STATE OF MINNESOTA

Board of Medical Practice and
Health Professionals Services Program

How Do Physician Health Program's Work: Accountability, Patient Safety and Value

Federation of State Medical Boards
Federation of State Physician Health Programs
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INTRODUCTION

The State of Minnesota's Health Professionals Services Program ("HPSP") was created in Statute in 1994 to protect the citizens of Minnesota from regulated health care practitioners who have illnesses that, if not appropriately managed, could impact patient care. The HPSP serves and is supported by the health-related licensing boards and the emergency medical services regulatory board.

MISSIONS / GOALS

The mission of the HPSP is to enhance public protection and provide support for regulated health care professionals who may be impaired in their ability to practice safely. The goals of the HPSP are to promote early intervention, diagnosis and treatment of potentially impaired health professionals and to provide confidential monitoring services as an alternative to board discipline.

The mission and primary responsibility of the Board of Medical Practice is to serve and protect the public. The Board accomplishes its mandate by extending the privilege to practice certain health professions to qualified applicants and by investigating complaints relating to the competency or behavior of credentialed individuals.

BACKGROUND

In the late 1980s and early 1990s, Minnesota's health-related licensing boards, including the medical and nursing boards, collaborated to explore non-disciplinary alternatives for managing impairment in health care professionals. With the support of the health-related licensing boards and professional associations, attitudes changed and the stage was set for a series of legislative and procedural changes that impacted how the health-related licensing boards responded to reports of potentially impaired health care practitioners, as follows:

- In 1989, the Medical Practice Act was modified to exempt illness-based disciplinary actions from publication requirements via a media press release and a report to the National Practitioner Data Bank *[See Minn. Statutes § 147.02, Subd. 6a]*.
- In 1992, the Minnesota legislature delegated to the Minnesota Department of Health the responsibility for confidential reporting, oversight and non-disciplinary monitoring of regulated health care professionals with positive HIV, HBV, or HCV statuses *[See Minn. Statutes § 214.17 – 214.25]*.
- In 1994, the HPSP was established *[See Minn. Statutes § 214.31 – 214.37]*. Participating boards included the boards of medicine, nursing, dentistry, pharmacy and podiatry.
- In 2000, legislation was enacted to require all health-related licensing boards and the emergency medical services regulatory board to participate in a diversion program such as the HPSP *[See Minn. Statutes § 214.29]*.

HPSP PROGRAM DESCRIPTION

The HPSP is designed to monitor the treatment and continuing care of regulated health professionals (see below) who may be unable to practice with reasonable skill and safety if their illnesses are not appropriately managed. The HPSP provides an option for health professionals to confidentially report their illnesses or the illnesses of other health professionals. The HPSP also provides the health-related licensing boards with a non-public and non-disciplinary method to manage health professionals who recognize their illnesses and the need for continuing care and/or practice limitations, and who agree to be monitored.

PARTICIPATING BOARDS

Minnesota Statutes § 214.29 requires participation in the HPSP: "Each health-related licensing board, including the Emergency Medical Services Regulatory Board under chapter 214E, shall either conduct a health professionals service program or contract for a diversion program under section 214.28." These boards include:

- Behavioral Health and Therapy (counselors and alcohol and drug counselors)
- Chiropractic Examiners (chiropractors)
- Dentistry (dentists, dental hygienists and assistants)
- Dietetics and Nutrition (dieticians and nutritionists)
- Emergency Medical Services (EMTs, paramedics and first responders)
- Marriage and Family Therapy (marriage and family therapists)
- Medical Practice (physicians, physician assistants, residents, respiratory care practitioners, acupuncturists, athletic trainers, and traditional midwives)
- Nursing (RNs and LPNs)
- Nursing Home Administrators (nursing home administrators)
- Optometry (optometrists)
- Pharmacy (pharmacists, pharmacy technicians and students)
- Physical Therapy (physical therapists)
- Podiatric Medicine (podiatrists)
- Psychology (psychologists)
- Social Work (social workers)
- Veterinary Medicine (veterinarians)
- Department of Health (occupational therapists and assistants, speech language pathologists, alternative care providers, and hearing aid dispensers)
- Office of Mental Health Practice (regulates unlicensed metal health practitioners)

WHY IT WORKS

BOARD AND ASSOCIATION SUPPORT

The legislation enabling the HPSP was developed with the support of the regulatory boards and professional associations. The boards and associations shared (and continue to share) a vision of encouraging early diagnosis, treatment and monitoring of practitioners with illnesses that might impact their ability to practice. They believed early intervention and monitoring would improve public safety in health care while improving recovery outcomes for practitioners. They recognized the need for a confidential and non-disciplinary way to encourage self-reporting of illnesses and to obtain monitoring services.

In support of its efforts to explore alternatives to disciplinary action, the Board of Medical Practice has been involved for several years with the Minnesota Alliance for Patient Safety ("MAPS"), a partnership among the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Department of Health, health licensing boards, and many other public and private health care organizations working together to improve patient safety. MAPS participants, including the Board of Medical Practice, worked together to develop a statement that represents the collaborative efforts of health care organizations in Minnesota to improve patient safety and health care quality by promoting a fair and just response to medical errors and adverse outcomes. In 2006, the Board of Medical Practice adopted the MAPS Statement of Support for a Statewide Culture of Learning, Justice, and Accountability *[See MAPS Statement on page 8]*. The HPSP program is representative of the philosophy perpetuated by MAPS and its participants.

MUTUAL UNDERSTANDING AND RESPECT

Shared goal of protecting the public: Keeping public protection in the forefront of program services reinforces confidence in and commitment to the program.

Mutual understanding and respect for one another's roles: It is important for program and board staff to understand one another's roles and define boundaries. Some boundaries are established in Statute, such as those related to the classification of data, but others are less clear. Ongoing review and analyses of the roles and boundaries of the regulatory boards and the program allow the program and the boards to work more effectively together.

Acknowledging mistakes: It is natural for oversights and missteps to occur in the early stages of program development and implementation. As the boards and the program identified stumbling blocks and areas of concern, the HPSP acknowledged these and developed plans to address them. The program listened to board staff and invited feedback to identify problems and develop solutions. The willingness of the HPSP to acknowledge and address concerns increased board commitment to and confidence in the program.

Establishing expectations: Identifying and understanding the expectations of the regulatory boards was essential to the program's success. It was the starting point at which mutually agreed upon expectations were created. This was done both formally and informally. For example, the HPSP and board staffs worked together informally to clarify expectations regarding the program's responsibility to report participants for non-compliance with monitoring. The development of mutually agreeable expectations for reporting created a mechanism to measure program accountability. It was also essential for the boards to identify and understand the limitations of the program's services and to make appropriate referrals for monitoring. Clarification of non-illness related behaviors, including many Axis II diagnoses, disruptive behaviors, sexual addictions, and diversion, allowed the boards to more appropriately utilize the services of the program. Clear expectations enhance the overall success of the program.

Effective monitoring cannot be tied to black and white assumptions or processes. The program often reviews gray areas with board staff. Reviews are done by providing board staff with non-identifying information about a participant's situation. If a report to the regulatory board or discharge from monitoring will not result in improved public protection, the program may choose to continue to monitor a participant without involving the regulatory board. In such circumstances the program may, at its discretion, continue or increase the terms of monitoring. However, if public protection is in question, the program may choose to file a report with the regulatory board and/or discharge the participant.

Consider a participant who does not provide a required random urine specimen on a specified date. Should the participant be reported to the regulatory board if they did not provide the specimen because of a personal or family medical emergency? What if they were in a blizzard or an accident? What if they simply forgot to provide the specimen? Was it their first missed screen, or is there a pattern of missed screens? How does the rest of their compliance data look? The HPSP reviews all compliance data when analyzing instances of non-compliance and works closely with the boards to define expectations and establish appropriate protocols for managing and reporting non-compliance.

Collaboration and Trust: The HPSP worked closely with the boards to develop reasonable guidelines, consistent with statutory requirements, for reporting non-compliant participants, with the understanding that the circumstances resulting in non-compliance can vary significantly. The HPSP, by acting in accordance with these guidelines, promoted board trust in the program. Further, the HPSP sought opportunities for regular interaction with the boards to evaluate monitoring protocols and address the individual needs of the boards. Increased communication, collaboration, accountability, and a clear understanding of boundaries and expectations have served to boost confidence and promote trust between the boards and HPSP.

STATUTORY SUPPORT

The HPSP's responsibilities are defined in Statute, which increases the program's credibility and accountability. Also, work sites, treatment providers and participants

follow statutory reporting obligations *[See Minn. Statutes § 214.19 and § 147.111]*.

Significantly, the authorizing statute for the HPSP does not in any manner affect a board's authority to pursue disciplinary action against a regulated individual. Boards may utilize the services of the HPSP not only by non-disciplinary referral of a regulated individual to the program, but also by referral of a regulated individual for monitoring pursuant to the terms of a disciplinary order.

DOES NOT PROVIDE TREAMENT

The HPSP does not provide treatment. Rather, the program refers participants for substance, psychiatric, pain and other assessments/treatment. Because the HPSP is not involved in providing treatment, there is no dual relationship of providing both treatment and monitoring services, thereby eliminating any potential conflict of interest. An added benefit is the ability of treatment providers to maintain a therapeutic relationship with participants, while the program monitors compliance with treatment and intervenes only as necessary. The HPSP serves as the liaison between treatment providers and work site monitors.

STAKEHOLDER BENEFITS

The HPSP is successful because it offers expansive benefits to stakeholders. Following is a list of stakeholders and how they are positively impacted by program services and structure:

Regulatory Boards:

- When regulated individuals manage illnesses appropriately, the public is protected
- Expands non-disciplinary options for managing practitioners with illnesses
- Provides expertise regarding substance and psychiatric disorders
- Eliminates potential conflict of interest (board as both monitor and enforcer)
- Decreases legal costs, staff time and resources
- Allows for uninterrupted monitoring while boards complete investigations
- Immediate ability for the HPSP to ask practitioner to refrain from practice or limit practice vs. a board process to take action to suspend/restrict a credential
- Shared cost of program services is affordable for all boards
- Increases individual and organizational compliance with mandatory reporting requirements, since a report to the HPSP satisfies statutory reporting obligations
- Reduces ADA claims, since monitoring is based on individual clinical needs

Regulated individuals:

- Monitoring is confidential
- Rights are protected (property rights, due process and confidentiality)
- Sobriety/recovery is documented
- Provides expertise and resources
- Improved therapeutic outcomes
- Monitoring is based on individual clinical needs, ensuring correct level of care

- A report to the HPSP satisfies statutory reporting obligations

General Public:

- When regulated individuals manage illnesses appropriately, the public is protected
- Increased incentive for mandatory reporting increases likelihood that practitioners with illnesses will receive needed treatment and be monitored appropriately
- Monitoring is implemented expeditiously, increasing public safety
- Practitioners with illnesses are safely transitioned back to work
- Continuity of care for patients while practitioners participate in monitoring
- Single agency to report illnesses of all regulated health professionals
- Regulatory board may be involved as necessary to protect the public

Employers:

- Promotes workforce retention
- Reinforces healthy work environment
- Helps transition employees safely back to work
- Monitoring is available at no cost to employer
- Provides expertise and resources
- Single agency to report illnesses of all regulated health professionals
- Satisfies mandatory reporting obligations
- Reduces ADA claims, since monitoring is based on individual clinical needs

Treatment Providers:

- Helps coordinate the care of patients/clients
- Provides additional information on which to make treatment decisions
- Structured support of long-term recovery for patients/clients
- Provides incentive for treatment compliance
- Provides expertise and resources
- Satisfies mandatory reporting obligations
- Single agency to report illnesses of all regulated health professionals
- Decreases potential conflict of interest - since the HPSP does not provide treatment, there is not a dual role of providing treatment and providing monitoring services

Professional Associations:

- Provides resources and referrals for members and their families
- Expands non-disciplinary options for managing practitioners with illnesses
- Increases awareness of problem/solution regarding illness
- Helps maintain profession’s integrity
- Protects confidentiality of members who seek appropriate treatment for illnesses

MINNESOTA ALLIANCE FOR PATIENT SAFETY

Statement of Support for a Statewide Culture of Learning, Justice, and Accountability

Given that:

- Medical errors and patient safety are a national concern to all involved in health care delivery.
- We are legally and/or ethically obligated to hold individuals accountable for their competency and behaviors that impact patient care.
- A punitive environment does not fully take into account systems issues, and a blame-free environment does not hold individuals appropriately accountable.

We resolve that our organization will:

- Strive for a culture that balances the need for a non-punitive learning environment with the equally important need to hold persons accountable for their actions.
- Seek to judge the behavior, not the outcome, distinguishing between human error, at-risk behavior, and intentional reckless behavior.
- Foster a learning environment that encourages the identification and review of all errors, near-misses, adverse events, and system weaknesses.
- Promote the use of a wide range of responses to safety-related events caused by lapses in human behavior, including coaching, non-disciplinary counseling, additional education or training, demonstration of competency, additional supervision and oversight and disciplinary action when appropriate to address performance issues.
- Support and implement systems that enable safe behavior to prevent harm.
- Work to share information across organizations to promote continuous improvement and ensure the highest level of patient and staff safety.
- Collaborate in efforts to establish a statewide culture of learning, justice, and accountability to provide the safest possible environment for patients.

For more information about MAPS, visit their website at:

http://www.mnpatientsafety.org/index.php?option=com_frontpage&Itemid=1,

or Contact Tania Daniels at: **tdaniels@mnhospitals.org or (651) 641-1121**

MEDICAL BOARD STATISTICS

Prior to implementation of the HPSP, the only option for monitoring practitioners with illnesses was pursuant to the terms and conditions of a formal disciplinary action. Implementation of the HPSP offered health care professionals the opportunity to seek appropriate treatment and monitoring of their illnesses, through a confidential, non-disciplinary process.

Program participants who are unsuccessful in managing their illnesses, or who fail to comply with the terms of confidential HPSP monitoring plans, are subject to a regulatory review process. Failure to succeed in the HPSP may result in formal disciplinary action. Disciplinary actions, although public, often allow practitioners to continue practicing while undergoing monitoring. In fact, orders frequently reflect the same or similar terms to those which might be included in an HPSP monitoring plan.

Statistics demonstrate that, prior to implementation of the HPSP, a significant number of illness-based complaints resulted in formal disciplinary action. For example, in 1990, 76 % of illness based complaints resulted in disciplinary action. By 1995, just one year after the HPSP was implemented, less than 50% of illness-based complaints resulted in disciplinary action. Currently, less than 30% of illness-based complaints result in disciplinary action.

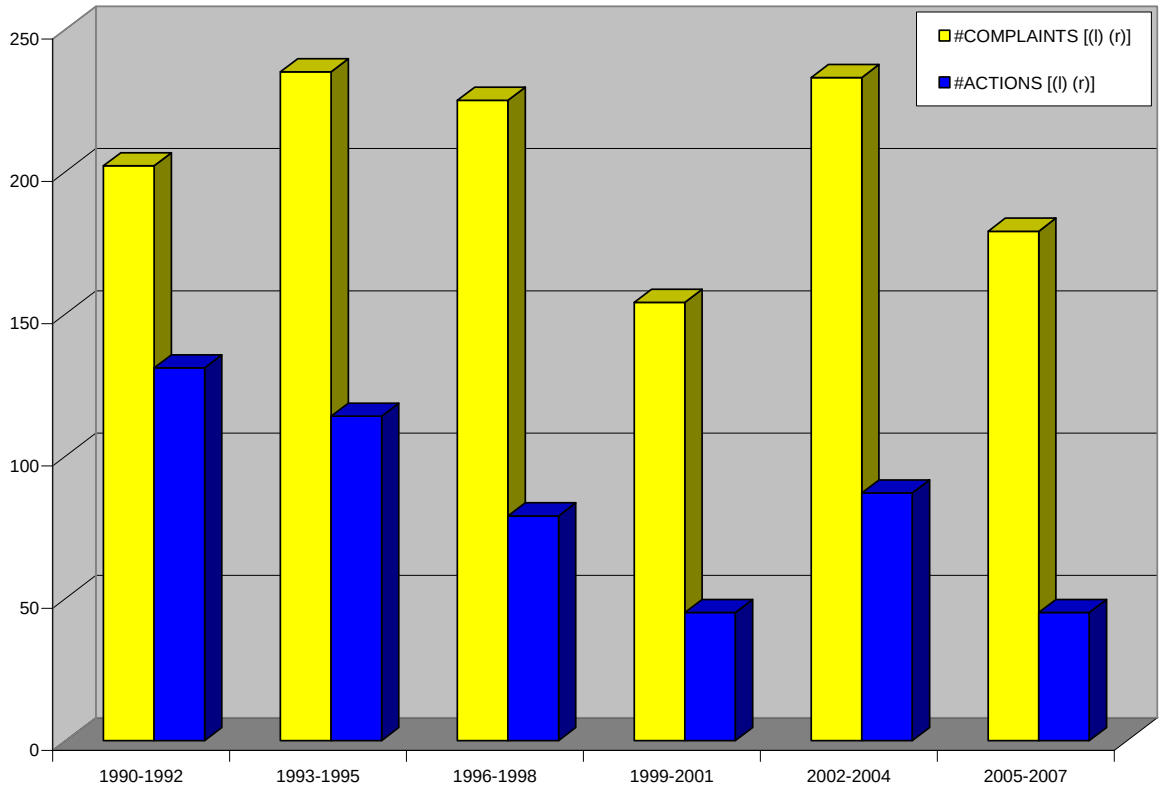
The charts, below, clearly demonstrate the significant decrease in the percentage of illness-based complaints resulting in disciplinary action, following implementation of the HPSP. Somewhat surprisingly, the number of illness-based complaints did not substantially decrease upon implementation of the program. The bar graph below actually reflects an increase in the number of illness-based complaints filed with the board between 1993 and 1998, while the number of actions taken steadily decreased. This may have resulted from one of two factors:

> 1) Practitioners and consumers were unfamiliar with the HPSP in the mid-1990s and continued to submit reports of practitioners with illnesses to the board; or
>
> 2) Practitioners were more likely to comply with mandatory reporting obligations once they understood that the outcome might include confidential monitoring, via a non-disciplinary referral to the HPSP, rather than formal disciplinary action.

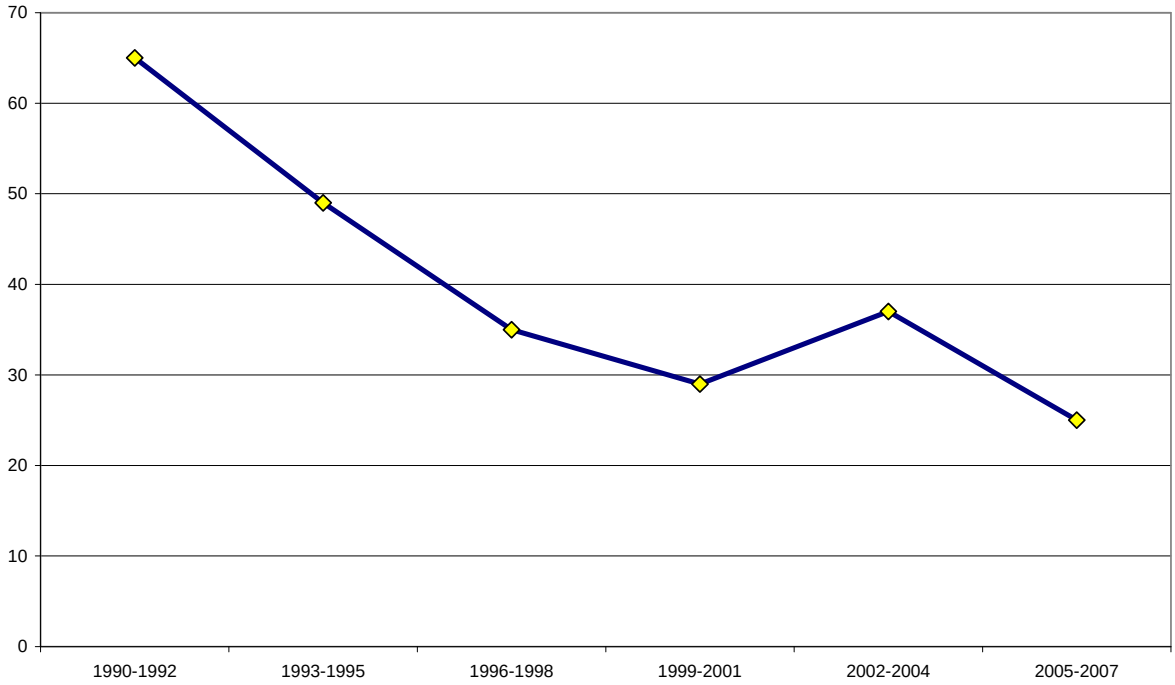
The implementation of confidential monitoring clearly provided greater incentive for compliance with statutory reporting requirements. However, the regulatory boards and the HPSP recognized that not everyone was familiar with the program and reporters did not realize that a report to the program would satisfy statutory reporting obligations. Outreach efforts increased awareness of the program and helped clarify reporting obligations. Joint efforts by the regulatory boards, the HPSP and professional associations included meetings with stakeholder groups and distribution of program information, postings in newsletters and on websites, and links on many stakeholder websites to the HPSP website.

The medical board also revised its procedures to immediately refer illness-based reports to the HPSP for an intake assessment, without creating a complaint file or conducting an investigation. Currently, the board receives approximately 25 self-reports, annually, which are referred without investigation to the HPSP.

The medical board currently regulates over 23,000 health care practitioners, of which almost 19,000 are physicians. Less than 10% of the total complaints received by the board are based on illness. The Board of Medical Practice generally does not take action based on illness against individuals who have not first attempted to participate in confidential monitoring through the HPSP. Disciplinary action generally results only after a regulated individual has refused or failed to comply with HPSP monitoring, or who has violated other sections of the practice act (i.e. engaged in sexual misconduct, fraud, or who has failed to cooperate with a board investigation).



Percent of Complaints Resulting in Actions
(Illness Based)



PROGRAM REPORTS - ACCOUNTABILITY

The HPSP provides summary reports to the Program Committee, the Administering Board, the regulatory boards, and the Advisory Committee, consistent with the program's statutory authority and with other applicable federal and state laws regarding data privacy.

Annual and Mid-Year Reports
The HPSP develops an annual and mid-year report. This report is submitted to the Program Committee and then to the Executive Directors of the regulatory boards. The report documents how the HPSP is meeting its statutory obligations and is a mechanism of accountability from the HPSP to the Program Committee, regulatory boards, regulated individuals 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.

Annual Survey of Executive Directors
The HPSP surveys the executive directors of the regulatory boards on an annual basis to obtain feedback about program services. The survey assists staff in developing program objectives for the following fiscal year.

Cost Allocation Reports
The HPSP creates and distributes monthly statistical reports to the regulatory boards. The reports include the following statistical information regarding regulatory board participants:

- Number of cases to date
- Number of closed cases for the month
- Number of new cases for the month
- Active cases at the end of the month
- Cost allocation per board

PROGRAM MANAGEMENT AND STRUCTURE

The HPSP is managed through inter-related mechanisms of a Program Committee, an Advisory Committee and an Administering Board. The HPSP and board staffs also meet informally on a quarterly basis to address questions or concerns and share information about programmatic changes.

PROGRAM COMMITTEE

One representative from each board serves on the Program Committee. Each participating board may choose its representative in any manner acceptable to that board.

The Program Committee exists to provide direction to the program, assuring the participating boards that the HPSP is operating effectively and efficiently to achieve the purposes outlined in the statute. The Program Committee's goals are to:

- Ensure public protection
- Ensure program participants are treated with respect
- Affirm the program is well-managed
- Affirm the program is financially secure
- Ensure the program is operating consistent with statutory requirements

The Program Committee designates one of the health-related licensing boards to act as the Administering Board to provide administrative management to the Program.

ADVISORY COMMITTEE

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), and two public members.

The Advisory Committee is established to advise the Program Committee and the program manager to whom the Program Committee has delegated authority. The Advisory Committee serves as a resource for the HPSP. For example, Advisory Committee members provide program staff with information about normative practice settings and supervision. Advisory Committee members also act as a liaison between the program and their membership.

ADMINISTERING BOARD

The Program Committee designates an Administering Board from among the health-related licensing boards. 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) provides support services, including financial, personnel and other services required to maintain program operations. These may include but are not limited to, hiring the program manager, 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.

HPSP AND BOARD STAFF WORK GROUP

Participating boards are asked to designate one or more representatives to meet quarterly with the HPSP staff as part of a work group to discuss issues relating to program policies, procedures and activities. The meetings for the work group are designed to foster effective communication between board representatives and the HPSP staff.

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

PROGRAM MANAGER / STAFF

The HPSP program manager implements the program consistent with the policies established by the Program Committee, state statute and policies of the Minnesota Department of Employee Relations. HPSP staff consists of:

- 0.6 Administrative Assistant
- 0.6 Case Management Assistant
- 1 Office Manager – Toxicology Screening Coordinator
- 5 Case Managers
- 1 Program Manager
- 3 Medical Consultants (utilized as needed)

EXECUTIVE DIRECTORS' FORUM

The HPSP program manager attends monthly meetings with the Executive Directors of the health-related licensing boards. Program updates are provided and questions are addressed.

DATA AND RECORDS MANAGEMENT

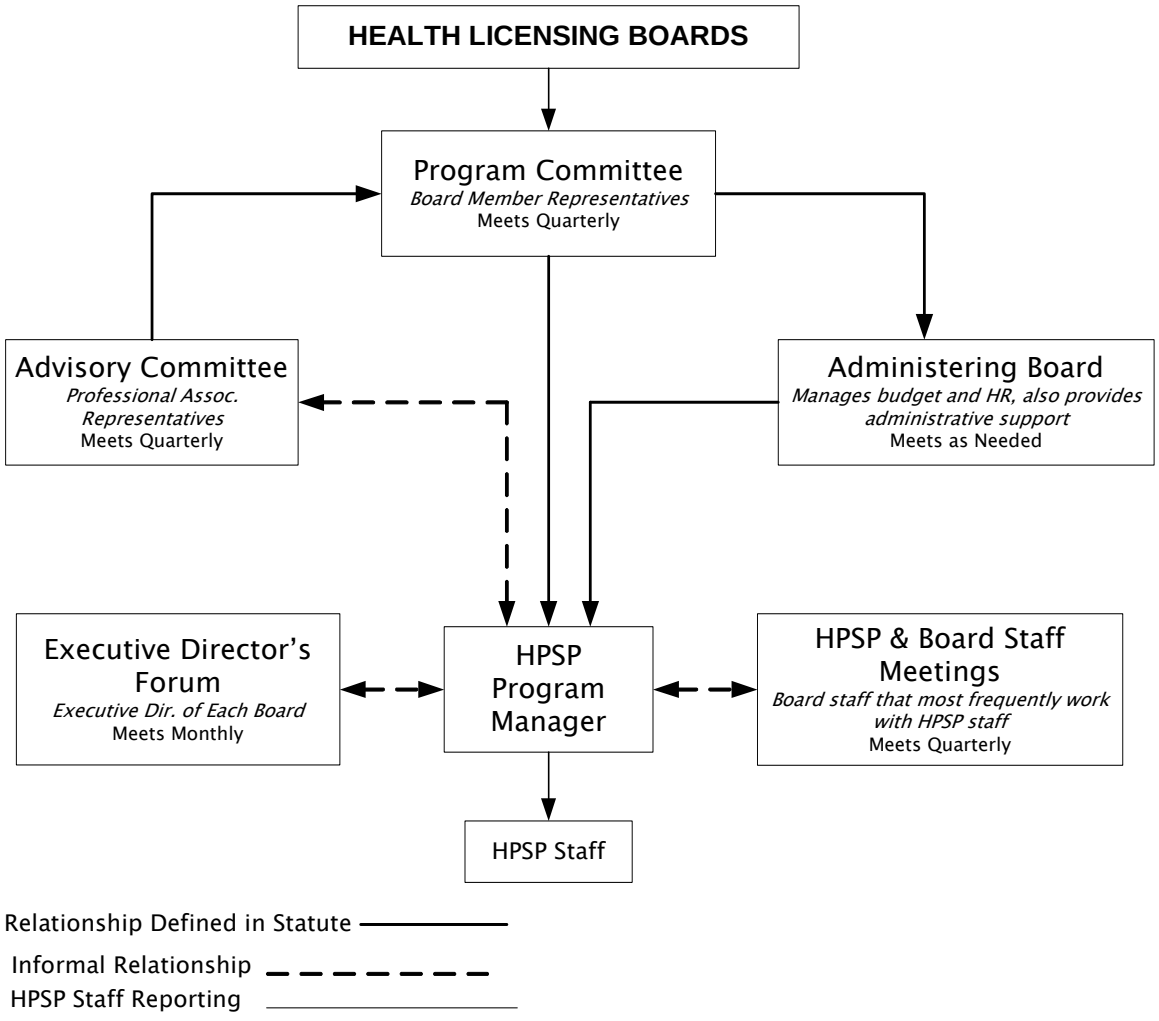
All information regarding persons enrolled in the HPSP is classified as confidential *[See Minn. Statutes § 13.41]*, except compliance data, which is classified as private *[See Minn. Statutes § 13.02, Subd. 12]*. The Monitoring Plan and compliance data are forwarded by the HPSP to third parties and/or regulatory authorities only when

authorized by statute *[See Minn. Statutes §§ 214.32, Subd. 5 and 214.33]*. The data is subject to applicable state laws governing data practices, except as otherwise stated in the program's statutory authority.

FUNDING

The HPSP is funded by the health-related licensing boards and the Department of Health, with income generated by credentialing fees held in the 171 State Government Special Revenue Fund. Each board pays an annual $1,000 fee and a pro-rata share of program expenses based on their number of participants in the program.

ORGANIZATIONAL CHART

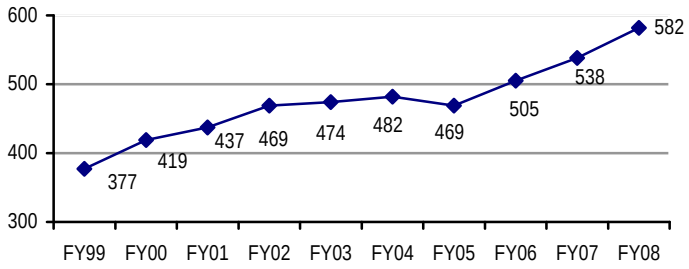


PROGRAM PARTICIPATION

Opened and Closed Cases by Fiscal Year and Board:
The following table shows the number of cases opened, closed and active by fiscal year and board:

FY Joined	BOARD	Opened in FY03	Closed in FY03	Open at End of FY03	Opened in FY04	Closed in FY04	Open at End of FY04	Opened in FY05	Closed in FY05	Open at End of FY05	Opened in FY06	Closed in FY06	Open at End of FY06	Opened in FY07	Closed in FY07	Open at End of FY07
01	BENHA	0	0	1	0	1	0	1	1	0	0	0	0	0	0	0
05	Behavioral Health & Therapy	0	0	0	0	0	0	0	0	15	4	13	6	10	11	5
96	Chiropractic Examiners	1	5	7	4	6	5	5	3	7	16	11	12	18	18	12
94	Dentistry	25	17	25	33	26	32	24	25	31	23	28	26	25	26	25
02	Dept. of Health	7	4	7	10	6	11	20	16	15	0	0	0	4	1	3
02	Dietetics & Nutrition	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0
01	Emerg. Med. Services	5	4	5	2	2	5	10	8	7	11	8	10	14	11	13
95	Marriage and Family Th.	0	0	0	0	0	0	0	0	0	0	0	0	2	1	1
94	Medical Practice	78	69	118	51	59	110	60	77	93	53	48	98	60	65	93
94	Nursing	163	181	257	189	180	266	180	183	263	237	203	297	265	235	327
06	Office of Mental Health	0	0	0	0	0	0	0	0	0	2	1	1	0	1	0
01	Optometry	3	3	2	1	1	2	1	3	0	2	1	1	0	1	0
94	Pharmacy	18	15	23	9	8	24	8	7	25	15	11	29	20	15	34
94	Physical Therapy	5	6	6	5	3	8	5	7	6	5	5	6	3	5	4
94	Podiatric Medicine	2	1	1	2	2	1	0	0	1	0	0	1	0	1	0
02	Psychology	4	3	4	6	4	6	6	7	6	5	5	6	4	3	7
97	Social Work	15	12	17	5	11	11	6	5	12	10	13	9	13	12	10
99	Veterinary Medicine	0	2	0	4	3	1	2	0	3	2	2	3	2	1	4
	Total	327	323	473	321	312	482	328	342	469	385	349	505	440	407	538

Participation by Fiscal Year:
The following chart shows the HPSP's growth from 1999 through March 27, 2008.



CASE MANAGEMENT

REFERRING - REPORTING

Health care professionals who are credentialed by the health-related licensing boards, the Emergency Services Regulatory Board, or the Department of Health, and who may be unable to practice with reasonable skill and safety due to illness or illness-related behaviors are required under their practice act and/or the HPSP's governing statute *[See Minn. Statutes § 214.33]* to report themselves to the HPSP or to their board.

All reports to the HPSP are confidential. In addition, reports are subject to immunity if made in good faith *[See Minn. Statutes § 214.34]*. Reports made to the HPSP may also fulfill individual, organizational and other regulated professional's reporting requirements related to illness.

Regulated health care professionals can be referred to the HPSP in the following ways:

- **Self-Referral:** Regulated individuals may self-refer to the HPSP for monitoring.

- **Third Party Referral:** Third parties may refer regulated individuals to the HPSP. Third party referrals are often from colleagues, employee health programs, supervisors or treatment providers. Third party referrals are confidential and subject to immunity.

- **Board Voluntary Referrals:** Regulatory boards may refer individuals to the HPSP to determine whether the individuals have illnesses that warrant monitoring. Referrals may be made prior to or following a board investigation that substantiates an illness. This type of referral is non-public and non-disciplinary. Boards are not entitled access to any compliance information from the HPSP relating to non-disciplinary referrals.

- **Board Disciplinary Referrals:** Regulatory boards may refer individuals to the HPSP pursuant to disciplinary orders when they have determined that the individuals have illnesses that warrant monitoring. A disciplinary order is public and the HPSP acts as the board's designee to monitor terms of the order pertaining to the diagnosed illness. Boards are entitled access to all compliance data relating to the terms of the order being monitored by the HPSP.

- **Re-Referral:** Regulatory boards may re-refer individuals to the HPSP through either non-disciplinary or disciplinary means. However, individuals may not re-refer themselves to the program after they have been discharged by any means other than *successful completion of monitoring* or *a determination that their condition is non-jurisdictional and does not require monitoring*. Exceptions include persons who the HPSP unsatisfactorily discharged and whose board closed the underlying complaint.

Regardless of how individuals are referred to the HPSP, the intake process is similar. If the HPSP identifies an illness that warrants monitoring, a Participation Agreement and Monitoring Plan are developed for the individual. If the HPSP does not identify an illness that warrants monitoring, the HPSP closes the case as *non-jurisdictional.*

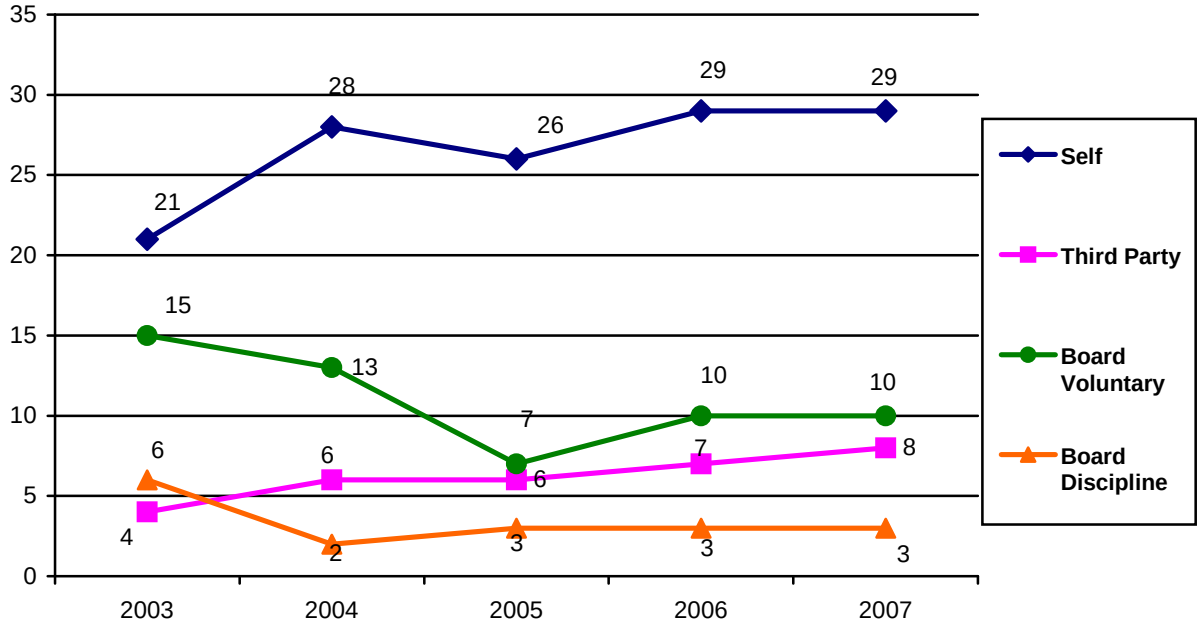
Referrals by Referral Source and Profession (January 1, 2003 to December 31, 2007):

Referral Source	Physician	Dentist	Pharmacist	LPN	RN	Chiropractor
Self	56%	31%	46%	39%	50%	24%
Third Party	14%	28%	25%	14%	16%	0%
Board Voluntary	23%	31%	13%	28%	19%	72%
Board Discipline	7%	10%	16%	19%	15%	4%

Physician Re-Referrals:
From January 1, 2003 to December 31, 2007, 25% of physician referrals were for physicians who had previously been referred to the program. Of these, 28% referred themselves back to the program (generally after successful completion of a previous monitoring plan), 17% were referred back by a third party, 28% were board-referred without discipline, and 27% were board-referred with discipline.

Board Disciplinary Referrals:
Of physicians referred by the board with discipline, 94% had previously been enrolled in the program and discharged to the board due to non-compliance with monitoring. Additionally, 1% of physicians who were board-referred without discipline and 1% that self-referred were later placed under board disciplinary orders in response to non-compliance with monitoring.

Physician Referrals by Fiscal Year and Referral Type:



INITIAL CONTACT

During initial contacts with regulated individuals, the HPSP case managers: 1) describe the program, 2) provide a Tennessen Warning, and 3) review program eligibility requirements *[See Minn. Statutes § 214.32, Subd. 4)*. If, after being provided the above information, an individual chooses to enroll in the HPSP, a new case is opened and the case manager obtains the individual's name, profession, and demographic information, as well as brief social, psychiatric, substance, and employment histories. If the individual chooses not to enroll in the HPSP, a case is not opened and no further action is taken on the part of the HPSP. The HPSP does not monitor practitioners with competency, behavioral or boundary issues.

ENROLLMENT

After initial contact with a regulated individual, an enrollment packet (Enrollment Form and release of information forms) is mailed to the individual. They are instructed to complete and return the forms to the HPSP within a specified period of time. They are notified that if they choose not to cooperate with the intake process, they will be discharged from the program and a report will be filed with their regulatory board.

Upon the HPSP's receipt of a regulated individual's completed Enrollment Forms, the individual becomes a program *'participant'*.

REQUESTING A REGULATED INDIVIDUAL'S MEDICAL RECORDS

After receipt of enrollment materials, case managers mail/fax release of information forms to appropriate parties in order to gather relevant records. Case managers review data to determine whether monitoring is warranted and, if so, to develop Participation Agreements and Monitoring Plans that best reflect the participant's needs and ensure public safety.

Case managers request data/records that specifically address the reason for referral. These may include but are not limited to:

- Complete records of chemical dependency treatments (dating back 5 years)
- Psychiatric or psychological treatment records, requested in a hierarchical approach:
- Admission and discharge summaries, as well as consultative reports from inpatient psychiatric treatments
- Clinical narrative summaries of outpatient psychiatric/psychological treatments from current treatment providers
- Medical records, as needed to determine appropriate monitoring requirements.

If the above are deemed insufficient for the purposes of determining whether monitoring is indicated or developing an appropriate Monitoring Plan, the case manager may request additional records and/or request assessments, or meet with an HPSP medical consultant.

The HPSP contracts with three medical consultants for services (two psychiatrists who specialize in addiction medicine and one pain management specialist).

PARTICIPATION AGREEMENTS - MONITORING PLANS

Participation Agreements and Monitoring Plans:
When monitoring is deemed appropriate, a Participation Agreement and Monitoring Plan are developed for the participant. The Participation Agreement is signed by the participant and serves as a contractual agreement between the HPSP and the participant. It includes the participant's demographic information, treatment focus, and the responsibilities of both the participant and the HPSP. The Participation Agreement is classified as confidential data while the regulated individual is actively participating in the program and classified as private data upon the participant's discharge from the program.

Monitoring Plans establish a set of conditions for participants to follow. These conditions provide a means for participants to document appropriate illness management, and for the HPSP to monitor their illness management and, in turn, protect the public.

Standard conditions of Monitoring Plans:

- Identify mutually acceptable treatment providers and authorize the treatment providers to provide the HPSP with quarterly reports about the participant's illness status and management
- Identify a work site monitor (if working in a regulated profession) and authorize the work site monitor to provide the HPSP with quarterly (or more frequent, if deemed appropriate) reports
- Maintain current release of information forms
- Provide the HPSP with quarterly updates (Participant Updates)
- Notify the program of changes in address, phone number and employment, as well as treatment providers and symptoms

Monitoring Plans also contain illness-specific and individualized conditions that are based on past and current symptoms, the participant's practice setting, and the potential risk to the public:

- Provide documentation of self-help group attendance
- Follow the HPSP's toxicology screening procedures
- Abstain from the use of alcohol and chemicals of abuse
- Follow the treatment and practice recommendations of treatment providers (i.e. complete treatment, aftercare, or specific mental health therapy)
- Follow practice restrictions/limitations (i.e. refrain from practice until treatment is completed, practice hour limitations)

Monitoring Plans are amended, as needed, to ensure proper illness management and public safety. Monitoring Plans are classified as private data and may be provided to the participant, as the subject of the data, and to third parties upon the written authorization of the participant.

MONITORING

Monitoring is initiated upon receipt of the signed Participation Agreement/Monitoring Plan. Participants are mailed monitoring materials with a letter acknowledging their status in the HPSP. Monitoring protocols are established (i.e.: toxicology screening). If a participant is board-referred, the HPSP notifies the board that the regulated individual has signed the Participation Agreement.

Treatment providers may be contacted by phone and are sent a copy of a release of information form, the Monitoring Plan, report forms and a letter outlining their reporting requirements.

Work site monitors are contacted by phone prior to the participant starting a new job or returning to work. They are also sent a letter with a copy of a release of information form, work quality assessment forms, and a letter outlining their reporting requirements. Practice limitations or restrictions are also reviewed both by phone and letter. The HPSP does not provide work site monitors with illness-related information, unless necessary to ensure public safety.

Case managers review compliance data and continually assess the participant's illness management and symptoms to ensure that the Monitoring Plan accurately reflects the participant's needs as well as public safety. Case managers adjust the Monitoring Plan as deemed appropriate to ensure public safety and appropriate illness management.

CASE MANAGEMENT REPORTING GUIDELINES

The HPSP and board staff worked together to develop mutually agreeable reporting guidelines. It should be noted that these are guidelines and subject to discretion based on individual circumstances. Additionally, the HPSP may contact board staff to review whether a report is warranted without providing participant-identifying information.

Positive Screens/Return to Substance Use:

Board Ordered Participants: Case managers file a report with the regulatory board within 24-hours upon receipt of a confirmed positive screen or report of return to use.

Self, Third Party or Board Voluntary Referred Participants: Case managers file a report with the regulatory board within 24-hours upon receipt of a confirmed positive screen or when return to use is reported by someone other than the participant.

Disclosure: Case managers file a report with the regulatory board upon participant disclosure of return to use if:

- The use was not the first occurrence of return to use while in the program
- The use occurred in the course of regulated practice (i.e. diversion, being under the influence of alcohol or drugs of abuse while at work)
- The participant continues to use alcohol or drugs of abuse, or

- The participant does not agree to follow the practice or treatment recommendations made by the HPSP and/or treating professionals.

Provided none of the above applies, the case manager consults with other HPSP staff and takes the following into consideration when determining whether to report a participant to the regulatory board:

- Relapse Elements
- Length of sobriety
- Severity of relapse
- Practice setting
- Response to relapse
- Prior history or behavior
- Cooperation with treatment
- Cooperation with increased monitoring

Exacerbation of Psychiatric Symptoms:
Case managers consult with other HPSP staff and take the following into consideration when determining whether to report a participant's exacerbation of psychiatric symptoms to the regulatory board:

- Current symptoms and response to symptoms (i.e. Takes self out of practice, decreases hours, contacts psychiatrist for medication change)
- Symptoms in relation to practice
- Potential for harm in the practice setting
- Illness or symptom history and compliance with treatment
- Insight regarding symptoms and/or functional level
- Cooperation with treatment recommendations
- Cooperation with increased monitoring and/or practice limitations

Deterioration of Physical/Medical Condition:
Case managers will consult with other HPSP staff and take the following into consideration when determining whether to report the deterioration of a participant's physical or medical condition to the regulatory board:

- Current symptoms and response to symptoms (i.e. take self out of practice, decrease hours, contact treatment providers)
- Illness or symptom history
- History of compliance with treatment (i.e. medication compliant, makes doctor appointments)
- Insight regarding symptoms and/or functional level
- Cooperation with treatment providers
- Cooperation with the HPSP recommendations and or practice limitations
- Potential for harm in the practice setting

Inability to Practice Due to Chronic Illness:
Participation Agreements and Monitoring Plans are designed to ensure that public safety concerns are met with regard to the illnesses/conditions of regulated individuals.

Monitoring Plans are established with the goal that the terms and conditions can be met and, in turn, for participants to have the opportunity to successfully complete the program. Participants are discharged from the HPSP if, in the course of monitoring, it becomes evident that their illness is so severe and chronic in nature that it disables the participant from practicing in the future.

PROGRAM COMPLETION AND DISCHARGE

Program Discharge by Discharge Category and Profession (January 1, 2003 to December 31, 2007):

The rate at which participants successfully complete monitoring varies by profession as shown in the chart below.

Discharge Category	Physician	Dentist	Pharmacist	LPN	RN	Chiropractor
Successfully completed monitoring	74%	59%	60%	27%	43%	43%
Non-compliant with monitoring	10%	32%	32%	57%	44%	48%
Voluntarily withdrew from monitoring	3%	3%	2%	12%	7%	0%
Credential suspended during monitoring for non-compliance with monitoring	6%	0%	3%	0%	3%	0%
Illness is disabling – cannot practice in the future	3%	3%	0%	2%	1%	0%
Violated their practice act	<1%	3%	0%	1%	<1%	0%
Retired their credential	2%	0%	3%	0%	0%	9%
Deceased	1%	0%	0%	1%	1%	0%

Some factors that influence completion rates (based on qualitative analysis) include:

- Identification with profession
- Income and access to resources
- Support system
- Living environment
- Access to controlled substances
- Level of education (time and financial investment in profession)

ILLNESSES MONITORED

From January 1, 2006 to December 31, 2007, a total of 523 health professionals entered into Participation Agreements with the HPSP. They were monitored for the following illnesses:

- **78% were monitored for a substance disorder, listing the following as their substance of choice:**
  - 42% alcohol
  - 1% amphetamine
  - 1% benzodiazepine
  - 3% cannabis
  - 2% cocaine
  - 5% methamphetamine
  - 27% opiates
  - 19% polysubstance (typically includes an opiate) *(roughly 48% abused a prescription medication)*
- **60% were monitored for the following psychiatric disorders (only 20% without a comorbid substance disorder):**
  - 17% with bipolar disorder
  - 69% with depression and/or anxiety
  - 14% with another psychiatric disorder (i.e.: ADD, PTSD)
- **11% were monitored for a medical disorder** (only 2% without a comorbid substance or psychiatric disorder)

Substances of Abuse Vary by Profession:
The table below shows variances in the substance of choice for persons who signed Participation Agreements with the HPSP, by profession in two different timeframes (January 1, 2000 through December 31, 2001 and January 1, 2006 through December 31, 2007).

Substance of Choice	Physician		Dentist		Pharmacist		LPN		RN	
	1/1/00 to 12/31/01	1/1/06 to 12/31/07	1/1/00 to 12/31/01	1/1/06 to 12/31/07	1/1/00 to 12/31/01	1/1/06 to 12/31/07	1/1/00 to 12/31/01	1/1/06 to 12/31/07	1/1/00 to 12/31/01	1/1/06 to 12/31/07
Alcohol	66%	59%	50%	70%	27%	27%	48%	44%	40%	39%
Amphetamines	0	0	17%	0	0	0	0	0	2%	0
Barbiturate	2%	0	0	0	9%	0	4%	0	2%	0
Benzodiazepines	3%	2%	0	0	0	0	1%	2%	2%	1%
Cannabis	2%	2%	0	0	0	0	3%	4%	1%	3%
Cocaine	0	2%	0	0	0	0	6%	3%	2%	2%
Methamphetamine	0	0	0	0	0	0	3%	12%	1%	4%
Opiate	15%	22%	33%	20%	55%	50%	19%	16%	34%	31%
Polysubstance	12%	13%	0	10%	9%	23%	16%	19%	16%	20%

STATUTES

§214.28 to 214.36 – HPSP GOVERNING STATUTE

214.28 Diversion program.

A health-related licensing board may establish performance criteria and contract for a diversion program for regulated professionals 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. HIST: 2000 c 284 s 8

214.29 Program required.

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. HIST: 2000 c 284 s 9

214.31 Authority.

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. HIST: 1994 c 556 s 2; 2000 c 284 s 10

214.32 Program management, services, participant costs, eligibility, completions, voluntary termination and discharge.

Subdivision 1. **Management.**

(a) 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. If the participating boards change which board is designated to provide administrative management of the program, any appropriation remaining for the program shall transfer to the newly designated board on the effective date of the change. The participating boards must inform the appropriate legislative committees and the commissioner of finance of any change in the administrative management of the program, and the amount of any appropriation transferred under this provision.

(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.

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

(1) 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

(2) 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 expires June 30, 2007.

Subd. 2. **Services.**

(a) The program shall provide the following services to program participants:

(1) referral of eligible regulated persons to qualified professionals for evaluation, treatment, and a written plan for continuing care consistent with the regulated person's illness. The referral shall take into consideration the regulated person's financial resources as well as specific needs;

(2) development of individualized program participation agreements between participants and the program to meet the needs of participants and protect the public. An agreement may include, but need not be limited to, recommendations from the continuing care plan, practice monitoring, health monitoring, practice restrictions, random drug screening, support group participation, filing of reports necessary to document compliance, and terms for successful completion of the regulated person's program; and

(3) monitoring of compliance by participants with individualized program participation agreements or board orders.

(b) The program may develop services related to sections 214.31 to 214.37 for employers and colleagues of regulated persons from participating boards.

Subd. 3. **Participant costs.**

Each program participant shall be responsible for paying for the costs of physical, psychosocial, or other related evaluation, treatment, laboratory monitoring, and random drug screens.

Subd. 4. **Eligibility.** Admission to the health professional services program is available to a person regulated by a participating board who is 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. Admission in the health professional services program shall be denied to persons:

(1) who have diverted controlled substances for other than self-administration;

(2) who have been terminated from this or any other state professional services program for noncompliance in the program;

(3) currently under a board disciplinary order or corrective action agreement, unless referred by a board;

(4) regulated under sections 214.17 to 214.25, unless referred by a board or by the commissioner of health;

(5) accused of sexual misconduct; or

(6) whose continued practice would create a serious risk of harm to the public.

Subd. 5. **Completion; voluntary termination; discharge.**
A regulated person completes the program when the terms of the program participation agreement are fulfilled. A regulated person may voluntarily terminate participation in the health professionals service program at any time by reporting to the person's board. The program manager may choose to discharge a regulated person from the program and make a referral to the person's board at any time for reasons including but not limited to: the degree of cooperation and compliance by the regulated person, the inability to secure information or the medical records of the regulated person, or indication of other possible violations of the regulated person's practice act. The regulated person shall be notified in writing by the program manager of any change in the person's program status. A regulated person who has been terminated or discharged from the program may be referred back to the program for monitoring. HIST: 1994 c 556 s 3; 1997 c 192 s 31; 1998 c 407 art 2 s 94; 2000 c 284 s 11; 2001 c 161 s 41; 2003 c 87 s 51

214.33 Reporting.

Subdivision 1. **Permission to report.** A person who has personal knowledge that a regulated person has the inability 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 may report that knowledge to the program or to the board. A report to the program under this subdivision fulfills the reporting requirement contained in a regulated person's practice act.

Subd. 2. **Self-reporting.** A person regulated by a participating board who is 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 shall report to the person's board or the program.

Subd. 3. **Program manager.** The program manager shall report to the appropriate participating board a regulated person who does not meet program admission criteria, violates the terms of the program participation agreement, or leaves the program except upon fulfilling the terms for successful completion of the program as set forth in the participation agreement. The program manager shall report to the appropriate participating board a regulated person who is alleged to have committed violations of the person's practice act that are outside the authority of the health professionals services program as described in sections 214.31 to 214.37. The program manager shall inform any reporting person of the disposition of the person's report to the program.

Subd. 4. **Board.** A board may refer any regulated person to the program consistent with section 214.32, subdivision 4, if the board believes the regulated person will benefit and the public will be protected. HIST: 1994 c 556 s 4

214.34 Immunity.

Subdivision 1. **Reporting immunity.**
Any individual, agency, institution, facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report in good faith to the program under this section or for cooperating with an investigation of a report or with staff of the program. Reports are confidential and are privileged communication.

Subd. 2. **Program immunity.** Members of the participating boards and persons employed by the boards and program, program consultants, and members of advisory bodies for the program are immune from civil liability and criminal prosecution for any actions, transactions, or reports in the execution of, or relating to, their duties under sections 214.31 to 214.36. HIST: 1994 c 556 s 5

214.35 Classification of data.

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. HIST: 1994 c 556 s 6

214.36 Board participation.

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. HIST: 1994 c 556 s

§214.10 COMPLAINT, INVESTIGATION, AND HEARING.

Subdivision 1. **Receipt of complaint; notice.** The executive director or executive secretary of a board, a board member or any other person who performs services for the board who receives a complaint or other communication, whether oral or written, which complaint or communication alleges or implies a violation of a statute or rule which the board is empowered to enforce, shall promptly forward the substance of the communication on a form prepared by the attorney general to the designee of the attorney general responsible for providing legal services to the board.
Before proceeding further with the communication, the designee of the attorney general may require the complaining party to state the complaint in writing on a form prepared by the attorney general. Complaints which relate to matters within the jurisdiction of another governmental agency shall be forwarded to that agency by the executive director or executive secretary. An officer of that agency shall advise the executive director or executive secretary of the disposition of that complaint. A complaint received by another agency which relates to a statute or rule which a licensing board is empowered to enforce shall be forwarded to the executive director or executive secretary of the board to be processed in accordance with this section. No complaint alleging a matter within the jurisdiction of the board shall be dismissed by a board unless at least two board members have reviewed the matter. If a board makes a determination to investigate a complaint, it shall notify a licensee who is the subject of an investigation that an investigation has been initiated at a time when such notice will not compromise the investigation.
Subd. 2. **Investigation and hearing.** The designee of the attorney general providing legal services to a board shall evaluate the communications forwarded by the board or its members or staff. If the communication alleges a violation of statute or rule which the board is to enforce, the designee is empowered to investigate the facts alleged in the communication. In the process

of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director, executive secretary, or, if the board determines, a member of the board who has been appointed by the board to assist the designee. The designee may also consult with or seek the assistance of any other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation. The executive director, executive secretary, or the consulted board member may attempt to correct improper activities and redress grievances through education, conference, conciliation and persuasion, and in these attempts may be assisted by the designee of the attorney general. If the attempts at correction or redress do not produce satisfactory results in the opinion of the executive director, executive secretary, or the consulted board member, or if after investigation the designee providing legal services to the board, the executive director, executive secretary, or the consulted board member believes that the communication and the investigation suggest illegal or unauthorized activities warranting board action, the person having the belief shall inform the executive director or executive secretary of the board who shall schedule a disciplinary hearing in accordance with chapter 14. Before directing the holding of a disciplinary hearing, the executive director, executive secretary, or the designee of the attorney general shall have considered the recommendations of the consulted board member. Before scheduling a disciplinary hearing, the executive director or executive secretary must have received a verified written complaint from the complaining party.

A board member who was consulted during the course of an investigation may participate at the hearing but may not vote on any matter pertaining to the case. The executive director or executive secretary of the board shall promptly inform the complaining party of the final disposition of the complaint. Nothing in this section shall preclude the board from scheduling, on its own motion, a disciplinary hearing based upon the findings or report of the board's executive director or executive secretary, a board member or the designee of the attorney general assigned to the board.

Nothing in this section shall preclude a member of the board, executive director, or executive secretary from initiating a complaint.

Subd. 2a. **Proceedings.** A board shall initiate proceedings to suspend or revoke a license or shall refuse to renew a license of a person licensed by the board who is convicted in a court of competent jurisdiction of violating section 609.224, subdivision 2, paragraph (c), 609.23, 609.231, 609.2325, 609.233, 609.2335, 609.234, 609.465, 609.466, 609.52, or 609.72, subdivision 3.

Subd. 3. **Discovery; subpoenas.** In all matters pending before it relating to its lawful regulation activities, a board may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the board or by a subpoena of the board to do so may, upon application to the district court in any district, be ordered to comply therewith; provided that in matters to which the Peace Officers Standards and Training Board is a party, application shall be made to the district court having jurisdiction where the event giving rise to the matter occurred. The chair of the board acting on behalf of the board may issue subpoenas and any board member may administer oaths to witnesses, or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon any person named therein, anywhere within the state by any officer authorized to serve subpoenas or other process or paper in civil actions, with the same fees and mileage and in the same manner as prescribed by law for service of process issued out of the district court of this state. Fees and mileage and other costs shall be paid as the board directs.

Subd. 4.[Repealed, 1993 c 326 art 7 s 22]

Subd. 5.[Repealed, 1993 c 326 art 7 s 22]

Subd. 6.[Repealed, 1993 c 326 art 7 s 22]

Subd. 7.[Repealed, 1993 c 326 art 7 s 22]

Subd. 8. **Special requirements for health-related licensing boards.** In addition to the provisions of this section that apply to all examining and licensing boards, the requirements in this subdivision apply to all health-related licensing boards, except the Board of Veterinary Medicine.

(a) If the executive director or consulted board member determines that a communication received alleges a violation of statute or rule that involves sexual contact with a patient or client, the communication shall be forwarded to the designee of the attorney general for an investigation of the facts alleged in the communication. If, after an investigation it is the opinion of the executive director or consulted board member that there is sufficient evidence to justify disciplinary action, the board shall conduct a disciplinary conference or hearing. If, after a hearing or disciplinary conference the board determines that misconduct involving sexual contact with a patient or client occurred, the board shall take disciplinary action. Notwithstanding subdivision 2, a board may not attempt to correct improper activities or redress grievances through education, conciliation, and persuasion, unless in the opinion of the executive director or consulted board member there is insufficient evidence to justify disciplinary action. The board may settle a case by stipulation prior to, or during, a hearing if the stipulation provides for disciplinary action.

(b) A board member who has a direct current or former financial connection or professional relationship to a person who is the subject of board disciplinary activities must not participate in board activities relating to that case.

(c) Each health-related licensing board shall establish procedures for exchanging information with other Minnesota state boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. The procedures must provide for the forwarding to other regulatory bodies of all information and evidence, including the results of investigations, that are relevant to matters within that licensing body's regulatory jurisdiction.

Each health-related licensing board shall have access to any data of the Department of Human Services relating to a person subject to the jurisdiction of the licensing board. The data shall have the same classification under chapter 13, the Minnesota Government Data Practices Act, in the hands of the agency receiving the data as it had in the hands of the Department of Human Services.

(d) Each health-related licensing board shall establish procedures for exchanging information with other states regarding disciplinary actions against licensees. The procedures must provide for the collection of information from other states about disciplinary actions taken against persons who are licensed to practice in Minnesota or who have applied to be licensed in this state and the dissemination of information to other states regarding disciplinary actions taken in Minnesota. In addition to any authority in chapter 13 permitting the dissemination of data, the board may, in its discretion, disseminate data to other states regardless of its classification under chapter 13.

Before transferring any data that is not public, the board shall obtain reasonable assurances from the receiving state that the data will not be made public.

Subd. 9. **Acts against minors.** (a) As used in this subdivision, the following terms have the meanings given them.

(1) "Licensed person" means a person who is licensed under this chapter by the Board of Nursing, the Board of Psychology, the Social Work Licensing Board, the Board of Marriage and Family Therapy, the Board of Unlicensed Mental Health Service Providers, the Board of Behavioral Health and Therapy, or the Board of Teaching.

(2) "Crime against a minor" means conduct that constitutes a violation of section 609.185, 609.19, 609.195, 609.20, 609.205, 609.21, 609.215, 609.221, 609.222, 609.223, 609.342, 609.343, 609.345, or a felony violation of section 609.377.

(b) In any license revocation proceeding, there is a rebuttable presumption that a licensed person who is convicted in a court of competent jurisdiction of committing a crime against a minor is unfit to practice the profession or occupation for which that person is licensed.

§214.17 HIV, HBV, AND HCV PREVENTION PROGRAM; PURPOSE AND SCOPE.

Sections 214.17 to 214.25 are intended to promote the health and safety of patients and regulated persons by reducing the risk of infection in the provision of health care.
History: *1992 c 559 art 1 s 9*

§147.001 – 147.141 – MEDICAL PRACTICE ACT

147.001 PURPOSE.
The primary responsibility and obligation of the Board of Medical Practice is to protect the public. In the interest of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the license to practice medicine. **History**: 1996 c 334 s 2

147.01 BOARD OF MEDICAL PRACTICE.

Subdivision 1. Creation; terms. The Board of Medical Practice consists of 16 residents of the state of Minnesota appointed by the governor. Ten board members must hold a degree of doctor of medicine and be licensed to practice medicine under this chapter. One board member must hold a degree of doctor of osteopathy and either be licensed to practice osteopathy under Minnesota Statutes 1961, sections 148.11 to 148.16; prior to May 1, 1963, or be licensed to practice medicine under this chapter. Five board members must be public members as defined by section 214.02. The governor shall make appointments to the board which reflect the geography of the state. In making these appointments, the governor shall ensure that no more than one public member resides in each United States congressional district, and that at least one member who is not a public member resides in each United States congressional district. The board members holding the degree of doctor of medicine must, as a whole, reflect the broad mix of expertise of physicians practicing in Minnesota. A member may be reappointed but shall not serve more than eight years consecutively. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements are as provided in sections 214.07 to 214.09. The provision of staff, administrative services and office space; the review and processing of complaints; the setting of board fees; and other provisions relating to board operations are as provided in chapter 214.

Subd. 2. Recommendations for appointment. Prior to the end of the term of a doctor of medicine or public member on the board, or within 60 days after a doctor of medicine or public member position on the board becomes vacant, the State Medical Association, the Mental Health Association of Minnesota, and other interested persons and organizations may recommend to the governor doctors of medicine and public members qualified to serve on the board. Prior to the end of the term of a doctor of osteopathy, or within 60 days after a doctor of osteopathy membership becomes vacant, the Minnesota Osteopathic Medical Society may recommend to the governor three doctors of osteopathy qualified to serve on the board. The governor may appoint members to the board from the list of persons recommended or from among other qualified candidates.

Subd. 3. Board administration. The board shall elect from among its number a president, a vice-president, and a secretary-treasurer, who shall each serve for one year, or until a successor

is elected and qualifies. The board shall have authority to adopt rules as may be found necessary to carry out the purposes of this chapter. The members of the board shall have authority to administer oaths and the board, in session, to take testimony as to matters pertaining to the duties of the board. Nine members of the board shall constitute a quorum for the transaction of business. The board shall have a common seal, which shall be kept by the executive director, whose duty it shall be to keep a record of all proceedings of the board, including a register of all applicants for license under this chapter, giving their names, addresses, ages, educational qualifications, and the result of their examination. These books and registers shall be prima facie evidence of all the matters therein recorded.

Subd. 4. Disclosure. Subject to the exceptions listed in this subdivision, all communications or information received by or disclosed to the board relating to any person or matter subject to its regulatory jurisdiction are confidential and privileged and any disciplinary hearing shall be closed to the public.

(a) Upon application of a party in a proceeding before the board under section 147.091, the board shall produce and permit the inspection and copying, by or on behalf of the moving party, of any designated documents or papers relevant to the proceedings, in accordance with the provisions of rule 34, Minnesota Rules of Civil Procedure.

(b) If the board imposes disciplinary measures of any kind, whether by contested case or by settlement agreement, the name and business address of the licensee, the nature of the misconduct, and the action taken by the board are public data. If disciplinary action is taken by settlement agreement, the entire agreement is public data. The board shall decide disciplinary matters, whether by settlement or by contested case, by roll call vote. The votes are public data.

(c) The board shall exchange information with other licensing boards, agencies, or departments within the state, as required under section 214.10, subdivision 8, paragraph (c), and
may release information in the reports required under section 147.02, subdivision 6.

(d) The board shall upon request furnish to a person who made a complaint, or the alleged victim of a violation of section 147.091, subdivision 1, paragraph (t), or both, a description of the activities and actions of the board relating to that complaint, a summary of the results of an investigation of that complaint, and the reasons for actions taken by the board.

(e) A probable cause hearing held pursuant to section 147.092 shall be closed to the public, except for the notices of hearing made public by operation of section 147.092.

(f) Findings of fact, conclusions, and recommendations issued by the administrative law judge, and transcripts of oral arguments before the board pursuant to a contested case proceeding in which an administrative law judge found a violation of section 147.091, subdivision 1, paragraph (t), are public data.

Subd. 5. Expenses; staff. The Board of Medical Practice shall provide blanks, books, certificates, and such stationery and assistance as is necessary for the transaction of the business pertaining to the duties of such board. The expenses of administering this chapter shall be paid from the appropriations made to the Board of Medical Practice. The board shall employ an executive director subject to the terms described in section 214.04, subdivision 2a.

Subd. 6.[Repealed, 1997 c 225 art 2 s 63]

Subd. 7. Physician application fee. The board may charge a physician application fee of $200. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

History: (5706) RL s 2295; 1921 c 68 s 1; 1927 c 188 s 1; 1963 c 45 s 1; 1967 c 416 s 1; 1969 c 927 s 1; 1973 c 638 s 6; 1975 c 136 s 5; 1976 c 2 s 65; 1976 c 222 s 32; 1976 c 239 s 53; 1984 c 588 s 1; 1985 c 247 s 1-3,25; 1986 c 444; 1Sp1986 c 3 art 1 s 22; 1987 c 86 s 1; 1990 c 576 s 1-3; 1991 c 105 s 1; 1991 c 106 s 6; 1991 c 199 art 1 s 40; 1992 c 513 art 7 s 9; 1Sp1993 c 1 art 5 s 6; 1995 c 186 s 44; 1995 c 207 art 9 s 38; 1996 c 334 s 3; 2000 c 284 s 2; 2004 c 270 s 1; 2004 c 279 art 11 s 2

147.02 EXAMINATION; LICENSING.

Subdivision 1. **United States or Canadian medical school graduates.** The board shall issue a license to practice medicine to a person not currently licensed in another state or Canada and who meets the requirements in paragraphs (a) to (i).

(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed an examination as described in clause (1) or (2).

(1) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the National Board of Medical Examiners, the Federation of State Medical Boards, the Medical Council of Canada, or the appropriate state board that the board determines acceptable. The board shall by rule determine what constitutes a passing score in the examination.

(2) The applicant taking the United States Medical Licensing Examination (USMLE) must have passed steps one, two, and three. Step three must be passed within five years of passing step two, or before the end of residency training. The applicant must pass each of steps one, two, and three with passing scores as recommended by the USMLE program within three attempts. The applicant taking combinations of Federation of State Medical Boards, National Board of Medical Examiners, and USMLE may be accepted only if the combination is approved by the board as comparable to existing comparable examination sequences and all examinations are completed prior to the year 2000.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization.

(e) The applicant shall make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a fee established by the board by rule. The fee may not be refunded. Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs; and

(2) clearly identify to the applicant the payment schedule of additional costs.

(g) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(h) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(i) If the examination in paragraph (c) was passed more than ten years ago, the applicant must either:

(1) pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(2) have a current certification by a specialty board of the American Board of Medical

Specialties, of the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

Subd. 1a. **Examination extension; active military service.** The board may grant an extension to the time period required to pass the United States Medical Licensing Examination (USMLE) as specified in subdivision 1, paragraph (c), clause (2), if an applicant is mobilized into active military service, as defined in section 190.05, subdivision 5, during the process of taking the USMLE, but before passage of all steps. Proof of active military service must be submitted to the board on the forms and according to the timelines of the board.

Subd. 1b. **Examination extension; medical reasons.** The board may grant an extension to the time period and to the number of attempts permitted to pass the United States Medical Licensing Examination (USMLE) as specified in subdivision 1, paragraph (c), clause (2), if an applicant has been diagnosed with a medical illness during the process of taking the USMLE but before passage of all steps, or fails to pass a step within three attempts due to the applicant's medical illness. Proof of the medical illness must be submitted to the board on forms and according to the timelines of the board.

Subd. 2.[Repealed, 1985 c 247 s 26]

Subd. 2a. **Temporary permit.** The board may issue a temporary permit to practice medicine to a physician eligible for licensure under this section only if the application for licensure is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the physician's application or licensure.

Subd. 3.[Repealed, 1971 c 485 s 6]

Subd. 4.[Repealed, 1984 c 432 art 2 s 55]

Subd. 5. **Procedures.** The board shall adopt a written statement of internal operating procedures describing procedures for receiving and investigating complaints, reviewing misconduct cases, and imposing disciplinary actions.

Subd. 6. **Disciplinary actions must be published.** At least annually, the board shall publish and release to the public a description of all disciplinary measures taken by the board. The publication must include, for each disciplinary measure taken, the name and business address of the licensee, the nature of the misconduct, and the disciplinary measure taken by the board.

Subd. 6a. **Exception to publication requirement.** The publication requirement does not apply to disciplinary measures by the board which are based exclusively upon grounds listed in section 147.091, subdivision 1, clause (l) or (r).

History: *(5707) RL s 2296; 1909 c 474 s 1; 1927 c 188 s 2; 1937 c 203 s 1; 1953 c 290 s 1; 1959 c 346 s 1; 1963 c 45 s 2; 1967 c 416 s 2; 1969 c 6 s 25; 1969 c 927 s 2; 1971 c 485 s 2; 1973 c 638 s 7; 1974 c 42 s 1; 1975 c 93 s 1,2; 1976 c 222 s 33; 1983 c 290 s 17; 1985 c 247 s 4-6; 1986 c 444; 1988 c 557 s 1,6; 1989 c 282 art 2 s 39; 1990 c 576 s 6; 1993 c 21 s 2,3; 1Sp1993 c 1 art 5 s 7; 1998 c 254 art 1 s 37; 1999 c 33 s 1; 2006 c 188 s 1; 2006 c 199 s 1; 2007 c 13 art 1 s 11; 2007 c 123 s 4,5*

147.091 GROUNDS FOR DISCIPLINARY ACTION.

Subdivision 1. **Grounds listed.** The board may refuse to grant a license, may refuse to grant registration to perform interstate telemedicine services, or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

(a) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements.

(b) Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to: (1) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having

unauthorized possession of any portion of a future, current, or previously administered licensing examination; (2) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (3) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine or osteopathy. Conviction as used in this subdivision shall include a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.

(e) Advertising which is false or misleading, which violates any rule of the board, or which claims without substantiation the positive cure of any disease, or professional superiority to or greater skill than that possessed by another physician.

(f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 148A.02, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

(g) Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(h) Failure to supervise a physician's assistant or failure to supervise a physician under any agreement with the board.

(i) Aiding or abetting an unlicensed person in the practice of medicine, except that it is not a violation of this paragraph for a physician to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority.

(j) Adjudication as mentally incompetent, mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise.

(k) Engaging in unprofessional conduct. Unprofessional conduct shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice in which proceeding actual injury to a patient need not be established.

(l) Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.

(m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(n) Failure by a doctor of osteopathy to identify the school of healing in the professional use of the doctor's name by one of the following terms: osteopathic physician and surgeon, doctor of osteopathy, or D.O.

(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298 or to furnish a medical record or report required by law.

(p) Fee splitting, including without limitation:
(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;
(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;
(3) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the referring physician has a "financial or economic interest," as defined in section 144.6521, subdivision 3, unless the physician has disclosed the physician's financial or economic interest in accordance with section 144.6521; and
(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest. The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.
(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.
(r) Becoming addicted or habituated to a drug or intoxicant.
(s) Prescribing a drug or device for other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency or referring a patient to any health care provider as defined in sections 144.291 to 144.298 for services or tests not medically indicated at the time of referral.
(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.
(u) Failure to make reports as required by section 147.111 or to cooperate with an investigation of the board as required by section 147.131.
(v) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.
(w) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:
(1) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;
(2) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;
(3) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5 ; or
(4) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.
(x) Practice of a board-regulated profession under lapsed or nonrenewed credentials.
(y) Failure to repay a state or federally secured student loan in accordance with the provisions of the loan.
(z) Providing interstate telemedicine services other than according to section 147.032.

Subd. 1a. **Conviction of a felony-level criminal sexual conduct offense.** (a) The board may not grant a license to practice medicine to any person who has been convicted of a felony-level criminal sexual conduct offense.
(b) A license to practice medicine is automatically revoked if the licensee is convicted of a felony-level criminal sexual conduct offense.

(c) A license that has been denied or revoked pursuant to this subdivision is not subject to chapter 364.
(d) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, and "criminal sexual conduct offense" means a violation of sections 609.342 to 609.345 or a similar statute in another jurisdiction.

Subd. 1b. **Utilization review.** The board may investigate allegations and impose disciplinary action as described in section 147.141 against a physician performing utilization review for a pattern of failure to exercise that degree of care that a physician reviewer of ordinary prudence making utilization review determinations for a utilization review organization would use under the same or similar circumstances. As part of its investigative process, the board shall receive consultation or recommendation from physicians who are currently engaged in utilization review activities. The internal and external review processes under sections 62M.06 and 62Q.73 must be exhausted prior to an allegation being brought under this subdivision. Nothing in this subdivision creates, modifies, or changes existing law related to tort liability for medical negligence. Nothing in this subdivision preempts state peer review law protection in accordance with sections 145.61 to 145.67, federal peer review law, or current law pertaining to complaints or appeals.

Subd. 2. **Automatic suspension.** (a) A license to practice medicine is automatically suspended if (1) a guardian of a licensee is appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other than the minority of the licensee; or (2) the licensee is committed by order of a court pursuant to chapter 253B. The license remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee, the suspension is terminated by the board after a hearing.
(b) Upon notice to the board of a judgment of, or a plea of guilty to, a felony reasonably related to the practice of patient care, the credentials of the regulated person shall be automatically suspended by the board. The credentials shall remain suspended until, upon petition by the regulated person and after a hearing, the suspension is terminated by the board. The board shall indefinitely suspend or revoke the credentials of the regulated person if, after a hearing, the board finds that the felonious conduct would cause a serious risk of harm to the public.
(c) For credentials that have been suspended or revoked pursuant to paragraphs (a) and (b), the regulated person may be reinstated to practice, either with or without restrictions, by demonstrating clear and convincing evidence of rehabilitation, as provided in section 364.03. If the regulated person's conviction is subsequently overturned by court decision, the board shall conduct a hearing to review the suspension within 30 days after receipt of the court decision. The regulated person is not required to prove rehabilitation if the subsequent court decision overturns previous court findings of public risk.
(d) The board may, upon majority vote of a quorum of its members, suspend the credentials of a regulated person without a hearing if the regulated person fails to maintain a current name and address with the board, as described in paragraph (e), while the regulated person is: (1) under board investigation, and a notice of conference has been issued by the board; (2) party to a contested case with the board; (3) party to an agreement for corrective action with the board; or (4) under a board order for disciplinary action. The suspension shall remain in effect until lifted by the board pursuant to the board's receipt of a petition from the regulated person, along with the regulated person's current name and address.
(e) A person regulated by the board shall maintain a current name and address with the board and shall notify the board in writing within 30 days of any change in name or address. If a name change only is requested, the regulated person must request revised credentials and return the current credentials to the board. The board may require the regulated person to substantiate the name change by submitting official documentation from a court of law or agency authorized under law to receive and officially record a name change. If an address change only is requested, no request for revised credentials is required. If the regulated person's current credentials have been lost, stolen, or destroyed, the person shall provide a written explanation to the board.

Subd. 2a. **Effective dates.** A suspension, revocation, condition, limitation, qualification, or restriction of a license or registration shall be in effect pending determination of an appeal unless

the court, upon petition and for good cause shown, shall otherwise order. A revocation of a license pursuant to subdivision 1a is not appealable and shall remain in effect indefinitely.

Subd. 3. **Conditions on reissued license.** In its discretion, the board may restore and reissue a license to practice medicine, but as a condition thereof may impose any disciplinary or corrective measure which it might originally have imposed.

Subd. 4. **Temporary suspension of license.** In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a physician if the board finds that the physician has violated a statute or rule which the board is empowered to enforce and continued practice by the physician would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the physician, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The physician shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

Subd. 5. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, paragraph (c) or (d), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency which entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of the contents thereof.

Subd. 6. **Mental examination; access to medical data.** (a) If the board has probable cause to believe that a regulated person comes under subdivision 1, paragraph (1), it may direct the person to submit to a mental or physical examination. For the purpose of this subdivision every regulated person is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that the same constitute a privileged communication. Failure of a regulated person to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstance beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A regulated person affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of the regulated profession with reasonable skill and safety to the public.

In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a regulated person in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a regulated person or applicant without the person's or applicant's consent if the board has probable cause to believe that a regulated person comes under subdivision 1, paragraph (1). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

Subd. 7. **Tax clearance certificate.** (a) In addition to the provisions of subdivision 1, the board may not issue or renew a license if the commissioner of revenue notifies the board and the licensee or applicant for a license that the licensee or applicant owes the state delinquent taxes in the amount of $500 or more. The board may issue or renew the license only if (1) the commissioner of revenue issues a tax clearance certificate and (2) the commissioner of revenue or the licensee or applicant forwards a copy of the clearance to the board. The commissioner of

revenue may issue a clearance certificate only if the licensee or applicant does not owe the state any uncontested delinquent taxes.
(b) For purposes of this subdivision, the following terms have the meanings given.
(1) "Taxes" are all taxes payable to the commissioner of revenue, including penalties and interest due on those taxes.
(2) "Delinquent taxes" do not include a tax liability if (i) an administrative or court action that contests the amount or validity of the liability has been filed or served, (ii) the appeal period to contest the tax liability has not expired, or (iii) the licensee or applicant has entered into a payment agreement to pay the liability and is current with the payments.
(c) In lieu of the notice and hearing requirements of subdivision 1, when a licensee or applicant is required to obtain a clearance certificate under this subdivision, a contested case hearing must be held if the licensee or applicant requests a hearing in writing to the commissioner of revenue within 30 days of the date of the notice provided in paragraph (a). The hearing must be held within 45 days of the date the commissioner of revenue refers the case to the Office of Administrative Hearings. Notwithstanding any law to the contrary, the licensee or applicant must be served with 20 days' notice in writing specifying the time and place of the hearing and the allegations against the licensee or applicant. The notice may be served personally or by mail.
(d) The board shall require all licensees or applicants to provide their Social Security number and Minnesota business identification number on all license applications. Upon request of the commissioner of revenue, the board must provide to the commissioner of revenue a list of all licensees and applicants, including the name and address, Social Security number, and business identification number. The commissioner of revenue may request a list of the licensees and applicants no more than once each calendar year.

Subd. 8. **Limitation.** No board proceeding against a regulated person shall be instituted unless commenced within seven years from the date of the commission of some portion of the offense or misconduct complained of except for alleged violations of subdivision 1, paragraph (t).

History: *1971 c 485 s 3; 1974 c 31 s 1; 1975 c 213 s 1; 1976 c 222 s 34; 1981 c 83 s 1; 1982 c 581 s 24; 1985 c 21 s 1; 1985 c 247 s 7,25; 1986 c 444; 1Sp1986 c 1 art 7 s 7; 1Sp1986 c 3 art 1 s 82; 1987 c 384 art 2 s 1; 1988 c 557 s 2; 1989 c 184 art 2 s 3; 1992 c 559 art 1 s 3; 1992 c 577 s 1; 1Sp1994 c 1 art 2 s 3,4; 1995 c 18 s 4-8; 1996 c 334 s 4; 1997 c 103 s 1; 1999 c 227 s 22; 2001 c 137 s 7; 2002 c 361 s 3; 2004 c 146 art 3 s 6; 2004 c 198 s 16; 2005 c 56 s 1; 2007 c 147 art 10 s 15*

147.111 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline under sections 147.01 to 147.22 may report the violation to the board.

Subd. 2. **Institutions.** Any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the board any action taken by the institution or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition a physician's privilege to practice or treat patients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action.
The institution or organization shall also report the resignation of any physicians prior to the conclusion of any disciplinary proceeding, or prior to the commencement of formal charges but after the physician had knowledge that formal charges were contemplated or in preparation. Each report made under this subdivision must state the nature of the action taken, state in detail the reasons for the action, and identify the specific patient medical records upon which the action was based. No report shall be required of a physician voluntarily limiting the practice of the physician at a hospital provided that the physician notifies all hospitals at which the physician has privileges of the voluntary limitation and the reasons for it.

Subd. 3. **Medical societies.** A state or local medical society shall report to the board any termination, revocation, or suspension of membership or any other disciplinary action taken against a physician. If the society has received a complaint which might be grounds for discipline under sections 147.01 to 147.22 against a member physician on which it has not taken any disciplinary action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the Board of Medical Practice. This subdivision does not apply to a medical society when it performs peer review functions as an agent of an outside entity, organization, or system.

Subd. 4. **Licensed professionals.** A licensed health professional and persons holding a residency permit under section 147.0391, shall report to the board personal knowledge of any conduct which the person reasonably believes constitutes grounds for disciplinary action under sections 147.01 to 147.22 by any physician or person holding a residency permit under section 147.0391, including any conduct indicating that the person may be medically incompetent, or may have engaged in unprofessional conduct or may be medically or physically unable to engage safely in the practice of medicine. A licensed physician or other health professional licensed under this chapter shall also report to the board any occurrence of any adverse reaction resulting from an optometrist's prescription, use, or administration of any legend drug. Any reports received by the board must be reported to the Board of Optometry. No report shall be required if the information was obtained in the course of a physician-patient relationship if the patient is a physician or person holding a residency permit under section 147.0391, and the treating physician successfully counsels the person to limit or withdraw from practice to the extent required by the impairment.

Subd. 5. **Insurers and other entities.** (a) Four times each year as prescribed by the board, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to persons regulated by the board, shall submit to the board a report concerning the regulated persons against whom professional malpractice settlements or awards have been made to the plaintiff.

(b) A medical clinic, hospital, political subdivision, or other entity which provides professional liability coverage on behalf of persons regulated by the board shall submit to the board a report concerning malpractice settlements or awards paid on behalf of regulated persons, and any settlements or awards paid by a clinic, hospital, political subdivision, or other entity on its own behalf because of care rendered by regulated persons. This requirement excludes forgiveness of bills. The report shall be made to the board within 30 days of payment of all or part of any settlement or award.

(c) The reports in paragraphs (a) and (b) must contain at least the following information:

(1) the total number of settlements or awards made to the plaintiff;

(2) the date the settlements or awards to the plaintiff were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made to the plaintiff;

(4) the dollar amount of each settlement or award;

(5) the regular address of the practice or business of the regulated person or entity against whom an award was made or with whom a settlement was made; and

(6) the name of the regulated person or entity against whom an award was made or with whom a settlement was made.

The reporting entity shall, in addition to the above information, report to the board any information it possesses which tends to substantiate a charge that a regulated person may have engaged in conduct violating a statute or rule of the board.

Subd. 6. **Courts.** The court administrator of district court or any other court of competent jurisdiction shall report to the board any judgment or other determination of the court which adjudges or includes a finding that a physician is mentally ill, mentally incompetent, guilty of a felony, or guilty of a violation of federal or state narcotics laws or controlled substances act, guilty of an abuse or fraud under Medicare or Medicaid, appoints a guardian of the physician pursuant to sections 524.5-101 to 524.5-502 or commits a physician pursuant to chapter 253B.

Subd. 7. **Self-reporting.** A physician shall report to the board any personal action which

would require that a report be filed with the board by any person, health care facility, business, or organization pursuant to subdivisions 2 to 6.

Subd. 8. **Deadlines; forms.** Reports required by subdivisions 2 to 7 must be submitted not later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

Subd. 9. **Subpoenas.** The board may issue subpoenas for the production of any reports required by subdivisions 2 to 7 or any related documents.

History: *1985 c 247 s 14; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1988 c 557 s 3; 1990 c 576 s 5; 1991 c 106 s 6; 1991 c 199 art 2 s 1; 1993 c 21 s 9; 1993 c 121 s 2; 1994 c 497 s 4; 1Sp1994 c 1 art 2 s 5; 1995 c 44 s 1; 2003 c 62 s 1; 2004 c 146 art 3 s 47*

147.121 IMMUNITY.

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to the board pursuant to section 147.111 or for otherwise reporting to the board violations or alleged violations of section 147.091. All such reports are confidential and absolutely privileged communications.

Subd. 2. **Investigation; indemnification.** (a) Members of the board, persons employed by the board, consultants retained by the board for the purpose of investigation of violations, the preparation of charges and management of board orders on behalf of the board are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under sections 147.01 to 147.22.

(b) Members of the board and persons employed by the board or engaged in maintaining records and making reports regarding adverse health care events are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of or relating to their duties under section 147.155.

(c) For purposes of this section, a member of the board or a consultant described in paragraph (a) is considered a state employee under section 3.736, subdivision 9.

History: *1985 c 247 s 15,25; 1991 c 199 art 2 s 1; 1993 c 21 s 10; 1995 c 18 s 9; 2004 c 186 s 3*

147.141 FORMS OF DISCIPLINARY ACTION.

When the board finds that a licensed physician or a physician registered under section 147.032 has violated a provision or provisions of sections 147.01 to 147.22, it may do one or more of the following:

(1) revoke the license;

(2) suspend the license;

(3) revoke or suspend registration to perform interstate telemedicine;

(4) impose limitations or conditions on the physician's practice of medicine, including the limitation of scope of practice to designated field specialties; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(5) 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 the physician of any economic advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding;

(6) order the physician to provide unremunerated professional service under supervision at a designated public hospital, clinic, or other health care institution; or

(7) censure or reprimand the licensed physician.

History: *1985 c 247 s 17; 1991 c 199 art 2 s 1; 2002 c 361 s 4*

147.0391 RESIDENCY PERMIT.

Subdivision 1. **Permit required.** A person must have a residency permit to participate in a residency program unless licensed by the board. Upon issuance of a license by the board, the board will terminate a residency permit. A person must have a license to practice medicine to practice outside of a residency program, except as set forth in section 147.09. An applicant for a residency permit must pay a $20 nonrefundable fee upon initial application and upon a change in residency program a lesser nonrefundable fee set by the board in such amount that is necessary to cover administrative costs incurred by the board. The applicant must also have been accepted into either:

(1) a graduate medical education program accredited by a national accrediting organization approved by the board; or

(2) other nonaccredited graduate training approved by the board as meeting standards comparable to those of a national accrediting organization.

The approvals required by clauses (1) and (2) must have been granted by the board before the applicant enrolls in the training.

Subd. 2. **Terminating participation in residency program.** Upon a change in residency programs, a person holding a residency permit must notify the board in writing no later than 30 days after termination of participation in the residency program being terminated. A separate residency permit is required for each residency program until licensure is obtained.

Subd. 3. **Reporting obligation.** A person holding a residency permit and faculty of residency programs are subject to the reporting obligations of section 147.111. The intent of this subdivision

is not to replace routine academic corrective action undertaken by a residency training program.

History: *1993 c 21 s 7*

§13.02 to 13.41 - DATA PRACTICES

13.02 COLLECTION, SECURITY, AND DISSEMINATION OF RECORDS; DEFINITIONS.

Subdivision 1. **Applicability.** As used in this chapter, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Administration.

Subd. 3. **Confidential data on individuals.** "Confidential data on individuals" means data which is made not public by statute or federal law applicable to the data and is inaccessible to the individual subject of that data.

Subd. 3a. **Criminal justice agencies.** "Criminal justice agencies" means all state and local prosecution authorities, all state and local law enforcement agencies, the Sentencing Guidelines Commission, the Bureau of Criminal Apprehension, the Department of Corrections, and all probation officers who are not part of the judiciary.

Subd. 4. **Data not on individuals.** "Data not on individuals" means all government data which is not data on individuals.

Subd. 5. **Data on individuals.** "Data on individuals" means all government data in which any individual is or can be identified as the subject of that data, unless the appearance of the name or other identifying data can be clearly demonstrated to be only incidental to the data and the data are not accessed by the name or other identifying data of any individual.

Subd. 6. **Designee.** "Designee" means any person designated by a responsible authority to be in charge of individual files or systems containing government data and to receive and comply with requests for government data.

Subd. 7. **Government data.** "Government data" means all data collected, created, received,

maintained or disseminated by any government entity regardless of its physical form, storage media or conditions of use.

Subd. 7a. **Government entity.** "Government entity" means a state agency, statewide system, or political subdivision.

Subd. 8. **Individual.** "Individual" means a natural person. In the case of a minor or an incapacitated person as defined in section 524.5-102, subdivision 6, "individual" includes a parent or guardian or an individual acting as a parent or guardian in the absence of a parent or guardian, except that the responsible authority shall withhold data from parents or guardians, or individuals acting as parents or guardians in the absence of parents or guardians, upon request by the minor if the responsible authority determines that withholding the data would be in the best interest of the minor.

Subd. 8a. **Not public data.** "Not public data" means any government data which is classified by statute, federal law, or temporary classification as confidential, private, nonpublic, or protected nonpublic.

Subd. 9. **Nonpublic data.** "Nonpublic data" means data not on individuals that is made by statute or federal law applicable to the data: (a) not accessible to the public; and (b) accessible to the subject, if any, of the data.

Subd. 10. **Person.** "Person" means any individual, partnership, corporation, association, business trust, or a legal representative of an organization.

Subd. 11. **Political subdivision.** "Political subdivision" means any county, statutory or home rule charter city, school district, special district, any town exercising powers under chapter 368 and located in the metropolitan area, as defined in section 473.121, subdivision 2, and any board, commission, district or authority created pursuant to law, local ordinance or charter provision. It includes any nonprofit corporation which is a community action agency organized pursuant to the Economic Opportunity Act of 1964 (Public Law 88-452) as amended, to qualify for public funds, or any nonprofit social service agency which performs services under contract to a government entity, to the extent that the nonprofit social service agency or nonprofit corporation collects, stores, disseminates, and uses data on individuals because of a contractual relationship with a government entity.

Subd. 12. **Private data on individuals.** "Private data on individuals" means data which is made by statute or federal law applicable to the data: (a) not public; and (b) accessible to the individual subject of that data.

Subd. 13. **Protected nonpublic data.** "Protected nonpublic data" means data not on individuals which is made by statute or federal law applicable to the data (a) not public and (b) not accessible to the subject of the data.

Subd. 14. **Public data not on individuals.** "Public data not on individuals" means data which is accessible to the public pursuant to section 13.03.

Subd. 15. **Public data on individuals.** "Public data on individuals" means data which is accessible to the public in accordance with the provisions of section 13.03.

Subd. 16. **Responsible authority.** "Responsible authority" in a state agency or statewide system means the state official designated by law or by the commissioner as the individual responsible for the collection, use and dissemination of any set of data on individuals, government data, or summary data. "Responsible authority" in any political subdivision means the individual designated by the governing body of that political subdivision as the individual responsible for the collection, use, and dissemination of any set of data on individuals, government data, or summary data, unless otherwise provided by state law.

Subd. 17. **State agency.** "State agency" means the state, the University of Minnesota, and any office, officer, department, division, bureau, board, commission, authority, district or agency of the state.

Subd. 18. **Statewide system.** "Statewide system" includes any record keeping system in which government data is collected, stored, disseminated and used by means of a system common to one or more state agencies or more than one of its political subdivisions or any combination of state agencies and political subdivisions.

Subd. 19. **Summary data.** "Summary data" means statistical records and reports derived

from data on individuals but in which individuals are not identified and from which neither their identities nor any other characteristic that could uniquely identify an individual is ascertainable.
History: *1974 c 479 s 1; 1975 c 401 s 1; 1976 c 239 s 2; 1976 c 283 s 1-5; 1977 c 375 s 1-5; 1978 c 790 s 1; 1979 c 328 s 2-6; 1980 c 603 s 1-6; 1980 c 618 s 25; 1981 c 311 s 2-6,39; 1982 c 545 s 1,24; 1984 c 436 s 1; 1989 c 351 s 2; 1996 c 440 art 1 s 1; 1999 c 227 s 22; 2000 c 468 s 3; 2001 c 202 s 1; 2005 c 163 s 5; 2007 c 129 s 1,2*

13.41 LICENSING DATA.

Subdivision 1. **Definition.** As used in this section "licensing agency" means any board, department or agency of this state which is given the statutory authority to issue professional or other types of licenses, except the various agencies primarily administered by the commissioner of human services. Data pertaining to persons or agencies licensed or registered under authority of the commissioner of human services shall be administered pursuant to section 13.46.

Subd. 2. **Private data; designated addresses and telephone numbers.** (a) The following data collected, created or maintained by any licensing agency are classified as private, pursuant to section 13.02, subdivision 12: data, other than their names and designated addresses, submitted by applicants for licenses; the identity of complainants who have made reports concerning licensees or applicants which appear in inactive complaint data unless the complainant consents to the disclosure; the nature or content of unsubstantiated complaints when the information is not maintained in anticipation of legal action; the identity of patients whose medical records are received by any health licensing agency for purposes of review or in anticipation of a contested matter; inactive investigative data relating to violations of statutes or rules; and the record of any disciplinary proceeding except as limited by subdivision 5.
(b) An applicant for a license shall designate on the application a residence or business address and telephone number at which the applicant can be contacted in connection with the license application. A licensee shall designate a residence or business address and telephone number at which the licensee can be contacted in connection with the license. By designating an address under this paragraph other than a residence address, the applicant or licensee consents to accept personal service of process by service on the licensing agency for legal or administrative proceedings. The licensing agency shall mail a copy of the documents to the applicant or licensee at the last known residence address.

Subd. 3. **Board of Peace Officer Standards and Training.** The following government data of the Board of Peace Officer Standards and Training are private data:

(1) home addresses of licensees and applicants for licenses; and

(2) data that identify the government entity that employs a licensed peace officer.

The board may disseminate private data on applicants and licensees as is necessary to administer law enforcement licensure or to provide data under section 626.845, subdivision 1, to law enforcement agencies who are conducting employment background investigations.

Subd. 4. **Confidential data.** The following data collected, created or maintained by any licensing agency are classified as confidential, pursuant to section 13.02, subdivision 3: active investigative data relating to the investigation of complaints against any licensee.

Subd. 5. **Public data.** Licensing agency minutes, application data on licensees except nondesignated addresses, orders for hearing, findings of fact, conclusions of law and specification of the final disciplinary action contained in the record of the disciplinary action are classified as public, pursuant to section 13.02, subdivision 15. The entire record concerning the disciplinary proceeding is public data pursuant to section 13.02, subdivision 15, in those instances where there is a public hearing concerning the disciplinary action. If the licensee and

the licensing agency agree to resolve a complaint without a hearing, the agreement and the specific reasons for the agreement are public data. The license numbers, the license status, and continuing education records issued or maintained by the Board of Peace Officer Standards and Training are classified as public data, pursuant to section 13.02, subdivision 15.

Subd. 6. **Releasing data.** Any licensing agency may make any data classified as private or confidential pursuant to this section accessible to an appropriate person or agency if the licensing agency determines that failure to make the data accessible is likely to create a clear and present danger to public health or safety.

History: *1981 c 311 s 27,39; 1982 c 545 s 12-14,24; 1984 c 436 s 16; 1984 c 654 art 5 s 58; 1987 c 351 s 6; 1990 c 573 s 5; 1993 c 351 s 5; 1994 c 618 art 1 s 8; 1997 c 214 s 1; 1Sp1997 c 3 s 4; 1999 c 227 s 22; 2000 c 468 s 11; 2002 c 375 art 1 s 1; 2002 c 389 s 1; 2007 c 129 s 22*