistants)
- 28 Limited or Full Faculty licenses
- 63 Resident Licenses
- 888 Professional Firms Registered

Professional Development/Continuing Education

- 85% of Portfolios Passed Audit

Complaints & Discipline

- Investigate ~250 complaints against regulated dental professionals annually
- Resolved 33 complaints through corrective action
- Resolved 16 complaints through disciplinary action
- Supported monitoring of dental professionals in Health Professional Services Program (avg 12/mo)

(annual data as of 6/30/10)

Funding

- Board generates its own revenue through fees
- Funds are managed through the Special Revenue Fund (***no*** General Fund dollars are appropriated to the Board of Dentistry)
- Annual Budget: $1,571,051 (direct & indirect)

Staffing

a. Stable over recent years at ~ 10.0 FTE

Advisory Councils

b. Board participates as member of Council of Health Boards, on HPSP Program Committee, Access Commission(s), Central Regional Dental Testing Service, etc.

c. Board does not utilize Advisory Committees; rather, the Board utilizes active Committees of the Board that are function-specific, which the public and professional associations are invited to attend and provide input to

On-Line Services

1. Robust, interactive website, featuring on-line license renewals and license verification

The Minnesota Board of Dentistry has a long history of protecting the public through regulation of dental professionals. As an independent state agency, the Board has been able to focus on innovation and relevance that is specific to the unique qualities and nature of dental care delivery. For those areas of business operations where the Board, as a small agency, cannot justify having dedicated staff (purchasing, payroll, budget, contracts/human resources, information technology, etc.) we have joined in partnership with the other health regulatory Boards to form, manage and fund the Administrative Services Unit (ASU). In doing so, the Board has demonstrated its effectiveness, efficiency, and responsiveness to our primary stakeholder, the people of Minnesota.

Section I. Key Functions, Powers, Duties, Mission

History

The Minnesota Board of Dentistry was established in 1883 to protect the public based on a mission "to ensure that Minnesota citizens receive quality dental care from competent dental health professionals." Originally, the dental profession approached the State to seek title protection so as to ensure that only qualified individuals could hang up a shingle and call themselves 'dentists.' The State recognized the inherent public good in regulating the dental professions, and the Board has worked diligently to protect the public ever since, and currently regulates close to 17,000 dental professionals.

The Board Achieves its Mission by…

1. Carrying out activities authorized by Minnesota statues and rules
2. Ensuring that educational standards for prospective licensees are met and continuing education for licensees are maintained.
3. Licensing qualified individuals so that Minnesotans seeking to use their services will be able to identify those working in the field with skills necessary to provide services in compliance with Minnesota Statutes and Rules.
    a. Public health and safety considerations lead to the conclusion that health care professionals should be required to demonstrate minimum educational achievement and minimum clinical expertise. Further, once a license is issued limitations can be placed on the licensed individuals, as necessary, who provide inappropriate care.
4. Renewing dental, dental therapy, dental hygiene, and dental assisting licenses.
    a. Periodic renewal of licenses is necessary to provide the agency an opportunity to assure that licensees have complied with continuing education requirements, that events have not occurred that could affect the licensee's fitness to practice, and to make sure that holders of special certifications (e.g., anesthesia) remain qualified.
5. Investigating all complaints received.
    a. Every jurisdictional complaint is potentially a situation in which the safety of a patient has been compromised or puts patients at risk of harm.
6. Implementing disciplinary and compliance actions when licensees do not perform in compliance with standards.
7. Monitoring compliance of disciplined licensees with their respective board actions.
8. Formulating and advising on policy relevant to the needs of the public
9. Educating the public on health-related professions, practitioners, and standards.
10. Disseminating information regarding dental practice regulations and Minnesota licensees to the public and to dentists, dental therapists, dental hygienists and licensed dental assistants
11. Operating an agency that utilizes human and fiscal resources efficiently and effectively

Practice Act

Minnesota Statutes §214 affirm the public need for the health professions regulatory Boards. Based upon that enabling statute, the Minnesota Board of Dentistry was established under MS §150A. MS §214.01, subd 1 states that "the legislature finds that the interests of the people of the state are served by the regulation of certain occupations." The chapter further delineates criteria for regulation in Subdivision 2, including that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of the state. In evaluating whether an occupation shall be regulated, statutes establish that the following factors shall be considered:

(1) whether the unregulated practice of an occupation may harm or endanger the health, safety and welfare of citizens of the state and whether the potential for harm is recognizable and not remote;

(2) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;

(3) whether the citizens of this state are or may be effectively protected by other means; and

(4) whether the overall cost effectiveness and economic impact would be positive for citizens of the state.

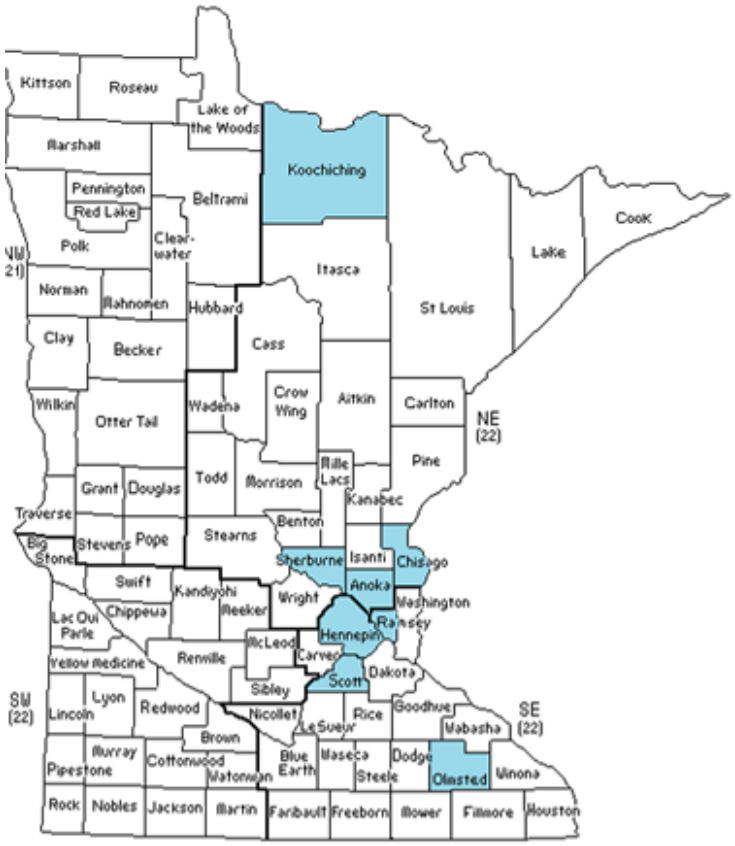
Minnesota Statues §§214 and 150A.02 authorize the Minnesota Board of Dentistry (BOD). The statutes provide for the composition, governance, and powers of the Board. The scopes of practice, credentialing and licensure, requirements of examination, grounds for discipline, listing of duties, etc. for the dental professions are further defined in Chapter 3100 of the Minnesota Rules. Various state laws govern the Board, including Chapter 214, the Administrative Procedures Act (Chapter 14), and the Minnesota Government Data Practices Act (Chapter 13).

Board Members

- **Legal Authority [MS §§150A.02 and 150A.03]**

- **Composition**

  The Minnesota Board of Dentistry is comprised of 9 members, 5 of whom are dentists, 1 dental hygienist, 1 dental assistant, and 2 public members. Current Board members include the following appointees (term ending):



DENTIST BOARD MEMBERS:

Neal Benjamin, DDS (2013)
Lino Lakes, MN

David A. Linde, DDS (2012)
Prior Lake, MN

Candace A. Mensing, DDS
Rochester, MN

Joan A. Sheppard, DDS (2015)
Bloomington, MN

Paul O Walker, DDS (2015)
Shoreview, MN

DENTAL HYGIENE BOARD MEMBER:

Nancy Kearn, DH (2013)
Wyoming, MN

DENTAL ASSISTANT BOARD MEMBER:

Teri M. Youngdahl, LDA (2014)
Elk River, MN

PUBLIC BOARD MEMBERS:

John M (Jake) Manahan, JD (2015)
Bloomington, MN

Allen Rasmussen (2012)
International Falls, MN

- **Appointment and Term**

  Board members are appointed by the Governor to staggered 4-year terms, and are eligible for reappointment to one additional consecutive term. The year of the end of term for each of the current Board members is shown in parentheses above.

Role and Responsibility

- Board members are entrusted with oversight of the Board through establishing the general direction for the Board and hiring and supervising the Board's Executive Director, who acts as the Chief Executive Officer of the agency responsible for Board operations. The Board elects officers, staffs committees, and provides fiduciary oversight for the agency.
- Board members are appointed to their positions based on the expertise that they have demonstrated in their professions, yet *all* Board members hold the responsibility to represent and protect the *public* interest.
- Roles and responsibilities of Board members and the Executive Director are outlined in the Board's Internal Operating Policies and Procedures (IOPP), which is reviewed and revised annually and posted on the Board's website. Those responsibilities include:
- Adopting and enforcing rules for licensure of dentists, dental therapists, dental hygienists, and licensed dental assistants and for regulation of their professional conduct. *Public protection guides rulemaking.*
- Adopting rules establishing standards and methods of determining whether applicants and licensees are qualified. The rules provide for examinations, standards for professional conduct, and requirements for professional development.
- Issuing licenses to qualified individuals.
- Establishing and implementing procedures, including a standard disciplinary process, to ensure that individuals licensed as dentists, dental therapists, hygienists and dental assistants will comply with the Board's laws and rules.
- Enabling consumers to file complaints against licensees.
- Periodically reviewing the Practice Act to ensure its relevance.
- Establishing fees so that the total fees collected by the Board will equal anticipated expenditures, as closely as possible.

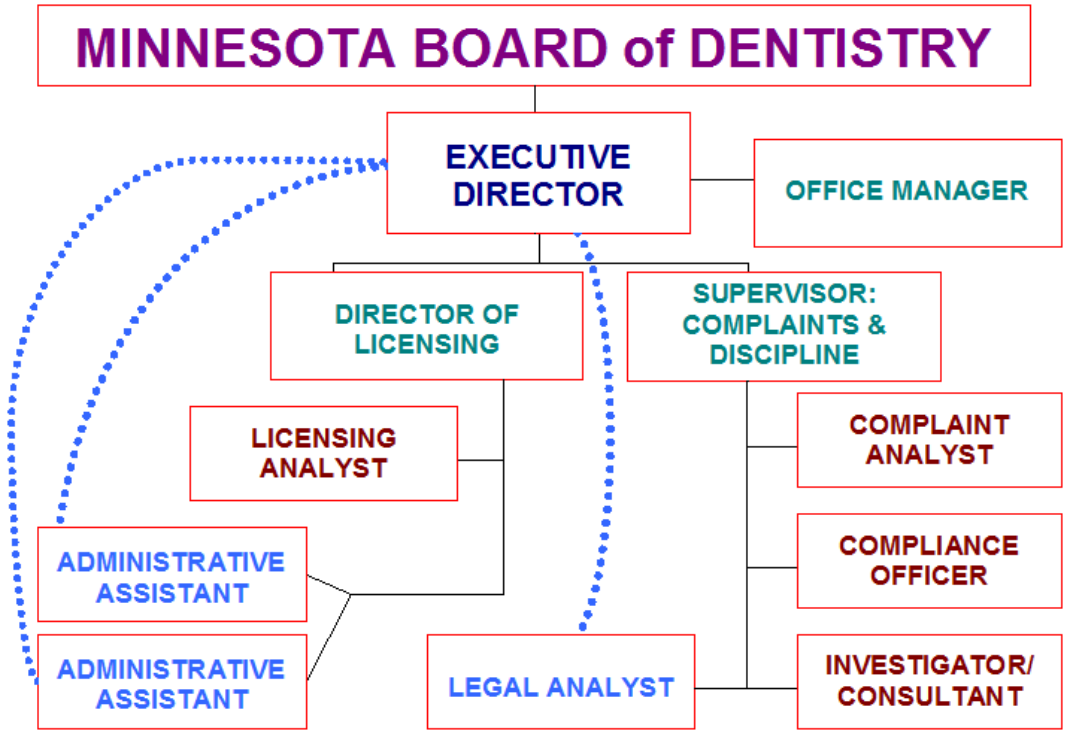
Reimbursement (per diem and expenses)

Board members of the Minnesota Board of Dentistry are eligible to receive per diem payments of $55/day when engaged in Board activities, in addition to reimbursement for travel expenses. For Fiscal Year 2011, those costs were approximately $41,835, or 4.08% of the Board's direct operating budget.

Key Functions

The major function of the Board is to protect the public. Board members articulate the mission and sustain the vision of the Board. To accomplish these functions, the Board creates policy to establish education and testing requirements for the dental professions, examines and licenses duly qualified applicants, ensures continued competence of the regulated dental professionals by establishing Professional Development requirements, and enforces the laws and rules of dental practice.

The Board meets 4-5 times per year as full group in open, public session. Throughout the balance of the year, the Board conducts its business utilizing extremely active Committees and its daily operations through a highly dedicated and professional staff. The following organizational chart depicts the reporting structure for the Board of Dentistry staff.



Board Staff

The positions indicated in the Organizational Chart are ably filled by:

- Marshall Shragg, MPH (Executive Director)
- Sheryl Herrick (Office Manager)
- Joyce Nelson, LDA/CDA (Director of Licensing)
- Mary Liesch, DH (Complaints & Compliance Supervisor)
- Amy Johnson (Licensing Analyst)
- Judith Bonnell, LDA/CDA (Complaint Analyst)
- Deborah Endly, DH (Compliance Officer)
- Kathy T Johnson, LDA (Legal Analyst)
- Paul Kukla, DDS (Consulting Dentist)
- Linda A Johnson (Administrative Assistant)
- Cynthia Thompson (Administrative Assistant)

Committees

The Minnesota Board of Dentistry conducts its business through many topic-related meetings of standing Committees of the Board, which are typically open to the public. Recommendations of the individual Committees are forwarded to the full Board for final approval. Active Committee include the following:

- Executive Committee (elected officers)
- Complaint Committee (x 2)
- Licensure & Credentials Committee
- Policy Committee
- Professional Development (CE) Committee
- Allied Dental Education Committee
- Sedation Committee
- Jurisprudence Committee
- Dental Assistant Education Committee
- Clinical Licensure Exam Committee
- Dental Therapy Program Committee

Open Meetings/Open Access

Public input is sought at nearly all Committee meetings of the Board, with the exception of the Complaint Committees and the Licensure & Credentials Committee, which must be conducted in closed session due to the nature of the issues that they address with regard to individual licensees or applicants.

Rulemaking, which is addressed with some regularity, is also a process that involves significant public input, through discussion at the Board's Committees as well as through the established process of legislative, gubernatorial, and administrative law judge review. The Board maintains a list of those individuals interested in being informed about the rulemaking process, and published information regarding proposed rules in the State Register and on its website.

Representation

The Board also appoints liaisons to active roles with various programs and organizations, and establishes Task Forces including:

- Health Professionals Services Program (HPSP) Program Committee
- Central Regional Dental Testing Service (CRDTS) liaison
- CRDTS Examination Review Committee (Dental and Dental Hygiene)
- National Dental Examining Board (NDEB) of Canada
- NDEB Test Item Selection Committee
- Council of Health Boards
- American Association of Dental Boards (AADB)
- Commission on Dental Accreditation (CODA) Program Site Visits
- Advertising Task Force
- American Association of Dental Administrators (AADA)

Registration of Professional Firms

In addition to regulating dental professionals, statutes require that the Board also register professional dental corporations. Minnesota Statute §319B mandates that a professional firm— which includes corporations, limited liability companies and limited liability partnerships— may not furnish professional services until the firm files with its respective Board. Once registered the firm must file annually with the respective Board.

The Board informs the Minnesota Department of Health (MDH) when a new firm registers with the Board and sends forms from the MDH with our confirmation letter regarding a dental practice's responsibilities when utilizing ionizing radiation producing equipment.

Each year the Board of Dentistry renews the registration for approximately 900 firms. The annual renewal fee is $25 per firm.

Outreach

The Minnesota Board of Dentistry is committed to outreach efforts to educate licensees about regulations affecting their practice(s), as well as to increasing public awareness. Board and staff members are regularly invited to make presentations to educational institutions, professional study groups, professional associations, and other groups throughout the state (and nationally). The Board also utilizes an extremely robust and interactive website to communicate important information to the dental professions and the public. The Board of Dentistry publishes an on-line newsletter, and sends out e-mail alerts to licensees to inform them of significant changes, The Board has been exploring the use of social media to provide another way to disseminate information.

Examinations

Dentistry, more so than other professions, relies on clinical examinations to demonstrate competence as a prerequisite to licensure. As such, Board members and staff are heavily involved with the regional clinical process and oversight. In addition to the clinical exams for dentists, dental therapists, and dental hygienists, the Board is actively engaged in advising the National Dental Examining Board (NDEB) of Canada on their written and OSCE exams.

Dental Assistants are now required to pass the Dental Assisting National Board (DANB) certification examination to qualify for licensure in Minnesota. The Board of Dentistry also works with an outside vendor to develop and administer the Dental Assistant Licensure Exam and the Board's Jurisprudence exam electronically at secure testing sites.

Section II. Operations — Collaboration and Effectiveness

Cooperative Efforts of the Minnesota Health-Related Licensing Boards

This Board, although an independent state agency, acts in a collaborative manner with the Health Related Licensing Boards to maximize efficiencies and effectiveness.

Individually and as a group, the Minnesota Health-related Licensing Boards (HLBs) protect the public by:

a. Enforcing standards of safe practice and ethical conduct
b. Investigating and resolving complaints against licensed health professionals
c. Providing public information to consumers of health care services, and
d. Assuring an ethical and competent healthcare workforce

Cooperative Activities for the Biennium ending June 30, 2010

- *Executive Director's Forum*
  The Executive Directors (ED) Forum consists of the Executive Directors of each independent Board. The Forum meets at least once a month to discuss issues and concerns affecting all Boards, and is governed by standard set of Bylaws. The Forum was created with a goal of working together on matters of common concern, thus increasing the efficiency and effectiveness of each individual Board. The Forum establishes committees to develop recommendations for consideration by the Forum at their monthly meetings. These committees include the Policy Committee and the Management Committee. The primary objective of public safety is achieved most effectively and efficiently when Board staff is assigned to focus on a specific health profession, in our case, the dental team. To assure fiscal efficiency, Boards review general objectives and promote cooperation among the Boards through the Executive Director's Forum in an effort to eliminate duplication of similar effort. The Forum reviews general objectives, reviews policy, promotes intra-Board cooperation, assures fiscal efficiency, and eliminates duplication of similar effort.

- *Council of Health Boards*
  The health-related licensing Boards may establish a *Council of Health Boards* consisting of representatives of the health-related licensing Boards and the Emergency Medical Services Regulatory Board. When reviewing legislation or legislative proposals relating to the regulation of health occupations, the council shall include the commissioner of health or a designee. [M.S. §214.001, Subd. 4]

  During the recent biennial session, legislative requests were made to the Council to review proposed legislation— and the Council responded by sending the Legislature reports— regarding the following emerging professions and issues:
  - Body Artists
  - Laboratory Technicians
  - Massage Therapists
  - Genetic Counselors
  - Review of Criminal Sexual Conduct as consideration in denial or revocation of professional license
  - Review of Minnesota Chapter 214 for process improvement

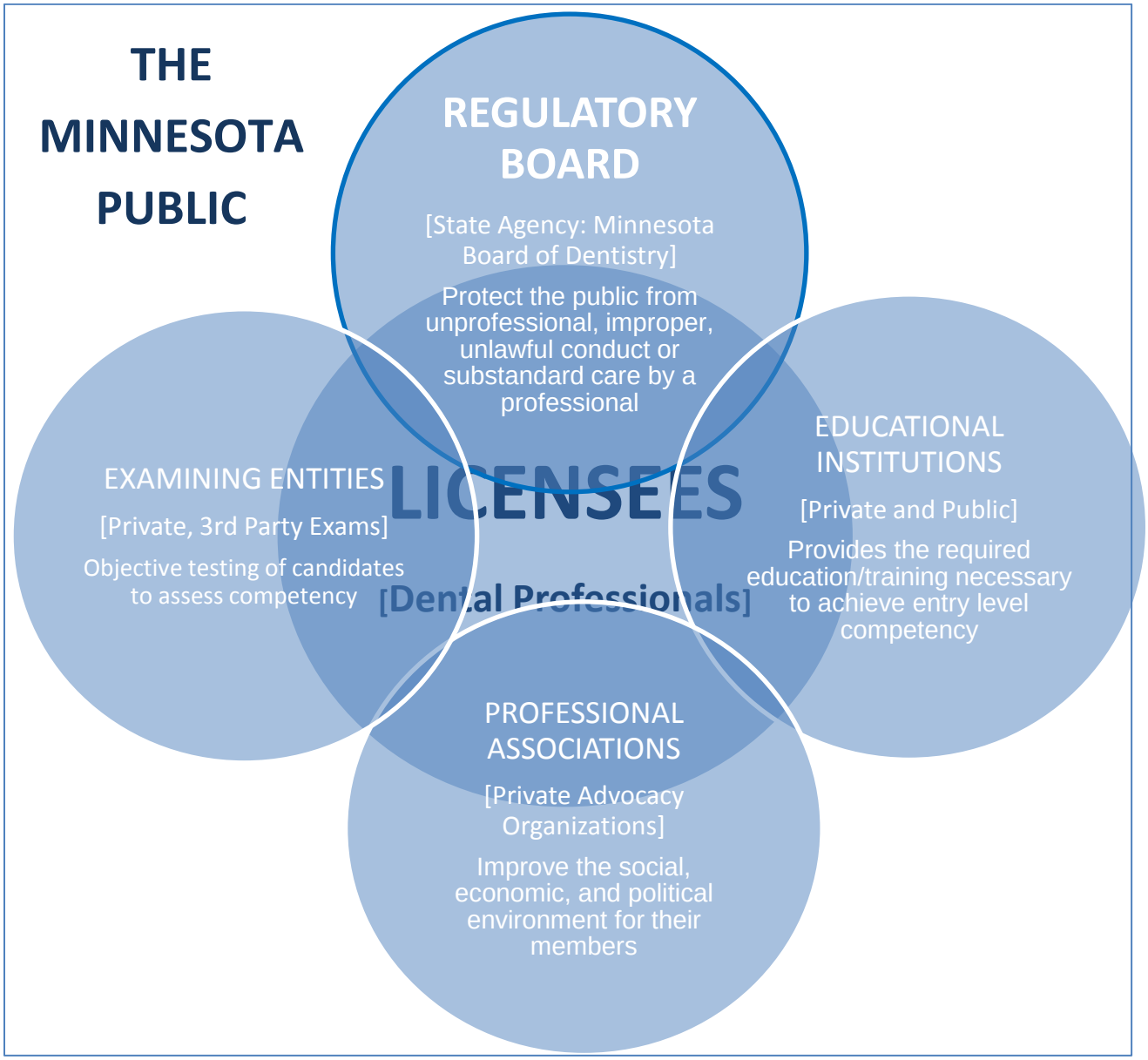
- *Health Professionals Services Program (HPSP)*
  Each health-related licensing board, including the emergency medical services regulatory board under chapter 144E, shall either conduct a health professionals services program under sections 214.31 to 214.37 or contract for a diversion program under section 214.28.

  At present, all Health Licensing Boards, the Emergency Medical Services Regulatory Board, and additional professions regulated by the Department of Health, participate in HPSP.

  The Board of Dentistry acts as the Administering Board for this program, which is addressed in great detail in PART II of this report.

- *Voluntary Health Care Provider Program*
  Effective July 1, 2002 Minnesota Statutes, section 214.40 required the Administrative Services Unit to create procedures to allow volunteer dentists, dental hygienists, physicians, physician assistants, and nurses to apply for medical professional liability insurance while volunteering at community charitable organizations. This program is financially supported by the three Boards involved (Medical Practice, Nursing, and Dentistry) through the fees of all other licensees.

Organizational Relationships

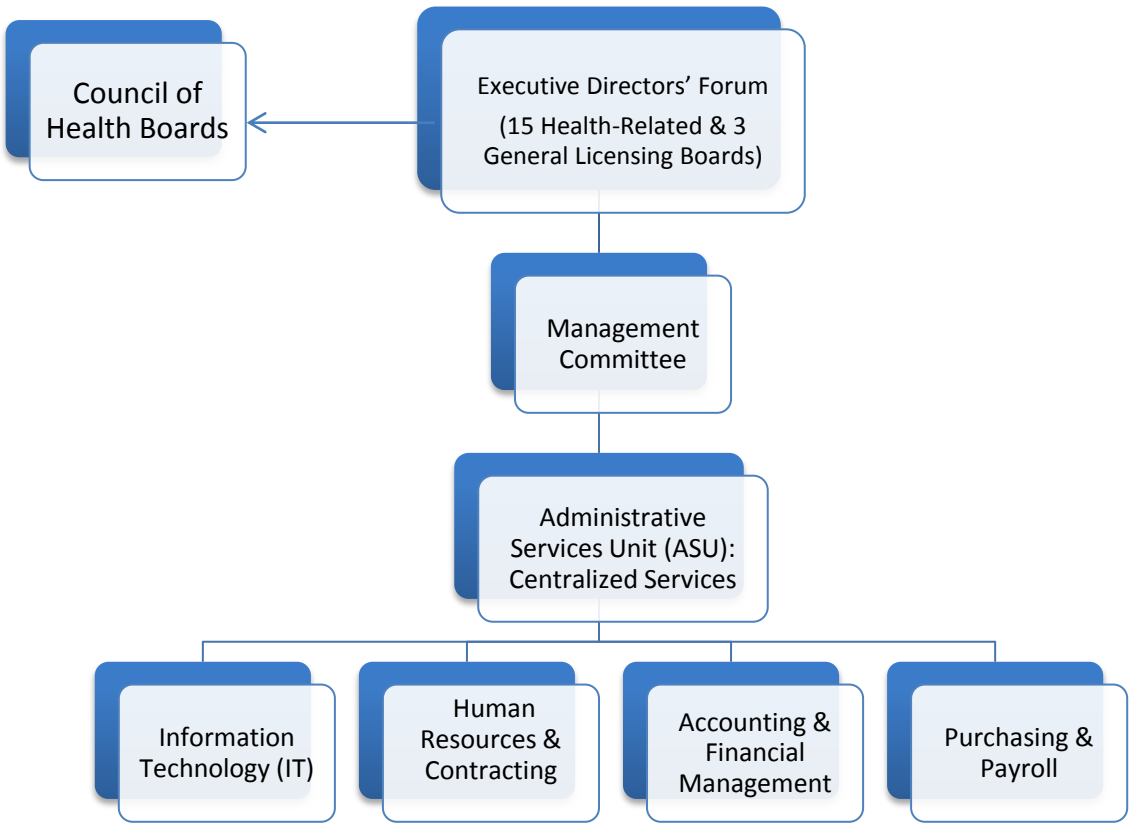


Each Board—comprised of governor appointed members— oversees the regulation of health-related professions in Minnesota. These Board members, who work in the Minnesota community outside of state government in addition to their role on these Boards, put in extra hours to offer public and professional expertise to Minnesota state government.

In collaboration with each Board's staff, these individuals work with other stakeholders and are entrusted with the protection of public health and safety through licensing of health-related professionals, and through resolution of complaints regarding health-related practitioners.

Administrative Services Unit

The Administrative Services Unit (ASU), established under M.S. §214.07, is funded by all the independent Health Regulatory Boards and consists of 7.12 FTE staff members who perform *shared* administrative and business services for *all* of the Boards. ASU provides shared service to the Boards in the areas of finance, budgeting, accounting, purchasing, reporting, banking, human resources, professional and technical contracts, information technology, policy development and payroll (as outlined below). ASU also facilitates the Boards' cooperative policy and planning efforts, and coordinates the Voluntary Health Care Provider Program (which provides malpractice coverage for physicians, physician assistants, dentists, dental hygienists, and nurses serving in a voluntary capacity at a charitable organization). ASU's annual budget is determined by the Executive Directors Forum, and the oversight of ASU is assigned on a rotating basis to one of the health-related Boards: the current ASU oversight Board is the Minnesota Board of Examiners for Nursing Home Administrators. ASU is managed collaboratively through the Executive Directors Forum's Management Committee.



Information Technology Workgroup

Under the auspices of the Executive Director's Forum, an Information Technology Work group has been in operation for several years, and this group is responsible for coordination of HLB technological projects and implementation of technological improvements. The Health Related Licensing Boards have developed cooperative IT capabilities, as shown in the table below. This collaborative structure will now become part of the state's IT enterprise through the Office of Enterprise Technology.

Certified and Diversified IT Administrators	Award Winning Security Model	Advanced Hardware Standards
• Collaborative financial resources to achieve a combination of developers, data base experts, and security credentialed staff members, including two Certified Information Systems Security Professionals (CISSIP) IT Administrators.	• HLBs received National Association of State Chief Information Officers (NASCIO) award for its Continuity of Operations Plan (COOP) • HLBs received national awards for work performed in IT security and emergency preparedness • Minnesota Board of Medical Practice received the Minnesota Government Recognition Award • Enforced strict passphrase policy across HLB since 2006 which exceeds industry standards	• Advanced technology infrastructure that integrates storage area network (SAN) devices to centralized secure data storage • Segmented internal network traffic and utilization of an active industry-leading firewall • Advanced technology typically utilized in larger agencies including: server virtualization and clustering, automated computer patching/updating, and vulnerability scanning • VMware clusters enable HLBs to manage server hardware with no downtime

Online Services

The Board supports electronic technology to meet the efficient licensing processes for Minnesota Licensees. Currently the Board is capable of electronic renewal of licensees, a fully searchable web site, online license verification, online registration of Dental Hygiene collaborative agreements, access to Professional Development self-assessments, online address changes for licensees, and e-mail notification of licensees regarding key general or targeted information. The Board of Dentistry first implemented online Electronic Government Services in 2004 with a steady growth of licensees using the service for renewals, to where online renewals have increased to 82% of all renewals in 2011. The transition to online renewals has had numerous positive results, including reduced staff and mailing costs (postcards used rather than stuffed envelopes; data entry reduced and reconciliation streamlined). Additionally, the public has been provided access to online license verification, enabling anyone to determine at any time whether a person is or has been licensed in Minnesota as a dental professional, and whether they hold any certifications or have ever had action taken against their license. From May to mid-November 2011, 12,992 "hits" were recorded on the Board's website for online license verifications (averaging 2,362/month). The Board is frequently complimented on its advanced technology to provide an interactive user-friendly website for public assess.

The following table depicts some of the online services available through the shared IT services established by the HLBs.

Applicants	Licensees	Public
• Applications for licensure • Submission of documents • Download of national examination scores • Application review • Examination site authorization • Permit for practice • Examination retake authorizations • Application status	• Downloadable forms and applications • Online applications and license renewal • Continued competency (CE) tracking • Address changes • Secure credit card transactions • License verifications for other jurisdictions • Notification of license renewal • E-newsletters • E-mail updates regarding practice standard updates	• Public orders and compliance history • Board disciplinary and adverse action reports • License verification • Data requests • Automated license verification for large employers • "Locate a Doctor" • Automated licensure data with other state agencies • Customized data requests

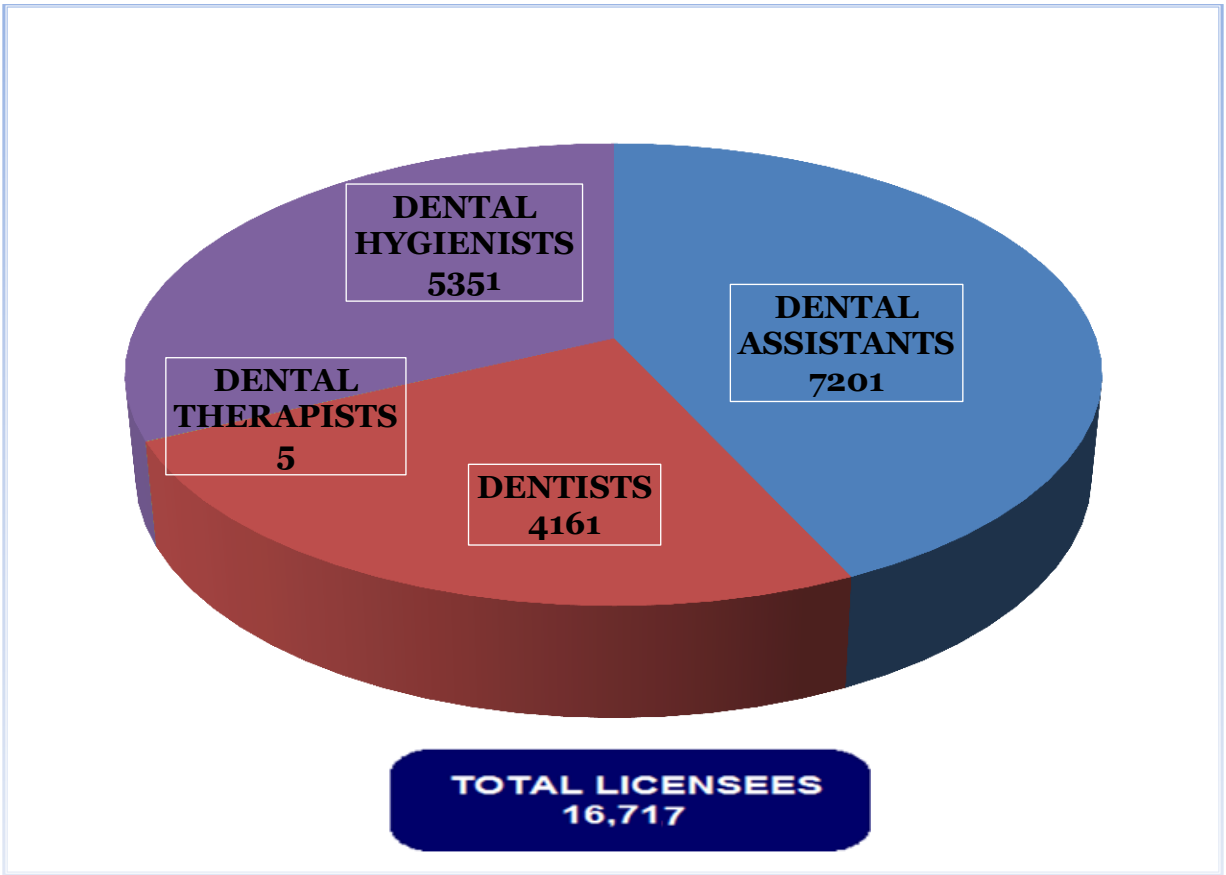
The sharing of IT services through the Administrative Services Unit has enabled the Minnesota Board of Dentistry to automate many of its functions. Among the most notable improvements have been online renewal functions, a transition away from paper to computer-based meetings, and support of communication systems.

Licensure

The Board licenses and regulates close to 17,000 individuals to ensure their competence to practice dentistry, dental therapy, dental hygiene and dental assisting services. The Board also develops and implements rules and regulations to ensure that licensees engage in safe practices. All U.S. jurisdictions require that an individual obtain a license in order to legally practice dentistry. The Board of Dentistry is the state agency responsible for these functions in Minnesota.

The following tables provide an overview of some of the key measures that describe the types and numbers for dental licensure in Minnesota.

Dental Professions Regulated in Minnesota (November 2011)



PERCENTAGE OF LICENSEES BY PROFESSION (2011)

DENTISTS	**24.9%**
DENTAL THERAPISTS	**0.03%**
DENTAL HYGIENISTS	**32.0%**
DENTAL ASSISTANTS	**43.1%**

Applications Received (Board of Dentistry)

The Board receives the following types of applications pertaining to licensure:

Initial licensure by exam applications: (dentist, dental therapists, dental hygienists, dental assistants, Specialists, Faculty, Residents, Limited General Licenses, Guest Licenses). These types of applications address the needs of newly graduating dental professionals and those who are entering into an advanced educational program, where they will be performing duties with limited supervision.

Credential applications: (dentists, dental hygienists), address applicants who hold state licensure elsewhere and have not taken a clinical exam to determine competency in the previous five years. Candidates for licensure by credentials also may have initially taken exams that the Minnesota Board does not recognize.

Reinstatement applications: (dentists, dental therapist, dental hygienists, dental assistants) address dental professionals who have either voluntarily or administratively terminated their licenses. The requirements for reinstatement vary dependent on the number of years the individual has been out of clinical practice.

Renewal applications: (all license types), which is required biennially (staggered by birth month/birth year) for a majority of license types. Typically, the Board renews between 600-800 licenses monthly. There are license types that require annual renewal (i.e., residents [every June 30th], and guest licenses [December 31st]).

Nitrous Oxide Administration applications: (dentists, dental therapists, dental hygienists, dental assistants) certification which is granted initially and does not require renewal.

Moderate/Deep Sedation applications: (dentists) certification which is granted initially and requires renewal at time of license renewal.

Restorative Function applications: (dental hygienists, dental assistants) certification which is granted at some point upon completion of additional approved training and does not require renewal.


Minnesota Board of Dentistry

No. 51

To All to Whom these Presents shall come, Greeting

Be it Known that

having complied with all the requirements of the laws of the State of Minnesota was

Licensed as a General Dentist

in the State of Minnesota on the 5th day of July, 1974 subject in all respects to the provisions of the laws of said State then and thereafter.

In Witness Whereof, We, the President, Secretary and Members of the Board of Dentistry of the State of Minnesota have hereunto respectively set our hands and caused the seal of said Board to be affixed.

Newly Licensed and Newly Credentialed Licensees for Minnesota (1-year totals: 2010)

Licenses Issued (2010)	
License Type	**# Licensed**
Dental Assistant Application	239
Dental Assistant Reinstatement Application	32
Dental Hygiene By Exam Application	249
Dental Hygiene Reinstatement Application	7
Dentist By Exam Application	119
Dentist By Foreign Trained Application	4
Dentist Reinstatement Application	6
Full Faculty Dentist Application	3
Guest Dentist Application	1
Resident Dentist Application	27
Specialty Dentist Application	3
Total INITIAL Licenses	**690**
Dental Hygiene By Credential Application	7
Dentist By Credential Application	12
Total CREDENTIAL Licenses	**19**
Total Licensed 2010	**709**

Licenses and Certifications Granted

There are nearly 700 initial applications received annually by the Board of Dentistry, of which the majority are administratively reviewed and processed by staff. Of those that have disclosed prior criminal convictions, staff works with the Licensing and Credentials Committee and the AGO to determine appropriateness of licensure. There are approximately 20 applications for License by Credential received and processed annually. Those dentists and dental hygienists who hold licensure in another state and whose exams where passed at least five years or more, prior to making application to the Board, will go through an oral interview process and case presentation (for dentists) with the Board's Licensure and Credentials Committee and staff. There are approximately 700 applications for certification to administer Nitrous Oxide received and processed annually. These are approved by staff, based on meeting the academic criteria outlined in rule, and providing proof of appropriate Healthcare Provider CPR certification. There are approximately 30 applications for Moderate/Deep Sedation certification received and processed annually. The Board staff works in conjunction with the Sedation Committee to evaluate program criteria as established in Rule and determine whether the applicant qualifies. There are approximately 64 applications (48 Dental Hygienists; 16 Dental Assistants) for Restorative Function certification processed annually by the Board.

a. Applications Denied or Withdrawn

The Board of Dentistry has the statutory authority to deny any applicant a license to practice. If concerns are raised as to competency or minimal knowledge in areas of patient and public safety, the Committee would provide the applicant with notice of denial. The applicant would be allowed due process, if they wish to appeal. The appeal would be heard by an Administrative Law Judge, who would advise the Board as to the appropriateness of its proposed action. Once the process is complete, if the Board acts to deny an application for licensure, it would be reported to the National Practitioner Data Bank. Denial of applications is a rare occurrence.

b. Licenses Issued Under Board Order

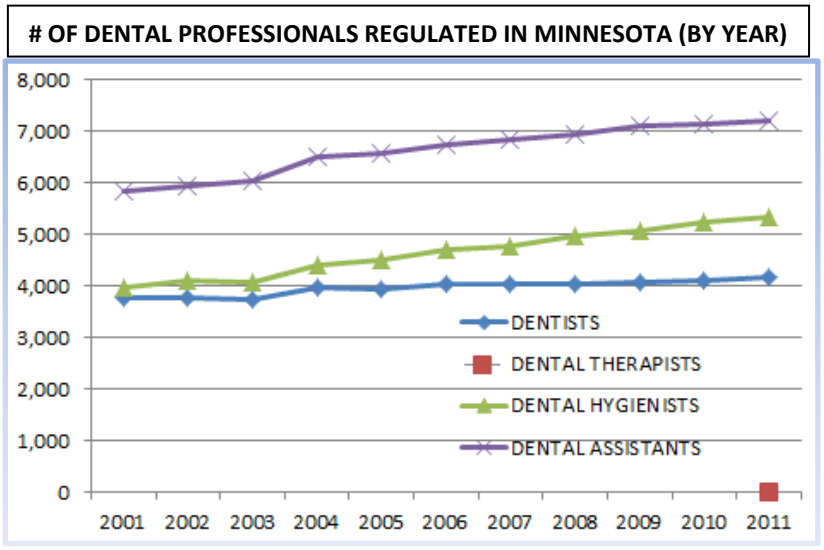
The Board of Dentistry has the statutory authority to issue conditional licensure to any applicant. If there are concerns raised as to competency or minimal knowledge in areas of patient and public safety, the Committee could propose a Stipulation and Order that would grant licensure dependent upon qualifications specific to that applicant. The Committee would conduct a conference with the applicant (and legal counsel, as desired). They are given adequate time to agree to the Order, which would be adopted by the Board at its next public meeting. Licenses issued under order are an infrequent occurrence.

c. Reinstatement of Licenses

When a dental professional's license has lapsed, been terminated, or has otherwise expired, the individual may apply for reinstatement of the license based on criteria laid out in Rule or in their Order. Approximately 40-50 applicants apply for reinstatement of licensure annually (FY11: 31 LDAs, 7 DHs, and 6 DDSs applied).

Number of Credentials Issued

- As of June 30, 2010, a total of 252,724 persons were licensed or registered by all of the Health-Related Licensing Boards. Approximately 7% of the total licensees are regulated by the Minnesota Board of Dentistry. The number of licensees regulated by the Board of Dentistry increases annually.
- A total of 260,158 credentials were issued or renewed during the biennium ending June 30, 2010 by all of the Boards. Approximately 7% of the total credentials are issued by the Minnesota Board of Dentistry.



Section III. Authority for Additional Activities Not Specified in Statute

A. Advisory Council Activity

- The Minnesota Board of Dentistry does not utilize a separate advisory council. The Board members themselves comprise the council, bringing their expertise to the Board. Additionally, nearly all Board and Committee meetings are open to the public and include extensive opportunities for public input.

B. Support to Other Federal/State Agencies

- Exchange of information, including *Data Exchange* in compliance with State law, (i.e., MDH Rural Health, BeReady MN, testing services, DEA, etc.). The Board is permitted to share information with other jurisdictions related to cases being investigated by the Board.

C. Compliance with Federal/State Law

- Examples include license suspension for delinquencies related to taxes, child support, spousal maintenance, student loans, etc.

VOLUNTARY ENTITIES

The following groups have been organized collaboratively by the health regulatory Boards to enhance the value of Board operations through specific shared functions, which otherwise work as independent agencies.

Executive Directors Forum

The Executive Directors of each independent Board meet monthly to collaborate and to address issues of shared concern, including policy development, legislation and technological improvements. The Forum establishes committees to develop recommendations for consideration by the Forum. These committees include the Policy Committee and the Management Committee. To assure fiscal efficiency, Boards review general objectives and promote cooperation among the Boards through the Executive Director Forum in an effort to eliminate duplication of effort and resources.

Some of the ongoing efforts and tasks accomplished through the action of the Executive Directors Forum include:

- Participation in cooperative efforts with the Department of Health and among the Boards to share information regarding licensee investigations in full compliance with Data Practices Act controls. This has included ad hoc Just Culture/Health meetings regarding coordinating Department of Health investigations and Health Board investigations, and exchange of information under § 214.10, subd. 8(c). These efforts include development of a data sharing memo with the AGO that permits joint investigations to be conducted among health licensing boards, and provides for sharing of investigative data.
- Review of requirements and limitations pertaining to criminal background checks of applicants, and shared updates on proposed legislation from law enforcement entities.
- Standardization of online complaint forms throughout health licensing Boards. Review was undertaken, with cooperation and guidance from Attorney General's Office, of methods to provide standard (as appropriate) information to complainants at the time of opening a complaint file, as well as standardization of appeal information in closing letters under the auspices of an ad hoc Chapter 214 Work Group.
- Centralized response to surveys regarding IT capacity, security and functionality.
- Enactment and approval of the Boards' first AWAIR plan, in compliance with federal and state requirements.
- Policy Committee meets regularly to provide coordinated response for Boards regarding legislative initiatives.

- A joint workforce planning report was completed to prepare for ensuring a qualified, competent workforce.
- The ED Forum worked collaboratively in providing information to *MN Responds!* to ensure that credentials of licensed health professionals are quickly available in case of a major emergency, as well as arranging for regular transfer of specific data between Department of Health and health licensing databases.
- Increase and improvement of electronic governmental services, including expanded information and greater interactivity available online.
- Virtualization of servers, resulting in substantial savings and greater storage capacity. On behalf of the Executive Directors Forum, a submission was made to the National Association of State Chief Information Officers (NASCIO) for Disaster Recovery Planning regarding the Health Licensing Boards' project of virtualizing its servers arising from its development and application of its *Continuity of Operations Plan* (COOP).
- Technological advances include addition of a Shared Storage Area Network, tripling storage capacity of the Boards, and advances toward using technology at Board meetings to reduce reliance on paper documents.
- Dramatic increase in efficiency of data security for all of the Boards has resulted from the ED Forum and working together

Individual Board staff and Executive Directors have participated in numerous local, state, regional, national and international organizations regarding health and safety, including:

A. Minnesota Alliance for Patient Safety
B. National Board of Medical Examiners Committee on Irregular Behavior and Score Validity for the United States Medical Licensing Examination.
C. National Association of Boards (NAB) Executive Committee
D. State Executive Forum and State Governance Committees of the National Association of Boards
E. Future Workforce Analysis Cabinet in Washington, D.C.
F. Association of Chiropractic Board Administrators
G. National Council of State Boards of Nursing Commitment to Ongoing Excellence (CORE) project
H. Minnesota Center for Nursing
I. Minnesota Alliance for Patient Safety
J. Home Care Advisory Group
K. Department of Human Services' Dental Access Advisory Committee
L. Department of Human Services task force on licensing standards
M. State Information Security Council
N. HPSP Program Committee
O. Drive to Excellence Licensing Steering Committee
P. Drive To Excellence Procurement
Q. Drive to Excellence Sourcing Communication
R. Drive To Excellence MAPS Project
S. Continuation of Operations Planning (COOP)
T. DHS Oral Health Initiatives
U. MDH and Oral Health Coalition

Marshall Shragg, Executive Director of the Minnesota Board of Dentistry, has served as president and in other leadership positions with the American Association of Dental [Board] Administrators.

Administrative Services Unit

The Administrative Services Unit (ASU) is funded by all the independent boards and consists of 7.12 FTE staff members who perform shared administrative and business services for all the Boards. The unit provides service to the Boards in the areas of budgeting, accounting, purchasing, human resources, professional and technical contracts, information technology, policy development and payroll. ASU also facilitates the Boards' cooperative policy and planning efforts, frequently staffs Executive Directors Forum committees, and coordinates the Voluntary Health Care Provider Program (which provides malpractice coverage for physicians, physician assistants, dentists, dental hygienists, and nurses serving in a voluntary capacity at charitable organizations). ASU's annual budget is determined by the Executive Directors Forum, and the oversight of ASU is assigned on a rotating basis to one of the health-related Boards (the current ASU oversight Board is the Minnesota Board of Examiners for Nursing Home Administrators). An annual assessment of ASU effectiveness is performed by the Executive Directors Forum.

Management Committee

The Management Committee makes recommendations to the Executive Directors Forum on issues relating to the internal management of the Boards' cooperative activities. The responsibilities of the committee include the following:

- Management of the Administrative Services Unit budget and review of ASU performance
- Administration of shared conference rooms and shared equipment, such as copiers, through the Administrative Services Unit
- Coordination of the Boards' computer collaboration efforts
- Review of best practices, including development of recommended policies and procedures for all Boards

Policy Committee

The functions of the policy committee have been to make recommendations to the Executive Directors Forum on issues relating to public policy. The responsibilities of the committee have included the following:

- Review of legislative proposals upon request
- Recommendation for response to legislative initiatives affecting all the Boards
- Initiation of efforts to make investigative data more readily available to share among health Boards
- Consultation on HLB shared public messages

Information Technology Workgroup

Under the auspices of the Executive Directors Forum, an Information Technology Work group has been in operation for several years. This group is responsible for coordination of HLB technological projects and implementation of technological improvements. The Workgroup assists with translation of techno-speak into information that Boards can act on.

Section IV. Authority Related to Fees, Inspections

The Minnesota Board of Dentistry generates revenue primarily from license and application fees, which are deposited into the State's Special Revenue Fund. A small amount of the Board revenues come from cost recovery or the imposition of civil penalties related to disciplinary action. By statute (MS §§ 16A.1285 and 214.06) require that the Board only collect fees that will "as closely as possible equal anticipated expenditures during the fiscal biennium."

The Board receives NO General Fund dollars.

Comparison to other states/jurisdictions

The Minnesota Board of Dentistry provides public protection services to the state at a relatively low cost to licensees as compared to other states. Minnesota provides effective services as efficiently as possible. Measures of efficiency include the number of staff dedicated to providing services necessary for regulating dental professionals, and the average cost per licensee for provision of those services. In both cases, the Minnesota Board of Dentistry measures up well.

The Minnesota Board of Dentistry regulates 16,715 licensees with 10 staff members at an annual budget (FY12, direct and indirect) of $1,571,051. This calculates to the following measures:

1,672 licensees per staff member (national average: 1,448/staff)

$ 93.99 per licensee per year (national average: $140.01/licensee)

☑ As indicated, the *Minnesota* Board of Dentistry functions with fewer staff proportionate to the number of dental professionals regulated, and at a lower cost per licensee, than most other states.

Fees – (fee schedule on following pages)

Fees were *reduced* in 1999, and were recently adjusted to the amount statutorily allowed for FY12. The fee language in MS §150A.091 establishes fees *not to exceed* a certain amount (see table on next page), which permits the Board to adjust fees within a specified range to meet the biennial needs of Board operations. Ultimately, the Board is only permitted to spend the amount appropriated by the legislature each biennial cycle, with any surplus dollars retained as Board reserves to meet unanticipated needs for contested case hearings or other significant matters.

MINNESOTA BOARD OF DENTISTRY: FEE SCHEDULE (2011)

Application Fees/ Initial License Fees*	Current Fee	Statutory Authority
Dentist	$140 + $14 X # of initial months	MS 150A.091, Subd. 2 and 3
Dental Therapist	$100 + $10 X # of initial months	MS 150A.091, Subd. 2 and 3
Dental Hygienist	$55 + $5 X # of initial months	MS 150A.091, Subd. 2 and 3
Licensed Dental Assistant	$55 + $3 X # of initial months	MS 150A.091, Subd. 2 and 3
Limited Dental Assistant	$15 + $1 X # of initial months	MS 150A.091, Subd. 2 and 3
Full Faculty	$140 + $14 X # of initial months	MS 150A.091, Subd. 2 and 3
Limited Faculty	$140	MS 150A.091, Subd. 2 and 3
Resident Dentist	$55	MS 150A.091, Subd. 2 and 3
Resident Dental Therapist	$55	MS 150A.091, Subd. 2 and 3
Resident Dental Hygienist	$55	MS 150A.091, Subd. 2 and 3
Guest Dentist/Hygienist/Assistant	$50	MS 150A.06, Subd. 2c(5)
Limited General License	$140	MS 150A.091, Subd. 9b
Licensure by Credential Fees		
Dentist	$725 + $14 X # of initial months	MS 150A.091, Subd. 9
Hygienist	$175 + $5 X # of initial months	MS 150A.091, Subd. 9
**Initial License fees are based on the months from when the application is approved to the date of their first biennial renewal.*		
Reinstatement Fees		
Dentist	$140	MS 150A.091, Subd. 10
Dental Therapist	$85	MS 150A.091, Subd. 10
Dental Hygienist	$55	MS 150A.091, Subd. 10
Licensed Dental Assistant	$35	MS 150A.091, Subd. 10
Renewal Fees		
Dentist (Biennial)	$336	MS 150A.091, Subd. 5
Dental Therapist	$180	MS 150A.091, Subd. 5
Hygienist (Biennial)	$118	MS 150A.091, Subd. 5
Dental Assistant (Biennial)	$80	MS 150A.091, Subd. 5
Limited Dental Assistant (Biennial)	$24	MS 150A.091, Subd. 5
Full Faculty (Biennial)	$336	MS 150A.091, Subd. 5
Limited Faculty (Annual)	$168	MS 150A.091, Subd. 4
Resident Dentist (Annual)	$59	MS 150A.091, Subd. 4
Resident Provider Dental Therapist (Annual)	$59	MS 150A.091, Subd. 4
Resident Provider Dental Hygienist (Annual)	$59	MS 150A.091, Subd. 4
Guest DDS/DH/LDA (Annual)	$50	MS 150A.06, Subd. 2(b)
Limited General License (Annual)	$155	MS 150A.091, Subd. 9b
Renewal Late Fees		
Dentist	$84.00	MS 150A.091, Subd. 7
Dental Therapist	$45.00	MS 150A.091, Subd. 7
Hygienist	$29.50	MS 150A.091, Subd. 7
Dental Assistant	$20.00	MS 150A.091, Subd. 7
Limited Registration	$ 6.00	MS 150A.091, Subd. 7
Full Faculty	$84.00	MS 150A.091, Subd. 7
Limited Faculty	$42.00	MS 150A.091, Subd. 7
Resident Dentist	$29.50	MS 150A.091, Subd. 6
Resident Provider Dental Therapist	$29.50	MS 150A.091, Subd. 6
Resident Provider Dental Hygienist	$29.50	MS 150A.091, Subd. 6
Limited General License	$77.50	MS 150A.091, Subd. 9b

Corporation Fees		
Initial	$100	MS 319B11, Subd. 3(3)
Renewal (Annual)	$25	MS 319B11, Subd. 4(8b)
Miscellaneous		
Affidavit of License (has seal)	$10	MS 150A.091, Subd. 14
Duplicate License	$35	MS 150A.091, Subd. 8
Duplicate Certificate	$10	MS 150A.091, Subd. 8
License Verification (Fee for paper verification; No fee for on-line verification)	$5	MS 150A.091, Subd. 15
Public Information	$5 for each document. If the document is over 20 pages, 25 cents/page for each additional page over 20.	
NSF Fee	$20	
Credential Review – Nonaccredited dental Institute	$200	MS 150A.091, Subd. 9a
Advanced Dental Therapist Application Fee	$100	MS 156A.091, Subd 2
Anesthesia/Sedation		
Initial Application	$250	MS 150A.091, Subd. 11
Recertification	$500	MS 150A.091, Subd. 11b
Late Fee		MS 150A.091, Subd. 11a
Duplicate certificate	$10	MS 150A.091, Subd. 12

In addition to the fees established in statute, the Board has additional authorities granted to it to facilitate licensee compliance with laws and rules pertaining to the practice of dentistry. The following provisions allow the Board to act in resolving complaints to impose the most appropriate remedy for the specific case before it.

Minnesota Statutes § 150A.08
Subd. 3a. **COSTS; ADDITIONAL PENALTIES**
(a) The board may impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including, but not limited to, fees paid for services provided by the office of administrative hearings, legal and investigative services provided by the office of the attorney general, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(b) In addition to costs and penalties imposed under paragraph (a), the board may also:
(1) order the dentist, dental hygienist, or dental assistant to provide unremunerated service;
(2) censure or reprimand the dentist, dental hygienist, or dental assistant; or
(3) any other action as allowed by law and justified by the facts of the case.

Enforcements: Statutory Authority

As one of the sixteen Minnesota Health Licensing Boards, the Minnesota Board of Dentistry has the authority to investigate any complaint that is jurisdictional pursuant to Minn. Stat. §214.10. A complaint is jurisdictional if it alleges a violation of a statute or rule which the Board is empowered to enforce (which includes Minnesota Statute 150A and Minnesota Rules 3100.0100 – 3100.9600).

The Minnesota Dental Practice Act contains specific grounds for which the Board may take disciplinary or corrective action on a practitioner's credential. The specific grounds for disciplinary action in the Medical Practice Act are found in Minn. Stat. § 150A.08, subd 1.
The specific forms of disciplinary action the Board may take on a license are found in Minn. Stat. §§ 150A.08, subd 3 and 8, and 150A.12. These actions include:

(1) Revoke the license
(2) Suspend the license
(3) Impose limitations or conditions on the license
(4) Impose a civil penalty
(5) Assess cost recovery fees
(6) Order unremunerated community service
(7) Censure or reprimand
(8) Other action as allowed by law and justified by the facts of the case

In any given Board disciplinary action, one or a number of these actions may be imposed so as to make the remedies appropriate for the violations of the particular case. The Board also has the authority to enter into a non-disciplinary Agreement for Corrective Action with a practitioner to remediate identified deficiencies. The authority for the health licensing Boards to utilize Agreements for Corrective Action is found in Minn. Stat. § 214.103, subd. 6 (2).

Disciplinary or corrective action is necessary to protect the public from those practitioners who have demonstrated an inability to meet the standard of care in certain areas of practice or who, because of a physical, mental or chemical impairment, are unsafe to continue in practice without some level of Board intervention.

Other Enforcement related Statutes:

1. Minn. Stat. §. 214.10, subd. 1. Receipt of Complaint; Notice
2. Minn. Stat. § 214.10, subd. 2. Investigation and Hearing
3. Minn. Stat. § 210.10, subd. 3. Discovery; Subpoenas
4. Minn. Stat. § 214.103. Health related licensing Board complaint, investigation and hearing
5. Minn. Sta. § 210.11. Injunctive relief for unauthorized practice or any threatened violation of a Board law or rule
6. Minn. Stat. § 147.091, subd. 1a. Automatic revocation of license for conviction of felony level criminal sexual misconduct
7. Minn. Stat. § 147.091, subd. 2. Automatic suspension of License

Limited Board Authority

The Board has limited authority to enforce the *practice of dentistry without a license* by individuals or entities that are not trained or otherwise regulated for the provision of dental care.

When the Board is presented with a complaint alleging unlicensed practice for which a public health concern may exist, a *Cease and Desist* letter may be sent to the subject of the complaint. Complaints are also forwarded to the county or city attorney offices for criminal prosecution, pursuant to Minn. Stat. §§150A.11 and 150A.12. However, such cases are rarely criminally prosecuted because the jurisdictions lack resources to arrange for investigation and gathering of evidence of unlicensed practice.

The Board may proceed with injunctive remedies only if the information provided to the Board includes evidence of actual harm to the public.

Litigation of Disciplinary Matters (Contested Case Proceedings)

The term "contested case" is defined in Minn. Stat. §14.02, subd. 3 as a "proceeding before an agency in which the legal rights, duties, or privileges of specific parties are required by law or constitutional right to be determined after an agency hearing." A contested case is a type of proceeding in which the Board makes a specific factual, legal or factual and legal determination regarding a specific party. Generally, contested cases will involve one of two situations: (1) The Board denies licensure to an applicant because of a failure to meet qualification requirements or because of some past activity of the applicant, or (2) The Board initiates a disciplinary hearing because of past or current activities engaged in by an individual already licensed by the Board. When a licensee and a Board complaint committee cannot agree on the facts or the disciplinary action to be taken concerning a licensee, a contested case becomes the method of resolving the disputes.

A contested case hearing is a formal proceeding similar to a trial by a judge, without a jury. The hearing is presided over by an administrative law judge (ALJ) appointed by the Office of Administrative Hearings. Each ALJ is an attorney, independent from any state agency other than the Office of Administrative Hearings. In the hearing process, one party is the Board's complaint committee, represented by the Attorney General's Office; the licensee or a license applicant is the other party. Each party has a right to present witnesses and documentary evidence, and to cross-examine any witnesses presented by the other party.

After completion of the hearing, the ALJ issues a report to the Board consisting of findings of fact, conclusions and a recommendation. This report, a transcript of the testimony, all documentary evidence, and the written arguments of the parties are submitted to the Board following the completion of the hearing. The ALJ's report is a recommendation to the Board. The Board is not bound by the report and is, in fact, obliged to make its own determination.

Inspections

The Board does not currently conduct inspections of dental practices on a routine or periodic schedule. Inspections that are done by the Board commonly relate to patient records reviews and infection control matters, usually conducted in concert with a complaint investigation or resulting from a Board action. The Minnesota Department of Health does conduct regular inspections of dental practices utilizing ionizing radiation (x-rays), and reports to the Board when significant violations are noted.

Moderate/Deep sedation certificated dentists, however, *are* required to have periodic facility inspections related to their provision of sedation services. Initially the dentist is required to obtain an on-site inspection within the first twelve months of receiving a sedation certificate, and another on-site inspection within every five years thereafter. The Board's role is to determine that the sedation dentist has the appropriate equipment and processes in place to adequately and safely sedate patients and address adverse reactions. The Board has designated inspectors that conduct these inspections and report any concerns back to the Sedation Committee. Board staff will maintain this information in each individual sedation dentist's profile.

Audits: Professional Development/Continuing Education

The Board conducts audits to determinate compliance of licensed dental professionals with their Professional Development requirements. Professional Development is the Minnesota Board of Dentistry's approach to continuing education, or lifelong learning. The minimum standards have been established to help ensure that dental professionals stay current with evolving science and technology, and therefore remain competent throughout their careers. The majority of the Board's audits are randomly selected. However, in the event of a "failed" audit, the Board is mandated by Rule to conduct an audit at the licensee's next renewal period. Audits can also be designated from the Complaint Committees to determine compliance related to licensees who are being investigated relative to a pending complaint. In the event a licensee has failed their audit, the Board can either grant a grace period for the licensee to make up deficiencies, or initiate disciplinary proceedings. If the licensee is non-complaint or fails to make up their deficiencies by the end of the grace period, the Board has the authority to administratively terminate the license. Recent statutes also allow the Board to impose a penalty for consecutive failed audits.

Examinations

The Board contracts with a third party testing company (Prometric) to administer (1) the State (Dental) Jurisprudence Exam, which tests knowledge of Minnesota's Laws and Rules pertaining to the practice of dentistry, and (2) the State Dental Assisting Licensure Exam. This exam is required for any dental assistant to apply for licensure and tests the applicants' knowledge of specific expanded functions allowed in our State. The applicant is given authority to sit for this exam, based on their completing a Board approved course.

Dental assistants are now required to pass the Dental Assisting National Board (DANB) examination to qualify for licensure in Minnesota. The Board maintains a relationship with DANB through the American Association of Dental Boards, the American Association of Dental (Board) Administrators, and other professional partnerships.

While the Board doesn't administer the dental, dental therapy and dental hygiene clinical exams, it designates licensed dentists and hygienists to serve as examiners with the Central Regional Dental Testing Service (CRDTS), and is involved with CRDTS oversight. Dentists are also required to take a two-part National Board exam to qualify for licensure. Recently, the Minnesota Board of Dentistry has worked closely with the National Dental Examining Board (NDEB) of Canada on test development, which is an examination option for some candidates graduating from the University of Minnesota or accredited Canadian dental schools.

Internationally Educated Dentists

Minnesota, like most other states, is concerned about access to dental services. Many Minnesotans, particularly in rural and underserved areas, do not have access to dental care, and dental industry experts predict a future nationwide shortage of dentists.

In 2001, the Legislature recognized the importance of access to dental health care by addressing such issues as reviewing education of foreign trained dentist to increase the number of available dental providers. As the agency responsible for licensure of dentists in the state, the Dental Board plays a role in addressing Minnesota oral health care needs through its licensing and examination policies. The Board's Licensure and Credentials Committee was delegated the authority to review the education of foreign trained dentists to determine whether it met the established threshold of being *equal to or greater than that of a dental graduate of a CODA-accredited dental program*.

Regulation and Public Protection:

The Board of Dentistry serves to protect the public in many ways through regulation. The Minnesota Board is the only one in the country with legislative language that requires review of credentials of foreign trained dentists to qualify for licensure in Minnesota. The Board is working on proposed rules regarding this process. The statutory language has been in effect since 2001. The Board carries out a thorough process of a comparison of dental courses and credit hours, English proficiency, current work experience, and scores on National Dental Board exams as considerations to determine if a foreign trained dentist has education that is equal to or greater than that of a U.S. dental graduate. This process of reviewing credentials can involve an oral interview and review of patient records. It is because of the Board's thoroughness and commitment to ensuring that the applicant demonstrates minimal competency, that the Beard meets our responsibility to protect the citizens of Minnesota.

The Dental Board also has to consider out of state applications for dental, dental hygiene and dental assisting licensure. The credentials process for dentists and dental hygienists involves a face to face interview and opportunity to ask questions related to patient and public safety. This process again ensures that before granting licensure, the applicant has demonstrated minimal competency and knowledge in areas concerning public/patient safety. For out of state dental assistants seeking Minnesota licensure, the Board also reviews the program curricula to ensure that the education is equivalent to what is provided at Minnesota accredited dental assisting schools. This particular profession has delegated duties that vary from state to state. Minnesota has some of the highest standards in the country with regard to the dental assisting curriculum and scope of practice.

When reviewing applications, besides education and exams, we also require the applicant to answer disclosure questions. These questions are asked to determine if the applicant has been convicted of any past criminal convictions. In the event there has been any previous convictions involving alcohol or controlled substances, we often times will refer the applicant to HPSP to determine whether the individual may have impairment issues that require a monitoring agreement before issuing the license. A drawback to this process is that the information is only forthcoming if the applicant is willing to disclose it on their application as it is contingent on the honor system for self-disclosure. Other convictions will sometimes be referred to our Licensing and Credentials Committee to meet with the applicant. The purpose is to ensure that our Board does not issue licensure to someone who might pose imminent risk of harm to the public. In some cases the Board may issue a conditional license, which is implemented through a disciplinary order. To try and ensure that the Board is privy to information that might impact the issuance of a license, the Board has pursued passage of a bill to require applicants to obtain a criminal background check. In this manner, the Board would be made aware of any conviction for all applicants, not just those who honestly report.

Section V. Regulation and Public Protection

Licensure vs. Registration

Licensure is the most restrictive form of credentialing. Only those individuals who meet the rigorous educational, training and examination requirements set forth in State law may be granted a license to practice dental professions in Minnesota. All jurisdictions in the United States require licensure for an individual to practice dentistry.

In order to protect the health and safety of Minnesota patients, only the most highly qualified individuals should be granted the privilege to practice certain health care professions. Licensure ensures that individuals have met and continue to meet these standards. The unlicensed practice of dentistry is against the law and may be subject to criminal prosecution.

The Board of Dentistry and the legislature have determined that licensure is the appropriate level of credentialing for dentists, dental therapists, and dental hygienists. Recent legislation (2009) changed the regulatory credential for dental assistants from *registration* to *licensure*, recognizing the significance of the requirements, responsibility, and risk that all dental professionals are involved with.

The Minnesota Board of Dentistry has regulated dental assistants since 1977, long before many other states recognized the importance of doing so. More states continue to move in the direction of regulation, and are determining that licensure is the appropriate level of credentialing by the state Boards.

While all the states provide for the credentialing of dental professionals, there are differences among the states as to the appropriate level of credentialing. All states, however, provide that licensing is the appropriate level of credentialing for dentists and dental hygienists. Other forms of credentialing include registration and certification. Each time a new or emerging health profession is considered for regulation, the various credentials are considered to determine the most appropriate for that particular profession. Minnesota was the first state to consider *dental therapists* as the newest member of the dental team, and the legislature established that licensure was the mechanism for regulating this new profession.

Both licensure and registration assure the public that the credentialed individuals meet the annual continuing educational requirements set forth in statute. In addition, licensure and registration by a health licensing board enhances public protection by providing a credentialing authority and its attendant investigative and disciplinary powers to ensure that health care professionals continue to practice with reasonable skill and safety to patients. For the dental professionals, licensure offers title protection and all of the rights that go along with it.

Other State Credentials

All states provide for credentialing of health care professionals. An individual who holds a credential in Minnesota may also hold credentials in other jurisdictions. A complaint against a credentialed health care professional is investigated by the state Board in which the patient encounter occurred. Any resulting *disciplinary* action by the state Board is reported to all other states in which a credential is held and, in most cases, those states would impose similar disciplinary action on their state's credential. The law also provides for the sharing of investigative data between states (Minn. Stat. § 214.10, subd. 8 (e)).

Room for Improvement

The Board has recently instituted **Case Conferences**. Case Conferences have a former Board member meet with licensees to discuss a particular issue that resulted in a complaint being filed, but which doesn't appear to require a meeting with the Committee to resolve (questionable knowledge or judgment may have been alleged, but circumstances won't likely result in the need for corrective or disciplinary action). These have been very effective with licensees, and have proven to be an efficient way to address specific concerns for staff and Complaint Committee members, streamlining the process while assuring public protection. The concept of Case Conferences came from discussions with the Board of Medical Practice, and their experience with consultants conducting *Care* Conferences. This is an example of how the Board continually assesses its processes, and seeks ways to provide greater service with limited funds.

There are systems issues that demonstrate to the Board that centralization of services is not necessarily in the best interest of the Board, the licensees regulated, or the general public. The Board has discussed potential benefits for example, in seeking to hire in-house staff to provide legal counsel and investigations. Internal investigations, which are currently conducted by Board staff, could be conducted to a greater degree versus depending on the Office of the Attorney General Licensing Investigations Division for all field investigations. Minnesota Statutes § 214 requires the Boards to utilize the Attorney General's Office for legal counsel, which (despite its positive aspects) has proven to be an expensive approach. The ongoing e-licensing surcharge for the Office of Enterprise Technology created an unnecessary and redundant system in the name of improving efficiency. Although well underway, the program has been a costly drain on Board resources.

Another area where improvements could be realized relates to the funding process, in which the legislature must authorize the biennial spending limits for the Boards on revenue that is generated by the Boards themselves. A different, more flexible model should be considered. Also worth considering are modifications to the recently implemented Prescription Monitoring Program that would allow Boards to access data as an investigative adjunct.

Section VI Agency Structure and Program Administration

The Board of Dentistry regulates the members of the dental team; no other agencies or entities perform this function specific to dental professionals. The nuances of dental education, testing, and practice do not lend themselves well to generalized, broad-based regulatory structures. No other state agencies are authorized to perform licensing and regulatory functions.

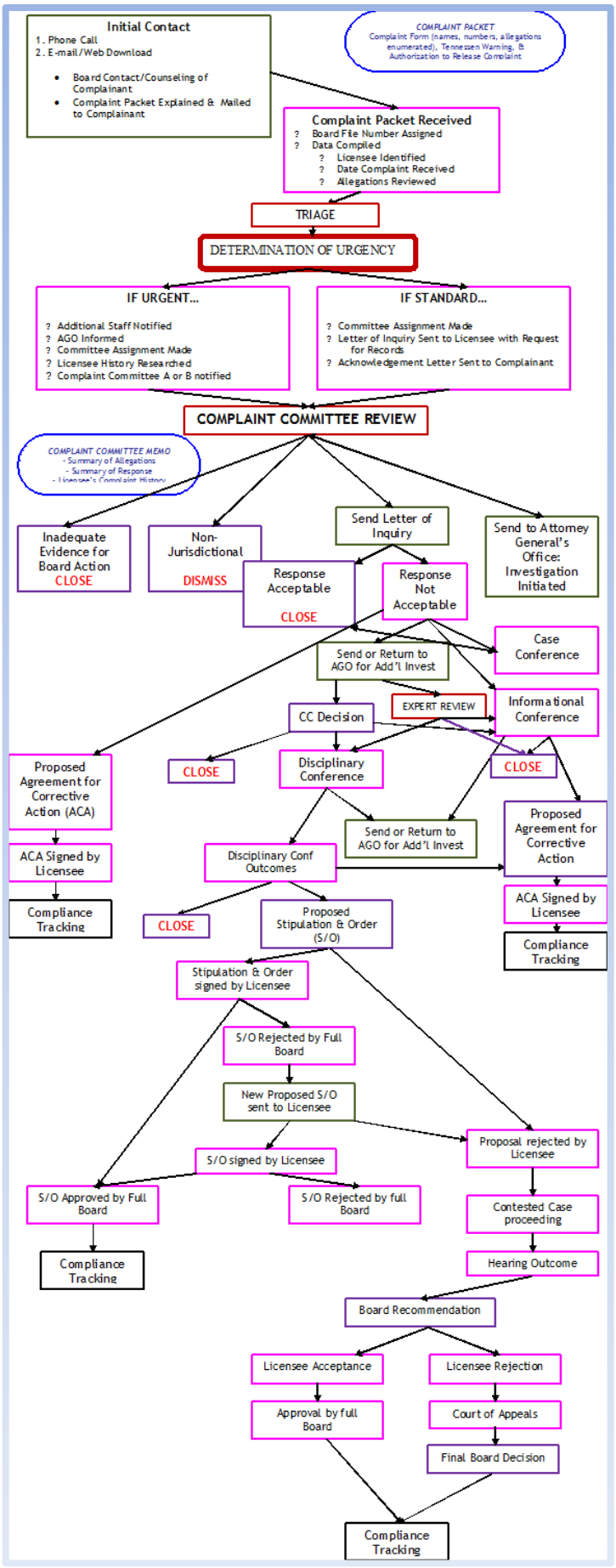
As outlined elsewhere in the report, however, the Board of Dentistry does rely on some shared services with other health regulatory Boards in areas that are not specific to the oral health professions. Whereas consolidation is less than ideal, based upon reports and experience from other states with various organizational structures, many agree that the Minnesota model of independent Boards sharing some services through ASU is highly functional, effective, and efficient.

Section VII Complaint Resolution Process & Enforcement

This section contains a number of flowcharts, diagrams, and tables to illustrate the Board of Dentistry's complaint resolution process and results. The detailed information in the tables includes the number of complaints over time that the Board has addressed, the type of complaints received, length of time for reviewing complaints from start to finish, trends, common remedies, and other data. Although the Board is able to report these items based on counting process variables, the most important measure (whether outcomes are *effective*) is not something that is easily tracked, if even possible. Anecdotally, however, the remedies selected for resolving complaint cases continue to evolve and improve as the Board receives feedback from licensees, complainants, and instructors.

The flow chart on the following page shows the complaint process, from receipt of the initial complaint through investigation, deliberation, and resolution. The process appears to be complicated, as it allows for the many permutations that arise in the complaint review process. When followed from top to bottom (start to finish), though, the flow chart and decision points it represents are logical and straightforward. Detail is important to this and most other Board functions.

COMPLAINT PROCESS



Complaints

The following tables summarize key information related to the Board of Dentistry's complaint process.

Primary Complaint Allegations:	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11
1. competency	104	95	106	101	73	87	90	125	121	91
2. licensure	12	5	6	28	11	20	19	12	13	11
3. prescribing/drugs	11	8	25	14	11	14	13	19	11	20
4. sexual misconduct	1	0	1	1	0	1	0	2	4	1
5. auxiliary misuse	1	5	10	8	8	5	7	8	10	12
6. sanitary/safety	11	9	15	8	37	26	5	3	3	6
7. advertising	5	10	8	20	9	13	16	3	5	7
8. unprofessional conduct	55	70	74	82	67	68	55	53	62	69
9. fraud	8	16	20	16	9	20	11	6	13	15
10. failure to cooperate w/Board	0	1	0	0	5	2	6	15	4	8
11. unconscionable fees	5	3	1	6	3	5	6	2	3	1
12. disability	0	4	2	3	5	5	4	2	0	2
13. mandatory reporting	0	3	0	1	1	0	0	1	1	2
TOTAL:	213	229	268	288	239	239	232	251	250	245

Complaint Sources:	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Patient	¢	¢	161	158	198	146	146	134	217	130
Other Practitioner/Employee (current or former)	¢	¢	23	46	48	46	46	40	22	19
Law Enforcement	¢	¢	58	0	0	91	91	0	0	1
Other	¢	¢	0	75	0	18	18	59	43	73
TOTAL:	248	208	242	279	246	301	232	233	282	223

¢ = data not available

Complaint Processing Time

Closed Complaints

Note: The numbers below include complaints that had been open at the start of the biennium. Thus, the numbers cannot be compared to the number of complaints listed above.

	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10
1. Number of complaints closed	135	100	254	218	272	247	290	225	246	365
2. Disposition by type*: **[Note: a) - f) are disciplinary actions]***										
a) revocation	0	0	0	0	0	0	0	1	0	0
b) voluntary surrender	2	4	2	2	3	5	6	2	6	3
c) suspension with or without stay	2	2	2	3	3	2	2	12	5	1
d) restricted/limited/conditional	9	5	2	9	10	5	3	1	10	12
e) *civil penalties**	*5*	*3*	*0*	*3*	*3*	*2*	*1*	*2*	*3*	*2*
f) reprimand	0	0	0	0	0	0	0	0	3	1
g) agreement for corrective action	14	14	18	13	22	31	18	23	16	33
h) *referral to HPSP **	*2*	*6*	*14*	*12*	*7*	*13*	*16*	*26*	*10*	*14*
i) dismissal or closure	110	75	204	167	¢	177	259	197	206	315

** Subparts 2.e. and 2.h., above, are not included in the total number of cases closed. Civil penalties and referrals to HPSP are not considered separate actions, but rather, they are included as part of disciplinary board orders].*

	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10
Number of cases closed that were open for more than 1 year:	¢	¢	52	41	58	74	37	46	20	21

Open Complaints on June 30 of each fiscal year of the biennium

Note: The numbers below include complaints that were open previous to the biennium. The numbers cannot be compared to the number of complaints listed under part A, above.

	FY 01	FY 03	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10
1. All complaints open on June 30th	91	139	72	137	138	109	120	139	132	124
2. Open less than 3 months	¢	¢	11	16	18	26	47	28	57	42
3. Open more than 3 mos., but less than 6 mos.	¢	¢	20	11	20	5	11	32	24	24
4. Open more than 6 mos., but less than 9 mos.	¢	¢	3	4	10	4	9	20	16	25
5. Open for more than 1 year [Note: see following page for explanations]	¢	¢	37	30	82	35	22	39	29	23

¢ = data not available

Explanations of complaints open for more than one year

FY10 N=23

Of the 23 complaints that remained opened on June 30, 2010 for more than one year, 16 of the complaints (regarding 12 separate licensees) involved AGO investigations. One of the 23 complaints was proceeding to a contested case hearing. Four of the open complaints involved two separate licensees for whom negotiations remained underway at the end of the biennium. Finally, five of the complaints involve pending conferences for four separate licensees as of 06/30/2010.

FY09 N=29

Of the 29 complaints that remained open for more than one year at the end of fiscal year 2009, each had involved AGO investigations. For 11 of the complaints, scheduling of disciplinary conferences and resolution negotiation processes took several months. Six of the 29 complaints, involving four separate licensees, still remained unresolved at the end of fiscal year 2010.

FY08 N=39

Of the 39 complaints that remained opened on June 30, 2008 for more than one year, nine of the complaints (regarding five different individuals) remained at AGO for investigation. 17 complaints, against three separate dentists, were proceeding to contested case hearings. 11 of the open complaints involve six separate licensees for whom negotiations for disciplinary or corrective actions were underway as of 06/30/2008. Finally, two of the complaints involved pending conferences for two separate licensees as of 06/30/2008.

FY07 N=22

Of the 22 complaints that remained open for more than one year, all but one of the complaints involved AGO investigations. The other complaint involved an individual who failed to comply with Health Professionals Services Program (HPSP). For 11 of the complaints, scheduling of disciplinary conferences and resolution negotiation processes took several months. The other 11 complaints proceeded or were in the process of proceeding to contested case hearings.

FY06 N= 35

Of the 35 complaints that remained opened on June 30, 2006 for more than one year, all but two involved AGO investigations and/or expert reviews arranged by Board staff. Twelve complaints were being prepared for contested case hearings: 3 for one licensee, 3 for another licensee and 6 for one more licensee. Eight of the open complaints were undergoing investigations for six separate licensees. Four of the open complaints involved three separate licensees with whom negotiations for disciplinary actions were being finalized. Eleven of the complaints involved pending conferences for 10 separate licensees.

FY04 N=30

Of the 30 complaints that remained open on June 30, 2004, 12 were among those that also remained open on 6/30/03 (9 for one licensee, 2 for one licensee and 1 for one licensee). The 30 complaints that remained open for more than one year all involved AGO investigations and/or expert reviews arranged by Board staff. 10 of the open complaints involved a licensee (for whom negotiations for disciplinary actions are being finalized as of 09/30/2004; six cases involved a licensee who AGO was advising on possible disciplinary action. Two cases involved a licensee (who had met for a conference in 2003 and for which disciplinary action has been proposed but rejected, and a contested case is likely). Four complaints involved two separate licensees (who had met for conferences subsequent to 06/30/04 and corrective actions has been proposed); one complaint involved aregistrant (who had met for a conference in 09/2004 and corrective actions had been proposed). Five of the complaints involved pending conferences.

FY03 N=37

Of the 37 complaints that remained open for more than one year, all involved AGO investigations; all but one ultimately involved proposed or final disciplinary or corrective action; and one had a pending conference. Nine cases involved one licensee (who had met for a conference in 2001 for which disciplinary action negotiations occurred, but new complaints and subsequent investigation occurred); six complaints involved a licensee (who had met for a conference in 2002 for which disciplinary action negotiations occurred, but new complaints and subsequent investigation occurred); and five cases involved one licensee for whom a felony conviction for fraud was pending in Hennepin County. Four complaints involved one licensee (who had met for a conference in 2002 for which disciplinary action negotiations were under way). Six cases involved two separate licensees, each with two complaints against them, and seven additional complaints were individual complaints involving one Licensee.

[Note: FY01 & FY02 data not available]

AGREEMENTS FOR CORRECTIVE ACTION

Establishment of an Agreement for Corrective Action (ACA) is a common remedy when violations of dental practice regulations are found. These *non-disciplinary* contracts between the Board and a licensee typically establish requirements for the licensee to pursue remedial training related to the deficiencies found in the case. Other remedies may also be considered for ACAs, such as community service, retaking of the jurisprudence examination, changes made to business or clinical practice, requirement for a records inspection or infection control inspection, and other actions relevant to the specific case.

Tracking of Status & Violations: Agreements for Corrective Action*

FY03 - FY12

1. The codes used to describe the violations that serve as the bases for the ACAs are listed on the final page

A. **^ =** the ACA was issued without holding a conference with the licensee

B. Bold print = the requirements of the ACA have not yet been met

FY 12 (July 1, 2011 – December 31, 2011) [through 11/21/11]

Licensee	Date of Action	Status	Violation (code)
1. LB	10/06/11	Open	*A1, A8*
2. CD	09/19/11	Open	*A1, A8*
3. WL	10/06/11	Open	*A6, A8, A12, C3*
4. KM	08/05/11	Open	*A1, A6, A7, H4*
5. LO	10/13/11	Open	*A1, A8, H, I3*
6. FW	10/07/11	Open	*F2, E*

FY 11 (January 1, 2011 – June 30, 2011)

Licensee	Date of Action	Status	Violation (code)
1. AB	01/19/11	Open	*A1, A8*
2. ED	03/21/11	Open	*A8*
3. WG	05/02/11	Open	*H4, C3, B1*
4. CJH	01/24/11	Open	*A1, A8*
5. EH	01/05/11	Open	*B1*
6. TK	01/11/11	Closed	*E, B1, B2, J*
7. DVP	04/05/11	Open	*A1*
8. TP	04/15/11	Open	*A1, A6, A7, A8*
9. JT	01/18/11	Open	*A1, A8*

FY 11 (July 1, 2010 – December 31, 2010)

Licensee	Date of Action	Status	Violation (code)
1. GB	11/16/10	Open	*F2, A1, A6, A8*
2. KE	07/06/10	Closed	*A1*
3. MH	10/20/10	Open	*F2*
4. LS	08/02/10	Closed	*A1, A6, A7, A8, H*
5. RT	10/05/10	Closed	*A8*
6. TW	11/24/10	Open	*B3*
7. MW	12/10/10	Open	*A8*

FY 10 (January 1, 2010 – June 30, 2010)

Licensee	Date of Action	Status	Violation (code)
1. AB	06/28/10	Closed	*A7, A8*
2. BB	**04/09/10**	**Open**	*B1, B2*
3. SB	**03/26/10**	**Open**	*C2*
4. PB	04/20/10	Closed	*H2, H3, A6*
5. WG	05/11/10	Closed	*A2, A8*
6. TH	**06/30/10**	**Open**	*E*
7. CH	03/29/10	Closed	*A1. A7, A8*
8. MH	05/07/10	Closed	*A7, E, A8*
9. DJ	04/26/10	Closed	*A1. A8. I3*
10. KL	04/19/10	Closed (VT)	*E*
11. AL	06/29/10	Closed	*B1*
12. MM	**02/09/10**	**Open**	*A6. A8. A1, C3*
13. YN	03/26/10	Closed	*A6, B1, A1, A8*
14. SP	03/31/10	Closed	*A1, A8,.G*
15. PS	06/23/10	Closed	*A7. A8. A1*
16. GS	06/29/10	Closed	*B2*
17. ST	**04/20/10**	**Open**	*B1, B2*
18. PT	**04/30/10**	**Open**	*A2, A1, A3, A6, A8*
19. MZ	04/15/10	Closed	*E*

FY 10 (July 1, 2009 – December 31, 2009)

Licensee	Date of Action	Status	Violation (code)
1. GB	10/26/09	Closed	*C3, A6, A8*
2. JB	10/29/09	Closed	*C3, A1, B1, A8*
3. SB	**08/31/09**	**Open**	*C3, F2, A1, A6, A7, A8*
4. GD	09/04/09	Closed	*A1, A6, A8*
5. MF	12/07/09	Closed	*C3, A1*
6. DG	12/09/09	Closed	*E*
7. JI	11/24/09	Closed	*B1*
8. RJ	**07/06/09**	**Open**	*A8*
9. SK	10/26/09	Closed	*A1. A6, A8*
10. JM	11/05/09	Open	*E*
11. AS	08/28/09	Closed	*B3*
12. CS	12/09/09	Closed	*E*
13. PV	12/09/09	Closed	*E*
14. MW	12/09/09	Closed	*E*

FY 09 (January 1, 2009 - June 30, 2009)

Licensee	Date of Action	Status	Violation (code)
1. LB	03/26/09	Closed	*C3, A2*
2. DB	04/08/09	Closed	*E*
3. MD	04/13/09	Closed	*E*
4. AK	06/16/09	Closed	*E, A8*
5. JJ	04/08/09	Closed	*E*
6. DL	05/13/09	Closed	*A3, A8, A4*
7. WP	06/09/09	Closed	*O2*
8. PP	02/02/09	Closed	*J (cons.sed.cert.)*
9. MS	02/09/09	Closed	*B3, F1*
10. AS	**04/27/09**	**Open**	*A1, A6,A8,*
11. PZ	05/01/09	Closed	*A2. A8, B1, G*

FY 09 (July 1, 2008 - December 31, 2008)

Licensee	Date of Action	Violation (code)
1. RA	07/14/08	*F2, A8, H5*
2. GB	08/06/08	*F2, A8*
3. MF	12/18/08	*A1, A3, A8, A6, A4, F2*
4. MJ	09/08/08	*F2, E, A8*
5. PZ	07/14/08	*C3, B1, A8, H2, I3*

FY 08 - All closed (January 1, 2008 - June 30, 2008)

Licensee	Date of Action	Violation (code)
1. JC	04/02/08	*A5, A8*
2. TD	06/16/08	*B1, B2*
3. PF	04/02/08	*A1. A6. A8, E, F2*
4. FH	06/26/08	*A1. A8, C3*
5. SR	01/17/08	*C3*
6. TS	02/19/08	*H5, H3, A8, H5*

FY 08 (July 1, 2007 - December 31, 2007)

Licensee	Date of Action	Violation (code)
1. AM	10/11/07	*B1*
2. JB	10/26/07	*B2*
3. KB	08/27/07	*B2*
4. RB	09/19/07	*A6, A8, A1, F2, C1*
5. RB	10/17/07	*A2, A1, A8*
6. CB	09/10/07	*A1, A8*
7. GC	11/15/07	*C3, F3, G, H4*
8. JC	08/28/07	*B1*
9. RD	07/31/07	*A4, A8, A6, A1, F2, E*
10. JH	08/20/07	*F1*
11. JH	12/03/07	*B2*
12. DJ	10/15/07	*B1, E*
13. LP	08/23/07	*B2*
14. SP	08/31/07	*B2*
15. KS	12/06/07	*B3 - Prof.Dev.audit*
16. ST	12/14/07	*A1, A6, A8*
17. KV	10/18/07	*A1, A6, A8*

FY 07 - All closed (January 1, 2007 - June 30, 2007)

Licensee	Date of Action	Violation (code)
1. CA.	03/01/07	*A1, A3, A8*
2. DF	01/24//07	*A1*
3. RG	05/29/07	*E*
4. MH	01/22/07	*A6. A1, A8*
5. PK	03/22/07	*A1, A8*
6. AR	05/18/07	*E*
7. SS	01/22/07	*A2, A8, A1, A3*

FY 07 (July 1, 2006 - December 31, 2006)

Licensee	Date of Action	Violation (code)
1. PB	10/31/06	F2, A4, A8
2. MB	08/28/06	A1, H4, A6
3. BD	09/08/06	A2. A8, F3
4. ME	07/14/06	A8, G
5. DJ	10/25/06	A1, A8
6. MF	08/17/06	F3
7. EM	12/12/06	A2, A8, A1, A3
8. MO	08/07/06	A1, H4
9. CR	07/14/06	F2
10. GR	08/09/06	A8
11. DT	10/05/06	F2, A8, A2, E

FY 06 - All closed (January 1, 2006 - June 30, 2006)

Licensee	Date of Action	Violation (code)
1. GE	04/21/06	*A6, A8, C3*
2. GE	01/03/06	*A8*
3. JJ	05/18/06	*A8, B1*
4. DL	02/16/06	*A1, A6, A8, H2, H4*
5. RM	05/11/06	*A2*
6. PM	06/19/06	*B1*
7. HN	04/13/06	*A1, A6, A8, H4*
8. LO	05/25/06	*A4, A8, F2, H4*
9. KP	05/17/06	*B1*
10. RP	06/13/06	*A1, A2, A3, A4, A5, A6, A7, A8, E, F2*
11. WS	01/05/06	*A8, H2*
12. SS	01/05/06	*I1*
13. TS	01/06/06	*B2*

FY 06 (July 1, 2005 - December 31, 2005)

Licensee	Date of Action	Violation (code)
1. PB	07/29/05	*B1*
2. DB	11/15/05	*B2*
3. JF	08/18/05	*B1*
4. TH	**10/10/05**	***A8***
5. KJ	10/28/05	*B2*
6. PJ	08/30/05	*B1*
7. JK	09/26/05	*L 1,2*
8. JL	09/20/05	*B2*
9. JP	11/21/05	*A8*
10. DS	09/20/05	*B2*
11. KS	12/23/05	*F2*
12. BS	09/20/05	*B2*
13. DT	12/21/05	*A1, A2, A7, A8*
14. KT	09/20/05	*B2*
15. KV	10/12/05	*A8*
16. GW	09/16/05	*B2*
17. RW	09/20/05	*B2*
18. MZ	09/20/05	*Failure to display renewal certificate*

FY 05 - All closed **(January 1, 2005 - June 30, 2005)**

Licensee / Registrant	Date of Action	Violation (code)
1. DA	03/14/05	*A8*
2. DB	01/28/05	*H2*
3. PB	03/09/05	*A2, A6, A8, H2*
4. MG	01/20/05	*A 8, A1*
5. CH	05/10/05	*E*
6. MJ	01/25/05	*A2, A7, A8, C3*
7. JK	05/12/05	*B2*
8. JN	05/10/05	*E*
9. SN	05/10/05	*E*
10. JS	03/04/05	*A6, A1, A3, A8, F2*
11. PS	01/25/05	*A8*

FY 05 (July 1, 2004 - December 31, 2004)

Licensee	Date of Action	Violation (code)
1. JB	08/24/04	*A8*
2. RE	08/24/04	*A8, A1*
3. DE	11/04/04	*A 8*
4. TM	11/10/04	*F2, A8*
5. YM	11/09/04	*F2, A8*
6. AP	10/25/04	*A 8*
7. KR	10/21/04	*H2*
8. MR	07/30/04	*B2*
9. RR	07/13/04	*F2*
10. RW	09/02/04	*A8*
11. TW	08/13/04	*B1*

FY 04 - All closed (January 1, 2004 - June 30, 2004)

Licensee	Date of Action	Violation (code)
1. AB	03/01/04	*H2, A3, A8, A2*
2. TD	01/21/04	*A3, A8*
3. ME	01/21/04	*A4, A8*
4. SF	03/26/04	*E, A8*
5. RG	05/07/04	*A4, C3, A6, A8, A1*
6. SH	06/02/04	*A8*
7. WK	02/23/04	*E*

FY 04 (July 1, 2003 - December 31, 2003)

Licensee	Date of Action	Violation (code)
1. JC	09/18/03	*A1, A3, A6, A8*
2. JP	09/30/03	*F2, A8, F1*
3. RS	07/16/03	*A8, A6*

FY 03 - All closed **(January 1, 2003 - June 30, 2003)**

Licensee	Date of Action	Violation (code)
* **PB**	03/13/03	*A6, A8, A7*
* **SJ**	02/12/03	*A8*
* **MJ**	06/11/2003	*F2*
* **DL**	05/09/2003	*A1, A5, A8*
* **LQ**	06/04/2003	*A5, A8, H4*
* **FS**	02/22/03	*F2, C3*

FY 03 (July 1, 2002 - December 31, 2002)

Licensee	Date of Action	Violation (code)
* **SE**	08/22/02	*F2, F3*
* **MG**	09/10/02	*A6, A8*
* **RH**	09/05/02	*E*
* **MM**	07/26/02	*A8, C3*
* **NN**	10/02/02	*A8*
* **KO]**	10/15/02	*A8, M*
* **NP**	09/10/02	*B1*
* **SS**	11/01/02	*H2*
* **JT**	09/10/02	*B1*
* **GW**	09/17/02	*A8, F2, M*
* **DT**	11/26/02	*A2, A6, A8, F2*
* **LW**	12/19/02	*A8*

VIOLATION CODES used in this report

A **Substandard Care**

- Diagnostic (incl. inadequate pain control)
- Endodontic
- Operative
- Oral Surgery
- Orthodontic
- Periodontal
- Prosthodontic
- Recordkeeping

B **Licensure**

- Practice Beyond Scope
- Practice Without Current License
- Failed audit of Professional Development Portfolio

C **Drugs**

- Alcohol abuse / dependency
- Chemical abuse / dependency
- Improper prescribing / dispensing / storage

D **Sexual Misconduct**

E **Auxiliary Misuse**

F **Inadequate Safety/Sanitary Conditions**

- Not current in CPR
- Inadequate infection control
- Other

G **Advertising**

H **Unprofessional Conduct**

- Failure to transfer records
- Verbal abuse / Inappropriate communications
- Physical abuse
- Other - (e.g. failure to obtain adequate informed consent/improper display of certificates /etc.)

I **Fraud**

- Insurance
- Medical Assistance
- Other

J **Failure to Cooperate w/the Board**

K **Unconscionable Fees**

L **Disability**

1. Emotional / Mental
2. Physical

M **Failure to Comply with Current Board Disciplinary/Corrective Action**

N **Action taken by Licensing Authority of Another State**

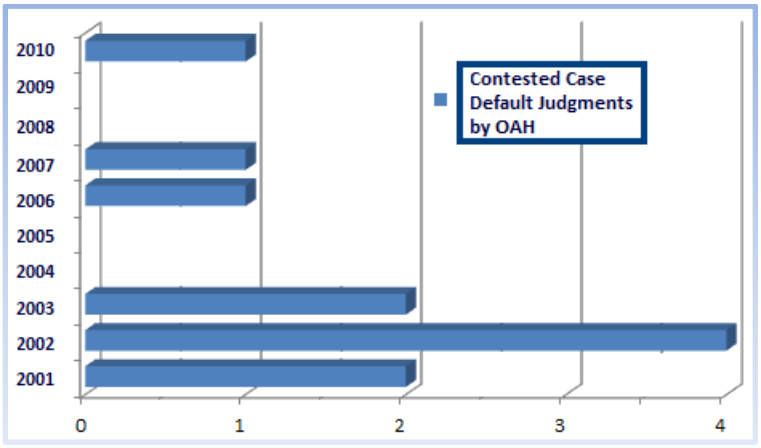
O **Gross Misdemeanor/Felony**

1. Offense related to dental practice
2. Offense not related to dental practice

Contested Case Activity (Settlements, Hearings, Appeals)

There have been only two full contested case hearings for the Minnesota Board of Dentistry in the recent past. One of the cases was in regard to WR, D.D.S. in December 2000, and the other in March 2008 related to RB, D.D.S. The contested case process tends to be extremely draining of Board staff, funds, time and other resources, but is essential to ensure that the licensee receives due process in defending their professional license, a property right.

For a number of other matters, preparation for contested cases were initiated (including obtaining depositions of experts and other potential witnesses), but as a result of licensees not appearing for pre-conference meetings and other failures to reply to communications, default judgments were rendered by the Administrative Law Judge. In such cases, the most common remedy applied by the Board was an Order for Indefinite Suspension. Eleven contested cases resulted in default judgments in recent years, distributed as follows:



In matters relating to four separate licensees (one in FY08, two in FY09 and one in FY10), preparations for contested cases proceeded while negotiations for settlements continued, including utilizing mediation services in some instances. Each of the four matters was ultimately settled with a disciplinary order.

At this point in time (FY12), the Board of Dentistry has three contested case hearings pending.

Alternatives to Disciplinary Action

The Board has identified several alternatives to formal discipline that serve to remediate and rehabilitate deficiencies while assuring public protection, including:

- Case conferences: meetings between a respondent licensee and a former Board member for the purpose of offering education and professional advice
- Agreements for corrective action: public non-disciplinary agreements between a licensee and a complaint review committee in which the licensee agrees to complete remedial education and/or other remedies
- Referral to the Health Professional Services Program for confidential, non-disciplinary monitoring of a health condition

Section VIII Rules, Policy, Legislation Enactment/Development & Stakeholder Participation

Assessment of Board's Rulemaking Process

The Board's rulemaking process is primarily managed by the Board's Legal Analyst and the Executive Director with guidance at times from an attorney with the Attorney General's Office.

The procedures for administrative rulemaking are found in the Minnesota Administrative Procedure Act within Minnesota Statutes, chapter 14, and Minnesota Rules, chapter 1400. The Board's statutory authority to adopt rules is found in Minnesota Statutes, section 150A.04, subdivision 5, which provides: *"The Board may promulgate rules as are necessary to carry out and make effective the provisions and purposes of sections 150A.01 to 150A.12, in accordance with Chapter 14. The rules may specify training and education necessary for administering general anesthesia and intravenous conscious sedation."* Additionally, the Board has statutory authority to adopt rules related to continuing education within Minnesota Statutes, section 214.12, subdivision 1, which states: *"The health-related and non-health-related licensing Boards may promulgate by rule requirements for renewal of licenses designed to promote the continuing professional competence of licensees."* Under these statutes, adopted and effective prior to January 1, 1996, the Board of Dentistry has the necessary statutory authority to adopt rules. Minnesota Statutes, section 14.125 does not apply. [See Minnesota Laws 1995, chapter 233, article 2, section 58.]

Extent of Public Participation

While the rulemaking process is complex, it is designed to offer adequate opportunity for the public to provide input to the Board regarding the content of any rule being considered. To accomplish this, the Board makes every reasonable effort to inform those individuals affected by the proposed rules through state and local publications, electronic posting, and mailing of public notices. Based upon this notification, the Board may conduct a public hearing within the time frame required by law. This public hearing offers an opportunity for members of the Board to hear from dental professionals and others affected by the proposed new rules or rule changes. The law requires that all public input be heard by the Board through either oral or written testimony. Following the hearing, the Board thoroughly considers all of the testimony that is received and decides whether to make changes to the rules as proposed. The entire rulemaking process is highly transparent.

Extent of Results Benefiting Public

The primary purpose of the Board's laws and rules is to serve as a safeguard for the health, welfare, and safety of the public and to protect the public against unqualified practitioners of dentistry. The Board strongly encourages and relies on public input to guide its rulemaking actions. The expertise of dentists and other dental professionals working in a variety of healthcare settings is essential if the Board's rules are to be reasonably enforceable, clear, and consistent. The need for rule changes is often generated through the complaint process where the public directly and indirectly helps identify when statutes or rules may not adequately protect them in the current practice environment.

Section IX Compliance w/Federal & State Laws Re: Employment, Data Privacy, Purchasing

Employment

The Board complies fully with federal and state laws regarding equality of employment opportunity, and the rights and privacy of individuals. The Executive Director is entrusted with responsibility for ensuring that federal and state equal employment opportunity laws are fully complied with. This is achieved with assistance from the Board's designated affirmative action officer, an employee of the Administrative Services Unit. This Board has received no complaints of violation of equal employment opportunity laws.

The Board maintains and updates an Affirmative Action Plan (AAP) on a biannual basis. Criteria for affirmative action plans are established by state law, MS. 43A.19 and 43A.191, and MMB Administrative Procedure 19.1. The Executive Director prepares and implements the Plan, and signs its Statement of Commitment. The Affirmative Action Plan is posted on the Board's website and on the employee bulletin board. Likewise, the Board fully complies with the Minnesota Human Rights Act and applicable federal equal opportunity laws. The Board works cooperatively with the Administrative Services Unit, which provides expertise on equal opportunity issues.

All new employees are informed of equal employment opportunity policies and laws upon orientation, and a copy of the Board's AAP is reviewed with them, including equal opportunity provisions and the Board's complaint process. Training on equal opportunity/affirmative action requirements is periodically provided to staff through in-person training sessions and online training. Equal opportunity/affirmative action matters are regularly reviewed at Executive Director meetings and Office Manager meetings.

The Board conducts its hiring processes in accordance with all applicable collective agreements, and state and federal law. This is accomplished through consultation with the Board's affirmative action designee. The Board uses the State's résumé-based, skill-matching process. Résumés are evaluated against established minimum qualifications. Hiring processes are closely reviewed to insure compliance with equal employment opportunity. Interview questions are established based on knowledge, skills, and abilities required to perform the responsibilities of each position.
The Board's home webpage lists the phone number for hearing/speech relay, and provides an e-mail address for comments on the web page.

Applicants and the general population are becoming increasingly diverse, including cultural and language diversity. The licensing Boards continue to examine matters pertaining to possible barriers in licensure, as well as issues surrounding working with clients and patients from diverse populations. The Board of Dentistry is committed to recruiting and retaining a diverse workforce.

Purchasing and Contracting

The Board complies with all purchasing requirements, including the State's Targeted Group/Economically Disadvantaged small business program and MinnCor. Contractual guidance is provided by the Administrative Services Unit. The Administrative Services Unit also provides the services of a buyer who has been trained in all State purchasing requirements.

The Board is aware of State contracting requirements regarding accessibility for IT services over $25,000; assistance in these matters is provided by Administrative Services Unit. Training on these matters has been provided by the Department of Administration, Materials Management Division.

Applicable laws and rules include but are not limited to:

- Minnesota Statutes Chapters 13, 16A, 16B, and 16C,
- Minn. Stat. §§ 10A.07, 15.43, 43A.38, 609.43, and 609.456,
- Minnesota Rules Chapter 1230, and
- Uniform Commercial Code (UCC) as adopted by Minnesota (see Minnesota Statutes Chapter 336).

Tennessen Warnings

Individual subjects of data are given specific rights by the Minnesota Government Data Practices Act. The "Tennessen Warning," contained in Minn. Stat. §13.04, subd. 2, is used when an individual is asked to supply private or confidential information. The individual must be informed of: (1) the purpose and intended use of the requested data; (2) whether the individual may refuse or is legally required to supply the requested data; (3) any known consequence arising from providing or refusing to provide private or confidential data; and (4) the identity of other persons or entities authorized by state or federal law to receive the data. The Tennessen Warning is not required to be given in writing, but if given orally, it should be documented in the appropriate Board file. The Tennessen Warning is integrated into much of the work done by the Board, as the Board frequently obtains information and documentation that is private or confidential.

Security Profiles: MAPS, SEMA4, SWIFT, Fiscal Notes, Budget, Payroll, HR, Warehouse Data

Certified profile reports are viewed annually and submitted to the Minnesota Department of Management and Budget. When profiles are added or changed, individual staff profiles are reviewed. Individual profiles are maintained and reviewed frequently to ensure compliance with statutes, rules, policies and procedures.

Financial Policies

The health related licensing Boards follow statutes, rules, policies and procedures related to financial operations. The Minnesota Department of Management and Budget and the Minnesota Department of Administration provide policies and procedures as well as training related to financial activities. The Administrative Services Unit provides guidance on policies and procedures for the Health Related Licensing Boards staff to follow to ensure that financial operations are in compliance.

Section X Potential Conflict of Interest

The Executive Director of the Board is responsible for enforcing rules relating to potential conflicts of interest of its employees. The Executive Directors of each Health-Related Licensing Board has agreed to have each incumbent employee review *State Code of Conduct* provisions and to be recertified in the employee's understanding of the Code annually. The State Code of Conduct (MMB Operating Policy & Procedure 01003-01) outlines the standards and expectations regarding employee honesty, integrity, and ethical behavior. All new Board employees are also informed of the Code at employment orientation, and are instructed to certify their understanding of responsibilities under the Code.

As an Executive Branch agency, the Code of Ethics for State Employees (Minnesota Statutes 43A.38) is reviewed at orientation with all new employees, and is also discussed regularly at Office Managers meeting and Executive Directors meetings.

Questions regarding conflict of interest may be directed to Administrative Services Unit staff, which seeks additional guidance as required from Minnesota Management and Budget. Advice is also available through the Attorney General's Office. Provisions regarding potential conflict of interest in regard to contracting are heavily regulated by Minnesota statutes. Provisions regarding institutional conflict of interest have been reviewed at meetings of Office Managers and of Executive Directors. Board staff have received training from the Department of Administration, Materials Management Division, regarding appropriate contracting procedures, including conflict of interest. Adherence to state contracting statutes and regulations minimizes the risk of conflict of interest.

More specific to the Board members, the Board of Dentistry has developed a set of Internal Operating Policies and Procedures (IOPP). Provisions in the IOPP address these concerns…

- **Conflict of Interest**
  Members of regulatory Boards must strive to avoid any actual or perceived conflict of interest that may compromise the integrity of the Board.
  - Reveal actual or perceived conflicts of interest and recuse oneself from Board decision making when appropriate.
  - Refrain from self-dealing or any conduct of private business or personal services between any member and the Board.
  - Board members must not use their positions to obtain employment within the agency for themselves, family members or close associates.
  - Should the Board consider Board members for employment, he/she must temporarily withdraw from Board deliberation, voting, and access to private Board information.
  - Those affiliated with the Executive Brach of state government are prohibited from accepting gifts, meals or any item of value according to Minnesota Statutes, Chapter 43A.38, Subd 2.
- **Recusal**
  Board members will recuse themselves from participating in complaint reviews where a conflict of interest exists relative to the complainant or the licensee. Every effort should be made to determine whether the Committee member's relationship with the complainant or licensee creates a situation that would negatively affect objectivity.

Section XI Compliance with Chapter 13: Data Practices & Requests for Information

The Board of Dentistry strictly adheres to the legal requirements for managing its data as required by Minnesota Statutes § 13, the Data Practices Act. Under the Data Practices Act, all data that are not made private or confidential by state or federal law are public data.

PUBLIC DATA

Under the law, the following data collected or retained by the Board are available to the public:

- The name and address of all applicants for a credential;
- All application data which has been submitted by individuals who hold a credential to practice in Minnesota;
- All Orders for Contested Case Hearing before the Office of Administrative Hearings unless specifically exempt by statute;
- Findings of Fact, Conclusions of Law and Disciplinary Orders which have gone through Contested Case and board decision making.
- All Stipulation and Orders for disciplinary action;
- Disciplinary Orders and the record of disciplinary hearing if the hearing was public;
- Board staff and consultants;
    - Name;
    - Salary or contract fees;
    - Pension and benefits information;
    - Expense and other reimbursement paid;
    - Job title and description;
    - Education, training and work experience;
    - Dates of employment;
    - Existence and status of any complaints and final discipline;
    - Action, including reasons therefore; and
    - Payroll records, work phone number and designated address
- Job Applicants:
    - Veteran status;
    - Test scores;
    - Eligibility ranking;
    - Job history;
    - Education and training; and
    - Names of job finalists.

PRIVATE DATA

Accessible to the subject of the data, but not the public:

- Data submitted by credential applicants;
- Inactive investigative data;
- Name of Complainant when it appears in inactive investigative data;
- Information relating to unsubstantiated complaints;
- Patient names and patient records;
- Record of disciplinary proceeding except for items classified as public;
- All other data on staff and consultants which is not public including unsubstantiated complaints, record of disciplinary proceeding, and non designated address; and
- Names of job applicants, except for finalists.

CONFIDENTIAL DATA

Not accessible to data subject or public.

- Includes active investigative data.

Retention Schedules

Public Data: All public data are retained by the Board indefinitely. A good deal of the documentation has been microfiched or electronically scanned into archive storage.

Private Data: Closed complaint files are retained in the Board office as space allows. When necessary, files are archived to State archives where they can be easily retrieved.

Private data on employees or consultants are retained indefinitely in various formats.

Section XII Effect of Federal Intervention and Funding

The Board of Dentistry is required to report its disciplinary actions to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank (collectively referred to as "The Data Bank"), within 30 days of the date of action. The Board of Dentistry also voluntarily participates in the Clearing House maintained by the American Association of Dental Boards (AADB). The Data Bank is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S.

There are significant consequences for failing to report to the Data Bank in a timely manner. The Secretary of Health and Human Services (HHS) publishes a public report that identifies those government agencies that have failed to report information on adverse actions as required. The AADB Clearing House is a similar database for reporting and verifying adverse actions against licensees in jurisdictions across the United States. Through the public and private sector databases, the Board is able to be notified of malpractice payments or actions taken by other Boards that may impact the licensure of a dental professional licensed in Minnesota.

Since licensure of health professionals is handled independently by each state, district, or territory, dental professionals in Minnesota rely on state licensure to qualify for reimbursement through federal programs, as well as for the ability to practice in the military, VA, Indian Health Service or US Public Health Service.

Section XIII Services, Collaboration and Oversight

Board members and staff of the Minnesota Board of Dentistry recognize that they can be most effective by being involved and participating collaboratively with colleagues in other agencies and organizations. This is demonstrated most dynamically by the shared services of ASU, along with other shared programs of the Boards, including HPSP, the Council of Health Boards, and the Executive Directors' Forum and its various committees. Collegiality is also an important aspect of working with the state's institutions providing education of dental professionals, professional associations, providing objective resources to the legislature, and participation in regional and national organizations focused on oral health care delivery and regulation.

Statutory Entities

Legislative Auditors Office

Recent Audits Conducted

- Board of Dentistry general audit: 2004 (for 7/1/00 – 6/30/03)
- Board of Dentistry purchasing card (VISA) audit: 2010 (for 7/1/07 – 6/30/09)

Minnesota Department of Health (MDH)

Although the 17 independent health licensing Boards, the Board of Barber and Cosmetologist Examiners, the Health Professionals Services Program, and the Department of Health are separate agencies, the Boards and the Department cooperate in administering health occupation licensing programs. The 17 Boards are housed together in the same building and collaborate in many ways. The Boards meet regularly with representatives of the Department of Health to discuss joint concerns.

The Department of Health administers one health occupation program which is defined as a health-related licensing Board under Chapter 214. This is the Office of Unlicensed Complementary and Alternative Health Care Practice. The Alcohol and Drug Counselor Licensing Program is now housed within the Board of Behavioral Health and Therapy, and the Office of Mental Health Practice is now housed within the Board of Social Work as administering agency.

Attorney General

The Attorney General's Office provides legal and investigative services to the Boards. Specific requirements of the Attorney General in investigating complaints are provided in Minnesota Statutes §214.10. The Attorney General's Office provides legal advice and representation services to the Boards pursuant to Minnesota Statutes, chapter 8. Minnesota Statutes, sections 214.10 and 214.103 specifically define the role of the Attorney General with regard to investigating complaints against licensees.

The Minnesota Board is statutorily required to utilize the Attorney General's Office (AGO) for legal counsel and primary investigations. The AGO is responsible for prosecuting complaints through formal or informal disciplinary proceedings; preparing and revising rules for adoption by the Board; processing open records requests; interacting with the public and the profession on matters of law and rules; providing legal advice on a range of issues, including open meetings and open records issues, and employment matters; advising the Board and its committees on legal matters; providing litigation support to the Office of the Attorney General regarding litigation; updating the Board on litigation matters; monitoring probationers' compliance with the requirements of their Board Orders; certifying non-profit organizations that are permitted to employ dentists.

Health Professionals Services Program (HPSP)

Effective July 1, 2001, Minnesota Statutes, section 214.29 requires mandates a health professionals services program:

> Each health-related licensing Board, including the emergency medical services regulatory board under chapter 144E, shall either conduct a health professionals service program under sections 214.31 to 214.37 or contract for a diversion program under section 214.28.

At present, all Health Licensing Boards, the Office of Unlicensed Complementary and Alternative Health Care Practice programs administered by Minnesota Department of Health, and the Emergency Medical Services Regulatory Board, participate in HPSP.

Voluntary Health Care Provider Program

Effective July 1, 2002 Minnesota Statutes, section 214.40 required the Administrative Services Unit to create procedures to allow volunteer dentists, dental hygienists, physicians, physician assistants, and nurses to apply for medical professional liability insurance while volunteering at community charitable organizations.

Office of Mental Health Practice

As of July 1, 2005, the Office of Mental Health Practice is considered part of the mental-health-related licensing Boards. M.S. §148B.61. The Office was transferred from the Minnesota Department of Health.

Council of Health Boards

The Council consists of one Board member from each Board and the Executive Directors. The Council meets periodically to discuss issues and concerns affecting all Boards. The Council is required to statutorily review emerging issues relating to health occupation regulation, such as proposals to regulate new health occupations, upon referral from the Legislature. The Council was given formal direction when legislation, Minn. Stat. § 214.025 was enacted on July 1, 2001:

> The health-related licensing Boards may establish a Council of Health Boards consisting of representatives of the health-related licensing Boards and the Emergency Medical Services Regulatory Board. When reviewing legislation or legislative proposals relating to the regulation of health occupations, the council shall include the commissioner of health or a designee.

Since 2003, the Council has received requests from the Senate and House to perform occupational reviews, and to provide a report to the Legislature, regarding legislation regarding the following occupations:

- Massage Therapy (2002 and 2009)
- Optometry Prescribing Authority
- Speech Language Pathology
- Dental Assistants
- Denturists
- Naturopaths
- Athletic Trainers
- Laboratory Scientists
- Body Art
- Genetic Counseling

Section XIV Priority Based Budget

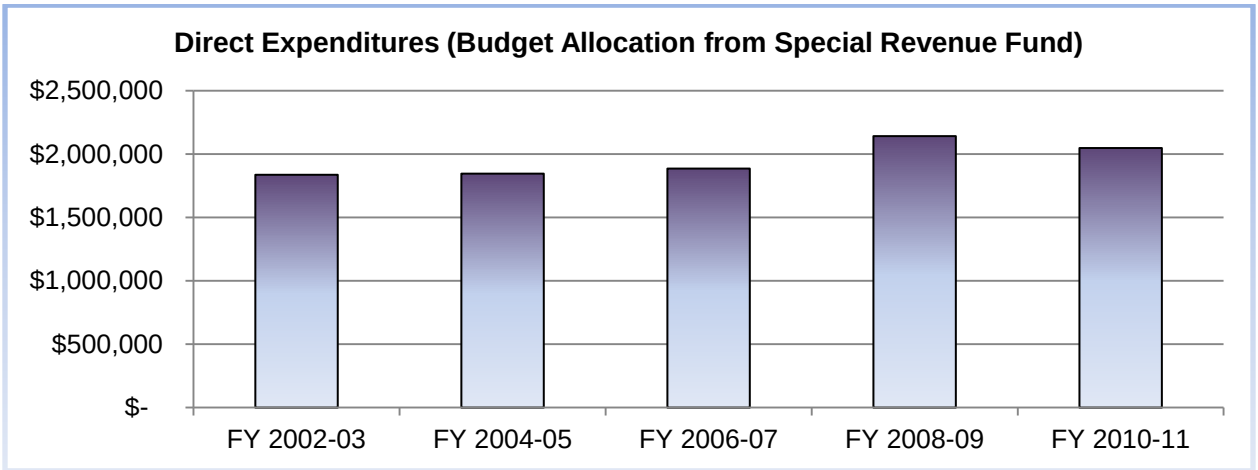
Funding/Budget

The Minnesota Board of Dentistry is funded through fees generated directly from licensees, and does not utilize General Fund dollars. The Board is required by statute to raise funds to meet its operational needs, and the Legislature authorizes the Board's biennial budgets. The Executive Director together with ASU staff identify issues, concerns, and problems that will be confronting the agency in the future. After the agency has prioritized budget needs, with guidance from the Board, the Board submits the proposed budget to Minnesota Management and Budget (MMB) through its Executive Budget Officer for departmental approval. The proposed budget is reviewed by MMB, and forwarded to the Governor's Office for consideration for inclusion in the Governor's biennial budget to be presented to the Legislature.

Recent revenues and expenses are for the Board of Dentistry (excluding the HPSP program) total the following…

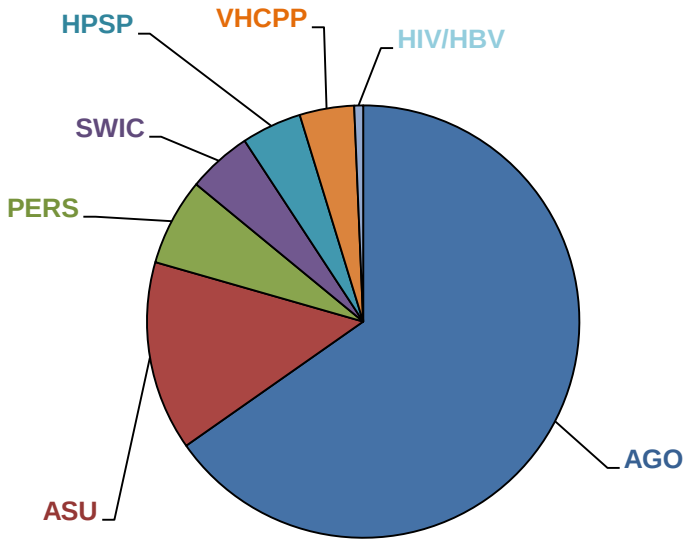
BIENNIUM	RECEIPTS (INCOME)	DISBURSEMENTS (EXPENSES)
FY 2009-2010	$ 2,715,823	$ 2,865, 584
FY2007-2008	$ 2,476,090	$ 2,759,013
FY 2005-2006	$ 2,968,160	$ 2,422,245

Since 1999, the Minnesota Board of Dentistry has intentionally operated on a negative cash flow to draw down its reserve funds. This has now been accomplished, and the Board is positioned to generate a positive cash flow in the coming biennium (FY2013-2014). As indicated in the table below, in addition to its own agency operating expenses, the Board is called upon to contribute funds to the operation of other programs.



Funding Other Programs

Estimated FY2010-11 Expenditures to Other Programs and Agencies



Attorney General's Office	$512,018
Administrative Services Unit	$111,146
Prescription Electronic Reporting Program	$51,133
Statewide Indirect Cost	$37,751
Health Professional Services	$35,278
Volunteer Health Care Provider Prog	$31,967
MDH HIV/HBV/HCV Monitoring	$5,200
Total Other Expenditures	**$784,493**

Expenditures for Agency Services (FY04-11)	ALL HLBs	BOARD of DENT SHARE
Office of the Attorney General	$ 17,350,380	$ 2,106,867
Health Professionals Service Program (HPSP)	$ 5,023,831	$ 203,709
Administrative Services Unit (ASU)	$ 3,530,965	$ 376,421

PROGRAM	FUNDING AMOUNT
Department of Health HIV/HBV/HCV Program (Dentistry, Medical Practice, Nursing) (2004-2011)	$1,227,792
Office of Mental Health Practice (BBHT, MFT, Medical Practice, Nursing, Social Work, Psychology) (2006-2009)	$268,227.94
Volunteer Health Care Provider Program (Dentistry, Medical Practice, Nursing) (2004 – 2011)	$499,179
Department of Human Services Community – Scholarship Program (Nursing)	$3,116,000
Department of Health Loan Forgiveness Program (Medical Practice, Nursing)	$725,000
Department of Health Oral Health Pilot Project (Dentistry)	$150,000
Department of Health Rural Pharmacy Program (Pharmacy)	$400,000
Transfer to General Fund (all HLBs) (2004-2011)	$16,362,000
Office of Enterprise Technology (OET) E-Licensing Initiative (2010)	$1,663,486.33
Collection and Transfer to (OET)	$70,198.50
TOTAL	**$24,481,882**

STATE OF MINNESOTA

PART II:

MINNESOTA BOARD OF DENTISTRY

ADMINISTERING BOARD FOR THE

HEALTH PROFESSIONALS SERVICES PROGRAM (HPSP)

REPORT to the SUNSET COMMISSION 2011

Report to the Legislature in Compliance with Minnesota Statutes Section 3D.06

December 8, 2011

PART II: Department Contact Information (HPSP)

Monica Feider, MSW, LICSW
Program Manager
Health Professionals Services Program (HPSP)
1380 Energy Lane, Suite 202
St Paul, MN 55108
651-641-0487 (main)
651-643-2163 (fax)
www.hpsp.state.mn.us

PART II: HEALTH PROFESSIONALS SERVICES PROGRAM

Table of Contents

INTRODUCTION

The Health Professionals Services Program (HPSP) is collaborative program of the health-licensing Boards that provides monitoring services to health professionals with illnesses which may impact their ability to practice safely. HPSP implements Monitoring Plans to ensure that the health professionals do not cause patient harm and that they obtain needed treatment.

OVERVIEW

HPSP is a vital resource that promotes early intervention, diagnosis and treatment for health professionals with substance, mental health and other medical disorders that may impact their ability to practice safely.

HPSP's primary focus is to protect the public by assuring that health professionals receive appropriate care and intervention when needed. HPSP coordinates the illness management of health professionals and provides them with monitoring services. Health professionals engage in HPSP services both voluntarily and through Board intervention.

HISTORY

Why was HPSP Created?

Health professionals are as susceptible to substance, psychiatric and other medical disorders as the general public. Left untreated, some illnesses can impact clinical skills. Many health professionals do not get the help they need due to social stigma, fear of exposure, or lack of awareness. Additionally, many feel that they should be able to manage their illnesses on their own.

Prior to 1994, many health professionals were required to report their illnesses to their licensing Boards. However, many were reluctant to do this for fear of being disciplined by their Board, so they delayed or refused treatment. This ultimately put patients at greater risk of harm. Several health-licensing Boards and professional associations identified this risk and worked collaboratively to develop HPSP's legislation and establish the program.

Solution

In 1994, HPSP was created per Minnesota Statutes §§ 214.29 to 214.36:

> to protect the public from persons regulated by the boards who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals or any other material, or as a result of any mental, physical or psychological condition.

In 2000, legislation made it mandatory for all health licensing Boards to participate in HPSP (MS §§ 214.28 to 214.29). Then, in 2006, the Department of Health worked with the legislature to establish a change enabling Occupational Therapy Practitioners and Assistants, Audiologists, Speech-Language Pathologists, Hearing Instrument Dispensers, and Complementary and Alternative Health Care Practitioners to also be eligible for HPSP program services.

Advantages

Early Intervention and Patient Safety

As health professionals voluntarily participate in HPSP, the program is able to intervene immediately to ensure that they refrain from practice if their illness is not stable. HPSP also implements practice limitations when deemed appropriate. If the practitioner does not agree to comply with these restrictions, HPSP files a report with their licensing Board so that the Board is aware and can take additional steps.

Self Reporting

HPSP allows health professionals to report their illnesses to the HPSP in lieu of their licensing Boards, promoting early intervention, diagnosis, treatment and monitoring. In turn, this decreases the likelihood of patient care being compromised. It also decreases the likelihood or need for Board discipline against the licensee.

Concerned Party Reporting

HPSP provides others with permission to report health professionals to HPSP in lieu of the licensing Board. The reports are confidential and subject to immunity. This promotes the reporting of health professionals with illnesses, as colleagues or family members are more inclined to report their friend or family member to HPSP than to their licensing Board.

Case Management Ensures Appropriate Care

HPSP's case managers help coordinate care to ensure health professionals are safe to practice. This coordination takes place between treatment providers and employers.

Cost Effective Alternative to Board Discipline

Allowing health professionals to engage in voluntary confidential monitoring decreases the need of Boards to take public disciplinary action, which reduces litigation costs.

Sections I and II of this document further outline how HPSP protects the public.

SECTION I: MISSION, GOALS & KEY FUNCTIONS

MISSION & GOALS: PUBLIC SAFETY

The mission of HPSP is to enhance public safety in health care.

The goals of HPSP are to promote early intervention, diagnosis and treatment for health professionals with illnesses, and to provide monitoring services as an alternative to Board discipline. Early intervention enhances the likelihood of successful treatment, before clinical skills or public safety are compromised.

Illustration: How HPSP Protects the Public

Employers report licensees for:

- stealing narcotics
- being intoxicated
- being manic or psychotic
- being unable to function due to brain damage or some other medical condition

Health professionals self-report for:

- being terminated or put on leave due to symptoms of mania, psychosis, dementia or other medical disorders
- being terminated for stealing drugs
- seeking treatment for substance disorder
- being hospitalized for a suicide attempt

How HPSP responds:

HPSP intervenes immediately. HPSP may request that the practitioner refrain from practice pending assessment and/or treatment to determine the appropriate level of care and whether the practitioner is safe to return to practice. After the assessment is completed, HPSP implements monitoring contracts and reviews the practitioner's compliance with the monitoring contract.

HPSP meets it mission by performing the *Key Functions* described on the following pages.

KEY FUNCTIONS

HPSP's key functions are consistent with its mission and goals, and address:

- Intake Services
- Monitoring Contracts
- Monitoring the Continuing Care and Compliance of Program Participants, and
- Communication

Intake Services

Provide health professionals with services to determine if they have an illness that warrants monitoring

- Respond to referrals/reports regarding health professionals who may have illnesses that may impact their ability to practice safely
- Provide licensees with a Tennessen Warning, review program eligibility requirements and provide general overview of the program
- Obtain substance, psychiatric, medical, social and vocational information from licensees
- Assess licensees' current health symptoms, treatment needs, immediate safety and potential risk to public
- Determine and implement immediate practice limitations, if necessary
- Obtain licensees' substance, psychiatric and/or medical records pursuant to state and federal data practice regulations
- Assess medical records and information received from treatment provider(s) regarding the licensees' illness history, current status, treatment recommendations, and practice imitations/recommendations
- Coordinate subsequent evaluations or treatment, if needed
- Maintain accurate case documentation
- Collaborate with external medical consultants concerning participant needs
- Identify any specific terms and conditions in Board Stipulation and Orders
- Secure records consistent with state and federal data practice regulations
- Collaborate with medical consultants and community providers concerning treatment

Monitoring Contracts

Create and implement monitoring contracts for those requiring monitoring:

- Design and implement individualized contractual agreements that stipulate monitoring requirements
- Determine the basis for and length of monitoring, including illness-specific and practice-related conditions
- Specify requirements for continuing care and practice restrictions or conditions
- Review monitoring conditions with licensees, treatment providers and work site monitors as needed

- **Monitor the Continuing Care and Compliance of Program Participants:**
  - Communicate monitoring expectations to treatment providers, work site supervisors and other collaborating parties
  - Develop and maintain positive working relationships with community providers, employee health providers, employers, and regulating Boards
  - Review and analyze records and reports from treating professionals, work site supervisors and other sources regarding participant level of functioning and compliance with the terms of the contractual agreement
  - Coordinate unscheduled toxicology screening process
  - Maintain current and accurate documentation
  - Intervene as necessary regarding participant non-compliance, ineffective monitoring, inappropriate treatment, or exacerbation of symptoms

- **Communication**

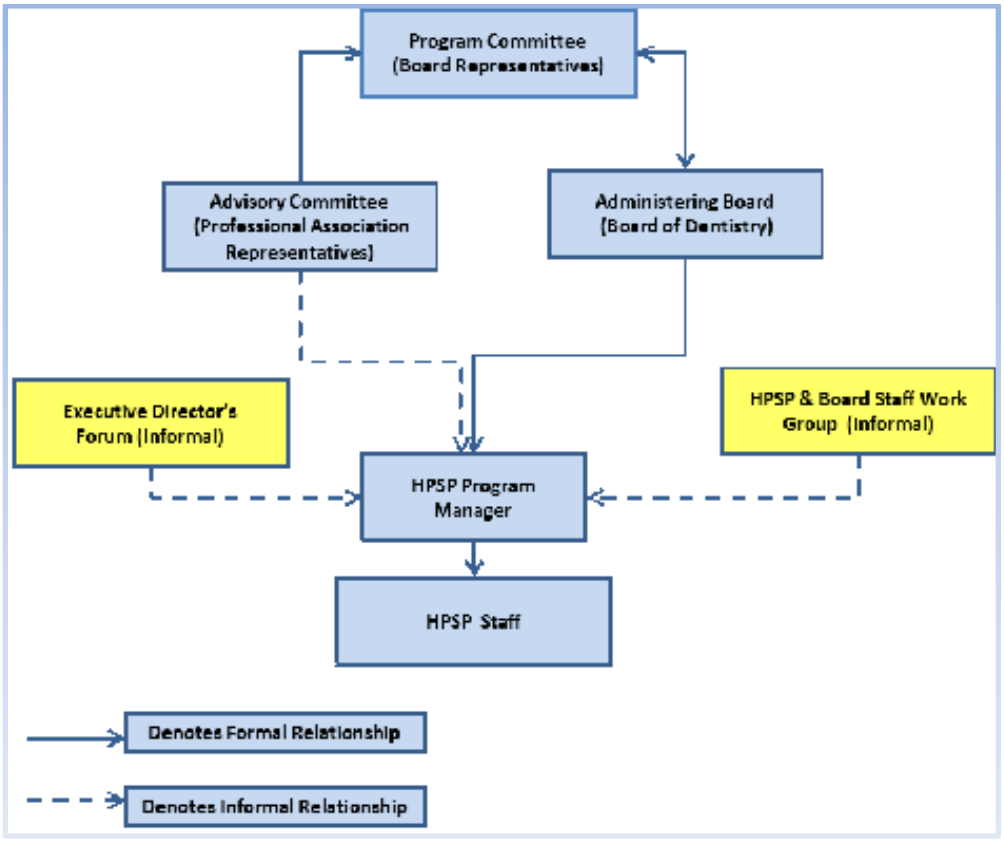
  Consult with licensees, licensing boards, health employers, practitioners, and medical communities:

  - Develop and promote program visibility through contact with professional groups, community providers, and state agencies
  - Prepare documents regarding program services
  - Provide expertise for state licensing Boards, employers, and the public on matters of impairment and risk-potential of health professionals
  - Design and implement HPSP policies, procedures, and quality assurance practices
  - Remain current with issues and trends in the fields of state regulation, monitoring, and clinical care of impaired health professionals
  - 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

ADMINISTRATION

HPSP is managed through the inter-related mechanisms of a Program Committee, an Advisory Committee, an Administering Board, and the Program Manager/Staff.

Organizational Chart



The Program Committee

Minn. Stat. § 214.32, subd. 1 (a) established HPSP Program Committee:

> A Health Professionals Services **Program Committee** is established, consisting of one person appointed by each participating Board, with each participating Board having one vote. The committee shall designate one Board to provide administrative management of the program, set the program budget and the pro rata share of program expenses to be borne by each participating Board, provide guidance on the general operation of the program, including hiring of program personnel, and ensure that the program's direction is in accord with its authority. The Program Committee exists to provide direction to the program, assuring the participating Boards that HPSP is operating effectively and efficiently to achieve the purposes outlined in the statute. Its goals are to ensure public protection; assure program clients are treated with respect, affirm the program is well-managed, verify the program is financially secure and operating consistent with the statute. The committee designates one of the health-related Boards to act as the Administering Board to provide administrative management to the program.

HPSP developed the following processes to meet this statutory obligation:

Appointment of Committee Members

One representative from each participating Board serves on the Program Committee. Each participating Board may choose its representative (and an alternate) in any manner acceptable to that Board. The representative may be a current or former Board member, a staff person or any interested person. The Board representative should have an understanding of the role of health licensing Boards in public protection.

Annually, on November 1st, the HPSP program manager will notify each participating Board of the need to make a new appointment or confirm the continuation of the current appointee and alternate. By January 15th, each participating Board will notify the program manager in writing of the appointed representative and alternate.

Officers: Duties and Election of Program Committee Chair and Vice-Chair

At the first meeting of the Program Committee of the new biennium (July 1; even years), the Program Committee elects a Chair and a Vice-Chair from its membership. The Chair of the Program Committee presides at Committee meetings. The Chair will confer as necessary with the program manager to set Committee meeting agendas and discuss Committee business when the Committee is not in session. The Vice Chair presides at Committee meetings in the absence of the Chair.

The following persons are appointed for 2011 to the Program Committee by their respective Boards:

Program Committee Member Name	Representing the Board of:
Judi Gordon	Behavioral Health and Therapy
Kay Strobel	Chiropractic Examiners
Neal Benjamin	Dentistry
Kyle Renell , Chair	Department of Health
Susan Parks	Dietetics and Nutrition
Jennifer Deschaine	Emergency Services
Denny Morrow	Marriage and Family
Keith Berge	Medical Practice
Maria Reines	Nursing

Program Committee Member Name	Representing the Board of:
Randy Snyder	Nursing Home Administrators
Michelle Falk	Optometry
Stacey Jassey	Pharmacy
Kathy Polhamus	Physical Therapy
Esther Newcombe	Podiatric Medicine
Susan Ward	Psychology
Rosemary Kassekert	Social Work
Sharon Todoroff	Veterinary Medicine

There are four scheduled Program Committee meetings per year. Committee members are paid a per-diem by the Board they represent for attending the meeting.

Program Committee Goals

The Program Committee provides HPSP with guidance to ensure the direction of HPSP is in accord with its statutory authority. The Program Committee established the following five goals to meet this responsibility:

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
- Self and third party reporting of illness made up 59% of referrals in fiscal year 2011
- 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 day-to-day involvement with participants, the following HPSP procedures and activities demonstrate respect for clients:

- Simple process for reporting to the program developed and maintained
- Monitoring guidelines that are based on research and national norms developed and utilized
- Consistent service to all health professionals provided
- Motivated, competent staff proficient in substance and psychiatric disorders and case management recruited and retained
- Sensitive to costs of participation (e.g., in FY11, HPSP contracted with Hennepin County Medical Center to centrally test all participant urine samples, resulting in reduced cost of screens for most participants)
- Feedback from participants collected and reviewed on a regular basis
- Participant feedback incorporated as deemed appropriate
- Accessible collection sites sought for participants (e.g., HPSP posted 166 potential collection sites in 114 different cities on its website)

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:

- Collaboration with Board staff and solicitation of input regarding the monitoring process and guidelines
- Quarterly meetings held with Board staff to review program processes and Board concerns
- HPSP is staffed with competent employees who are invested in the program's success
  - the average staff retention rate is 11 years with a low of 3 years and a high of 14 years
- Case managers hired who provide quality intake, case management and monitoring services
- Annual performance reviews of employees conducted
- Executive directors surveyed by program manager annually to obtain input on program services
- Monthly billing reports submitted to the Boards on a timely basis
- National recognition received for 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 and the Administering Board representatives to track spending.

HPSP's fiscal security is associated to that of the health licensing Boards. The Boards pay for HPSP as an indirect cost. Therefore, the cost of HPSP does not come from the Boards' legislatively established operating budget.

Since HPSP's inception, its budget has expanded to address increasing numbers of health professionals seeking services. As the current budget is stagnant, HPSP has been reviewing creative ways to become increasingly efficient and decrease spending.

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 when legal questions arise regarding the program's authority.

Summary

HPSP is committed to protecting the Minnesota public by providing the most effective and efficient service possible. HPSP does this by seeking feedback and input from a variety of sources; including participants, boards and professional associations; and by keeping current on monitoring programs in other states and national developments in healthcare, impairment and recovery.

HPSP provides the Program Committee with an annual report that outlines how it is meeting these goals.

The Advisory Committee

Minn. Stat. § 214.32, Subd. 1 (c) established HPSP's Advisory Committee:

An advisory committee is established to advise the program committee consisting of:

- one member appointed by each of the following: the Minnesota Academy of Physician Assistants, the Minnesota Dental Association, the Minnesota Chiropractic Association, the Minnesota Licensed Practical Nurse Association, the Minnesota Medical Association, the Minnesota Nurses Association, and the Minnesota Podiatric Medicine Association;
- one member appointed by each of the professional associations of the other professions regulated by a participating board not specified in clause (1); and
- two public members, as defined by section 214.02.

Members of the advisory committee shall be appointed for two years and members may be reappointed.

The Advisory Committee has four scheduled meetings per year. As members are appointed by their respective professional associations, they graciously volunteer their time and expertise to be a part of the Advisory Committee. They receive no compensation for attending the meetings. The program is able to utilize their profession-specific expertise as well as reach out to the associations to promote the reporting of potentially impaired health professionals.

HPSP developed the following processes to meet this statutory obligation:

Appointments

The Advisory Committee consists of one person appointed by each professional association by any means acceptable to them as identified in Minnesota Statutes 214.32 subd. 1 (c) (1):

Each participating Board shall notify the program manager of the names and addresses of known professional associations not specified in clause (1) but representing the other professions regulated by the participating Board. The program manager shall notify the identified professional association(s) of the opportunity to appoint a representative to the Advisory Committee. The associations that choose to do so shall each appoint one person to serve on the Advisory Committee by any means acceptable to them, and may select an alternate as well.

Public Members/Appointment by Program Committee

The Program Committee shall appoint two public members to the Advisory Committee. The Advisory Committee may provide the Program Committee with the names of public persons interested in appointment to the Advisory Committee. As vacancies for public members occur in the membership of the Advisory Committee, the Program Committee shall determine how to fill the positions. Options available include but are not limited to: advertising in appropriate media, contacting the office of open appointments in the office of the Secretary of State and/or the Governor's Office to learn of persons who have submitted applications for public member appointments through the open appointments process, contacting members of participating boards or members of the Advisory Committee for suggestions of interested persons, identifying potential candidates directly.

Biennial Notice of Appointments to Program Manager

Biennially on November 1st of odd numbered years, the program manager will notify each participating association of the need to make a new appointment or confirm the continuation of the current appointee by the coming January 15th.

Each participating association must notify the program manager in writing on or before January 15th of the even numbered year of who their representative is and who their alternate is (if they use an alternate). On the same timeframes noted above, the program manager shall notify the Program Committee of their responsibility to make new or continuing existing appointments of two public members or make new appointments. At any point that an appointed Advisory Committee member or alternate resigned from their appointment, the association shall appoint a replacement. The Program Committee will be asked to appoint a replacement for any public member who resigns from the Advisory Committee.

Duties and Election of Advisory Committee Chair and Vice Chair

The members of the Advisory Committee shall annually, at their first meeting after July 1, elect from among their group, a Chair, who shall be responsible for presiding at meetings of the committee and conferring with the program manager regarding committee business when the Committee is not in session. At the first meeting after July 1, the member shall also elect from among their group, a Vice-Chair, who shall preside at Committee meetings in the absence of the Chair.

The following persons have been appointed for 2011 to the Advisory Committee from their respective professional associations.

Advisory Committee Member Name	Representing the:
Jim Alexander, Chair	MN Pharmacists Association
Bruce Benson	MN Health Systems Pharmacists
Lois Cochran Schlutter	MN Psychological Association
Mary Ann Foldesi	MN Academy Of Physician Assist.
Stephen Gulbrandsen	MN Dental Association
Jody Haggy	MN Nurses Association
Megan Hartigan	MN Ambulance Association
Randy Herman	MN Assoc. Of Social Workers
Therese Schumacker	MN Dietetics Association

Advisory Committee Member Name	Representing the:
Rose Nelson	Public Member
Not appointed	MN Society for Respiratory Care
Jeff Morgan	Physicians Serving Physicians
-open-	Public Member
Karen Sames	MN Occupational Therapy Assoc.
Debra Sidd	MN Dental Hygienists Association
Karolyn Stirewalt	MN Medical Association
Sandy Swanson	MN Physical Therapy Association
Scott Wells	MN Veterinary Association

Advisory Committee Goals

Goal 1: Promote Early Intervention, Diagnosis, Treatment and Monitoring for Potentially Impaired Health Professionals

It is in the interest of HPSP Advisory Committee members to promote the ethical standards of their individual professions. Advisory Committee members are, therefore, invested in ensuring potentially impaired health professionals in their respective fields of practice receive care as early as possible. Obtaining early assistance promotes the overall profession in that, (1) there is a reduction of patient harm, and (2) there is a reduced likelihood of negative consequences to the professional as well as negative publicity around consequences.

Goal 2: Provide Expertise to HPSP staff and Program Committee

The Advisory Committee identifies profession-specific norms, as monitoring multiple professions requires access to experts in each profession. Given that HPSP monitors over 30 professions, the Advisory Committee, representing many of the professions monitored by HPSP, is a vital resource to HPSP, providing practical up-to-date knowledge of the individual practice areas and identifying recent clinical and occupational trends in their specific fields. Additionally, the Committee regularly reviews all features of HPSP and recommends protocol changes and improvements in procedures, assists in the preparation of materials, assists with research, as well as provides technical information about the related fields. To illustrate, Committee members have assisted HPSP in better a understanding of the surgical setting and how controlled medications might be diverted by an impaired professional (such as an anesthesiologist, a nurse anesthetist, a circulating nurse, or a surgeon) in that setting, such that HPSP has been able to develop more precise practice restrictions in the surgery practice setting.

Goal 3: Act as a Liaison with Membership

Each Committee member acts as a communication link to the health occupations served by HPSP via that profession's societal organization or perhaps a peer support group, such as Dentists Concerned for Dentists. The Committee member identifies areas of cooperation and encourages more awareness of professional impairment among administrators and practitioners alike. The Advisory Committee facilitates connections between HPSP and identified individuals in various health systems and academic institutions to provide outreach and education to the widest number of professionals, which eases the fear of reporting oneself or a fellow professional. The liaison function of the Advisory Committee is perhaps the most important function of the committee, because as a practical matter it promotes HPSP's goal of early intervention.

The Administering Board

HPSP is not an independent State agency. By statute, one of the health licensing Boards is designated by the Program Committee to administer the program. The Board of Dentistry, under the leadership of Marshall Shragg, Executive Director, currently oversees HPSP's management. Minn. Stat. § 214.32, Subd. 1 (b):

> The designated Board, upon recommendation of the Health Professional Services Program Committee, shall hire the program manager and employees and pay expenses of the program from funds appropriated for that purpose. The designated Board may apply for grants to pay program expenses and may enter into contracts on behalf of the program to carry out the purposes of the program. The participating Boards shall enter into written agreements with the designated Board.

HPSP utilizes the following process to meet this statutory requirement:

The Program Committee designates an Administering Board from among the health-related Boards eligible to participate in HPSP. The Administering Board provides administrative management to the program. This includes, but is not limited to, establishing the program budget, providing guidance and monitoring the program's implementation in accordance with enabling legislation. The designated Administering Board— in conjunction with the Administrative Services Unit (ASU)— will provide all support services, including financial, personnel and other services required to maintain program operations. These include, but are not limited to, hiring the program manager and employees, paying expenses for the program from funds appropriated for that purpose, applying for grants to pay program expenses, and entering into contracts on behalf of the program to carry out the purposes of the program. The support services will be provided, consistent with the Administering Board's and the State of Minnesota's policies and procedures governing the operation of any state agency.

The designated HPSP Administering Board is credited $1,000.00 per month for each month the Board serves as HPSP Administering Board. The credit is deducted from the amount the Board would otherwise be paying HPSP. Any unused credit at the end of the Fiscal Year is not carried over.

Informal Relationships

As noted in the organizational chart, HPSP utilizes the health licensing Boards' Executive Director's forum to exchange information efficiently. Additionally, HPSP created a work group with Board staff who are responsible for managing persons who are not compliant with the conditions of monitoring. This group has helped the program identify weaknesses in operations and make improvements. While neither group has a statutory relationship with HPSP, both are integral to the program's efficient and effective operations.

HPSP & Board Staff Work Group

Participating boards are asked to designate one or more representatives to meet periodically with HPSP staff as part of a work group to discuss issues relating to program policies, procedures and activities. HPSP program manager schedules regular meetings for the work group with a frequency and duration designed to foster effective communication between board representatives and HPSP staff without overburdening the group members. HPSP staff arranges the meeting space and distributes agendas in advance of the regularly scheduled meetings. Each meeting concludes with a solicitation to group members for items of discussion at subsequent meetings.

The board representatives represent the interests and concerns of their respective boards. They also obtain information from HPSP staff (consistent with statute), which enhances their understanding of program processes and illness management. In turn, HPSP staff develop a greater awareness of board processes.

HPSP Program Staff:

Monica Feider, Program Manager
Sheryl Jones, Office Manager
Tracy Erfourth, Case Manager
Marilyn Miller, Case Manager
Mary Olympia, Case Manager
Kurt Roberts, Case Manager
Kimberly Zillmer, Case Manager

Each case manager has a caseload of roughly 118 participants. This caseload is nearly 20% higher than national recommendations for similar programs.

SECTION II: EFFECTIVENESS & EFFICIENCY THROUGH COLLABORATION

EFFECTIVENESS – PUBLIC PROTECTION

Public Protection

One measure of effectiveness is the ability to remove an impaired professional immediately from practice, prior to harm occurring. (Were harm to have occurred, HPSP would involve the regulatory agency.) This is done pursuant to the agreement of the participant and HPSP; that is, without formal involvement by the regulatory agency and, therefore, can be carried out immediately. Most often, this occurs when the participant initially presents to HPSP, but it sometimes occurs during the course of monitoring. In both instances, HPSP relies on treatment provider assessments to determine the course of treatment and return to work. In the latter instance of an exacerbation of illness during monitoring, the participant has demonstrated that a higher level of care is needed. The participant refrains from practice until he or she is determined to be stable by HPSP via the treating professionals' conclusions and recommendations.

Other effective public protection tools at HPSP are the use of practice restrictions as needed for a participant to practice safely and effectively. For example, a participant with bipolar disorder would not, in general, be permitted to work night shifts due to the correlation of circadian rhythm disruption and manic episodes.

Referrals

Effectiveness of a monitoring program which requires self-reports of illness and permits third party reports, can be measured by an increase in reports over time. Since inception in 1994, the HPSP client population has steadily increased. Importantly, self reports of illnesses (versus third party reports and Board referrals) are consistently higher than any other referral source. Additionally, third party reports (typically from employers) and Board non-disciplinary referrals have also increased. The only referral category that has not seen steady increases is that of Board disciplinary referrals.

Program Completion and Reports to Boards

Because the mission of HPSP is public protection, program effectiveness can be determined both by the success of completion and, ironically, by the failure to complete. A comparable agency in terms of measuring effectiveness might be county probation services where a person who violates the probationary agreement is sent back through the court system. The probation client has not been a success in the program, but public protection is not lost. Similarly, pursuant to HPSP statute, those who fail monitoring are reported to their regulatory health-licensing agency, demonstrating one important measure of effectiveness in public protection.

A more obvious measure of effectiveness is the overall completion rate of monitoring by HPSP, which is currently **fifty-three percent** of those eligible for monitoring services. There are several iatrogenic factors within monitoring itself which contribute to, or subtract from, program completion rates. First, nearly all of the illnesses monitored by HPSP are life-long, chronic illnesses, such as substance dependence, depression, or bipolar disorder, with a majority of participants having dual chronic disorders. Recovery from a chronic disorder, much less two chronic disorders takes ongoing professional assistance. Second, HPSP does not provide treatment services to its monitored professionals. Rather, HPSP monitors how professionals manage their illnesses during, and/or after receiving appropriate treatment and ongoing professional assistance. Monitoring itself helps the participant to establish a routine for ongoing recovery. Third, resources available to the various professionals can affect their success in managing their illnesses, as can level of education and motivators such as potential regulatory agency involvement and potential loss of income. For example, physicians, who comprise 19% of HPSP participants, have the highest income and education of all participants, and they also have the highest completion rate of HPSP participants.

These three factors likely contribute to HPSP completion rate not being higher. At the same time, however, if the completion rate for HPSP participants is compared to overall treatment program successes for certain categories of illnesses, HPSP monitoring has a statistically higher rate. The Substance Abuse and Mental Health Services Administration (SAMHSA) 2009 Treatment Episode Data Set statistic on the success rate of treatment for substance dependence is 35% (measured by sobriety at completion of treatment). At HPSP, the completion rate is 51% percent for substance dependence monitoring, and as reported earlier, the overall HPSP completion rate is 53%. The process of monitoring itself, combined with the motivation of potential regulatory agency investigation, contributes to participant success in managing the individual illness.

EFFICIENCY: A MODEL OF COLLABORATION

Every state in the country, whether governmentally or in private state associations, monitors its health professionals whose illnesses could adversely affect patient safety. However, most programs are profession-specific; that is, each professional monitoring program is a separate entity. HPSP is a unique model of monitoring across all the Minnesota regulated health professions resulting in efficiency of services and ease of access. (The participating entities are listed below.)

Health Licensing Boards & Minnesota Department of Health

- Behavioral Health & Therapy
- Chiropractic Examiners
- Dentistry
- Dietetics and Nutritionists
- Emergency Medical Services
- Marriage and Family Therapy
- Medical Practice
- Nursing
- Nursing Home Administrators
- Optometry
- Pharmacy
- Physical Therapy
- Podiatric Medicine
- Psychology
- Social Work
- Veterinary Medicine
- Department of Health

Professional Associations

MN Pharmacists Assoc.
MN Health Systems Pharmacists
MN Psychological Assoc.
MN Academy Of Physician Assist.
MN Dental Assoc.
MN Nurses Assoc.
MN Ambulance Assoc.
MN Assoc. of Social Workers
MN Dietetics Assoc.
MN Society for Respiratory Care
Physicians Serving Physicians
MN Occupational Therapy Assoc.
MN Dental Hygienists Assoc.
MN Medical Assoc.
MN Physical Therapy Associ.
MN Veterinary Assoc.

STAKEHOLDERS

HPSP has a wide array of stakeholders that are invested in the program's success. Some stakeholders are defined in statute while others are informal in nature. The following groups are represented in the diagram above, indicating how each touches on and influences the program, and in turn is impacted by the presence and involvement of HPSP.

Public

Consumers of health care in Minnesota

Health Care Employers and Systems

- Employee health programs
- Supervisors
- Medical directors
- Credentialing
- Human resources

Health Professionals

- Licensees wanting to report
- Colleagues, friends and family of health care practitioners wishing to make reports
- Treatment providers

Educational Programs

HPSP provides annual lectures/presentations to the educational programs (i.e., University of Minnesota's Schools of Pharmacy and Dentistry). These presentations are often the first opportunity for students to understand how to learn how to identify potential impairment in themselves and others. It also provides them with resources for managing these challenging situations.

Rate of Participation by Board

The following chart shows the number of persons regulated by Board, the number enrolled in HPSP at the end of fiscal year 2011 and the ratio of persons monitored by Board.

Board	Number Licensed	Number Open at End of FY 2011	*Ratio*
Behavioral Health	3,071	14	*4.56 per 1,000*
Medical Practice	25,946	105	*4.05 per 1,000*
Nursing	107,736	353	*3.28 per 1,000*
Physical Therapy	5,422	13	*2.40 per 1,000*
Chiropractic Examiners	4,217	9	*2.13 per 1,000*
Pharmacy	16,182	25	*1.54 per 1,000*
Psychology	3,450	5	*1.45 per 1,000*
Dentistry	16,417	23	*1.40 per 1,000*
Social Work	12,198	13	*1.10 per 1,000*
Veterinary Medicine	3,114	3	*0.96 per 1,000*
Marriage and Family	1,675	1	*0.60 per 1,000*
Dept. of Health**	5,810	3	*0.52 per 1,000*
Emergency Medical Services*	28,643	14	*0.49 per 1,000*
Dietetics & Nutrition	1,378	0	*0 per 1,000*
Nursing Home Administers	851	0	*0 per 1,000*
Optometry	1,023	0	*0 per 1,000*
Podiatric Medicine	262	0	*0 per 1,000*
Total:	237,395	581	*2.4 per 1,000*

The number licensed indicated above represents data gathered from the 2009-2010 Health Licensing Boards' Biennial Reports to the Legislature.

* Represents data from the designated agencies in May 2011.

** Represents persons regulated by the Dept. of Health on August 1, 2011.

The number monitored represents the number of persons open by Board at the end of fiscal year 2011.

Following are some advantages of a collaborative model monitoring agency, all of which are factors in ensuring public safety:

HPSP statute permits monitoring of any illness if the illness is serious and is not being appropriately managed by the individual. Prior to the enactment of HPSP law, the health-licensing entities were forced to address illnesses via the investigatory process in Minn. Stat. 214, which provides the due process structure to enforce the various codes of conduct via corrective and disciplinary measures. The investigatory process is time consuming and expensive; yet, few professionals with illnesses require disciplinary measures. Moreover, the regulatory entities might be forced to overlook or dismiss cases of licensees whose illnesses have the possibility of causing patient harm, but are not yet imminently dangerous.

Limited resources of smaller regulatory entities do not prevent them from participating in HPSP. Just as in the principle of an insurance fund, the fact that both large and small regulatory entities participate in an umbrella monitoring agency, affords smaller entities such as the Board of Podiatric Medicine or the Board Physical Therapy to offer monitoring services that would not otherwise be cost-effective.

HPSP is also a unique model of one-stop reporting across all the Minnesota regulated health professions. Importantly, the governing legislation for HPSP insightfully provides that any regulated health professional must report an impairing illness and gives permission for a third party to report (i.e.: colleague or supervisor). Further, HPSP legislation provides that such reports may be made *either* to the regulating board *or* to HPSP, therefore facilitating an alternative reporting source for earlier intervention. This streamlining of reporting, as well as offering alternative reporting, is insurance that professionals with impairing illnesses are not as likely to be hidden by employers, treatment providers, and others who have legitimate concerns.

HPSP loops back to the regulatory entity if the intervention or monitoring fails. Further, the regulatory entity is given access to the records gathered by HPSP which can be used in the investigatory process.

ADMINISTRATIVE SERVICES UNIT

The Administrative Services Unit (ASU) is another model of efficiency in state government. ASU provides the health licensing boards and HPSP with services including but not limited to:

- Information Technology
- Human Resources & Contracting
- Accounting and Fiscal Management
- Purchasing and Payroll

Having one resource for the above services has two advantages. The first is that it saves Boards money because they do not have to hire additional staff to serve this function. The second is that it ensures that the above services are performed in a consistent manner. In addition to utilizing ASU services, HPSP also utilizes conference rooms in the health licensing Boards' office building.

Why isn't HPSP located in the health licensing Boards' office? Due to the confidential nature of HPSP services, the health licensing Boards and professional associations identified that it was important to keep HPSP services separate from that of the Boards in order to avoid any perceived conflicts of interest and to assure licensees that when they came to HPSP office, they would not be identified by Board staff. This separation is critical to HPSP's success, as it assures licensees that HPSP does not share confidential monitoring information with the Boards, unless they are not compliant with monitoring.

ONLINE SERVICES

Program Information and Forms

HPSP provides licensees, their treatment providers, supervisors ("work site monitors"), and the public with information about program services via its website at www.hpsp.state.mn.us. The website includes general information as well as specific information and forms for program participants, their treatment providers, their work site monitors and the public. Providing forms online is both efficient and effective. Online forms are immediately accessible. The utilization of online forms reduces copying and postage fees for HPSP.

Reporting Forms

Persons who wish to report a health professional to HPSP can download the *Third Party Report* form from HPSP's website and fax it to the program.

Meeting Agendas and Minutes

HPSP provides Program Committee and Advisory Committee members with meeting agendas and minutes via email to reduces copying and mailing costs.

SECTION III: HPSP ACTIVITIES

HPSP's *Key Functions* (Activities) were reviewed in Section I of this document. Quantitative data regarding these functions is described by the following *Referrals* and *Discharges* sections of this document. Additional activities that support HPSP's mission and goals are also described in this section.

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 an illness is present that warrants monitoring. If it is determined that a licensee has an illness that warrants monitoring, a Participation Agreement is developed and monitoring initiated.

Licensees can be referred to HPSP in the following ways:

- **Self-Referrals:** Licensees refer themselves directly to the program.
- **Third-Party Referrals:** The most common referrals from third parties are from employers and treatment providers. The identity of all third party reporters is confidential.
- **Board Referrals:** Participating Boards have two options for referring licensees to HPSP:
    - **Determine Non-Disciplinary:** The Boards refer because there appears to be an illness to be monitored or because they are aware that the licensee has an illness that may warrant monitoring. This is a non-disciplinary referral. Therefore, there is no public knowledge of the individual's referral to or possible participation in HPSP.
    - **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.

Comparing Referrals – Fiscal Years 2008 to 2011

In fiscal year 2011, HPSP opened more cases than in any other fiscal year. The tables below show the numbers of health professionals referred to HPSP by board and referral sources over the past four fiscal years.

Referrals by First Referral Source and Board	Nursing Home Admin.				Behavioral Health & Therapy				Chiropractic				Dentistry				Dept. of Health				Dietetics & Nutritionists				EMSRB			
Fiscal Year	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**
Board Non-Discipline	0	2	0	0	5	0	8	9	9	11	12	12	23	26	44	43	6	3	3	0	0	0	0	0	18	3	7	20
Board Discipline	0	0	0	0	0	0	0	0	0	2	1	0	4	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0
Self	0	0	0	0	2	1	10	6	0	1	3	1	7	5	2	7	1	3	0	1	0	0	0	0	8	2	3	5
Third Party	0	0	0	0	2	4	3	4	0	1	0	1	2	4	5	6	0	0	0	0	0	0	0	0	0	1	3	5
Sum	0	2	0	0	9	5	21	19	9	15	16	14	36	35	53	56	7	6	3	1	0	0	0	0	27	6	13	30

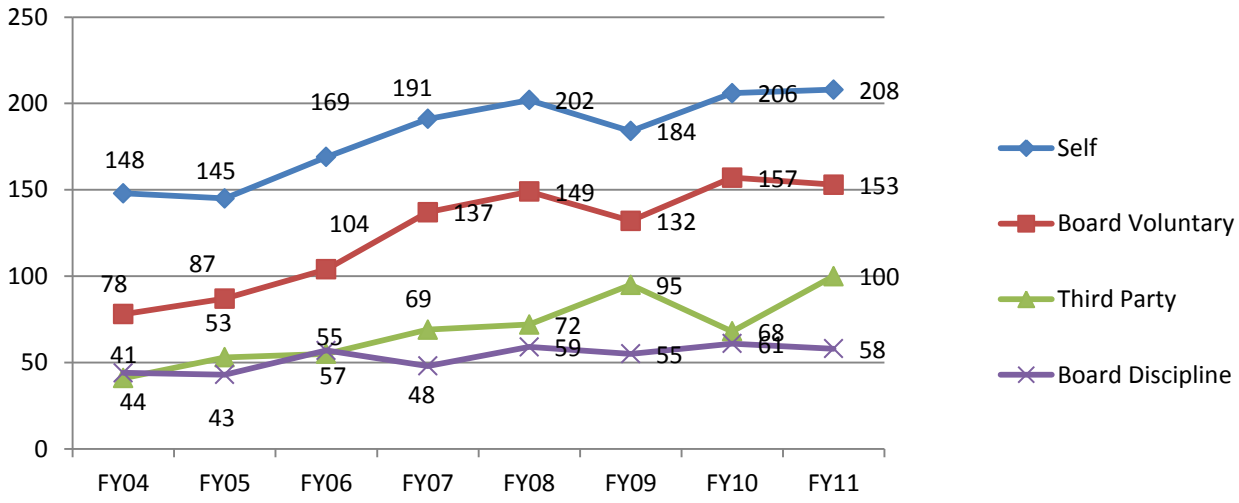
Referrals by First Referral Source and Board	Marriage & Family				Medical Practice				Nursing				Optometry				Pharmacy				Physical Therapy				Podiatric Medicine			
Fiscal Year	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**
Board Non-Discipline	0	0	1	0	15	23	21	14	60	50	49	32	0	0	0	0	3	5	3	3	4	3	3	8	0	0	0	0
Board Discipline	0	0	0	0	4	5	5	3	43	44	49	48	2	0	1	0	1	4	2	6	1	0	0	0	0	0	0	1
Self	1	3	1	2	34	32	28	37	128	125	136	133	0	0	0	0	5	4	9	9	1	4	3	4	0	0	0	0
Third Party	0	0	0	0	16	13	5	7	44	58	48	64	0	0	0	0	5	8	3	4	0	0	0	2	0	0	0	0
Sum	1	3	2	2	69	73	59	61	275	277	282	277	2	0	1	0	14	21	17	22	6	7	6	14	0	0	0	1

Referrals by First Referral Source and Board	Psychology				Social Work				Veterinary Medicine				Total			
Fiscal Year	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**
Board Non-Discipline	3	0	1	2	2	4	2	8	1	2	3	1	149	132	157	153
Board Discipline	0	0	1	0	2	0	0	0	1	0	0	0	59	55	61	58
Self	3	1	1	1	8	3	9	2	2	0	1	1	202	184	206	208
Third Party	2	2	1	2	0	4	0	4	1	0	0	1	72	95	68	100
Sum	**8**	**3**	**4**	**5**	**12**	**11**	**11**	**14**	**5**	**2**	**4**	**3**	482	466	492	**519**

Note: There were more referrals in fiscal year 2011 than in any other fiscal year!

Referrals by Fiscal Year

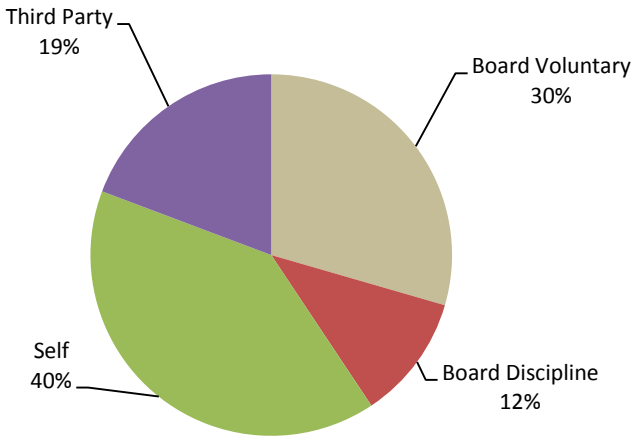
Over the past four years, 41% of health professionals referred themselves for services! An additional 17% were referred by employers, colleagues or other interested parties (third parties), resulting in 58% of those seeking services being unknown to their licensing boards. This is extremely important, as it shows HPSP is reaching health professionals before their illness results in a report to their licensing board.



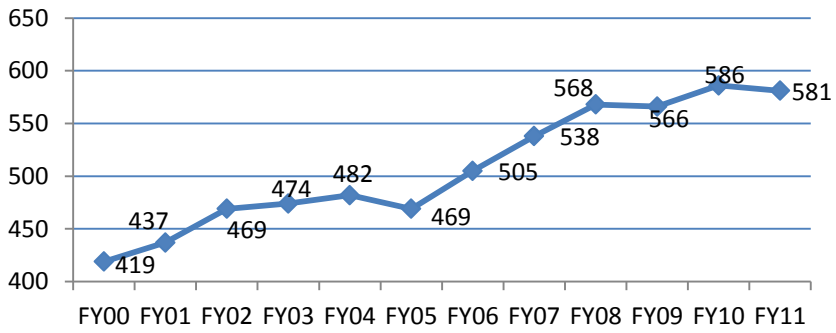
Fiscal Year 2011 Referrals by First Referral Source

The following chart shows the percentage of referrals by first referral source from July 1, 2010 to June 30, 2011:

NOTE: 59% were referred without Board involvement; showing practitioners are both self-referring to HPSP and being referred by others before their illnesses reach the level of requiring Board discipline



Open Cases at End of Fiscal Year



DISCHARGES

Definitions of Discharge Categories

When licensees are discharged from HPSP, the reason for the discharge is categorized as follows:

- **Completion:** Program completion occurs when the licensee satisfactorily completes the terms of the Participation Agreement and Monitoring Plan.
- **Non-Compliance:** Participant violates terms of his or her Participation Agreement/Monitoring Plan; case manager closes case and files a report with licensee's Board.
- **Voluntary Withdrawal:** Participant chooses to withdraw from monitoring prior to the completion of the Participation Agreement and Monitoring Plan; case manager closes case and files a report with the licensee's Board.
- **Ineligible Monitored:** Licensee is no longer eligible for program services due to reasons listed in statute; case manager files report with licensee's Board.* (determined after a period of monitoring)
- **Ineligible Not Monitored:** Licensee is not eligible for program services due to reasons listed in statute; case manager files report with licensee's Board. (determined at intake)
- **No Contact**: Initial report received by third party or Board; licensee fails to contact HPSP; case manager closes case and files a report with licensee's Board.*
- **Non-Cooperation**: Licensee cooperates initially, may sign Enrollment Form and/or releases, but then ceases to cooperate before the Participation Agreement is signed; case manager closes case and files a report with licensee's Board.*
- **Non-Jurisdictional:** No diagnostic eligibility established; the case is closed.

Comparing Discharges - Fiscal Years 2008 through 2011

The table below shows the number of persons discharged from HPSP by Board and discharge category. In fiscal year 2011, HPSP closed more cases than in any other year.

Discharges by Category and Board	Nursing Home Admin.				Behavioral Health & Therapy				Chiropractic				Dentistry				Dept. of Health				Dietetics & Nutritionists				EMSRB			
Fiscal Year	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**
Completion	0	0	0	0	1	1	1	2	5	3	3	4	6	5	5	5	1	1	1	3	0	0	0	0	1	6	2	4
Voluntary Withdraw	0	0	0	0	0	0	1	3	0	0	0	0	0	2	1	1	1	0	0	0	0	0	0	0	1	1	0	1
Non-Compliance	0	0	0	0	2	1	3	1	1	3	1	1	6	4	4	4	0	2	0	0	0	0	0	0	4	4	1	4
Deceased	0	0	0	0	0	0	1	0	0	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	1	1	0	0	0	0	1	1	0	2	0	1	0	0	0	0	0	0	0	0	1	0	0	0
Ineligible – Not Monitored	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
No Contact	0	0	0	0	0	0	5	3	0	1	0	0	4	1	2	4	0	0	0	0	0	0	0	0	0	1	0	8
Non-Cooperation	0	0	0	0	0	3	3	5	0	1	0	0	3	1	3	4	1	1	0	0	0	0	0	0	4	3	4	3
Non-Jurisdictional	0	2	0	0	2	2	0	1	5	8	9	9	18	25	32	37	2	2	2	0	0	0	0	0	10	1	3	7
Sum	1	2	0	0	6	8	15	16	11	17	14	15	37	40	47	59	5	6	3	3	0	0	0	0	21	16	10	27

Discharges by Category and Board	Marriage & Family				Medical Practice				Nursing				Optometry				Pharmacy				Physical Therapy				Podiatric Medicine			
Fiscal Year	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**
Completion	0	0	0	2	24	33	39	28	73	85	98	111	0	0	0	1	3	8	12	9	1	1	3	3	0	0	0	0
Voluntary Withdraw	1	0	0	0	0	3	3	2	11	9	11	21	0	0	0	0	1	1	1	3	0	0	0	0	0	0	0	0
Non-Compliance	0	0	0	0	6	2	1	4	98	79	74	70	0	0	0	0	9	1	3	6	0	1	1	0	0	0	0	0
Deceased	0	0	0	0	0	2	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ineligible - Monitored	0	0	0	0	6	4	2	2	10	13	16	20	0	0	0	0	1	0	3	0	0	0	0	1	0	0	0	0
Ineligible – Not Monitored	1	0	0	2	7	7	2	0	12	12	15	14	0	0	0	0	2	0	0	1	0	0	1	0	0	0	0	0
No Contact	0	0	0	0	2	5	0	0	4	12	11	6	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Non-Cooperation	0	0	0	0	5	3	2	1	27	20	32	31	0	1	0	0	2	5	4	2	0	0	0	0	0	0	0	0
Non-Jurisdictional	0	2	0	0	9	14	21	11	25	28	19	24	0	0	1	0	0	3	2	0	4	2	1	5	0	0	0	1
Sum	2	2	0	4	63	73	70	49	260	259	276	298	0	1	1	1	18	19	25	21	5	4	6	9	0	0	0	1

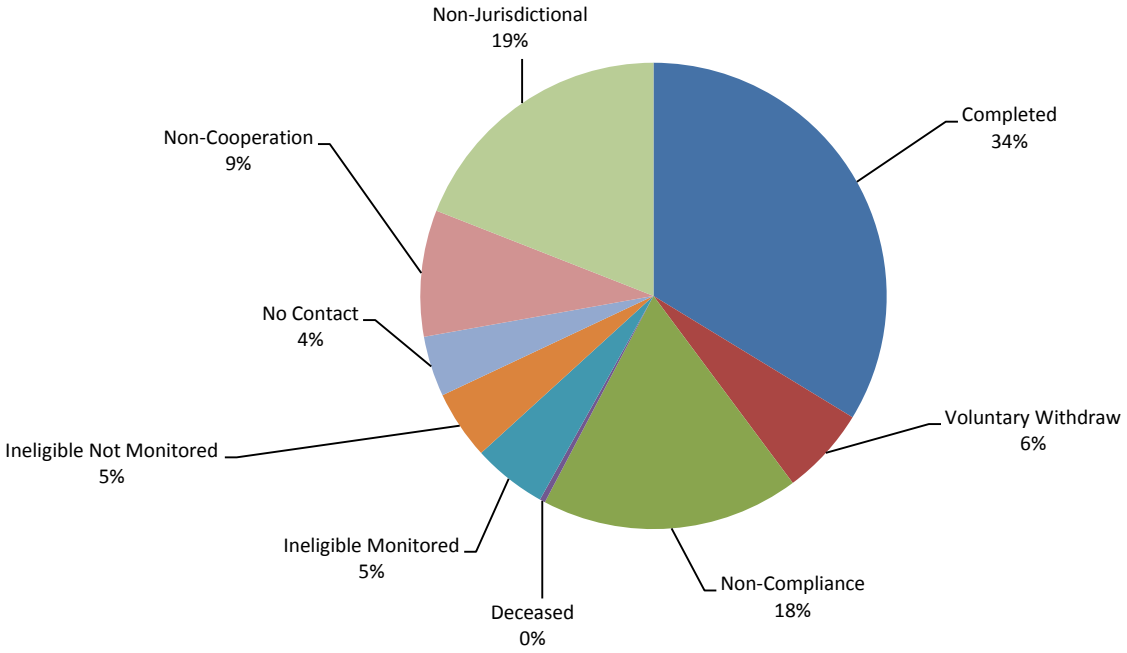
Discharges by Category and Board	Psychology				Social Work				Veterinary Medicine				Total			
Fiscal Year	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**	**08**	**09**	**10**	**11**
Completion	4	2	1	3	1	1	6	2	3	0	3	0	123	146	174	177
Voluntary Withdraw	0	0	0	0	2	0	1	1	1	0	0	0	18	16	18	32
Non-Compliance	1	0	0	1	1	1	1	2	0	0	1	1	128	98	90	94
Deceased	0	0	0	0	0	0	0	0	0	0	0	0	0	3	1	2
Ineligible - Monitored	0	0	1	1	1	0	0	1	0	1	0	0	20	23	23	27
Ineligible – Not Monitored	1	0	1	0	2	1	1	2	0	0	0	1	25	21	21	24
No Contact	0	0	0	0	1	0	1	1	0	0	0	0	11	21	19	22
Non-Cooperation	0	0	1	0	2	5	0	0	0	1	0	0	44	44	49	46
Non-Jurisdictional	2	1	0	1	2	0	2	3	1	0	1	1	80	90	93	100
Sum	8	3	4	6	12	18	12	12	5	2	5	3	449	462	488	**524**

Note: **There were more discharges in fiscal year 2011 than in any other fiscal year!**

Note: Discharge categories highlighted in blue represent categories of persons who did not engage in monitoring. Discharge category definitions found in Appendix A.

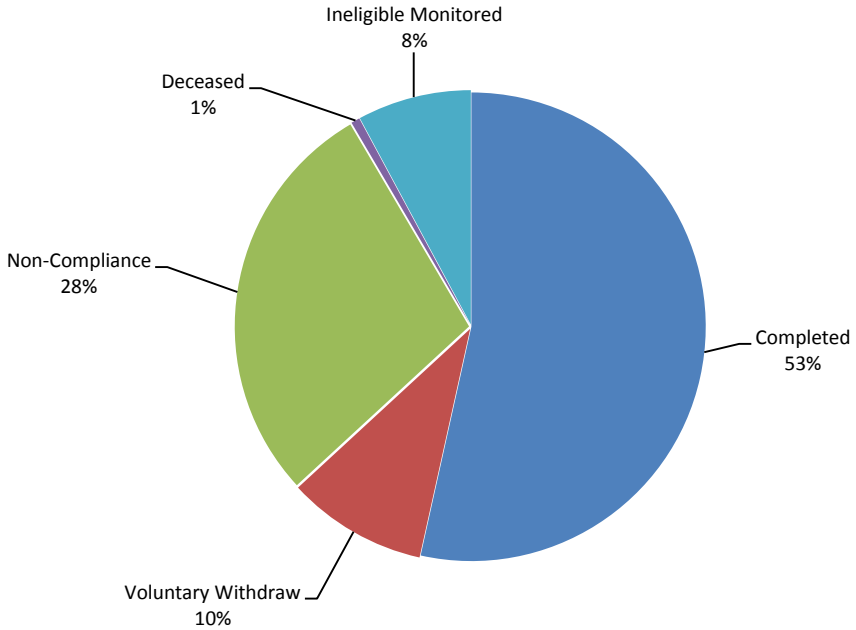
Fiscal Year 2011 Total Discharges

The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2011.



Fiscal Year 2011 Discharges of Those Monitored

The table below shows the discharge categories for persons who engaged in monitoring and were discharged from HPSP in fiscal year 2011.



ILLNESSES MONITORED

HPSP monitors individuals diagnosed with substance, psychiatric and/or medical disorders. The information provided below represents persons with signed Participation Agreements on July 22, 2011.

Substance Disorders: 82% of all participants have a substance use disorder

- 54% of persons monitored for a substance disorder are also monitored for a psychiatric disorder:
- 47% have anxiety and/or depression
- 5% have bipolar disorder
- 2% have another psychiatric disorder
- 4% of persons monitored for a substance disorder are also monitored for a medical disorder

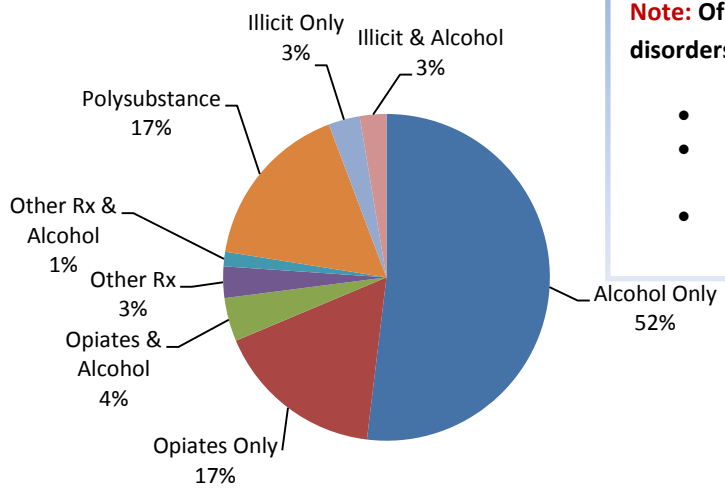
Psychiatric Disorders: 60% of all participants have a psychiatric disorder

- 16% have a psychiatric disorder without co-morbid substance disorder and of these:
- 11% have anxiety and/or depression
- 4% have bipolar disorder
- 1% have another psychiatric disorder
- 14% of persons monitored for a psychiatric disorder are also monitored for a medical disorder

Medical Disorders: 7%

- 2% have a medical disorder without any other co-morbid illness

Substances of Choice Among HPSP Participants (based 7/22/11 caseload)

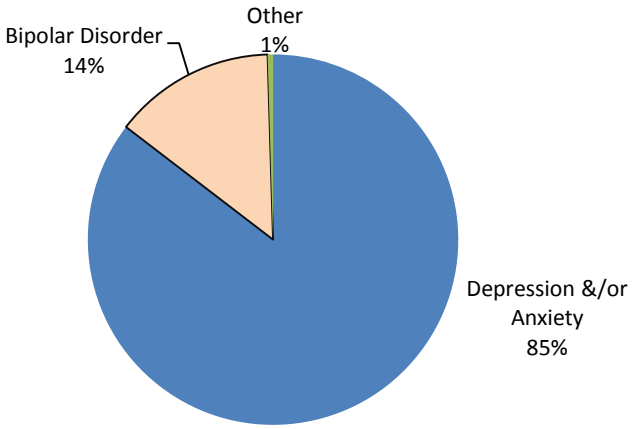


Note: Of participants monitored for substance disorders:

- **Alcohol is a substance of abuse for 60%**
- **A prescription medication is a substance of abuse for 42%**
- **An illicit substance is a substance of abuse for 6%**

Opiates are the most common prescription medication abused, followed by benzodiazepines. For the purposes of this report, the term "polysubstance" most commonly represents persons who abused a prescription medication and another substance.

Psychiatric Illnesses Among HPSP Participants (based 7/22/11 caseload)



Note: The chart on the left represents all HPSP participants monitored for a psychiatric disorder on July 22, 2011.

Note: The category of "Other" most commonly represents post traumatic stress disorder or attention deficit disorder.

PROGRAM REPORTS

HPSP provides summary reports to the Program Committee, the Administering Board, health licensing Boards as requested and to the Advisory Committee, consistent with the program's statutory authority and with other applicable federal and state laws regarding data privacy.

Annual Reports

HPSP program manager develops annual reports at the close of each fiscal year. This report is submitted to the Program Committee and then to the Executive Directors of the Boards. The report is designed to document how HPSP is meeting its statutory obligations. The report serves as a mechanism of accountability from HPSP to the Program Committee, licensing Boards, licensees and the public. The report summarizes the program's activity for the past fiscal year, including but not limited to a summary of the program's services, financial status, initiatives undertaken and statistics. It also includes the results of a survey to the Executive Directors and the program's objectives for the following fiscal year.

Mid-Year Reports

The program manager develops Mid-Year Reports that are similar to the Annual Reports. The greatest difference is that Mid-Year Reports cover a six-month timeframe (July to December), and do not include a survey of the Executive Directors.

Cost Allocation Reports

The program manager and office manager will create and distribute monthly statistical reports to the ASU and the licensing Boards. The reports include the following statistical information regarding licensing board participants:

- Number of cases to date;
- Number of closed cases for the month;
- New cases for the month;
- Active cases at the end of the month; and
- Cost allocation per Board (the number of new cases multiplied by two, plus the number of active cases at the end of the month per board multiplied by the per rata share).

ASU will provide licensing Boards with monthly reports of program costs based on the cost allocation formula described above and outlined in the Interagency Agreement.

Board Referral Reports

HPSP provides the participating boards with reports regarding the enrollment status of the licensees they referred to the program. The report includes the licensee's name, date of referral, date of contact with HPSP and the dates Enrollment Forms and Participation Agreements are completed and received.

OUTREACH

HPSP staff provides presentations about program services to educational programs, such as the University of Minnesota's schools of Dentistry and Pharmacy. HPSP also meets with large health care organizations, human resources groups, credentialing entities and others to provide information about program services. This is beneficial to public safety in three key areas:

3. Persons entering health care fields are made aware of the program in the event that they may need services, or that one of their peers may need services.
4. Health care facilities develop a clear understanding of reporting responsibilities, the program's role and how we can work together to promote early intervention, treatment and monitoring before clinical skills are compromised.
5. Professional associations

STATE AND NATIONAL INVOLVEMENT

HPSP participates on the Drug Diversion Prevention Coalition. HPSP's involvement educates the coalition about why health professionals divert controlled substances and assist in developing best practices to prevent diversion.

HPSP is an active member of the Federation of State Physician Health Programs and the National Association of Alternative Programs. These are important groups to work collaboratively with, as they are on the forefront of developing standards for monitoring. In a 2010 review of HPSP monitoring guidelines compared to other programs nationally, HPSP met nearly all national guidelines.

SECTION IV: HPSP AUTHORITY RELATING TO FEES, INSPECTIONS, ENFORCEMENTS & PENALTIES

The health licensing Boards, the Emergency Services Regulatory Board and the Department of Health fund HPSP. The health licensing Boards' income is generated through licensing fees and placed in the 171 *State Government Special Revenue Fund*, which accounts for 97% of HPSP's budget. The Emergency Services Regulatory Board and the Department of Health receive general fund dollars, which accounts for 3% of HPSP's budget. Each Board pays an annual $1,000 fee and a pro-rata share of program expenses based on the number of participants they have in the program.

HPSP's annual operating cost is $704,000 in fiscal year 2012 and 2013. The last increase to the budget was in fiscal year 2009. Roughly 90% of HPSP budget is directed to salaries and benefits. The remaining 10% covers rent and all other operational costs. Thus, moderate inflationary increases and expenses that are not accompanied by increased spending authorization force HPSP to reduce staff.

Participant Costs

Program participants are responsible for paying for the cost of treatment and urine toxicology testing (if required). Therefore, the cost of monitoring depends on their insurance and whether they need to provide toxicology screens.

Since HPSP's inception, the Program Committee and Advisory Committee have reviewed whether it would be appropriate to bill participants for services. The outcome has generally been that charging for services would negatively impact the rate of self-referrals and add stress to those who may already be out of work and in financial distress due to the status of their illness. Additionally, charging for services would require both statutory change and cost the program more to operate. The benefit of having the Boards fund the program is that it costs all licensees less than $3.00 per year to fund services for those in need.

SECTION V: LESS RESTRICTIVE ALTERNATIVES

HPSP *Is* The Least Restrictive Alternative

An Alternative to Discipline

HPSP provides the health licensing Boards, the Emergency Services Regulator Board and the Department of Health with an alternative to disciplining health professionals with potentially impairing illnesses. By referring health professionals to HPSP, the regulating entities give licensees an opportunity to manage their illnesses confidentially through monitoring. If they comply with treatment and monitoring requirements, no public disciplinary action may need to be taken. If they do not, the program notifies the Board and the Board has the option to discipline the licensee. (Refer to the *Introduction* of this document for further information)

Minnesota is one of a handful of states that provides monitoring services to all regulated health professionals. *Section II* outlines how this simplifies reporting. All regulated health professionals, hospitals, providers, health care institutions and other entities call one number to report a dentist, physician, nurse or any other regulated health practitioner.

Laboratory Services

In 2011, HPSP developed a zero dollar request for proposal and contract for one laboratory to provide toxicology services to the program. This resulted in program participants paying less for toxicology screens.

Summary of Other Models

Programs Managed by Private Entities:

States that contract with private vendors to provide services have identified the following problems with the lack of consistency in contractors:

- Data mismanagement
- Costly re-creation of a monitoring program by different vendors
- Poor continuity of monitoring
- Lack of investment in the success of the program
- Limited staff expertise

Programs Managed by Professional Associations

States that contract with professional associations to provide monitoring services often identify challenges related to associations acting as an advocate for the licensee instead of acting in the best interest of public safety. Most of these monitoring programs are administered by medical associations that work primarily with physicians. Smaller professional associations with members who do not have the financial resources of physicians are generally not able to afford to provide monitoring services to their membership.

Programs Managed by Licensing Boards

Some state Boards provide monitoring. Most monitor persons via disciplinary order and some also monitor persons in lieu of discipline. The greatest challenge these program face is that they do not promote early intervention, as licensees are less likely to report their illness to their Board, whom they fear will take disciplinary action against them.

SECTION VI: JURISDICTION

As mentioned in Section II, HPSP is a unique *collaborative* program in that provides services to persons regulated by all of the health licensing Boards, the Emergency Services Regulator Board, and the Department of Health. Therefore, there are is no duplication in the delivery of services. The statutes that provide HPSP with the authority to provide services to the above noted entities are:

The Health Licensing Boards: Defined in Minn. Stat. 214.01 (described on page 3)

The Emergency Services Regulatory Board: Defined in Minn. Stat. 144E.287

The Department of Health: Defined in:

- Occupational Therapists and Assistants: Minn. Stat. 148.6448, Subd. 6: "The Commissioner shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under this chapter. The health professionals services program does not affect the commissioner's authority to discipline violations of section 148.6401 to 148.6450."

- Hearing Instrument Dispensers: Minn. Stat. 153A.15, Subd.5: "Authority to contract. The commissioner shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under this chapter. The health professionals services program does not affect the commissioner's authority to discipline violations of this chapter."

- Speech Language Pathologists: Minn. Stat. 148.5195, Subd.7: "Authority to contract. The commissioner shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under this chapter. The health professionals services program does not affect the commissioner's authority to discipline violations of sections 148.511 to 148.5198."

- Complimentary and Alternative Healthcare Providers: Minn. Stat. 214.01, subd. 2 defines the Office of Complimentary and Alternative Health Care Providers as a health licensing board.

SECTION VII: COMPLAINTS

HPSP works collaboratively with the health licensing Boards to ensure the program is consistent with its statutory authority while meeting the needs of the Boards. While concerns about program operations are best managed as they occur, HPSP also sends the Executive Directors of the health licensing Boards an annual survey about program services. Any complaints identified are addressed.

If Boards are dissatisfied with HPSP services, they may choose to develop another monitoring program per Minn. Stat. 214.31:

> Two or more of the health-related licensing boards listed in section 214.01, subdivision 2, may jointly conduct a health professionals services program to protect the public from persons regulated by the boards who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition. The program does not affect a board's authority to discipline violations of a board's practice act. For purposes of sections 214.31 to 214.37, the emergency medical services regulatory board shall be included in the definition of a health-related licensing board under chapter 144E.

Minn. Stat. 214.36 further states:

> Participating boards may, by mutual agreement, implement the program upon enactment. Thereafter, health-related licensing boards desiring to enter into or discontinue an agreement to participate in the health professionals services program shall provide a written resolution indicating the board's intent to the designated board by January 1 preceding the start of a biennium.

SECTION VIII: RULEMAKING AND PUBLIC PARTICIPATION

HPSP functions solely on the enabling legislation (Minn. Stat. §214.29 to Minn. Stat. 214.36), which clearly defines the authority of the program, as well as program operations and responsibilities, reporting, immunity, classification of data, and Board participation.

SECTION IX: COMPLIANCE WITH STATE AND FEDERAL LAWS

Employment

HPSP complies fully with federal and state laws regarding equality of employment opportunity, and the rights and privacy of individuals. The Program Manager is entrusted with responsibility for ensuring that federal and state equal employment opportunity laws are fully complied with. This is achieved with assistance of HPSP's designated affirmative action officer in the Administrative Services Unit, which provides shared services to each Board.

HPSP maintains and updates an affirmative action plan on a biannual basis. Criteria for affirmative action plans are established by state law, MS. 43A.19 and 43A.191, and MMB Administrative Procedure 19.1. The Program Manager prepares and implements the Plan, and signs the Plan's Statement of Commitment. The current Affirmative Action Plan is available upon request. Likewise, HPSP fully complies with the Minnesota Human Rights Act and applicable federal equal opportunity laws. HPSP works cooperatively with the Administrative Services Unit, which provides expertise on equal opportunity issues. This Board has received no complaints of violation of equal employment opportunity laws.

All new employees are informed of equal employment opportunity policies and laws upon orientation, and a copy of HPSP's affirmative action plan is reviewed with them, including equal opportunity provisions and HPSP's complaint process. This Affirmative Action Plan is provided to all new employees, and is posted on the employee bulletin board. Training on equal opportunity/affirmative action requirements is periodically provided to staff through in-person training sessions and online training. Equal opportunity/affirmative action matters are regularly reviewed at Executive Director meetings and Office Manager meetings.

HPSP conducts its hiring processes in accordance with all applicable collective agreements, and state and federal law. This is accomplished through consultation with the Board's affirmative action designee. The Board uses the State's resume-base, skill-matching process. Resumes are evaluated against established minimum qualifications. Hiring processes are closely reviewed to insure compliance with equal employment opportunity. Interview questions are established based on knowledge, skills, and abilities required to perform the responsibilities of each position.

HPSP's home webpage has an affirmative action/equal opportunity statement, lists the phone number for hearing/speech relay, and provides an e-mail address for comments on the web page. HPSP responds to all applicable State surveys regarding equal opportunity/affirmative action, including an Annual ADA Survey.

Applicants and the general population are becoming increasingly diverse, including cultural and language diversity. The licensing boards continue to examine matters pertaining to possible barriers in licensure, as well as issues surrounding working with clients and patients from diverse populations.

Purchasing and Contracting

HPSP complies with all purchasing requirements, including the State's Targeted Group/Economically Disadvantaged small business program. Contractual guidance is provided by the Administrative Services Unit. The Administrative Services Unit also provides the services of a Buyer who has been trained in all State purchasing requirements, including Targeted Group/Economically Disadvantaged preferences in purchasing. The Board is also strongly supportive of Minncor purchasing, and applicable rules of any state agency regarding purchasing guidelines and programs for historically underutilized businesses.

HPSP is aware of State contracting requirements regarding accessibility for IT services over $25,000; assistance in these matters if provided by Administrative Services Unit IT and Contract staff. Training on these matters has been provided by the Department of Administration, Materials Management Division. When making purchases, HPSP acts in accordance with this authority must follow the policies and procedures and instructions contained in this manual and all applicable laws and rules, including but not limited to:

- Minnesota Statutes Chapters 13, 16A, 16B, and 16C,
- Minn. Stat. §§ 10A.07, 15.43, 43A.38, 609.43, and 609.456,
- Minnesota Rules Chapter 1230, and
- Uniform Commercial Code (UCC) as adopted by Minnesota (see Minnesota Statutes Chapter 336).

Security Profiles (related to MAPS, SEMA4, SWIFT, Fiscal Notes, Budget, Payroll, HR, Warehouse data)
Certified profile statue reports are viewed and are due to the Minnesota Department of Management and Budget every year. When profiles are added or changed individual staff profiles are reviewed. Individual profiles are maintained and reviewed frequently to ensure compliance with statutes, rules, policies and procedures.

Financial Policies

The health related licensing boards follow statutes, rules, policies and procedures related to financial operations. The Minnesota Department of Management and Budget and the Minnesota Department of Administration provide policies and procedures and training related to financial activities that staff are required to maintain. The Administrative Services unit provides policies and procedures for the Health Related Licensing Boards staff to follow. This will ensure compliance with financial operations.

SECTION X: CONFLICTS OF INTEREST

Conflicts of Interest
The Program Manager is responsible for enforcing rules relating to potential conflicts of interest of its employees.

The Program Manager of HPSP agreed to have each incumbent employee review State Code of Conduct provisions and to be recertified in the employee's understanding of the code annually. All new employees are also informed of the Code at employment orientation, and are instructed to certify understanding of their responsibilities under the code. The State Code of Conduct (MMB Operating Policy & Procedure 01003-01) outlines the standards and expectations regarding employee honesty, integrity, and ethical behavior.

The Code of Ethics for State Employees [Executive Branch] with the State of Minnesota (Minnesota Statutes 43A.38) is reviewed at orientation with all new employees, and is also discussed regularly at Office Managers meeting and Executive Directors meetings.

Questions regarding conflict of interest are directed to the Program Manager, who, depending on the nature of the conflict, consults with the Office of the Attorney General or the Administrative Services Unit staff (which seeks additional guidance as required from Minnesota Management and Budget).

Provisions regarding potential conflict of interest in regard to contracting are heavily regulated by Minnesota statutes. Provisions regarding institutional conflict of interest have been reviewed at meetings of Office Managers and of Executive Directors.

HPSP staff have received training from the Department of Administration, Materials Management Division, regarding appropriate contracting procedures, including conflict of interest. Adherence to state contracting statutes and regulations minimize the risk of conflict of interest.

HPSP developed the following policy related to potential conflicts of interest with program participants:

> A real, perceived or potential conflict of interest exists when program staff or paid agents of the program have an existing or former financial, supervisory or collegial professional/support relationship with a program participant/enrollee, impacting enrollment/case management of the licensee. Any staff person who identifies a real, perceived or potential conflict of interest regarding a referral or an existing case, will contact the program manager who will reassign the participant/enrollee to a different case manager.
>
> HPSP follows the State of Minnesota's Organizational Conflicts of Interest Policy and Code of Conduct.

The most common potential conflicts of interest identified include situations in which a case manager is monitoring a health professional and that person's treatment provider is also on their caseload. In such cases, the case manager transfer one of the cases to a different case manager.

In addition to the above, most HPSP staff are licensed health care professionals and as such, are required to follow their professional practice acts as related to conflicts of interest, ethics and other practice issues.

SECTION XI: CHAPTER 13 COMPLIANCE

Records Management Training
HPSP requires all new staff to review state and federal data practices laws consistent with program operations. Per HPSP's Code of Conduct, staff is required to review data practice training materials during even numbered years. Any questions about data practices are directed to the Office of the Attorney General. All authorizations for the use and disclosure of protected health information were established in concert with the Office of the Attorney General.

Tennessen Warnings
HPSP training materials describe the process of providing Tennessen warnings. For example, when a licensee contacts HPSP by phone to report their illness, case managers provide a verbal Tennessen warning. After that, they review the program's eligibility requirements as defined in Minn. Stat. 214.32, Subd. 4 and obtain additional information. Following this initial contact with licensees, case managers provide licensees with program materials, including a written Tennessen warning.

Public Data

Minn. Stat. 214.35 defines HPSP's classification of data as:

> All data collected and maintained and any agreements with regulated persons entered into as part of the program is classified as active investigative data under section 13.41 while the individual is in the program, except for monitoring data which is classified as private. When a regulated person successfully completes the program, the data and participation agreement become inactive investigative data which shall be classified as private data under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals. Data and agreements shall not be forwarded to the board unless the program reports a participant to a board as described in section 214.33, subdivision 3.

Therefore, HPSP does not provide the public with data about program participants. HPSP creates the following public reports, which contain aggregate data:

Monthly Statistical Reports (Utilized for determining the pro-rata share of program expenses)

- Mid-Year Report
- Annual Report
- Board Reports (board-specific reports about the board's participation in the program)

In addition to the above reports, HPSP also provides reports and presentations to professional associations, educational institutions and health care organizations upon request and as able.

Data Security and Training

HPSP requests that the Health Licensing Board's Network Administrator provide the program with quarterly summaries of its security status. The reports include information about the following:

- Update Management
- Antivirus Management
- Change Management
- Back-Up Recovery Management
- Security Monitoring
- Security Audit

Detailed content of these reports are reviewed by the Program Manager and the Chair of the Program Committee on a quarterly basis. Summary information is provided to the Program Committee at quarterly meetings.

All new HPSP staff receive computer security training from the health licensing Boards' Network Administrator. They also review related State policies (i.e. Statewide Electronic Communication and Technology Policy). HPSP staff also attend health licensing Board computer security training seminars.

SECTION XII: FEDERAL INTERVENTION & FUNDS

HPSP does not receive Federal funds. Therefore, there is not a foreseeable loss of federal intervention or funds if HPSP were to be abolished. As noted earlier, HPSP is primarily funded by the Minnesota health licensing boards (97%), whose income is generated from licensing fees. A fraction of HPSP's budget comes from the general fund for the monitoring of persons regulated by the Department of Health and the Emergency Services Regulatory Board.