MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

FISCAL YEAR 2020 REPORT

July 1, 2019 to June 30, 2020
Report Date: August 2020

CONTENTS

OVERVIEW 1
PARTICIPATION 2
REFERRALS 2
DISCHARGES 6
CASELOAD 12
ILLNESSES MONITORED 15
GENERAL ILLNESS DATA 15
DIVERSION OF CONTROLLED SUBSTANCES 16
UPDATES 18
COVID-19 18
INCLUSION AND DIVERSITY 18
STAFFING 18
DATABASE ENHANCEMENTS 18
OUTREACH 19
LOOKING FORWARD 19
BUDGET 20
FUNDING 20
EXPENSES 20
PROGRAM COMMITTEE GOALS 21
COMMITTEE MEMBERS AND STAFF 24
PROGRAM COMMITTEE MEMBERS 24
ADMINISTERING BOARD 24
ADVISORY COMMITTEE MEMBERS 25
HPSP STAFF 25

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OVERVIEW

MISSION

The Health Professionals Services Program (HPSP) is a program of the Minnesota health related licensing boards that provides monitoring services to health professionals with illnesses that may impact their ability to practice safely.

FUNCTIONS

HPSP promotes public safety in health care by implementing Participation Agreements that oversee the participants' illness management and professional practice, both of which are tied to patient safety. A Participation Agreement may include the participant's agreement to comply with continuing care recommendations, practice restrictions, random drug screening, work site monitoring, and support group participation. HPSP's primary functions are described below.

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

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

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

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

PARTICIPATION

REFERRALS

Definitions of Referral Sources

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

Licensees can be referred to HPSP in the following ways:

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

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

3. **Board Referrals**
   Participating boards have three options for referring licensees to HPSP:

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

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

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

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

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

Referrals by First Referral Source and Board

In fiscal year 2020 (July 1, 2019 to June 30, 2020), 430 health professionals were referred to HPSP; 33 more than in fiscal year 2019. The greatest increase was among board voluntary referrals. The table below shows the number of health professionals referred to HPSP by board and first referral source for the past four fiscal years.

Board ▸	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health*				Dietetics and Nutrition			
Fiscal Year ▸ Referral Source ▾	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20
Board Voluntary	0	3	1	0	14	15	12	13	15	7	6	5	28	22	12	13	0	0	0	0	0	0	0	0
Board Discipline	0	0	0	0	0	0	1	2	0	2	1	0	4	6	1	2	1	0	0	0	0	0	0	0
Self	0	0	0	0	7	6	8	7	2	0	3	2	3	5	2	6	2	0	1	0	0	0	0	0
Third Party	0	0	0	0	9	8	8	8	0	0	0	0	1	3	5	2	0	0	1	0	0	0	0	0
SUM	0	3	1	0	30	29	29	30	17	9	10	7	36	36	20	23	3	0	2	0	0	0	0	0
Board ▸	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Occupational Therapy*				Optometry			
Fiscal Year ▸ Referral Source ▾	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20
Board Voluntary	10	17	9	6	0	0	2	2	13	16	18	33	48	28	30	51	-	0	7	0	0	0	0	0
Board Discipline	0	0	0	0	1	0	1	0	1	1	1	5	47	34	34	34	-	0	0	1	0	0	0	0
Self	11	6	7	5	3	1	3	0	20	32	34	39	102	82	92	95	-	2	2	1	0	0	1	0
Third Party	2	3	2	2	1	2	0	0	10	15	12	5	43	46	26	35	-	0	0	0	0	1	0	0
SUM	23	26	18	13	5	3	6	2	44	64	65	82	240	190	182	215	-	2	9	2	0	1	1	0
Board ▸	Pharmacy				Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine			
Fiscal Year ▸ Referral Source ▾	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20
Board Voluntary	1	4	3	3	12	10	6	4	0	2	1	0	1	3	0	4	7	1	3	4	0	2	3	1
Board Discipline	1	2	2	4	0	0	0	0	0	0	0	0	0	0	1	0	1	5	1	2	0	1	0	0
Self	8	6	6	8	3	2	2	1	2	0	0	0	1	2	3	0	9	7	12	8	1	1	1	3
Third Party	5	3	1	5	1	0	2	0	0	0	0	0	3	4	2	3	6	5	3	6	0	0	1	0
Sum	15	15	12	20	16	12	10	5	2	2	1	0	5	9	6	7	23	18	19	20	1	4	5	4

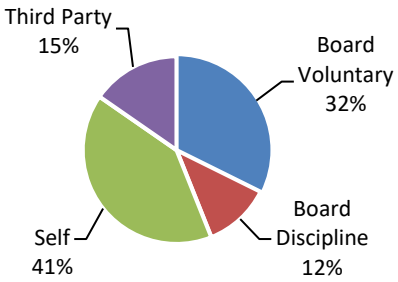
Referrals by First Referral Source and Fiscal Year

Fiscal Year ▸ Referral Source ▾	16	17	18	19	20
Board Voluntary	175	149	130	113	139
Board Discipline	52	56	51	43	50
Self	163	174	152	178	175
Third Party	64	81	90	63	66
Sum	454	460	423	397	430

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

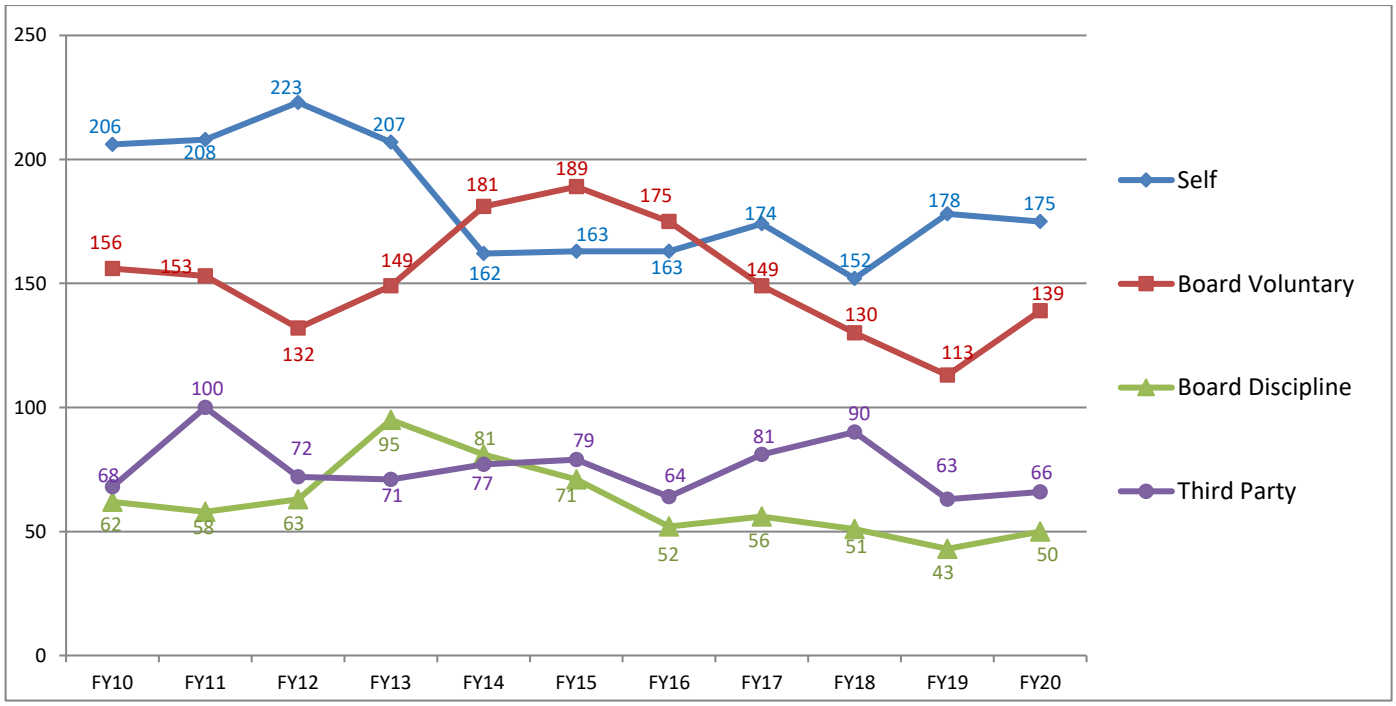
Referrals by First Referral Source

In fiscal year 2020, self and third-party referrals made up 56% of the total referrals while board referrals made up 44%. The chart on the right shows the percentage of referrals to HPSP by first referral source from July 1, 2019 to June 30, 2020.



Referral Trends

The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2010 through fiscal year 2020. Over the past year, board voluntary referrals increased by 20% while other referral sources remained fairly consistent.



Fiscal Year 2020 Referrals by Referral Source and Decade of Age:

The table below shows the number of referrals to HPSP by first referral source and decade of life. It is most common for practitioners to be referred in their 30s and 40s.

Referral Category	Decade of Age					
	20's	30's	40's	50's	60's	≥70
Board Voluntary	20	41	34	32	9	3
Board Discipline	4	18	13	10	5	0
Self	15	44	53	39	22	2
Third Party	7	20	24	11	3	1
Sum	46	123	124	92	39	6

Fiscal Year 2020 Referrals by Referral Source and Gender:

Women are referred to HPSP at a higher rate than men, regardless of referral source.

Referral Category	Gender	
	Female	Male
Board Voluntary	82 (59%)	57 (41%)
Board Discipline	36 (72%)	14 (28%)
Self	107 (61%)	68 (39%)
Third Party	43 (65%)	23 (35%)
Sum	268 (62%)	162 (38%)

About gender data: HPSP's database currently includes two options for gender. This will be revised as the database is updated.

Fiscal Year 2020 Referrals by Referral Source and Geographic Region

The data in the chart below represents person referred to HPSP between July 1, 2019 and June 30, 2020.

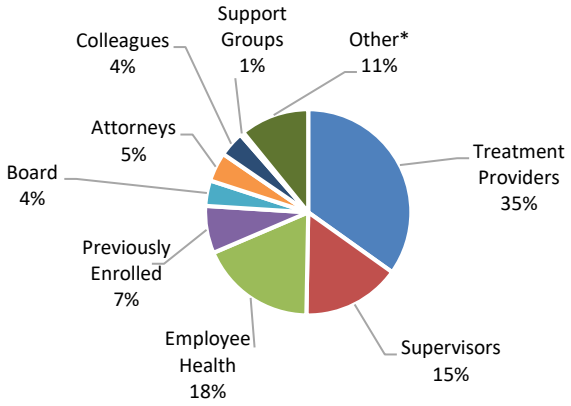
Referral Category	Geographic Region in Minnesota					
	Twin Cities 7 County Metro Area	Northeastern MN	Northwestern MN	Central MN	Southeastern MN	Southwestern MN
Board Voluntary	18	6	5	5	11	1
Board Discipline	22	1	1	6	12	3
Self	74	7	5	20	22	4
Third Party	20	1	3	3	5	0
Sum	134 (53%)	15 (6%)	14 (5%)	34 (13%)	50 (20%)	8 (3%)

The chart above and other charts in this report describe six regions of Minnesota. These regions include the following counties:

- **Twin Cities Metro Areas (TC)**: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties
- **HPSP defines Northeastern (NE):** Aitkin, Carlton, Cook, Koochiching, Lake, St. Louis counties
- **Northwestern (NW)**: Becker, Beltrami, Big Stone, Clay, Clearwater, Douglas, Grant, Kittson, Lake of the woods, Mahnomen, Marshall, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Traverse, Wadena, Wilkin counties
- **Central MN (CE)** Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wright counties
- **Southeastern (SE)**: Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Martin, Mower, Nicollet, Olmsted, Rice, Steele, Wabasha, Waseca, Watonwan, Winona counties
- **Southwestern (SW)**: Chippewa, Cottonwood, Jackson, Kandiyohi, Lac qui Parle, Lincoln, Lyon, Mcleod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Yellow Medicine counties

Self-Referrals – How did licensees learn about HPSP?

The chart below shows how the 175 practitioners who self-referred to HPSP in fiscal year 2020 learned about the program:



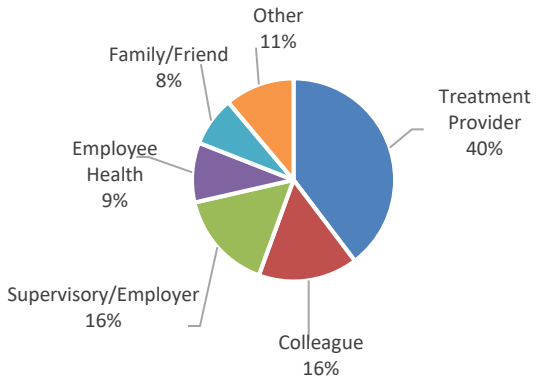
Treatment providers are the most common way practitioners learn about HPSP (35%). This may show the positive perception providers have about the benefits of HPSP services. Equally significant, 37% of those who self-referred in fiscal year 2020 learned about HPSP through an employment-related source.

*Other referral sources include HPSP's website, support groups, and unions.

Third Party Referrals – Who refers licensees to HPSP?

When HPSP receives a third-party report about a licensee, the licensee typically receives a letter directing them to contact HPSP within ten days to follow-up on the report. In cases where immediate public safety is at risk, HPSP calls the licensee upon receipt of the report to complete a phone intake interview. If the licensee does not follow-up on the initial letter, HPSP sends a follow-up letter requesting completion of a phone intake interview and return of enrollment materials within seven days. If the licensee does not contact HPSP after the second deadline, HPSP closes the case as *no contact* and files a report with the Board. If the licensee fails to cooperate with the intake process (i.e. will not obtain requested evaluations or does not sign authorizations), the licensee is discharged for *non-cooperation.* HPSP provides the licensee's board with a redacted copy of the third-party report when HPSP discharges due to *no contact* or *non-cooperation.* HPSP also asks the third party to sign an authorization allowing HPSP to forward an unredacted copy of their report to the Board.

The chart below shows the sources of third party reports to HPSP in fiscal year 2020:



Oftentimes when health professionals start the monitoring process, they state their illness did not impact their practice. However, 41% of third-party referrals came from work related sources (supervisor, employer, employee health and colleagues). As monitoring progresses, licensees develop insight into their illnesses and are able to identify how their illness impacted their practice.

Fiscal Year 2020 Additional Referral Sources

The previous data showed how health practitioners were referred to HPSP in fiscal year 2020 by first referral source. The following data shows subsequent referral sources for the same admission:

First Referral Source	Second Referral Source
Self (175)	• 9: Board voluntary • 5: Third party • 4: Board discipline
Third Party (66)	• 3: Self-reports • 1: Third party

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

Fiscal Year 2020 Re-Referrals

Of the 430 referrals HPSP received in fiscal year 2020, 88 (20%) were individuals who had previously been referred to and discharged from HPSP; some within the same fiscal year and some years earlier. The table below shows the average timeframe from discharge to re-referral and the timeframe range from discharge to re-referral.

Referral Source	Average time from date prior file closed to re-referral date	Timeframe
Board Disciplinary Referrals (#32, 36%)		
Previously Completed (#3)	6 years	1 year and two months to 12 years
Previously Monitored - Did Not Complete (#21)	2 years	1 month to 6 years
Previously Referred - Not Monitored (#8)	4 years	4 months to 11 years
Board Voluntary Referrals (#33, 38%)		
Previously Completed (#10)	7 years	1 year to 23 years
Previously Monitored - Did Not Complete (#13)	1 year	1 month to 8 years
Previously Referred - Not Monitored (#10)	2 years	1 month to 9 years
Self-Referrals (#19, 22%)		
Previously Completed (#14)	4 years	7 months to 10 years
Previously Monitored - Did Not Complete (#0)	N/A	N/A
Previously Referred - Not Monitored (#6)	2 years	3 months to 7 years
Third Party Referrals (#9, 10%)		
Previously Completed (#6)	7 years	2 years to 15 years
Previously Monitored - Did Not Complete (#2)	3 years	3 months to 5 years
Previously Referred - Not Monitored (#1)	4 years	4 years

About the data:

- The data was queried by months and rounded to the closest year except where months are noted.
- The percentages listed above do not add up to 100% because some people are represented more than once in the data.

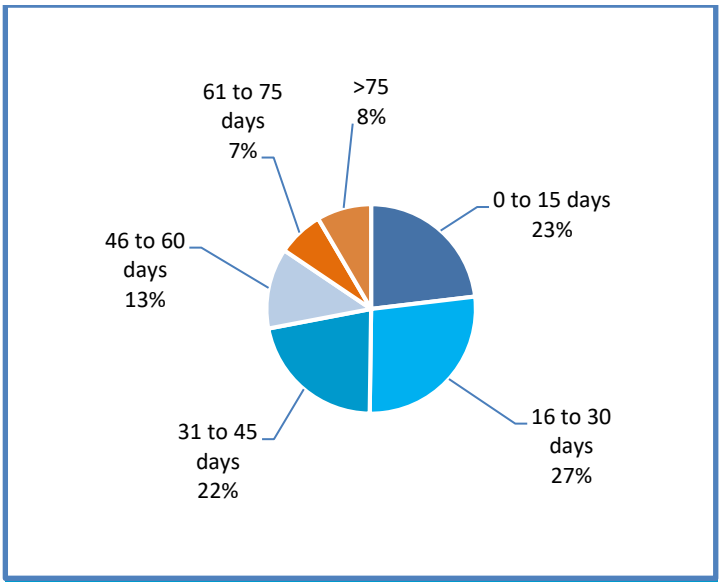
Participation Agreements

HPSP strives to complete the intake process and establish Participation Agreements, when appropriate, within 60 days of the licensee's contact with the program. A case manager's initial contact with a practitioner is the first step in the assessment and intervention phase of the intake. Depending on the presenting information and as a means to protect the public, case managers may ask practitioners to voluntarily refrain from practice until they can be assessed.

In fiscal year 2020, 225 Participation Agreements were signed. Of these, 85% were signed within 60 days of the practitioner's initial contact with the program. The average timeframe was 34 days. Some delays, such as obtaining neuropsychological, neurological and pain management assessments, are common. Practitioner cooperation may also contribute to delays.

COVID-19 created challenges in obtaining records and necessary evaluations in a timely manner. This slowed case managers' ability to determine whether monitoring was warranted and developing Participation Agreements.

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



DISCHARGES

Definitions of Discharge Categories:

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

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

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

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

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

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

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

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

8. **Non-Jurisdictional -** No diagnostic eligibility established; the case is closed.
   **Discharge results in report to board with copy of file.*

Discharges by Discharge Category and Board

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

Board ▸	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
Fiscal Year ▸ Discharge Category ▾	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20
Completion	0	0	0	0	3	5	7	8	3	3	0	3	8	8	4	3	2	1	0	1	2	0	1	1
Voluntary Withdraw	0	0	0	0	1	3	0	4	0	0	0	0	1	2	0	1	0	0	0	0	0	0	0	0
Non-Compliance	0	1	0	0	9	4	3	4	2	0	0	0	4	3	1	3	0	0	0	0	0	0	0	0
Deceased	0	0	0	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	2	0	1	0	0	0	0	1	0	0	1	1	0	1	0	0	0	0	0	0
Ineligible Not Monitored	0	0	0	0	3	0	1	3	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0
No Contact	0	0	0	0	3	5	2	1	1	0	0	0	4	5	3	3	0	0	0	0	0	0	0	0
Non-Cooperation	0	0	0	0	4	10	4	6	1	2	0	1	6	6	4	3	1	0	0	0	0	0	0	0
Non-Jurisdictional	0	1	1	0	3	1	5	7	13	5	4	3	19	12	5	6	1	0	0	0	0	0	0	0
SUM	0	2	1	0	28	28	23	29	20	10	4	8	43	36	18	20	4	2	1	1	2	0	1	1

Board ▸	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Occupational Therapy*				Optometry			
Fiscal Year ▸ Discharge Category ▾	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20
Completion	4	4	4	4	1	1	1	1	26	21	23	27	93	88	89	83	-	0	3	1	0	0	0	0
Voluntary Withdraw	1	2	1	1	0	1	1	0	0	0	3	3	13	16	24	17	-	0	0	0	0	0	0	0
Non-Compliance	0	1	1	1	0	0	0	2	0	1	0	0	12	27	7	33	-	0	0	1	0	0	0	0
Deceased	0	0	0	1	0	0	0	0	1	0	0	1	3	0	2	1	-	0	0	0	0	0	0	0
Ineligible Monitored	0	0	0	1	0	0	0	0	5	8	4	8	20	21	8	13	-	0	0	0	0	0	0	0
Ineligible Not Monitored	0	0	1	0	1	0	0	0	3	5	6	1	3	3	3	9	-	1	0	0	0	0	0	0
No Contact	5	5	2	2	0	0	0	0	3	1	0	4	11	7	4	5	-	0	1	0	0	0	0	0
Non-Cooperation	2	4	3	8	0	0	0	0	2	4	6	3	32	18	11	23	-	0	0	0	0	0	1	0
Non-Jurisdictional	5	11	7	3	3	0	1	0	10	8	21	28	32	22	19	16	-	0	3	0	0	1	0	0
SUM	17	27	19	21	5	2	3	3	50	48	63	75	219	202	167	200	-	1	7	2	0	1	1	0

Board ▸	Pharmacy				Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine			
Fiscal Year ▸ Discharge Category ▾	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20	17	18	19	20
Completion	11	4	6	5	3	3	4	2	1	0	0	0	4	1	2	0	6	5	6	8	1	4	1	0
Voluntary Withdraw	1	0	0	1	1	1	0	0	0	0	1	0	0	1	0	1	2	0	4	1	0	0	0	0
Non-Compliance	2	3	2	2	2	3	1	2	0	0	0	0	0	2	0	0	3	2	3	2	0	0	0	0
Deceased	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Ineligible Monitored	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	1	2	1	0	0	0	0	1
Ineligible Not Monitored	1	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1	1	3	1	1	0	0	0
No Contact	1	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	0	1	0	0	0	0
Non-Cooperation	3	1	2	5	2	0	1	1	0	0	0	0	1	0	0	2	1	5	1	1	0	0	0	0
Non-Jurisdictional	3	3	1	0	5	9	5	2	0	3	1	0	0	2	0	1	6	0	1	3	1	1	3	0
Sum	23	14	12	15	13	17	11	8	1	3	2	0	6	7	3	5	21	16	19	17	3	5	4	1

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

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

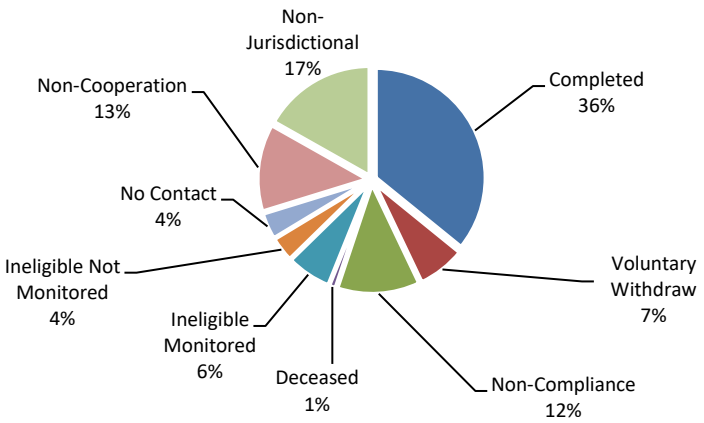
Discharges by Discharge Category and Fiscal Year

The chart below shows discharges by discharge category and fiscal year from fiscal year 2016 to fiscal year 2020.

Fiscal Year ▸ Discharge Category ▾	16	17	18	19	20
Completion	139	168	148	151	147
Voluntary Withdraw	23	20	26	34	29
Non-Compliance	61	34	47	18	50
Deceased	2	4	1	2	4
Ineligible Monitored	33	29	33	15	27
Ineligible Not Monitored	6	15	11	16	15
No Contact	19	29	26	14	16
Non-Cooperation	47	55	50	33	53
Non-Jurisdictional	94	101	79	77	69
Sum**	424	472	421	360	410

Discharges by Category

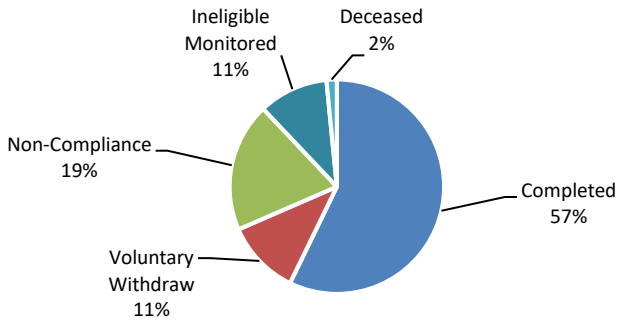
The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2020.



Of persons discharged in fiscal year 2020, 37% did not engage in monitoring, which is reflected in the table on the left (includes the categories of non-jurisdictional, non-cooperation, no contact, and ineligible-not monitored), which decreases the overall completion rate to 36%. The most common reason, however, for not engaging in monitoring is that HPSP did not identify an illness that warranted monitoring.

Discharges by Category for Those Monitored

The table below shows the discharge categories of persons who engaged in monitoring and were discharged from HPSP in fiscal year 2020.



The completion rate of 57% reflects only persons who engaged in monitoring.

Fiscal Year 2020 Discharges by Participant Decade of Age and Discharge Category

In fiscal year 2020, 77% of discharges were for practitioners between the ages of 30 and 59. The table below shows discharges by discharge category and the current age.

Discharge Category	Decade of Age					
	20's	30's	40's	50's	60's	≥70
Completion	4	34	44	41	24	0
Voluntary Withdraw	3	8	6	8	3	1
Non-Compliance	2	9	11	18	10	0
Deceased	0	1	0	1	1	1
Ineligible Monitored	1	3	12	5	4	2
Ineligible Not Monitored	1	3	6	3	2	0
No Contact	1	5	3	4	3	0
Non-Cooperation	5	16	14	14	3	1
Non-Jurisdictional*	13	21	14	14	6	1
SUM*	30 (7%)	100 (24%)	110 (27%)	108 (26%)	56 (14%)	6 (1%)

Fiscal Year 220 Discharges by Gender and Discharge Category

In fiscal year 2020, women made up 63% of practitioners who were discharged from HPSP. The chart below shows more specific information related to gender and discharge category.

Discharge Category	Gender	
	Female	Male
Completion	102	45
Voluntary Withdraw	20	9
Non-Compliance	40	10
Deceased	0	4
Ineligible Monitored	17	10
Ineligible Not Monitored	11	4
No Contact	8	8
Non-Cooperation	28	25
Non-Jurisdictional	34	35
SUM	260 (63%)	150 (37%)

Fiscal Year 2020 Discharges by Discharge Category and Geographic Region

Discharge Category	Geographic Region					
	Twin Cities 7 County Metro Area	Northeastern MN	Northwestern MN	Central MN	Southeastern MN	Southwestern MN
Completion	85	5	6	12	23	6
Voluntary Withdraw	12	1	2	8	3	0
Non-Compliance	25	6	1	6	8	2
Deceased	3	0	0	0	0	1
Ineligible Monitored	14	0	0	5	4	2
Ineligible Not Monitored	8	1	1	1	2	1
No Contact	8	0	2	1	2	1
Non-Cooperation	25	2	3	7	12	1
Non-Jurisdictional	34	2	6	6	13	1
SUM	214 (56%)	17 (4%)	21 (6%)	46 (12%)	67 (18%)	15 (4%)

Discharges Due to Ineligibility for Monitoring (42)

Forty-two (42) health professionals were discharged in fiscal year 2020 because they were not eligible for program services; 27 were monitored and 15 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (27)

- 23 – due to license suspension, revocation, expired, inactive or relinquished
- 3 – due to violation of practice act
- 2 – because illness was too severe

Not-monitored and discharged as ineligible (15)

- 7 – due to license suspension, revocation, expired, inactive or relinquished
- 4 – previously discharged to board
- 3 – practice act violation
- 1 – illness too severe

Discharges for Non-Compliance (50)

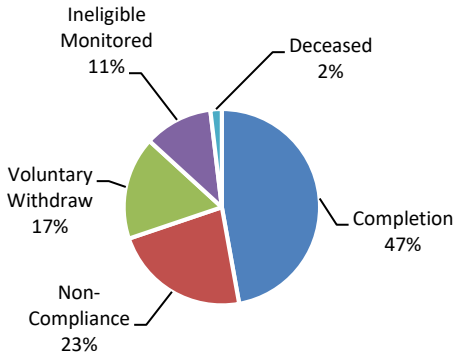
In fiscal year 2020, 50 health care professionals were discharged due to non-compliance and reported to their board. While there may be more than one reason for the discharge, the most prominent reason is listed below:

- 24 – non-compliance related to problem screens
- 17 – non-compliance with Participation Agreement
- 6 – non-compliance related to positive screens
- 3 – non-compliance with treatment

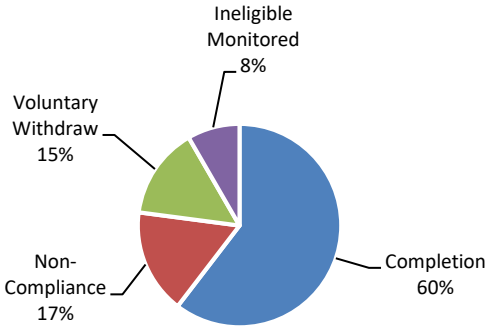
Discharges Category and First Referral Source for Those Monitored

The charts below provide data about licensees who engaged in monitoring and were discharged from HPSP in fiscal year 2020 based on first referral source and discharge category. Over the past year, persons who self-referred completed monitoring at the highest rate. Those referred by third parties completed at the lowest rate.

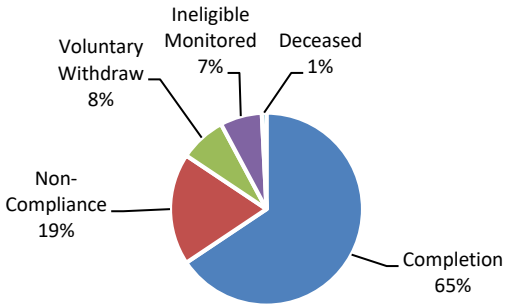
Board Voluntary Referrals: 53



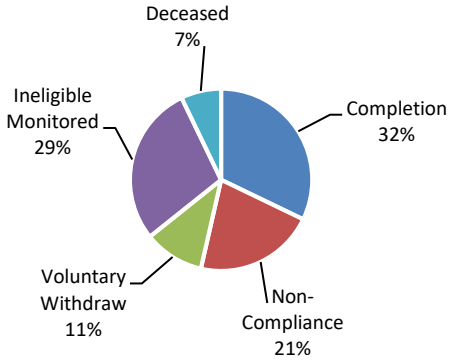
Board Discipline Referrals: 48



Self Referrals: 128



Third Party Referrals: 28



Length of Monitoring

Successful Completion: In fiscal year 2020, the average length of monitoring of practitioners who successfully completed monitoring was two years and seven months. The shortest length was seven months and the longest was six years. The average was 31 months.

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

Unsatisfactory Discharge: In fiscal year 2020, the average length of monitoring for practitioners who were monitored but did not complete monitoring was one year and two months. The shortest length was 13 days, and the longest was four years and five months. Forty-eight percent were discharged in the first year of monitoring, followed by 26% in the second year, 16% in the third year, and 9% percent after three years of monitoring.

CASELOAD

Estimated Rate of Participation by Board

The following table shows the number of persons regulated by board, the number active in HPSP and the rate of participation by board.

Board	Number Licensed or Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Licensed or Regulated
Board of Behavioral Health & Therapy	6,563	29	4.42
Board of Psychology	3,754	13	3.46
Board of Medical Practice	34,500	113	3.28
Board of Chiropractic Examiners	3,336	9	2.70
Board of Nursing	136,593	345	2.53
Board of Social Work	15,973	29	1.82
Board of Dentistry	17,473	29	1.66
Board of Marriage and Family Therapy	3,197	5	1.56
Board of Veterinary Medicine	6,730	8	1.19
Board of Physical Therapy	7,763	9	1.16
Board of Exam. of Nursing Home Admin.	924	1	1.08
Board of Pharmacy	21,764	23	1.06
Board of Occupational Therapy	8,996	7	0.78
Emergency Medical Services Regulatory Board	23,361	8	0.34
Board of Dietetics and Nutrition Practice	1,990	0	0.00
Department of Health	4,013	0	0.00
Board of Optometry	1,234	0	0.00
Board of Podiatric Medicine	557	0	0.00
Total	298,721	628	2.10

About the data:

- The *Number Licensed or Regulated* by board was provided to HPSP by each board within the first two weeks of July 2020.
- The *Number Active in HPSP* represents the number of open cases by board on July 2, 2020 (#628).
- The Department of Health data was provided on July 7, 2020 and includes the numbers of Speech Language Pathologists (#1,796), Audiologists (#474), Clinical Fellows (#85), Doctoral Externs (#17), and Body Artists (#1,400).
- Data regarding persons who are regulated by more than one board, represents the board that referred the individual to HPSP (if applicable) or the profession in which they predominately practice

Active Caseload by Board and Profession

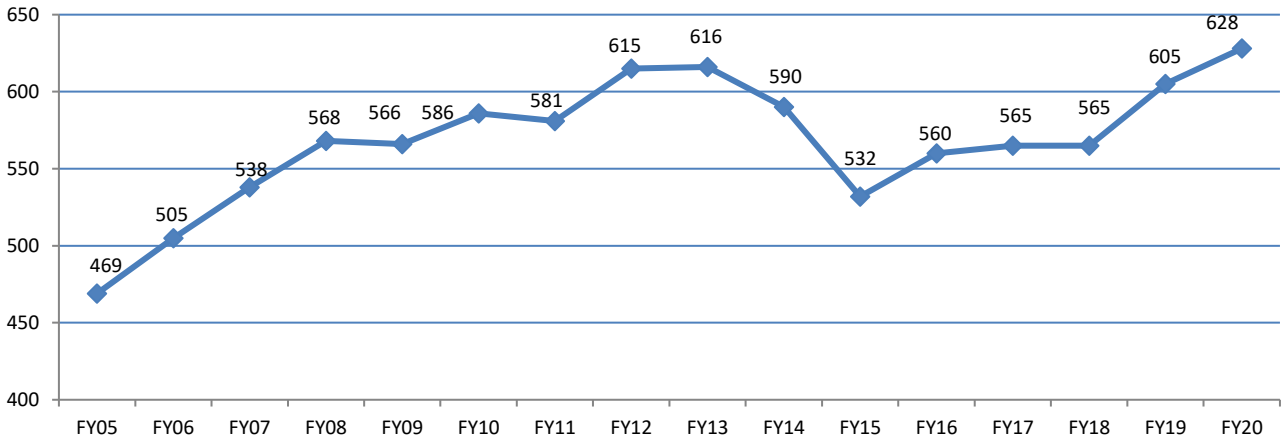
On July 2, 2020, there were 628 persons active in HPSP. The chart below shows the number of participants by board and profession.

Board	Number of Participants
Board of Behavioral Health & Therapy	29
LPC	2
LPCC	8
LADC	19
Board of Chiropractic Examiners	9
Board of Dentistry	29
Dental Assistants	12
Dental Hygienists	4
Dental Therapists	0
Dentists	13
Department of Health	0
Board of Dietetics and Nutrition Practice	0
Board of Exam. of Nursing Home Admin.	1
Emergency Medical Services Regulatory Board	8
CMPA (Community	0
EMR (Emergency Medical Responder)	1
EMT (Emergency Medical Technician	3
EMTP (Paramedic)	4
Board of Marriage and Family Therapy	5
LMFT	5
LAMFT	0
Board of Medical Practice	113
Acupuncturist	1
Physician Assistant	10
Physician	86
Respiratory Care Practitioner	6
Resident	10

Board	Number of Participants
Board of Nursing	345
LPN	60
RN	285
Board of Occupational Therapy	7
Occupational Therapist	4
Occupational Therapy Assistant	3
Board of Optometry	0
Board of Pharmacy	23
Pharmacist	19
Technician	4
Board of Physical Therapy	9
Physical Therapist	7
Physical Therapist Assistant	2
Board of Podiatric Medicine	0
Board of Psychology	13
Board of Social Work	29
LGSW	5
LICSW	18
LISW	0
LSW	6
Board of Veterinary Medicine	8

Open Cases at End of Fiscal Year

The following chart shows the number of open cases at the end of each of the last 16 fiscal years.



Participants with Participation Agreements Signed by Age Decade on July 1, 2020:

On July 1, 2020, there were 627 persons active in HPSP; 566 had signed Participation Agreements. The chart below shows the number of participants with signed Participation Agreements by age group and referral source.

Referral Source	Decade of Age					
	20's	30's	40's	50's	60's	≥70
Board Voluntary	10	37	23	17	12	1
Board Discipline	5	23	26	18	9	1
Self	20	74	104	77	36	2
Third Party	7	20	20	18	6	0
Sum	42 (7%)	154 (27%)	173 (31%)	130 (23%)	63 (11%)	4 (1%)

Participants with Participation Agreements Signed by First Referral Source and Geographic Region

The majority of HPSP participants live in the Twin Cities Seven County Metro Area.

Discharge Category	Geographic Region					
	Twin Cities 7 County Metro Area	Northeastern MN	Northwestern MN	Central MN	Southeastern MN	Southwestern MN
Board Voluntary	47	6	7	11	17	3
Board Discipline	41	4	4	10	14	7
Self	180	13	10	28	50	8
Third Party	41	5	6	7	9	1
SUM	309 (59%)	28 (5%)	27 (5%)	54 (10%)	90 (17%)	19 (4%)

About the data: On July 1, 2020, 566 had signed Participation Agreements. The data does not include those living outside of Minnesota.

ILLNESSES MONITORED

GENERAL ILLNESS DATA

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 1, 2020, there were 568 health professionals enrolled in HPSP with signed Participation Agreements (PAs). Many were monitored for more than one illness. The following data identifies the illnesses for which participants were being monitored.

Illness Category	Number of participants	Percent of 568 with PAs signed	
Substance Use Disorders	457	82%	
Psychiatric Disorders	407	72%	
Medical Disorders	58	10 %	
Substance Use Disorders (SUD)	**458 with a substance use disorder (SUD)**	**Percent of 458 with a SUD**	**Percent of 568 with a signed PA**
Alcohol	374	82%	66%
Prescription	100	22%	18%
Amphetamine	20	4%	4%
Barbiturate	2	<1%	<1%
Benzodiazepine	21	5%	4%
Opiate	91	20%	16%
Sedative/Hypnotic	12	3%	2%
Illicit	76	17%	14 %
Cannabis	42	9%	7%
Cocaine	14	3%	2%
Heroin	9	2%	2%
Methamphetamine	27	6%	5%
Psychiatric Disorders	**408 with a psychiatric disorder**	**Percent of 408 with a (385) psychiatric disorder**	**Percent of 568 with a signed PA**
Adjustment Disorder	13	3%	2%
Anxiety and/or Depression	357	88%	63%
Attention Deficit Disorder	43	11%	8%
Bipolar Disorder	39	10%	7%
Eating Disorder	6	1%	1%
Obsessive Compulsive Disorder	7	2%	1%
Post-Traumatic Stress Disorder	53	13%	9%
Other	12	3%	2%
Medical Disorders	**58 with a medical disorder**	**Percent of 58 with a medical disorder**	**Percent of 568 with a signed PA**
Pain Related	33	57%	6%
Neurological Related	18	31%	3%
Other	13	22%	2%

Single and Co-occurring Illnesses on July 2, 2020	Number of Participants	Percent of 568 with PAs signed
Substance Use Disorder Only	141	25%
Psychiatric Disorder Only	88	15%
Medical Disorder Only	9	2%
Substance and Psychiatric	281	49%
Substance and Medical	10	2%
Psychiatric and Medical	13	2%
Substance, Psychiatric & Medical	26	5%

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

While the numbers are small, from fiscal year 2019 to 2020, methamphetamine use among HPSP participants increased by 59% and heroin use increased by 80%.

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

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

About the data: HPSP's data changes throughout the day due to opening and closing cases and updating the status of cases. What might appear to be inconsistent numbers is an accurate reflection of varied times of the day that queries were run and the data at that point in time.

DIVERSION OF CONTROLLED SUBSTANCES

HPSP Definition of Diversion

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

Monitoring Conditions

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

Prescription Drug Abuse and Diversion

On July 22, 2020, a total of 553 health professionals had signed participation agreements. Of the 553 health professionals with signed agreements, 101 (18%) were addicted to prescription medications. Of the 101 addicted to prescription medications, 71 (70%) engaged in diversion.

Diversion by Board

The table below shows the number of participants with signed Participation Agreements on July 22, 2020, who diverted medications by board and whether the diversion took place at work. Some participants diverted in more than one way. The data is based on participant self-report of diversion, employer report of diversion and Board data (i.e. data provided to HPSP by the Board via a disciplinary order).

Board	Number of persons who diverted by board	Diversion took place at work	Diversion did not take place at work	Percent of HPSP's diversion cases**	Percent of board's participants who diverted ***
Nursing	50	35	20	70%	16%
Medical Practice	6	3	4	8%	6%
Pharmacy	6	6	0	8%	27%
Dentistry	3	3	3	4%	12%
Psychology	2	0	2	3%	17%
Veterinary Medicine	2	2	1	3%	25%
Other boards*	2	0	2	3%	4%
Totals	71	49	31		

About the data:

**Represents 1 person regulated by the Board of Social Work and 1 person regulated by the Board of Behavioral Health and Therapy.*

***Represents the number of participants who diverted by board divided by total who diverted*

****Represents the number of participants who diverted by board divided by the number of participants the board had in HPSP with signed Participation Agreements on 7/22/2020*

Methods of Diversion

As noted earlier, 71 participants engaged in diversion. Of these, 49 engaged in work-related diversion and/or 31 engaged in non-work-related diversion (some used more than one method of diversion). The tables below describe methods of diversion.

Work-related diversion (69%)	**63**
Took from waste	25
Took from Inventory	18
Withdrew more than patient needed and kept extra for self	7
Wrote prescription for patient and filled for self	6
Other	7

Non-work-related diversion (38%)	**36**
Took from family or friends	26
Ordering off the internet	4
Wrote prescription for self	3
Wrote prescription for fake patient	3
Other	0

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

Referral Sources of Persons who Diverted by First Referral Source:

When considering secondary referral sources, 72% of participants who engaged in diversion were known to a licensing board. The boards took disciplinary action in 59% of these cases. The referral sources of HPSP participants who diverted medications are described below:

- 31 (44%) were board disciplinary referrals
- 28 (39%) self-referrals
    - 9 were later board referred with discipline
    - 1 were later board referred without discipline
- 9 (13%) were board referred without discipline (voluntary)
    - 1 was later referred with board discipline
- 3 (4%) was referred by a third party
    - 1 was later referred with board discipline

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

Diversion and Addiction to Controlled Substances by Fiscal Year				
Fiscal Year	Number that diverted	Work-related diversion	Non-work-related diversion	Number addicted to prescription medications
2014	111	82	52	144
2015	64	47	36	117
2016	86	59	46	123
2017	77	49	46	125
2018	65	38	42	118
2019	81	56	36	119
2020	71	63	36	101

The table on the left shows that it is not uncommon for persons to divert medications to use more than one method of diversion.

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

UPDATES

COVID-19

COVID-19 was addressed by staff dedicated to public safety and the mission of HPSP. Staff worked diligently with participants to address questions and concerns. Staff aided participants in managing the changing landscape of telehealth. HPSP worked with community partners to identify new toxicology collection sites for toxicology screening.

To limit the impact of COVID-19 on the health and safety of staff, schedules were revised, and telecommuting was incorporated. HPSP staff have worked very closely as a team to meet the challenges of COVID-19. HPSP complies with protocols established by the Departments of Administration and Health, as well as national guidelines established by the Centers for Disease Control and Prevention.

INCLUSION AND DIVERSITY

At the November 12, 2019 Program Committee meetings, an Inclusion and Diversity Task Force was established to address how HPSP can support diversity and inclusion in its workforce and ensure that participants from all backgrounds are treated with respect and are guided toward services that reflect and support their differences, whenever possible. The Task Force members include James Bialke, Kathy Polhamus, and Sam Sands. Kimberly Zillmer, HPSP case manager, staffs the Task Force.

The Task Force met once before COVID-19 eliminated the possibility of meeting in person. The Task Force recommended HPSP staff increase the training they receive about diversity and inclusion. Future meetings will take place.

STAFFING

HPSP is fully staffed with a program manager, five case managers, a case management assistant, and an office and records administrator. Between July 2019 through April 2020, HPSP experienced 50% staff turnover. Veteran staff are commended for training new staff and all staff are appreciated for their commitment to a safe, productive and respectful work environment. Staff participated in trainings about diversity and inclusion.

DATABASE ENHANCEMENTS

HPSP completed the first of two database enhancements in June 2019. The first enhancement enables the automatic submission of over 13,000 toxicology screen results, annually, in the HPSP Case Management System (CMS) database in real time. This project affords case managers with robust tools to monitor toxicology screen results. It also saves staff time from manually entering and filing screen results.

The second enhancement is electronic submission of reports to HPSP's CMS database from a newly developed website. Each work site monitor, treatment provider and participant will receive a unique security code issued by the system for logging into the online portal to submit reports. This will enable

work site monitors, treatment providers, and participants to electronically enter quarterly compliance reports. Case managers will review the electronic reports prior to authorizing electronic loading into the CMS database. A testing phase with specific providers and work site monitors will take place prior to implementation. The enhancement will increase HPSP efficiency by reducing staff time spent entering paper reports. This feature will also enable work site monitors, treatment providers and participants to efficiently upload PDF documents.

OUTREACH

HPSP staff presented to 12 different stakeholder groups about program services (i.e. schools, professional associations, employers), which provided the opportunity to interface with over 300 individuals in fiscal year 2020. Due to COVID-19, outreach efforts in the second half of the fiscal year were limited.

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

LOOKING FORWARD

HPSP is leveraging technology to improve program effectiveness and efficiency. Substantial improvements have already been made with the advent of automated uploads of most toxicology screen results. In fiscal year 2021, the technological improvements will be focused on updating the database to include, but not be limited to, a portal for participants, treatment providers and work site monitors to provide reports electronically, and to revising HPSP's intake form.

BUDGET

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

FUNDING

The health licensing boards and the Department of Health fund HPSP. Each board pays an annual $1,000 fee and a pro-rata share of program expenses to HPSP's administering board based on the number of the board's participants in the program at the end of each month. No additional fees are collected by HPSP for program participation from licensees. Licensees are responsible for paying for costs associated with evaluations, treatment and toxicology screens (if warranted).

HPSP's base budget for the fiscal years 2020-2021 biennial budget is $2,025,000; $1,023,000 in fiscal year 2020 and $1,002,000 in fiscal year 2021. The increased appropriation will be directed toward salaries, benefits, and general operations, as well as making technological improvements.

EXPENSES

As a program of the health licensing boards, HPSP's expenses are similar to those of the boards. The majority of HPSP's expenses are directed toward salaries and benefits. The next largest expense is rent. HPSP has consistently spent within its appropriation. Costs associated with COVID-19 have been manageable.

PROGRAM COMMITTEE GOALS

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

GOAL 1: ENSURE THE PUBLIC IS PROTECTED

HPSP's protection of the public is multifaceted.

- HPSP works collaboratively with board staff to ensure monitoring is consistent with board expectations, national norms established by the American Society of Addiction Medicine, the National Council of State Boards of Nursing, the Federation of State Medical Boards, the Federation of State Physician Health Programs and emerging science.
- Self and third-party reporting of illness made up 55% of referrals in fiscal year 2020
- HPSP implements practice restrictions when appropriate to protect the public
- HPSP refers health professionals for appropriate assessments and evaluations
- HPSP requires participants follow treatment recommendations
- HPSP tracks participants' compliance with treatment and monitoring requirements
- HPSP intervenes when participants have exacerbations of symptoms
- HPSP serves as a liaison between employers and treatment providers
- HPSP reports health professionals who are not compliant with Participation Agreements to their licensing boards
- HPSP educates employers and the medical community about professional impairment
- HPSP encourages early intervention through its outreach to schools, professional associations and other groups

GOAL 2: ENSURE INDIVIDUAL CLIENTS ARE TREATED WITH RESPECT

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

- Ensuring staff receive ongoing training about cultural intelligence, inclusion and diversity
- Ensuring staff receive ongoing training regarding substance and psychiatric disorders
- Maintaining a simple process for reporting to the program
- Developing and utilizing monitoring guidelines that are based on research and national standards
- Providing a consistent service to all health professionals
- Maintaining motivated, competent staff who are proficient in substance and psychiatric disorders as well as case management
- Collecting and reviewing feedback from participants on a regular basis
- Incorporating participant feedback as deemed appropriate
- Finding accessible collection sites for participants and posting them on the HPSP website

- Maintaining a user-friendly website that includes participant, treatment provider and work site monitor information and forms
- Expanding electronic options for submitting quarterly compliance reports
- Promoting teamwork and staff development

GOAL 3: ENSURE THE PROGRAM IS WELL MANAGED

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

- HPSP follows the health licensing boards' Continuity of Operations Plan
- HPSP follows all State guidelines for managing COVID-19
- HPSP follows human resource and administrative procedures established by the Department of Administration, facilitated by the Small Agency Resource Team (SmART)
- HPSP collaborates with board staff and seeks input regarding the monitoring process and guidelines
- HPSP holds regular meetings with board staff to review program processes and board concerns
- HPSP completes the Department of Management and Budget's (MMB) Internal Control Self-Assessment tool annually to identify program strengths and vulnerabilities
- HPSP utilizes MN.IT for computer security, database development, and other electronic technology (i.e. phones, printers, email)
- HPSP is staffed with competent employees who are invested in the program's mission
- The program manager assures that case managers provide quality intake and case management monitoring services
- The program manager performs annual performance reviews of employees and undergoes a performance evaluation by the administering board
- The program manager surveys executive directors annually to obtain input on program services
- The program manager submits monthly billing reports to the SmART on a timely basis
- The program manager sends board executive directors monthly referral, discharge and cost allocation reports
- The program manager meets with the Administering Board Executive Director and to review program operations and spending on a regular basis
- The program manager ensures that all staff review relevant state policies upon hire and annually (i.e. data practices, code of ethics, respectful workplace, electronic communications and others)
- The program manager seeks legal advice from the Office of the Attorney General when needed
- HPSP is recognized nationally as a quality program
- HPSP utilizes specialized consultants to assist in developing the terms of Participation Agreements in complex situations

GOAL 4: ENSURE THE PROGRAM IS FINANCIALLY SECURE

The funding source of HPSP is defined in statute and is appropriated by the Legislature on a biennial basis. HPSP has sought funding increases when deemed necessary to address program growth and needs.

HPSP consistently spends within its allotted budget. HPSP has regular budget meetings with the Administering Board Executive Director. Spending is tracked through HPSP and confirmed with spending and budget reports from SmART.

The majority of HPSP's costs are related to staffing. All expenses are tracked and reconciled with reports from SmART. SmART also performs accounting audits.

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

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

COMMITTEE MEMBERS AND STAFF

PROGRAM COMMITTEE MEMBERS

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

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

Board	Member Name	Term Expires
Behavioral Health and Therapy	Jae Hyun Shim	1/1/2020 to 12/31/2020
Chiropractic Examiners	Nestor Riano	1/1/2020 to 12/31/2020
Dentistry	Ruth Dahl	1/1/2020 to 12/31/2020
Department of Health	Debbie Thao	1/1/2020 to 12/31/2020
Dietetics and Nutritionists	Margaret Schreiner	1/1/2020 to 12/31/2020
Emergency Medical Services	Matthew Simpson	1/1/2020 to 12/31/2020
Marriage and Family Therapy	Jennifer Mohlenhoff	1/1/2020 to 12/31/2020
Medical Practice	Allen Rasmussen	1/1/2020 to 12/31/2020
Nursing	Laura Warner	1/1/2020 to 12/31/2020
Nursing Home Administrators	Randy Snyder	1/1/2020 to 12/31/2020
Occupational Therapy	Jessica Engman	1/1/2020 to 12/31/2020
Optometry	Randy Snyder	1/1/2020 to 12/31/2020
Pharmacy	James Bialke	1/1/2020 to 12/31/2020
Physical Therapy	Kathy Polhamus, Vice Chair	1/1/2020 to 12/31/2020
Podiatric Medicine	Margaret Schreiner	1/1/2020 to 12/31/2020
Psychology	Jack Rusinoff (Alt: Samuel Sands)	1/1/2020 to 12/31/2020
Social Work	Kathy Lombardi	1/1/2020 to 12/31/2020
Veterinary Medicine	Jody Groat	1/1/2020 to 12/31/2020

ADMINISTERING BOARD

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

ADVISORY COMMITTEE MEMBERS

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

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

Professional Association	Member	Term
MN Academy of Nutrition and Dietetics	Andrew Pfaff	1/15/2020 to 1/14/2022
MN Academy of Physician Assistants	Tracy Keizer	1/15/2020 to 1/14/2022
MN Ambulance Assoc.	Patrick Egan (Alt: Debbie Gillquist)	1/15/2020 to 1/14/2022
MN Assoc. of Marriage & Family Therapy	Eric Hansen	1/15/2020 to 1/14/2022
MN Assoc. of Naturopathic Physicians	Crystalin Montgomery	1/15/2020 to 1/14/2022
MN Dental Assoc.	Stephen Gulbrandsen, Vice Chair	1/15/2020 to 1/14/2022
MN Medical Association	Eric Dick (Alt: Janet Silversmith)	1/15/2020 to 1/14/2022
MN Nurse Peer Support Group	Linda Halcon	1/15/2020 to 1/14/2022
MN Nurses Assoc.	Mary Kay Borgstrom	1/15/2020 to 1/14/2022
MN Occupational Therapy Assoc.	Karen Sames	1/15/2020 to 1/14/2022
MN Organization of Leaders in Nursing	Stephanie Johnson	1/15/2020 to 1/14/2022
MN Organization of Registered Nurses	Tracey Armstrong (Alt: Niki Gjere)	1/15/2020 to 1/14/2022
MN Pharmacists Assoc.	Sue Anderson	1/15/2020 to 1/14/2022
MN Podiatric Medicine Assoc.	Kari Prescott	1/15/2020 to 1/14/2022
MN Psychological Assoc.	Lois Cochrane-Schlutter	1/15/2020 to 1/14/2022
MN Society of Health Systems Pharmacists	S. Bruce Benson	1/15/2020 to 1/14/2022
MN Veterinary Assoc.	Marcia Brower	1/15/2020 to 1/14/2022
National Assoc. of Social Workers, MN Chap.	Judy Parr	1/15/2020 to 1/14/2022
Pharmacists Recovery Network	Jim Alexander	1/15/2020 to 1/14/2022
Physicians Serving Physicians	Jeff Morgan	1/15/2020 to 1/14/2022
Ad Hoc Member	Rose Nelson	1/15/2020 to 1/14/2022

HPSP STAFF

Staff Person	Position
Monica Feider, MSW, LICSW	Program Manager
Tracy Erfourth, BA	Case Manager
Marilyn Miller, MS, LICSW	Case Manager
Laura Carlisle, MA, LADC	Case Manager
Lisa Solberg, BS, LADC	Case Manager
Kimberly Zillmer, BA, LADC	Case Manager
Eldaa Delgado	Case Management Assistant
Patricia Rogers	Office and Records Administrator