



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

**Minnesota Board of Nursing:
Complaint Resolution Process**

MARCH 2015

PROGRAM EVALUATION DIVISION

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OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • James Nobles, Legislative Auditor

March 2015

Members of the Legislative Audit Commission:

One of the major responsibilities of the Minnesota Board of Nursing is to receive and resolve complaints against nurses. The board's primary goal is to protect the public from incompetent practice or inappropriate behavior by nurses. However, in resolving complaints, the board must also provide nurses with adequate due process. Achieving the right balance between public protection and due process is often complex and challenging.

Overall, we found that board decisions to discipline nurses or take other action to resolve complaints have been reasonable—that is, board decisions have generally been appropriate given the nurses' violations. At the same time, it has taken the board too long to resolve some complaints—sometimes placing the public at risk. We make several recommendations that should improve the board's ability to resolve complaints in a timely, fair, and consistent manner.

Our evaluation was conducted by Jo Vos (project manager) and KJ Starr, with assistance from Will Harrison and Sean Williams. The Minnesota Board of Nursing and the Health Professionals Services Program cooperated fully with our evaluation.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jim Nobles', written over a light blue circular stamp.

James Nobles
Legislative Auditor

Table of Contents

	<u>Page</u>
SUMMARY	ix
INTRODUCTION	1
1. REGULATING NURSING	3
Legal Framework	3
Structural Framework	6
Complaint Resolution Process	13
Complaints Received	19
Complaints Resolved	23
2. MANAGING THE COMPLAINT RESOLUTION PROCESS	29
Timeliness	29
Consistency	40
Fairness	49
Reasonableness	55
3. HEALTH PROFESSIONALS SERVICES PROGRAM	63
Alternative-to-Discipline Programs	63
Alternative-to-Discipline in Minnesota	66
Confidentiality Issues	79
Lapses in Monitoring	83
Communication and Cooperation	85
LIST OF RECOMMENDATIONS	91
AGENCIES' RESPONSES	93
Minnesota Board of Nursing	93
Health Professionals Services Program	97
RECENT PROGRAM EVALUATIONS	99

List of Exhibits

	<u>Page</u>
1. REGULATING NURSING	
1.1 Minnesota Board of Nursing	7
1.2 Grounds for Disciplinary Action of Nurses	8
1.3 Possible Actions the Minnesota Board of Nursing Can Take on Complaints	10
1.4 Internal Complaint Resolution Process	14
1.5 External Complaint Resolution Process	15
1.6 Primary Grounds of Complaints Received by the Minnesota Board of Nursing, Fiscal Years 2009 through 2014	20
1.7 Complaint Actions by the Minnesota Board of Nursing, Fiscal Years 2009 through 2014	23
1.8 Minnesota Board of Nursing Actions by Type of Resolved Complaint, Fiscal Years 2009 through 2014	24
1.9 Types of Disciplinary Actions Imposed by the Minnesota Board of Nursing, Fiscal Years 2009 through 2014	25
2. MANAGING THE COMPLAINT RESOLUTION PROCESS	
2.1 Average Number of Days to the Minnesota Board of Nursing's First Action on Complaints, Fiscal Years 2009 through 2014	30
2.2 Minnesota Board of Nursing Time-to-Resolution for Complaints Resolved through Nondisciplinary or Disciplinary Actions, Fiscal Years 2009 through 2014	31
2.3 Minnesota Board of Nursing Time-to-Resolution for Suspensions Issued, Fiscal Years 2009 through 2014	33
2.4 Cases of Serious Risk to the Public Where the Minnesota Board of Nursing Did Not Act Quickly Enough	34
2.5 Time-to-Resolution for Complaints by Seriousness Code, Fiscal Years 2009 through 2014	37
3. HEALTH PROFESSIONALS SERVICES PROGRAM	
3.1 Health-Related Licensing Boards' Costs to Participate in the Health Professionals Services Program, Fiscal Year 2014	68
3.2 Referrals to the Health Professionals Services Program by Health-Related Licensing Board, Fiscal Years 2009 through 2014	70
3.3 Referrals to the Health Professionals Services Program, Fiscal Years 2009 through 2014	71
3.4 Health-Related Licensing Boards' Participation in the Health Professionals Services Program, Fiscal Year 2014	73
3.5 Typical Monitoring Agreement for Nurses with Substance Abuse Problems	76

	<u>Page</u>
3.6 Discharges from the Health Professionals Services Program, Fiscal Years 2010 through 2014	77
3.7 Percentage of Nurses with Board Actions After Successfully Completing the Health Professionals Services Program in Fiscal Years 2000 through 2004	79
3.8 Minnesota Board of Nursing's Knowledge of Nurses Monitored by the Health Professionals Services Program, Cases Closed in Fiscal Years 2010 through 2014	81

Summary

Board decisions to discipline nurses or dismiss complaints have been generally reasonable, but it has taken too long to suspend nurses when public safety is at risk.

Key Facts and Findings:

- The Minnesota Board of Nursing received nearly 1,800 complaints in fiscal year 2014—about 15 complaints for every 1,000 licensed nurses in the state. (p. 19)
- In fiscal year 2014, 72 percent of board actions on complaints were dismissals, and 24 and 4 percent, respectively, involved disciplinary or nondisciplinary action. (pp. 23-24)
- Between fiscal years 2009 through 2014, the board imposed suspensions more frequently than any other form of discipline. (pp. 25-26)
- While complaint resolution outcomes have been generally reasonable, it has taken the board too long to resolve some complaints, putting public safety at risk. (pp. 32-34)
- The board’s ability to resolve many complaints in a timely, consistent manner has been adversely affected by its limited investigatory authority and lack of internal guidelines or administrative rules. (pp. 36-46)
- The board’s complaint resolution process has not always been fair to nurses, and some provisions of state law are too strict. (pp. 49-55)
- The board must sometimes process complaints against nurses who are participating in the Health Professionals Services Program (HPSP), an alternative-to-discipline monitoring program, without the board’s knowledge. (pp. 79-82)

Key Recommendations:

- The Legislature should:
 - Allow the board to continue using its authority under the *Nurse Practice Act* to suspend nurses. (p. 35)
 - Give board staff greater authority to investigate and dismiss complaints. (pp. 38-39)
 - Allow the board to expunge certain information about actions it has taken from nurses’ public records, when appropriate. (pp. 54-55)
 - Require the board to send a list of nurses who have complaints filed against them to HPSP, where staff would identify nurses enrolled in their program. (p. 83)
- The Minnesota Board of Nursing should:
 - Make greater and quicker use of its authority to temporarily suspend nurses. (p. 35)
 - Develop guidelines or administrative rules to help board members determine appropriate actions for certain types of complaints and delegate to staff greater responsibility to resolve some complaints. (pp. 46-47)
- The Minnesota Board of Nursing and HPSP should develop joint policies and procedures to identify when nurses participating in HPSP must be reported to the board. (pp. 88-90)

Report Summary

One of the Minnesota Board of Nursing's important responsibilities is to receive and resolve complaints against the nurses it regulates. The board's primary goal is to protect the public from incompetent practice or inappropriate behavior by nurses. At the same time, the board must provide nurses with adequate due process. Achieving that balance is often complex and challenging.

To help fulfill the board's mission, the 1995 Legislature created the Health Professionals Services Program (HPSP). This program monitors the practice of nurses (and other health professionals) with substance abuse problems or other physical, mental, or health conditions. The Minnesota Board of Nursing may refer nurses to HPSP. Nurses may also refer themselves or be referred by third parties. In these latter situations, the nursing board may not know that the nurses have conditions that, if left unmonitored or untreated, may affect their practice.

In fiscal year 2014, the board received 1,784 complaints. Of the board actions taken on complaints that year, 72 percent were dismissals, 24 percent involved disciplinary actions, and 4 percent involved nondisciplinary actions.

Overall, the board's final complaint resolution decisions have been generally reasonable.

Board decisions to dismiss or take other actions to resolve complaints have been reasonable—that is, its decisions have generally been appropriate given the nurses' violations. Complaint outcomes have adequately protected the public. The

board has generally imposed its most serious actions—license suspension or revocation—in situations where the public has been at risk. If anything, the board has tended to err on the side of public safety in disciplining nurses. For example, disciplinary actions made up 24 percent of all actions taken by the board in fiscal year 2014. The board most frequently disciplined nurses by suspending their licenses. Suspensions made up at least 43 percent of all disciplinary actions in 2014, up from 31 percent in 2009.

The board's high dismissal rate—72 percent in 2014—is misleading. Dismissals often involved complaints against nurses not working in Minnesota, or complaints that did not rise to the level of board action. The board also dismissed complaints that were unfounded, duplicative, had already been addressed by nurses or employers, or did not allege violations of state law. Finally, the board dismissed complaints that were too vague or general to investigate. In the complaints we reviewed, dismissal seemed the appropriate and reasonable decision.

The board has acted too slowly to suspend nurses, which has placed the public at risk.

Although the board has generally resolved complaints within timeframes set in statute and board policy, it has not always acted quickly enough when public safety is at risk.

The board has rarely used its authority to issue temporary suspensions to quickly remove nurses from practice. It issued only 11 temporary suspensions in fiscal years 2009 through 2014, with 7 of the 11 issued in 2014. Although temporary suspensions are done in situations where the public is at a serious risk

of harm, the board issued the suspensions within four months of receiving a complaint in only about half of these cases. We identified several instances where the board could have—and should have—acted more quickly than it did.

The Legislature should expand the authority of board staff to investigate and dismiss complaints.

Statutes require that the board forward complaints requiring investigation to the Office of the Attorney General. While the law does not define what constitutes an investigation, the board has generally interpreted it to include fieldwork and interviews with nurses. Consequently, board staff do not routinely conduct interviews with nurses or talk with other involved parties outside of discipline conferences.

The board's limited investigatory powers have led to delays and gaps in its ability to build sound cases in a timely manner. Some staff told us they could potentially conclude an investigation with a ten-minute phone interview, but they believe state law prevents them from doing this. Instead, in the majority of complaints that require investigation, board staff convene discipline review panels to interview nurses, which adds time to the resolution process.

The board's investigatory authority should be expanded, which is in keeping with national nursing guidelines for effective regulatory agencies. Several Minnesota state agencies, including the departments of Human Services and Health, routinely interview individuals and visit sites as part of their complaint investigation processes.

To reduce some of the workload and time required of board members, board staff should be able to dismiss more

complaints themselves—without requiring the approval of two board members. One board member told us that reviewing dismissed complaints takes time away from other work board members could be doing, especially since members rarely disagree with staff recommendations to dismiss. Further, allowing staff to dismiss complaints should reduce the board's reliance on discipline conferences to resolve some complaints.

The board should adopt guidelines or rules to ensure more timely and consistent decisions.

The board should develop guidelines or administrative rules that describe violations of state law and the range of board actions appropriate for each type of violation. Guidelines or rules are especially needed given that we found inconsistencies in how the board handled low-level practice complaints. They are also needed to help the board manage the increased number of complaints it will receive once it fully implements the criminal background checks required by the 2013 Legislature.

Further, the board should expand staff's ability to propose settlements in cases where violations do not pose a serious risk to the public. In keeping with current law, all disciplinary actions would not become final until full board approval. The board would need to develop guidelines that delineate the type of complaints staff could handle themselves. This could, in turn, reduce the number of discipline conferences needed.

The complaint resolution process is not always fair to nurses.

Participating in a discipline conference is the only time most nurses have to talk directly with staff

or the board member who ultimately decides what action to recommend to the board. But most nurses come to the conferences without attorneys to help them understand the process. Much of the process—as well as the documents staff send out in advance—are very legalistic. Related documents are not written in plain English. This can be very intimidating to nurses. Furthermore, the board’s website provides very little helpful information for nurses involved in the complaint process.

Also, state law may be unduly harsh in making all disciplinary and other actions public information indefinitely. For example, some advocates for nurses told us that nurses can have difficulty finding employment years after having completed remedial courses to improve their practice. Even in some cases of nurse discipline, it may not serve a public safety purpose to keep all actions public forever.

Unlike some states, Minnesota does not have a system that expunges parts of nurses’ records so that the public cannot see some actions taken against them. The 2014 Legislature amended state law to allow for expunging some criminal convictions from the public record. The same consideration should be bestowed upon nurses—especially for nurses not convicted of any crimes.

Staff must process complaints against nurses enrolled in HPSP without the board’s knowledge.

In theory, the board has no knowledge of nurses who self refer to HPSP or are referred there by third parties, such as employers. This makes it difficult for the board to investigate complaints against nurses. The board only learns about their participation if HPSP (1) notifies the board when nurses

do not comply with program requirements or (2) discharges nurses for any reason other than successful completion. Over half of the self-referred or third-party referred nurses in HPSP whose cases were closed in fiscal years 2010 through 2014 eventually came to the board’s attention, most often because they did not comply with HPSP requirements.

Overall, 83 percent of the nurses participating in and successfully completing HPSP without the board’s knowledge had no complaints filed against them while in HPSP. At the same time, however, board staff processed complaints against 17 percent of the nurses who successfully completed HPSP without the board’s knowledge.

Statutes should allow the board to learn if nurses with complaints filed against them have enrolled in HPSP.

The Legislature should amend statutes to allow the board to routinely submit a list of nurses with complaints filed against them to HPSP, where staff would identify whether any of those nurses were enrolled in their program.

It is not necessary that the board know the identity of all nurses successfully participating in HPSP if the board or HPSP has not received any complaints against them. Staff at HPSP have done a good job monitoring nurses; nurses who are compliant with the program likely do not pose a public safety risk. Thus, the confidentiality provisions that allow nurses to refer themselves or be referred by third parties without being reported to the board should continue, as long as the nurses thus referred do not have complaints filed against them.

Introduction

In late 2013, a series of articles in the *Minneapolis Star Tribune* reported that certain Minnesota nurses continued to practice despite being reported to the Minnesota Board of Nursing for unsafe practices.¹ The nurses allegedly neglected patients, worked while impaired by drugs or alcohol, or stole from patients. The articles suggested that the board's disciplinary actions were insufficient to protect the public from impaired nurses. A legislative hearing followed, and the board was asked for recommendations to address shortcomings in its discipline process. Several board recommendations were ultimately adopted by the 2014 Legislature.²

In April 2014, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate the Minnesota Board of Nursing's complaint resolution process, paying special attention to the board's working relationship with the Health Professionals Services Program (HPSP). This program, often referred to as an alternative-to-discipline program, monitors the practice of nurses and other health professionals with mental, physical, or substance abuse problems. Our evaluation addressed the following questions:

- **What is the Minnesota Board of Nursing's process for resolving complaints against nurses, and does it adequately protect the public and nurses?**
- **How well does the board review and resolve complaints?**
- **Does HPSP's work and organizational structure conflict with the board's mission? To what extent does the program's monitoring of nurses facilitate nurses' rehabilitation while protecting the public?**

We used several research methods to answer these questions:

- Analyzed Minnesota Board of Nursing complaint data for fiscal years 2009 through 2014 and HPSP participation data from fiscal years 2010 through 2014.
- Examined in detail a random sample of over 300 complaint files at the nursing board and HPSP, and we separately reviewed case files for all nurses cited in the *Minneapolis Star Tribune* articles.
- Reviewed the literature on regulating nurses and resolving complaints against them, including state laws, rules, policies, procedures, reports, and best practices.

¹ *Minneapolis Star Tribune*: "In Minnesota, Nurses in Trouble get Second Chance," October 6, 2013; "When Nurses Fail," October 19, 2013; and "Dayton: Minnesota Board of Nursing 'Asleep at the Wheel,'" November 11, 2013.

² *Laws of Minnesota* 2014, chapter 291, art. 4.

- Talked with board members and staff, staff from the Office of the Attorney General, attorneys who represent nurses in the disciplinary process, staff of other health-related licensing boards in Minnesota, representatives from professional nursing associations, professionals who treat nurses with substance abuse problems, and HPSP staff.
- Attended discipline conferences, mediation hearings, and nursing board and HPSP board and committee meetings.
- Looked at the organizational structure, laws, and practices of nursing boards and alternative-to-discipline programs in several other states, using information from the National Council of State Boards of Nursing and other professional and state associations.
- Reviewed case law from the boards of Chiropractic Examiners, Dentistry, Medical Practice, and Nursing.
- Read Office of Administrative Hearings' records for Minnesota Board of Nursing contested case hearings over the last five years.

Our evaluation did not examine other board duties that also seek to protect public health and safety, including approving nurse education programs, setting nurse practice standards, and issuing and renewing licenses for nurses.³ We also did not review the board's monitoring of nurses with the human immunodeficiency virus, hepatitis B virus, or hepatitis C virus.

This report is divided into three chapters. Chapter 1 discusses the legal underpinnings for state regulation and how Minnesota regulates the practice of nursing. It also describes the board's complaint resolution process and presents data on the number, source, type, and outcome of complaints it has received over time. Chapter 2 analyzes how well the board's complaint resolution process has worked. Chapter 3 examines nurse participation in HPSP and the nursing board's relationship with that program.

³ However, we did examine the board's licensing procedures as they related to nurses who had been the subject of complaints or board actions.

Chapter 1: Regulating Nursing

The State of Minnesota began regulating nurses in 1907 when it created the Minnesota State Board of Examiners of Nurses, about 20 years after it established similar boards for doctors and dentists.¹ From its beginning, the nursing board has had a key role in disciplining nurses. The 1907 Legislature authorized the board to revoke nurses' registrations for "just cause," but not before giving registrants 30 days notice and the opportunity for a "full and fair" hearing.² By the end of 1908, the board had registered 102 nurses, including some who had graduated from nursing schools as early as 1894.³ Today the state licenses and regulates the practice of approximately 118,000 nurses across Minnesota. However, few licensed nurses—about 1.5 percent of nurses in fiscal year 2014—ever come to the board's attention because of their behavior or nursing practice.

One of the Minnesota Board of Nursing's important responsibilities is to receive and resolve complaints against the nurses it licenses. The board's primary goal must always be to protect the public from incompetent practice or inappropriate behavior by nurses, but the board must also provide nurses with adequate due process. Achieving that balance is often complex and challenging.

This chapter begins with a description of the legal framework for nurse discipline, followed by the overall framework of nursing regulation in Minnesota. We then describe the Minnesota Board of Nursing's complaint resolution process and provide descriptive data on complaints received and resolved by the board over the last several years.

LEGAL FRAMEWORK

Historically, regulating healthcare professions to protect the health, safety, and welfare of citizens has been reserved to the states under the Tenth Amendment to the United States Constitution. Consequently, few federal laws regulate nurses or the practice of nursing.⁴

¹ *Laws of Minnesota* 1907, chapter 153; *Laws of Minnesota* 1883, chapter 125; and *Laws of Minnesota* 1885, chapter 199. In 1955, the Legislature renamed the nursing board the Minnesota Board of Nursing. *Laws of Minnesota* 1955, chapter 34, sec. 1.

² *Laws of Minnesota* 1907, chapter 153.

³ Minnesota Board of Nursing, "Celebrate our History, 1907-1917," <http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/history.jsp>, accessed October 27, 2014.

⁴ To be eligible for reimbursement for certain health-related services under Medicare and Medicaid, the services being claimed must be provided by individuals authorized to provide them. Also, federal laws require that regulatory bodies, such as licensing boards, report disciplinary actions they take against licensees to a national databank. *Patient Protection and Affordable Care Act of 2010*, Pub. L. No. 111-148, 124 Stat. 199.

Regulating the practice of nursing through licensure is largely a state responsibility undertaken to protect the public.

Healthcare professionals who are unprepared, incompetent, or impaired pose a risk to the public. As a result, states have adopted laws and rules designed to protect people who receive services from healthcare providers. In Minnesota, two major provisions of state law address the licensing and practice of nurses.

Minnesota Statutes 2014, Chapter 214, lays out a general framework that Minnesota's 16 health-related licensing boards, including the Minnesota Board of Nursing, must work under when licensing, regulating, or resolving complaints against licensees or applicants for licensure.⁵ This law sets forth three overarching principles.⁶ First, the state will regulate occupations only when it is necessary for the safety and well-being of its citizens. Second, boards comprised largely of regulated professionals should formulate the policies and standards that govern their professions. Third, procedural fairness in disciplining regulated individuals requires that boards separate their functions related to investigating complaints from their functions related to imposing disciplinary actions on licensees.

Minnesota Statutes 2014, 148.171-148.285, known as the *Nurse Practice Act*, creates the Minnesota Board of Nursing and lays out its specific duties in regulating nurses and their practice. The law also sets forth the specific grounds under which the board can discipline nurses and the various types of actions available to it.

In addition, the nursing board is subject to the *Criminal Rehabilitation Act*, which encourages the rehabilitation of convicted criminals by giving them the opportunity to work in their licensed professions.⁷ Notwithstanding other provisions of law to the contrary, the board cannot prohibit nurses from practicing their profession solely or in part due to their criminal backgrounds unless their crimes are directly related to the practice of nursing. One important exception relates to nurses convicted of first through fourth degree criminal sexual conduct. In 2014, the Legislature, at the request of the board, statutorily prohibited the board from granting or renewing the licenses of nurses convicted of a sexually related crime after August 1, 2014.⁸

Under the United States Constitution, a license to practice a profession is a property right, and regulatory boards cannot limit or take away that right without affording a license holder due process.

⁵ *Minnesota Statutes* 2014, 214.001-214.37.

⁶ *Minnesota Statutes* 2014, 214.001, subds. 1-2.

⁷ *Minnesota Statutes* 2014, 364.01-364.03. The *Criminal Rehabilitation Act* will be a major consideration as the board implements criminal background checks on all applicants and eventually on all licensees, as required in state law. Such checks must be in place by January 1, 2018. *Minnesota Statutes* 2014, 214.075.

⁸ *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 8.

Although few federal laws govern nurses' behavior, the United States Constitution affects state regulatory boards. Due process requires that licensees: (1) be informed of complaints lodged against them, (2) be given timely notice and opportunity for a hearing where they may present evidence and argument, (3) have the right to be represented by counsel, (4) have the right to an impartial decision maker, and (5) have the right to a reasonable decision based on the record.⁹

How much due process the government must provide a licensee is based on weighing the interest of the licensee against the governmental interest of protecting the public and the burden procedural requirements impose on the government.¹⁰ Licensees may waive some of their procedural rights as long as the waivers are made voluntarily and intelligently.¹¹ Furthermore, actions against licensees must not be arbitrary or capricious, and they must be reasonably related to licensees' fitness to practice.¹²

Minnesota law allows licensing boards to limit some due process rights when licensees' continued practice presents an imminent or serious threat to the public. For example, the nursing board may temporarily suspend a license before holding a hearing if there is probable cause to believe that the nurse has violated a statute and continued practice by that nurse would create an imminent risk of harm to others.¹³ The law sets forth specific timelines and notification requirements that the board must meet.

In order to take action on a license, the board must prove a violation of nursing standards by a "preponderance of evidence."¹⁴ Preponderance of evidence is the standard used in civil cases and is generally considered to mean that the facts presented are more likely than not to have occurred.

⁹ *Humenansky v. Minnesota Bd. of Medical Examiners*, 525 N.W.2d 559, 565 (Minn. Ct. App. 1994) citing *Goldberg v. Kelly*, 397 U.S. 254, 267-268 (1970).

¹⁰ For example, see *Matthews v. Eldridge*, 424 U.S. 319, 332-335 (1976).

¹¹ *In the Matter of Judnick*, #A12-1673 (Minn. Ct. App. 2013) at 7 citing *Majestic Inc. v. Berry*, 593 N.W.2d 251, 255 (Minn. Ct. App. 1999).

¹² *In the Matter of Weisman*, A03-450 (Minn. Ct. App. 2003) citing *In re Excess Surplus Status of Blue Cross & Blue Shield of Minn.*, 624 N.W.2d 264, 277 (Minn. 2001). A decision is arbitrary and capricious when it represents the exercise of the agency's will rather than its judgment. *Friedenson, Matter of*, 574 N.W.2d 463, 467 (Minn. Ct. App. 1998) citing *In re Petition of Minn. Power for Auth to Change Its Schedule of Rates for Retail Elec. Serv.*, 5454 N.W.2d 49, 51 (Minn. Ct. App. 1996).

¹³ *Minnesota Statutes* 2014, 214.077. The 2014 Legislature gave temporary suspension authority to all health-related licensing boards, including the Minnesota Board of Nursing, effective July 1, 2014. See *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 46. Previous to the passage of this law, the Minnesota Board of Nursing issued temporary suspensions under *Minnesota Statutes* 2014, 148.262, subd. 3, which has been part of state law since 1989. According to the Office of the Attorney General, the new law supersedes the board's authority under the 1989 law.

¹⁴ *Minnesota Rules*, 1400.7300, subp. 5, posted August 6, 2013. Also, the court said, in *Wang, Matter of*, 441 N.W.2d 488, 492 (Minn. 1989), that it trusts that "in all professional disciplinary matters, the finder of fact, bearing in mind the gravity of the decision to be made, will be persuaded only by evidence with heft."

STRUCTURAL FRAMEWORK

The Minnesota Board of Nursing is the state's lead agency in regulating nurses. However, other state agencies or programs play a support role, including the Office of the Attorney General, Office of Administrative Hearings, and the Health Professionals Services Program. This section discusses each of their roles and their relationship to the nursing board.

Minnesota Board of Nursing

As discussed previously, it is the state's policy that Minnesota's health-related professionals should formulate the policies and standards that govern the licensing standards of their professions. This responsibility includes regulating the behavior of their peers, both at work as well as after hours if that behavior could interfere with their ability to safely do their jobs.

In keeping with the state's philosophy of peer regulation, the Minnesota Board of Nursing is administered by a board comprised largely of nurses appointed by the Governor.

The Legislature created the Minnesota Board of Nursing as a state agency in the executive branch. As shown in Exhibit 1.1, the board consists of 16 members appointed by the Governor through the open appointments process set forth in state law.¹⁵ Members must include eight registered nurses, four practical nurses, and four public members.¹⁶ One nurse member must have executive or teaching experience in a baccalaureate degree program, and another nurse member must have executive or teaching experience in an associate degree program. In addition, one of the registered nurse members must have been working in a nursing home at the time of appointment. For the most part, the Governor appoints members to four-year terms that may be renewed through reappointment. To the extent possible, appointments are staggered so that one-fourth of members' terms expires each year.

¹⁵ *Minnesota Statutes* 2014, 15.0575 and 15.0597.

¹⁶ Registered nurses have, at a minimum, a two-year degree or three-year diploma; many have baccalaureate degrees. Registered nurses have a wide range of duties and are generally expected to do more critical thinking on the job than are practical nurses. Practical nurses have, at a minimum, about a year of nursing education. They provide basic nursing care under the supervision of a physician or registered nurse. Public members cannot be nurses or the spouses of nurses, nor can they have a financial interest in the nursing profession.

Exhibit 1.1: Minnesota Board of Nursing, Fiscal Year 2014

Total Number of Board Members ^a	16 members appointed by the Governor
Number of Nurse Members	12
Number of Public Members	4
Total Number of Staff ^a	33
Total Number of Nurses Regulated	117,937
Revenue	\$5,866,250
Expenditures	\$4,732,263

^a The numbers shown for board members and staff are current as of October 31, 2014.

SOURCE: Office of the Legislative Auditor.

Effective August 1, 2014, board members receive \$75 per day when their time is spent on activities authorized by the board.¹⁷ Authorized activities include attending board and committee meetings and hearings, representing the board at (or attending with board approval) national, state, or local meetings or conferences, and taking part in training activities. Authorized activities do not include any at-home preparation time members might put in prior to attending board meetings. Board members are also eligible to receive reimbursement for expenses they incur, such as meals, mileage, lodging, and, under certain circumstances, child care.

Statutes allow the board to delegate certain powers and duties to its executive director. The executive director, hired by the board, manages its daily activities and oversees a staff of 32. About half of the board's professional staff are registered nurses, including its executive director and two of its three division directors. The board had expenditures of approximately \$4.7 million in fiscal year 2014. The board does not receive General Fund dollars. Instead, the Legislature appropriates operating funds from the state's special revenue fund in which the board deposits licensure fees it collects. The board estimates that about half of its total budget is allocated to nurse discipline.

The Minnesota Board of Nursing's mission is to protect the public's health and safety through regulation of nursing education, licensure, and practice.

The board seeks to fulfill its mission by (1) approving nurse education programs, (2) setting practice standards, (3) issuing and renewing nursing licenses, and (4) resolving complaints.¹⁸ Together, board actions in these four areas provide

¹⁷ *Minnesota Statutes* 2014, 214.09, subd. 3. In 2014, the Legislature raised the daily rate received by board members from \$55 to \$75. *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 47.

¹⁸ The Minnesota Board of Nursing issues licenses to individuals who meet, for the first time, the requirements to practice nursing in the state. Licenses are permanent documents valid for individuals' lifetimes unless the board takes legal action to revoke them. Registration is the process the board uses to authorize licensed nurses to actually practice nursing in Minnesota. Nurses must renew their registrations every two years to remain eligible to practice nursing in the state. Minnesota Board of Nursing, *Commonly Used Terminology* (Minneapolis, May 2014), 7 and 10.

the public with reasonable assurance that nurses are competent, ethical practitioners with the appropriate levels of knowledge and skills. As noted previously, our evaluation focuses on the board's fourth responsibility—resolving complaints.

The Minnesota Board of Nursing investigates and resolves complaints involving violations of state laws and board rules. The *Nurse Practice Act* lists 27 types of behavior that are grounds for board action.¹⁹ As shown in Exhibit 1.2, these grounds generally fall into one of seven categories: (1) practice or skill-related deficiencies; (2) inability to practice with reasonable skill and safety due to illness, alcohol or drug abuse, or other mental or physical conditions; (3) criminal convictions; (4) misrepresentation or noncooperation during the licensure process; (5) actions against a nurse's license in other states; (6) abuse or neglect of vulnerable adults or minors; and (7) unprofessional or unethical behavior.

Exhibit 1.2: Grounds for Disciplinary Action of Nurses

Grounds	Description
Practice	Not adhering to proper standards of care, including documentation problems and issues regarding nurses' skill or competence
Alcohol, drugs, or other health issues	Actual or potential inability to practice safely due to illness, physical or mental conditions, or alcohol or drug abuse; includes mishandling or misusing drugs, diverting drugs from patients or the workplace, using illegal drugs, using prescribed drugs that results in impairment, and unauthorized attempts to obtain prescribed drugs
Criminal convictions	Information derived from criminal background checks, licensing applications, or the news media regarding criminal convictions in Minnesota or other states that are reasonably related to the practice of nursing
Misrepresentation/noncooperation	Providing false information to the nursing board or refusing to cooperate with a nursing board investigation
Action in other states	Revocation, suspension, limitation, condition, or other disciplinary action against a nurse's license in other states or countries, including failing to disclose other states' actions to the nursing board
Patient abuse/neglect	Physical, mental, or emotional maltreatment of patients
Unprofessional/unethical behavior	A wide range of problem behavior, including boundary and relationship issues, sexual misconduct, and theft of patients' property
Other	Miscellaneous behavior, including tax and child support delinquencies

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2014, 148.261.

¹⁹ *Minnesota Statutes* 2014, 148.261.

The Minnesota Board of Nursing resolves complaints alleging violations of state law by either dismissing the complaints or imposing disciplinary or nondisciplinary actions on nurses.

Exhibit 1.3 shows the range of actions the nursing board can take in response to complaints that nurses have violated state law or acceptable nursing practice, as outlined in the *Nurse Practice Act*. It also shows the extent to which board actions are classified as public information.

As we discuss later in this chapter, the board dismisses the majority of complaints it receives, mostly because they do not rise to the level of board action. Dismissed complaints are not available to the public, although the board retains the complaints indefinitely.

When the board and a nurse agree to resolve a complaint through nondisciplinary action, the board develops either an *Agreement for Corrective Action* or a *Stipulation to Cease Practicing* (depending on the nature of the resolution) that both parties sign. These documents are available to the public on the board's website.

When both parties agree to disciplinary action, board staff develop a *Stipulation and Consent Order* that both parties sign. In doing so, the nurse agrees to the discipline imposed by the board. These documents are also available to the public on the board's website.

In addition, the board reports all *Stipulation and Consent Orders* and *Stipulations to Cease Practicing* to national databanks, including NURSYS (the National Council of State Boards of Nursing's database of public actions) and the National Practitioner Data Bank.²⁰ Reporting to national databases allows nursing boards across the country to check the disciplinary histories of out-of-state nurses that might be applying for licensure in their respective states.

²⁰ Section 6403 of the *Patient Protection and Affordable Care Act of 2010* consolidated operations of the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank, as of May 6, 2013.

Exhibit 1.3: Possible Actions the Minnesota Board of Nursing Can Take on Complaints

Dismissal	<i>Not public.</i> Complaint is either outside the Minnesota Board of Nursing's jurisdiction, duplicative, previously addressed, false, too vague, or otherwise not meriting disciplinary or nondisciplinary action.
Nondisciplinary	<i>Public nature of action varies, as noted below.</i>
Stipulation to Cease Practicing	<i>Posted on state website and reported to national databanks.</i> Agreement whereby the nurse agrees to not practice nursing for a period of time
Agreement for Corrective Action	<i>Posted on state website only.</i> Specific corrective measures that a nurse must take; upon successful completion, the complaint is dismissed
Nondisciplinary HPSP referral	<i>Not public.</i> Referral to the Health Professionals Services Program (HPSP); once the nurse enrolls in the program, the complaint is dismissed
Disciplinary	<i>All disciplinary actions are posted on the state's website and reported to national databanks.</i>
Reprimand	Censure or admonishment for particular conduct
Civil penalty	Monetary fine ranging up to \$10,000 per violation
Limitations	Restrictions placed on a nurse's scope of practice; for example, requiring the nurse to work under the direct supervision of a registered nurse, prohibiting the nurse from accessing controlled substances, or barring the nurse from working in certain types of settings or with certain types of patients
Conditions	License retention is contingent upon the nurse meeting certain requirements, such as taking certain courses, abstaining from alcohol or drugs, or submitting periodic reports.
Disciplinary HPSP referral	Referral to the Health Professionals Services Program (HPSP) imposed as a condition, limitation, or part of a stay on a nurse's license
Suspension	Although still licensed, the nurse is not authorized to work in Minnesota for a definite or indefinite period of time; nurse is also prohibited from using the title of nurse.
Stayed suspension	Nurse's suspension is put in abeyance upon compliance with certain requirements.
Revocation	Nurse's authorization to practice nursing in Minnesota is taken away; subsequent relicensure is not anticipated.
Voluntary surrender	The nurse voluntarily gives up his or her authorization to practice nursing in Minnesota, including the ability to use the title of nurse.

NOTES: State law requires the Minnesota Board of Nursing to post certain types of actions taken against nurses' licenses on its public website. In addition, federal law requires the board to report certain types of actions taken to the federal National Practitioner Data Bank, a confidential information clearinghouse that can only be accessed by certain regulatory agencies and health care providers. See *Minnesota Statutes* 2014, 214.072, and *Patient Protection and Affordable Care Act of 2010*, Pub. L. No. 111-148, 124 Stat. 199.

SOURCES: Office of the Legislative Auditor and Minnesota Board of Nursing.

Office of the Attorney General Office

The Office of the Attorney General acts as general counsel to the nursing board and assists in investigating certain types of complaints.²¹ It does this in four major ways.²² First, board members and staff can seek legal advice from the office on a variety of issues, including jurisdiction, data privacy, and due process. The board can also ask for statutory interpretations and legal opinions.

Second, the Office of the Attorney General represents the board in its legal proceedings. For example, assistant attorneys general provide legal representation at all of the board's disciplinary conferences, meetings, contested case hearings, and court appeals and proceedings.

Third, statutes require the board to forward all complaints that require some type of "investigation" to attorney general staff for that investigatory work.²³ Statutes, though, do not specifically define what constitutes an investigation. The board has interpreted statutes to mean that, while its staff can obtain certain documents such as employment or patient records, they cannot do a "field investigation."²⁴ According to the board, field investigations often require site visits and may include questioning nurses, coworkers, employers, or patients. The board must obtain (and pay for) such work from the attorney general's office. Also, the board must forward complaints involving or alleging sexual contact or sexual conduct with a patient or client to the Office of the Attorney General for investigation.²⁵

Finally, board staff routinely forward complaints that fall under the board's jurisdiction (that is, they allege violations of the *Nurse Practice Act* by nurses licensed by the board) to attorney general staff for review before (1) dismissing certain types of complaints, (2) entering into agreements for corrective action, (3) attempting to resolve them through disciplinary actions, or (4) initiating contested case hearings (which we discuss below).²⁶

²¹ *Minnesota Statutes* 2014, 8.01. The Office of the Attorney General has consolidated its representation of all the health-related licensing boards into its Health Licensing Boards Legal Division.

²² The Office of the Attorney General also plays a significant role in administrative rulemaking. However, the nursing board has few substantive administrative rules directly related to its complaint resolution process.

²³ *Minnesota Statutes* 2014, 214.103, subds. 4(1) and 5.

²⁴ The board limits its investigatory powers to those specifically laid out in law regarding subpoenaing records. *Minnesota Statutes* 2014, 214.10, subds. 2-3; and 148.191, subd. 2.

²⁵ *Minnesota Statutes* 2014, 214.10, subd. 8(a); and 214.103, subd. 6(b).

²⁶ According to state law, the Office of the Attorney General must review before dismissal any complaints that allege (1) any violation of Minnesota's criminal code, state medical assistance laws, or federal laws; (2) maltreatment of minors or vulnerable adults; (3) sexual conduct with a client; or (4) inability to practice by reason of illness, use of drugs, or a mental or physical condition. *Minnesota Statutes* 2014, 214.103, subd. 8.

Office of Administrative Hearings

The Office of Administrative Hearings (OAH) holds mediation conferences and conducts contested case hearings when the nursing board cannot resolve complaints with nurses through its own internal complaint resolution process.²⁷ By holding mediation conferences and contested case hearings, OAH acts as an impartial third party for both the board and the nurses involved in the discipline process. In mediation conferences, administrative law judges try to work out settlements agreeable to both the board and nurses, thereby avoiding the more formal and costly contested case process.²⁸

Contested case hearings are formal proceedings similar to trials before judges but without juries.²⁹ After hearing testimony and reviewing evidence presented by the board and nurses (or their attorneys), administrative law judges issue reports with findings of fact, conclusions, and recommendations for discipline or no discipline. The Minnesota Board of Nursing is not bound to follow OAH's recommendations. After considering them, the board takes final action, which nurses can appeal to the Minnesota Court of Appeals.³⁰

Health Professionals Services Program

The Health Professionals Services Program (HPSP) is designed to protect the public by monitoring the practice of nurses (and other health professionals) with illnesses related to substance abuse or physical or mental conditions.³¹ The program is jointly operated by 17 health-related licensing boards. Initially created as an optional program, the 2000 Legislature required that all the health-related licensing boards, including the Emergency Medical Services Regulatory Board, either participate in HPSP or contract with a similar alternative program.³² The Minnesota Board of Nursing has always chosen to participate in HPSP rather than contract with another program.

As noted previously in Exhibit 1.3, the board may make nondisciplinary and disciplinary referrals to HPSP. Nurses may also refer themselves to HPSP or be referred by third parties. In these latter situations, the board may not know that

²⁷ *Minnesota Statutes* 2014, 214.103, subd. 7, require the approval of two board members to initiate a contested case hearing. Nurses may choose to proceed to a contested case hearing at any time during the complaint resolution process.

²⁸ *Minnesota Statutes* 2014, 14.57-14.62.

²⁹ *Ibid.*

³⁰ *Minnesota Statutes* 2014, 14.63.

³¹ All health-related licensing boards participate in HPSP. They include the Minnesota boards of Behavioral Health and Therapy, Chiropractic Examiners, Dentistry, Dietetics and Nutrition, Marriage and Family Therapy, Medical Practice, Nursing, Nursing Home Administrators, Optometry, Pharmacy, Physical Therapy, Podiatric Medicine, Psychology, Social Work, and Veterinary Medicine, the Emergency Medical Services Regulatory Board, and the Minnesota Department of Health. Chapter 3 provides a detailed discussion of HPSP.

³² *Laws of Minnesota* 2000, chapter 284, sec.1; and *Laws of Minnesota* 1994, chapter 556, sec. 2. In 2014, the Legislature required the boards to participate in HPSP for one year, a provision that expires in July 2015. *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 52.

the nurses have conditions that, if left unmonitored or untreated, may affect their practice. Because state law requires HPSP to report certain program dismissals and noncompliance to the nursing board, nurses can and do bounce back and forth between the board and HPSP.³³

COMPLAINT RESOLUTION PROCESS

Consistent with state law, the primary purpose of the Minnesota Board of Nursing's complaint resolution process is, first and foremost, to protect the public. Its purpose is not to rehabilitate or punish nurses unless doing so would advance public safety. According to policy statements adopted in 1996 and revised in 2012, the board strives to: (1) consider the facts of each complaint on an individual basis; (2) resolve similar complaints in a similar manner; (3) make decisions that are fair, impartial, and equitable; and (4) operate in a timely and fiscally responsible manner.³⁴ Throughout the process, the board is committed to treating all parties involved in the process with respect and courtesy.

The board's complaint resolution process is based upon the principle of individual responsibility; that is, nurses are responsible for their own practice. In its complaint deliberations, the board tries to distinguish among violations stemming from human error, at-risk behavior, and intentional reckless behavior, focusing on the behavioral choices made by nurses and not the outcomes of those choices. Furthermore, the board's philosophy is that individual nurses should not be held accountable for system flaws over which they have no control.³⁵

The Minnesota Board of Nursing strives to resolve complaints through agreements with nurses using an internal process, but an external process is available when necessary.

The Minnesota Board of Nursing initially uses an internal process to try to resolve all complaints, as shown in Exhibit 1.4. If an agreement cannot be reached internally—or at the request of the nurse—the complaint enters the contested case process, an external, more legalistic process shown in Exhibit 1.5. Except under certain circumstances prescribed in law, nurses may generally continue to practice during the board's internal process as well as the contested case process.³⁶ In addition, state law classifies complaints as confidential data, which means that they are not available to the public, including nurses and their employers.³⁷ The board can resolve complaints at any time during the resolution process, and some parts of the process may be skipped altogether.

³³ *Minnesota Statutes* 2014, 214.33, subd. 3.

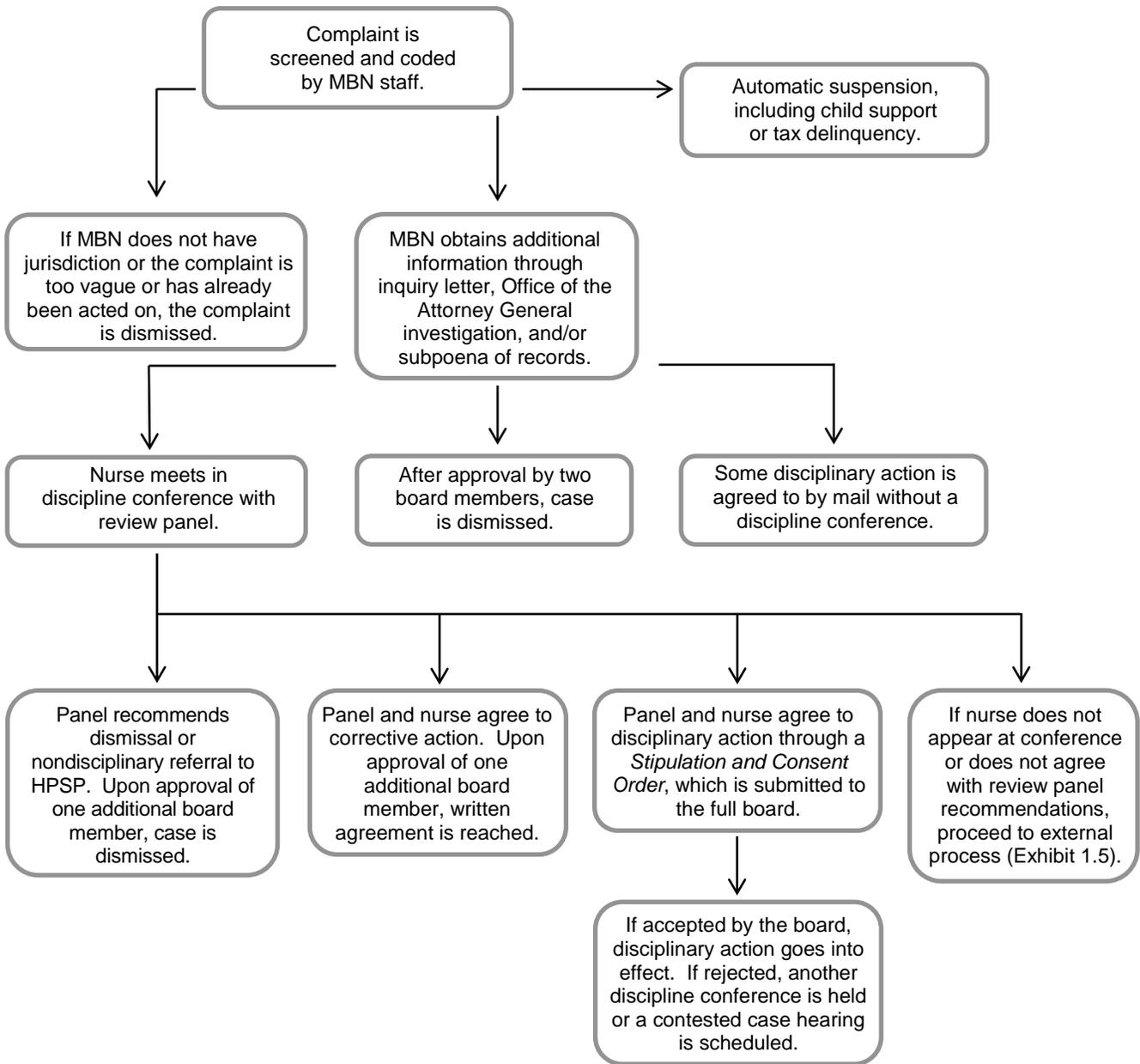
³⁴ Minnesota Board of Nursing, *Complaint Resolution Philosophy* (Minneapolis, August 2, 2012).

³⁵ This is often referred to as "Just Culture." National Council of State Boards of Nursing, *The Just Culture Algorithm* (Chicago: NCSBN, 2005).

³⁶ *Minnesota Statutes* 2014, 214.077; and 148.262, subds. 2-3.

³⁷ *Minnesota Statutes* 2014, 13.41, subd. 4. For the most part, settlement agreements entered into by the board and nurses are classified as public information.

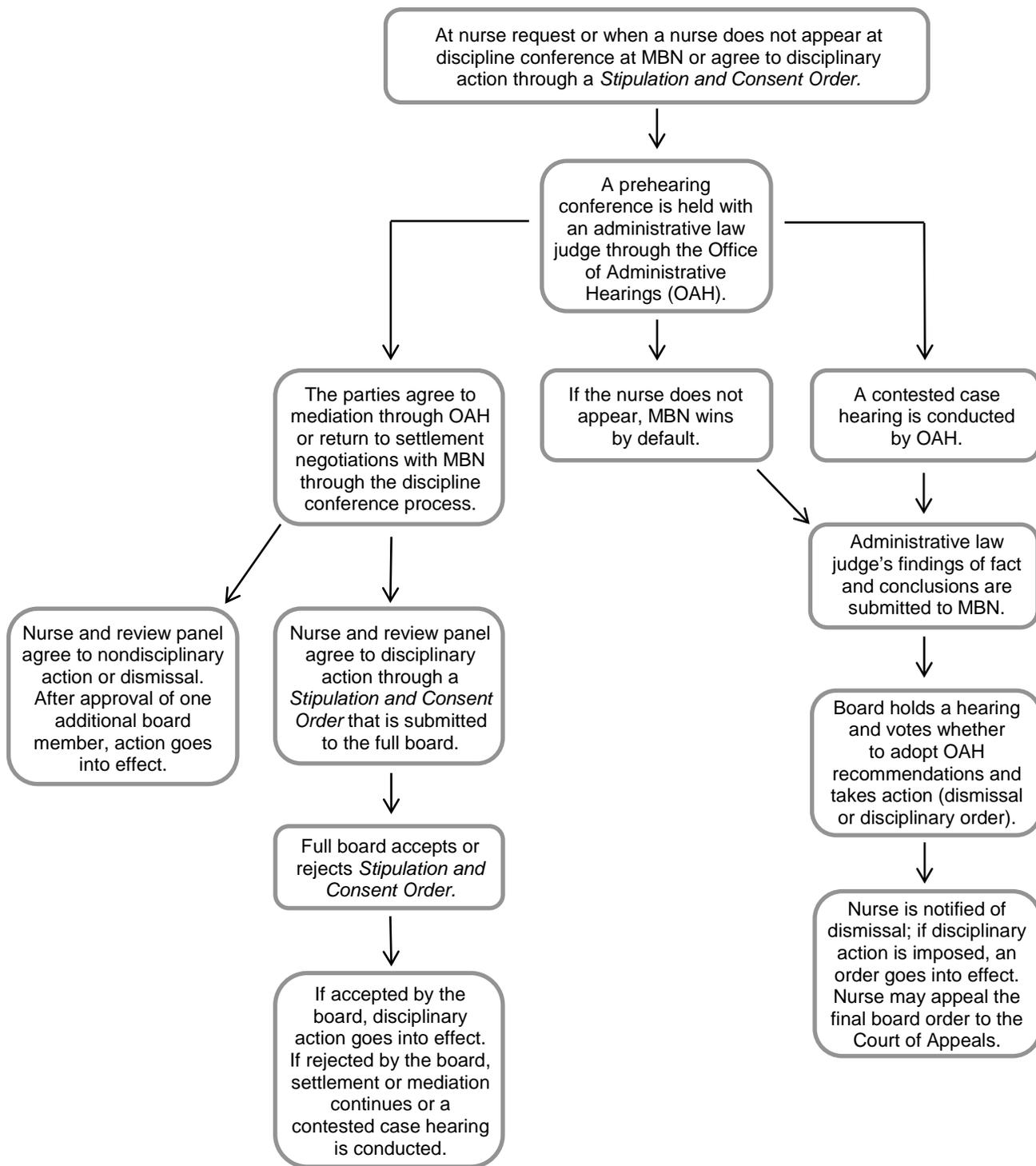
Exhibit 1.4: Internal Complaint Resolution Process



NOTES: MBN refers to the Minnesota Board of Nursing and HPSP refers to the Health Professionals Services Program.

SOURCES: Office of the Legislative Auditor and Minnesota Board of Nursing, 2014.

Exhibit 1.5: External Complaint Resolution Process



NOTE: MBN refers to the Minnesota Board of Nursing.

SOURCES: Office of the Legislative Auditor and Minnesota Board of Nursing, 2014.

Complaint Handling Components

Every complaint the Minnesota Board of Nursing receives starts out in its internal complaint handling process. All complaints must be submitted in writing. The nursing board defines a complaint as any report describing behavior or alleging practices that may be a violation of state law.³⁸

Complaints filed with the Minnesota Board of Nursing may or may not fall under the board's jurisdiction, and they may or may not result in the board taking any action against nurses.

Below we describe the various components of the board's internal and external complaint handling processes. Not all complaints go through all components. For example, suspensions for some violations, such as tax and child support delinquencies, occur automatically by statute.³⁹ Similarly, certain types of court orders, such as civil commitment orders, result in automatic suspensions.⁴⁰ In addition, some complaints that result in discipline are resolved by agreements through the mail without going through discipline conferences or contested case hearings.

Screening and Coding

As a first step, the board's discipline coordinator screens each complaint to determine whether it falls under the board's jurisdiction and, if so, whether the board has previously acted on the complaint. The discipline coordinator automatically dismisses complaints previously acted on as well as complaints not within the board's jurisdiction. Complaints that fall outside the board's jurisdiction include allegations of wrongdoing against individuals not licensed by the board, such as nurse aides or physicians, and nurses not working in Minnesota. They also include allegations against nurses that are not violations of the *Nurse Practice Act*. For example, a nursing home resident's complaint about a nurse serving bad food would be considered outside the board's jurisdiction and would be dismissed at this point of the process. Complaints dismissed by staff because of previous board action or because the complaints were not within the board's jurisdiction do not need to be approved by board members.

The board's discipline coordinator codes all complaints that allege new violations of the *Nurse Practice Act* by nurses licensed in Minnesota. Coding establishes: (1) the alleged grounds, (2) the seriousness of the complaint, (3) how quickly the complaint should be resolved, and (4) whether the complaint will likely result in discipline.

³⁸ Minnesota Board of Nursing, "The Complaint Review Process," <http://mn.gov/health-licensing-boards/nursing/public/complaints/complaint-review-process.jsp>, accessed January 19, 2015.

³⁹ *Minnesota Statutes* 2014, 214.101, subd. 1; 268.0625, subd. 1; 270C.72, subd. 1; and 518A.66.

⁴⁰ *Minnesota Statutes* 2014, 148.262, subd. 2.

Document Review

After coding, a complaint is generally assigned to one of the board's six nurse practice specialists for further review. Board staff obtain various types of records, which the board can subpoena if necessary, to help resolve complaints. Useful documents include employment records, nurse or patient medical records, law enforcement records, and investigations done by other agencies. As we discussed earlier, the board must refer complaints alleging sexual contact or sexual conduct with a patient or client to the Office of the Attorney General for investigation.

Nurse Response

When staff determine that a complaint is likely to not result in discipline, they write an "inquiry letter." Inquiry letters explain the nature of the complaint and ask nurses to "tell their side of the story." Staff use inquiry letters to clarify complaint issues and question nurses about their practice and behavior, including what remedial measures (such as continuing education courses) the nurse has taken since the incident. Complaints alleging one-time errors or events outside a nurse's control are sometimes dismissed after board staff receive a nurse's response to an inquiry letter. Two board members must approve the dismissal.

Discipline Conference

When a complaint is likely to result in disciplinary action, board staff issue a *Notice of Conference*.⁴¹ Staff may send a *Notice of Conference* in lieu of an inquiry letter or after a nurse sent an unsatisfactory response to an inquiry letter. The *Notice of Conference* summarizes the allegations against the nurse and notifies the nurse of a meeting it has scheduled called a discipline conference. In addition, the notice asks the nurse for a written response to the allegations and information about the nurse's current and past employers.

Board review panels convene discipline conferences. The panels consist of one board member and one staff member, advised by an assistant attorney general. The purpose of the discipline conference is twofold: (1) to complete the board's investigation of the complaint by obtaining additional information from the nurse, including his or her "side of the story," and (2) to reach an agreement to resolve the complaint. The board typically schedules five discipline conferences a day, three to four days a week. The conferences are scheduled to last about an hour and a half. All board members are expected to serve on review panels for at least one day each month (96 hours per year).⁴² The review panel's board member decides what action the panel will recommend.

⁴¹ The board will also issue a *Notice of Conference* when it believes the nurse would benefit educationally from a discipline conference or when a conversation with the nurse would be beneficial.

⁴² In reality, board members' attendance at review panels varies widely. According to data collected by the nursing board, board members spent, on average, 67 hours participating in review panels in fiscal year 2014. The time spent by individual board members ranged from 14 to 157 hours. In addition, board members spend hours reviewing documents assembled by staff prior to attending discipline conferences.

Discipline conferences, which are not open to the public, follow a prescribed format. They begin with (1) an opening statement by the assistant attorney general that provides the necessary legal warnings and describes the conference process. This is followed by (2) an opening statement by the nurse (or attorney), if desired, (3) questioning by review panel members, (4) review panel deliberations, and (5) the offering of a settlement proposal to the nurse. Nurses (and their attorneys) leave the conference room while the review panel deliberates. All proceedings but panel deliberations are recorded.

Complaints heard in discipline conferences may result in a recommendation to dismiss, a recommendation to impose nondisciplinary action, or a recommendation to impose disciplinary action. Dismissals and nondisciplinary actions must be approved by one additional board member before becoming final. Disciplinary actions must be approved by the full board.

Full Board Approval

If the nurse and the review panel agree to disciplinary action, the full board must approve the *Stipulation and Consent Order* before it becomes effective. These agreements are generally approved through a consent agenda en masse by the full board in closed session. Individual orders may be removed from the consent agenda for discussion at the request of individual board members.

Formal Hearing

As shown earlier in Exhibit 1.5, if the nurse and the board cannot come to an agreement or the nurse does not appear at the discipline conference, the board will schedule a contested case hearing before an administrative law judge from OAH. Prior to holding a contested case hearing, the board and the nurse may agree to mediation at OAH, where an administrative law judge tries to work out a mutually agreeable settlement.⁴³ If mediation is unsuccessful, the case proceeds to a contested case hearing. On average, about 25 cases per year go to OAH, and the majority of these are defaults—that is, nurses did not show up for the hearing. In these cases, the administrative law judge deems the allegations contained in the board’s hearing notice to be true and consistent with the *Administrative Procedures Act*.

Following OAH’s findings of fact and recommendation, the full board may hold a hearing to decide whether to accept the recommendation.⁴⁴ If the board rejects OAH’s recommendation, it must state specifically why it has done so. The board

⁴³ The nurse and the board’s review panel may also agree to return to the board to continue negotiating using its discipline conference process.

⁴⁴ If the nursing board does not hold a hearing to accept or reject OAH’s recommendation within 90 days, the recommendation automatically becomes the board’s final decision. *Minnesota Statutes* 2014, 14.62, subd. 2(a). Some complaints proceed to a full board hearing without going through the contested case process. In these cases, the nurses have agreed to forgo the contested case hearing and proceed directly to a full board hearing. All board hearings include protections to ensure that voting members are impartial. Board members that have reviewed a specific complaint at an earlier stage—for example, as part of the review panel for a discipline conference—recuse themselves from deliberation and voting on that order.

order is not effective until the full board has acted and issued its own findings of fact.

Judicial Review

Nurses have the right to appeal final board decisions to the Minnesota Court of Appeals.⁴⁵ However, there have been only two appeals regarding the nursing board's decisions since 1986.⁴⁶ Both cases involved nurses who admitted drug abuse or dependence in *Stipulation and Consent Orders*. In both instances, the nurses waived their rights to a contested case hearing, but later appealed to the Minnesota Court of Appeals because they were unhappy with the agreements they made with the board.

The court reviewed and found valid the waiver agreements made by the nurses. In both cases the courts noted that they would reverse only where there was an error of law or the findings were arbitrary, capricious, or unsupported by substantial evidence.⁴⁷ In both instances, the court sided with the nursing board.

COMPLAINTS RECEIVED

Exhibit 1.6 shows the number of complaints filed with the Minnesota Board of Nursing in fiscal years 2009 through 2014. As shown, the board received 1,784 complaints in fiscal year 2014, about the same as it received in 2013, but considerably less than it received in 2011 and 2012.⁴⁸

Although the board receives a large number of complaints each year, very few nurses have complaints filed against them. Furthermore, because a nurse may be the subject of multiple complaints, the actual number of nurses with complaints is less than the total number of complaints filed with the board. As of July 2014, nearly 118,000 nurses were licensed to practice in Minnesota. About 80 percent were registered nurses and 20 percent were practical nurses.⁴⁹

The Minnesota Board of Nursing received about 15 complaints for every 1,000 nurses licensed in fiscal year 2014.

Although the majority of complaints (66 percent) involved registered nurses, a disproportionate number of complaints were filed against practical nurses. In

⁴⁵ *Minnesota Statutes* 2014, 14.63.

⁴⁶ In the Matter of Mostrom, 390 N.W.2d 893 (Minn. Ct. App. 1986); In the Matter of Judnick, #A12-1673 (Minn. Ct. App. 2013).

⁴⁷ Mostrom at 895; Judnick at 8.

⁴⁸ As we discuss in Chapter 2, the nursing board changed questions on its application forms in 2010, which resulted in an increase in the number of complaints filed with the board.

⁴⁹ These data are duplicated counts of registered and practical nurses in fiscal year 2013. Many registered nurses are also licensed as practical nurses. In addition, the board did not begin issuing separate licenses to advanced practice registered nurses until January 1, 2015. Prior to 2015, the board issued certifications to registered nurses who met certain criteria.

Exhibit 1.6: Primary Grounds of Complaints Received by the Minnesota Board of Nursing, Fiscal Years 2009 through 2014

Grounds	Number and Percentage of Complaints											
	FY 2009		FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
Practice	632	40%	554	34%	652	27%	533	26%	499	28%	482	27%
Drugs, alcohol, health Misrepresentation/ noncooperation	295	19	308	19	397	16	338	16	304	17	340	19
Action in other states	154	10	223	14	248	10	226	11	280	16	305	17
Abuse/neglect	161	10	110	7	251	10	265	13	278	16	222	12
Unprofessional behavior	139	9	50	3	154	6	124	6	103	6	34	2
No grounds listed	98	6	56	3	83	3	82	4	75	4	78	4
Other	67	4	82	5	71	3	100	5	80	5	117	7
Criminal convictions	24	2	78	5	81	3	107	5	124	7	127	7
Total	9	1	158	10	507	21	282	14	26	1	79	4
	1,579		1,619		2,444		2,057		1,769		1,784	

NOTE: Percentages may not total 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing complaint data.

fiscal year 2013, the board received about 13 complaints per 1,000 registered nurses and 7 complaints per 1,000 advanced practice registered nurses. In contrast, it received about 35 complaints per 1,000 licensed practical nurses.⁵⁰

Source of Complaints

Complaints can come from many sources, including the nursing board itself. Other major sources include employers and coworkers, HPSP, and the Minnesota departments of Human Services and Health.

Approximately one-third of complaints received by the Minnesota Board of Nursing in fiscal year 2014 were filed by board staff, and slightly more than one-fourth were filed by employers and coworkers.

Board staff submitted about 33 percent of all complaints that the board received in fiscal year 2014, which is similar to previous years' data. Staff did so based on: (1) responses to questions on the board's application forms, (2) noncompliance with board orders, (3) actions undertaken by nursing boards in other states against nurses licensed in Minnesota, and (4) the discovery of other prohibited behavior during their investigation of a complaint.

Employer and coworker complaints comprised 27 percent of all complaints received in 2014. State law requires that employers report any disciplinary action they take against nurses, including revoking, suspending, limiting, or conditioning nurses' ability to practice in their institutions to the Minnesota

⁵⁰ Minnesota Board of Nursing, *Nursing Practice Report Fiscal Year 2013* (Minneapolis, July 18, 2014), 3.

Board of Nursing.⁵¹ Furthermore, statutes require the reporting of any suspension from work, termination, or resignation in lieu of termination. Employers must also report all nurses who resign while they are being investigated.⁵²

Other health-related licensed professionals, including nurses, must report all conduct they believe constitutes grounds for disciplinary action to the nursing board or, in the case of substance abuse or other health issues, to HPSP.⁵³ Employers and licensed health professionals are required to report even if they do not feel that a nurse merits disciplinary action or other action by the board. Nurses' treatment providers are exempt from reporting violations if they learn about them as a result of their professional doctor-client relationship.⁵⁴

Other state agencies and programs, mainly HPSP and the departments of Human Services and Health, also report nurse misconduct to the nursing board.⁵⁵ Complaints from other state agencies and programs made up about 27 percent of all complaints received in fiscal year 2014, with the most complaints coming from HPSP (about 11 percent).

The Minnesota Department of Human Services investigates complaints and reports of alleged maltreatment of vulnerable adults and children in the facilities that it licenses.⁵⁶ The department forwards all reports of alleged abuse or neglect by nurses and investigative reports substantiating abuse or neglect to the board for possible action against those nurses' licenses. In addition, statutes require that the human services department conduct background checks on all individuals having direct patient contact in state licensed health facilities, including nurses.⁵⁷ As a result of its checks, the department can disqualify a nurse from working in a particular work setting. The department notifies the board whenever it disqualifies nurses from working in licensed facilities.

The Minnesota Department of Health investigates maltreatment allegations and complaints in facilities that it licenses or certifies eligible for Medicare or

⁵¹ *Minnesota Statutes* 2014, 148.263, subd. 2. Other provisions of state law allow employers, under certain circumstances, to refer nurses to HPSP in lieu of reporting them to the nursing board. *Minnesota Statutes* 2014, 214.33, subd. 1.

⁵² *Ibid.*, and *Minnesota Rules*, 6321.0500, subp. 1, posted June 11, 2008.

⁵³ *Minnesota Statutes* 2014, 148.263, subd. 3. Employers are considered "mandated" reporters, as are nurses, other health-licensed professionals, nurse employers, insurance companies, and the courts. As such, they are required to report violations of state law to licensing bodies.

⁵⁴ Nurses' treatment providers are expected to counsel their clients to limit or stop their practice of nursing to the extent required by their impairment. For example, if a nurse's doctor or therapist becomes aware of a condition that could impair a nurse's ability to work, that treatment provider is exempt from reporting to the nursing board or HPSP if he or she successfully counsels the nurse to cease practicing. *Minnesota Rules*, 6321.0500, subp. 2, posted June 11, 2008.

⁵⁵ Other state agencies that employ nurses, such as the Department of Corrections, may also routinely file reports of nurse misconduct with the board due to requirements that employers report possible violations of the *Nurse Practice Act* to the board.

⁵⁶ *Minnesota Statutes* 2014, 626.556-626.557, and 626.5572.

⁵⁷ *Minnesota Statutes* 2014, 245C.

Medicaid reimbursement.⁵⁸ As does the human services department, the health department also forwards to the nursing board all investigative reports regarding possible abuse or neglect by nurses for possible action against those nurses' licenses.

Types of Complaints

State law lays out 27 grounds (or reasons) for which the nursing board can take disciplinary action against nurses.⁵⁹ These grounds are often referred to as “violations of the *Nurse Practice Act*.”

Over the last several years, complaints involving practice issues have accounted for the largest share of complaints received by the Minnesota Board of Nursing.

As shown in Exhibit 1.6, complaints about practice issues have consistently been the largest category of complaints received since 2009. Practice issue complaints are generally related to nurses exceeding their scope of practice, committing medication or treatment mistakes, making errors in documentation, or failing to assess, intervene, or report appropriately. For example, nurses who administer medication without an order exceed their scope of practice (unless they are advanced practice nurses with prescribing authority for that medication). In fiscal year 2014, practice-related complaints made up about 27 percent of all complaints received.

Impairment due to substance abuse or health problems made up about 19 percent of complaints in fiscal year 2014, which is generally consistent with data in previous years. This category includes complaints about nurses working while under the influence or aftereffects of alcohol or drugs. It also includes complaints about nurses who are not impaired at work, but who are dependent on or abuse drugs or alcohol. Finally, it includes allegations of nurses diverting or stealing drugs from their employers.⁶⁰ For example, nurses who take discarded medication for their own use (commonly referred to as “diverting from waste”) have committed drug diversion. Nurses who give patients less than their prescribed amounts of medication and take the “leftover” for themselves have also committed drug diversion.

⁵⁸ *Minnesota Statutes* 2014, 626.556-626.557, and 626.5572.

⁵⁹ *Minnesota Statutes* 2014, 148.261, subd. 1. The 2014 Legislature indirectly expanded the list by (1) prohibiting the board from licensing nurses convicted of a felony-level criminal sexual offense and (2) allowing the nursing board to treat noncompliance with HPSP requirements or dismissal from HPSP for any reason other than successful completion as grounds for disciplinary action. See *Laws of Minnesota* 2014, chapter 291, art. 4, secs. 8-9 and 56. Although the law specifically refers to violations of the *Nurse Practice Act* as “grounds for discipline,” the board can also dismiss or impose administrative actions on nurses who have violated the act. Other provisions of state law, such as *Minnesota Statutes* 2014, 148.262, subd. 2, require automatic suspensions for certain types of court orders. In addition, *Minnesota Statutes* 2014, 214.10, subd. 2a, requires the board to initiate proceedings to suspend or revoke a nurse’s license for certain crimes.

⁶⁰ The National Council of State Boards of Nursing uses the term “diversion” to describe a variety of activities used to obtain drugs illegally, including misappropriating drugs from patients, healthcare employers, or other sources. National Council of State Boards of Nursing, *Substance Use Disorder in Nursing* (Chicago: NCSBN, 2011), 247.

Misrepresentation or noncooperation with the board accounted for about 17 percent of all complaints filed in fiscal year 2014. Since 2009, the percentage of complaints involving misrepresentation or noncooperation has increased. These types of complaints include Medicare or other billing fraud, lying on a board renewal or initial licensure application, and making misrepresentations or failing to cooperate with the board during an investigation.

Since fiscal year 2010, complaints about nurses' criminal convictions have comprised between 1 and 21 percent of the nursing board's caseload. As we will discuss in Chapter 2, the number of complaints in this category increased dramatically in fiscal years 2010 through 2012 due to changes the board made on its application forms for licensure and registration.

COMPLAINTS RESOLVED

We looked at all complaints that the Minnesota Board of Nursing resolved over the last several years. We defined a complaint as resolved when the board took its first formal action on the complaint. Exhibit 1.7 shows how the board resolved complaints in fiscal years 2009 through 2014.⁶¹ During this timeframe, 69 to 79 percent of actions taken to resolve complaints were dismissals, 20 to 26 percent were disciplinary actions, and 2 to 4 percent were nondisciplinary actions.

Exhibit 1.7: Complaint Actions by the Minnesota Board of Nursing, Fiscal Years 2009 through 2014

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Number of actions	1,541	1,475	1,877	2,024	2,152	1,781
Percentage of actions:						
Dismissed	76%	69%	75%	79%	75%	72%
Disciplinary	20	26	21	20	22	24
Nondisciplinary	3	4	3	2	3	4

NOTE: Percentages may not total 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing complaint data.

Exhibit 1.8 shows board actions in relation to the different types of complaints. As the data show, the board imposed some form of disciplinary action in nearly 60 percent of the complaints that alleged nurse impairment due to drugs, alcohol, or health problems. Likewise, nearly 30 percent of complaints alleging unprofessional behavior or misrepresentation or noncooperation resulted in disciplinary action.

⁶¹ The number of complaint resolutions in each fiscal year is not directly related to the number of complaints received in each year for three reasons. First, complaints received in one fiscal year may not be resolved until the next fiscal year. Second, some complaints remain unresolved, especially complaints filed in fiscal year 2014. Lastly, the board sometimes resolves multiple complaints against a nurse at one time.

Exhibit 1.8: Minnesota Board of Nursing Actions by Type of Resolved Complaint, Fiscal Years 2009 through 2014

Type of Complaint	Number of Complaints Resolved	Type of Action Taken		
		Dismissal	Disciplinary	Nondisciplinary
Practice	3,499	82%	12%	6%
Drugs, alcohol, health	2,003	36	57	8
Criminal convictions	1,049	92	8	1
Misrepresentation/ noncooperation	1,405	66	33	1
Action in other states	1,273	94	6	<1
Abuse/neglect	627	87	11	2
Unprofessional behavior	497	65	29	6
Other	532	45	55	<1
No grounds listed	518	99	1	0
Total	11,403	73%	24%	4%

NOTE: Percentages may not total 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing complaint data.

Dismissals

As discussed previously, the Minnesota Board of Nursing automatically dismisses complaints that: (1) do not involve a nurse (in these cases the board refers the complaint to the proper authority), (2) do not allege a violation of the *Nurse Practice Act*, or (3) involve a nurse not registered to work in Minnesota. The board can also dismiss complaints that are within its jurisdiction if they: (1) are determined to be unfounded after board investigation or (2) have already been addressed by the nurse or employer or do not rise to the level of requiring board action. Finally, the board can also dismiss complaints that are too vague, incomplete, or too general to investigate.

In fiscal year 2014, nearly three-fourths of the actions taken by the Minnesota Board of Nursing to resolve complaints were dismissals.

Of the 1,781 complaint resolutions the board made in fiscal year 2014, about 72 percent were dismissals. When a complaint is dismissed, it does not appear on the nurse's public record. The complainant and the nurse are the only persons informed of the complaint and its outcome. The board keeps all complaints indefinitely. It may reopen a dismissed complaint if it receives new information about the complaint or if a new complaint is filed that shows a pattern of behavior.⁶²

⁶² *Minnesota Statutes* 2014, 214.104, subd. 8(b).

Disciplinary Actions

As shown earlier in Exhibit 1.3, state law gives the Minnesota Board of Nursing the authority to impose a wide range of disciplinary actions on nurses.⁶³ Exhibit 1.9 shows the types of disciplinary actions imposed by the board in fiscal years 2009 through 2014. The board can and does respond to individual complaints with more than one form of discipline—for example, imposing civil penalties and placing conditions on a license.

Exhibit 1.9: Types of Disciplinary Actions Imposed by the Minnesota Board of Nursing, Fiscal Years 2009 through 2014

	Percentage of Disciplinary Actions					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Nurse Removed from Practice						
Suspension	31%	30%	39%	36%	33%	43%
Suspension for tax or child support	3	8	11	13	16	13
Voluntary surrender	11	10	10	8	10	7
Revocation	<u>4</u>	<u>4</u>	<u>2</u>	<u>2</u>	<u>1</u>	<u>2</u>
Subtotal	49%	52%	62%	59%	60%	65%
Nurse Not Removed from Practice						
Conditions	23%	25%	21%	20%	23%	25%
Civil penalty	21	21	23	18	15	15
Stayed suspension	12	14	15	13	15	17
Reprimand	11	11	9	11	7	9
Disciplinary referral to HPSP	17	13	8	7	9	3
Limitations	8	8	7	9	11	9
Other	2	3	1	4	2	1

NOTE: Percentages do not total 100 percent due to the way the Minnesota Board of Nursing categorizes disciplinary actions taken.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing complaint data.

Over the last several years, the board has generally imposed disciplinary actions through *Stipulation and Consent Orders*. We estimated that about 90 percent of discipline imposed by the board is done through these mutual agreements. All disciplinary actions include findings of fact that support the board's decision. These actions are public information and remain so indefinitely.

There are three types of disciplinary actions the nursing board can take that remove nurses from practice: suspensions, revocations, and voluntary surrenders. For the most part, the board uses one of these three options when

⁶³ *Minnesota Statutes* 2014, 148.262.

nurses' continued practice places the public at risk.⁶⁴ Overall, 65 percent of disciplinary actions imposed by the board in fiscal year 2014 removed nurses from practice—up from 49 percent in 2009.

Since fiscal year 2009, the Minnesota Board of Nursing has imposed suspensions more frequently than any other form of discipline.

Suspensions were the most frequently used form of discipline that the board imposed in fiscal year 2014, comprising 43 percent of all disciplinary actions.⁶⁵ Compared to previous years, the board has increased its use of suspensions. For example, about 31 percent of disciplinary actions taken by the board in fiscal year 2009 were suspensions. When the board issues a suspension, the order outlines what actions the nurse must take to successfully petition for license reinstatement in order to practice again. For example, a suspension order due to a nurse's drug or alcohol use may require 12 months of sobriety, twice weekly attendance at Alcoholics Anonymous or similar types of meetings, and monthly sessions with a treatment provider.

The board uses revocations, the most stringent of its disciplinary options, only in cases where the public is most at risk of harm or where serious harm has occurred. To return to practice in Minnesota, the nurse has to retake the nursing exam and apply for relicensure. Nurses cannot petition for reinstatement until certain conditions have been met and generally not before a specified period of time has elapsed, such as five or ten years. As Exhibit 1.9 shows, revocations made up about 2 percent of disciplinary actions in fiscal year 2014, down from about 4 percent in 2009. According to the nursing board, once a license is revoked, subsequent relicensing is not anticipated.

Since fiscal year 2009, voluntary surrenders have comprised 7 to 11 percent of the board's disciplinary actions. The board may offer a voluntary surrender to nurses who have an illness or disability that affects their ability to practice safely, or nurses may agree to a voluntary surrender rather than go through the entire discipline process.

The remaining disciplinary options available to the board all allow nurses to continue to practice nursing. These include (1) placing conditions, limitations, and stays of suspensions on nurses' licenses, (2) imposing civil penalties, and (3) issuing reprimands.⁶⁶ Of these, the board used conditions and stayed suspensions most frequently in fiscal year 2014. Together, they comprised about 42 percent of disciplinary actions imposed by the board in that year.

⁶⁴ The board can also temporarily suspend nurses prior to a hearing. However, as we discuss in Chapter 2, temporary suspensions have been rarely issued.

⁶⁵ The board also imposed suspensions in another 13 percent of cases, but these were automatic suspensions for violating "social" laws—for example, not paying taxes or child support.

⁶⁶ The board makes disciplinary referrals to HPSP by placing conditions, limitations, or stays of suspension on nurses' licenses.

Nondisciplinary Actions

Nondisciplinary actions generally require that nurses do certain things; failing to do so can result in disciplinary action. They include some referrals to HPSP, which are considered not-public information, and *Stipulations to Cease Practicing* and *Agreements for Corrective Action*, both of which are public information.⁶⁷ Two board members must approve all nondisciplinary actions.

Over the last several years, the Minnesota Board of Nursing has imposed few nondisciplinary actions on nurses when resolving complaints.

Of the 1,781 complaint resolutions the board made in fiscal year 2014, slightly less than 5 percent resulted in some type of nondisciplinary action. Most frequently, the board referred nurses to HPSP for monitoring of a mental, physical, or chemical dependency problem. When the board makes a nondisciplinary referral to HPSP, the nurse is required to report to the program within a certain number of days. When the nurse enrolls in HPSP, the board is notified and the complaint is closed. If the referred nurse does not contact HPSP or fails to enroll in the program, HPSP notifies the board, and the board will reconsider the complaint.

Slightly less than 2 percent of complaint resolutions in fiscal year 2014 resulted in an *Agreement for Corrective Action*. Likewise, the nursing board resolved less than 1 percent of all complaints through *Stipulations to Cease Practicing*. Both documents are public information and available on the board's website indefinitely, with the latter also reported to national databanks.

⁶⁷ *Minnesota Statutes* 2014, 214.072 (a)(3). The board also issues stipulated monitoring plans for nurses infected with hepatitis B, hepatitis C, and human immunodeficiency virus. The names of the nurses are not public. These are nondisciplinary actions. We did not include these actions in our evaluation.

Chapter 2: Managing the Complaint Resolution Process

The Minnesota Board of Nursing receives nearly 2,000 complaints each year, the majority pertaining to the practice of nursing. This chapter examines whether the board’s complaint resolution process, which we described in Chapter 1, has resulted in timely, consistent, fair, and reasonable outcomes that are designed to protect public safety. The board’s process for resolving complaints is complex—partly because it is based on a philosophy that the circumstances surrounding each complaint be considered individually. Also, the board strives to resolve complaints in a manner that safeguards nurses’ due process rights, which can negatively affect other important aspects of the resolution process, such as timeliness.

Overall, we found the decisions that the board has reached in resolving complaints against nurses to be reasonable, and they have afforded the public a high degree of protection. Board decisions to either dismiss or impose disciplinary or other actions on nurses have usually been appropriate given the nurses’ violations or offenses. At the same time, it has taken the Minnesota Board of Nursing too long to resolve some complaints where the public could be at risk. In addition, we found problems with the consistency of board decisions and the fairness of the board’s complaint resolution process.

TIMELINESS

In this section, we review how long the Minnesota Board of Nursing has taken to resolve complaints. We compare the board’s complaint resolution times to standards established in law and board policy, examine the extent to which the board quickly responds to serious complaints, and look at board processes that affect timeliness.

Time-to-Resolution

Statutes require that the board resolve complaints within one year of their receipt, unless doing so would be unreasonable and not in the public interest.¹ Board policy further aims to have complaints that it codes as “fast track” resolved within six months of receipt.² Complaints coded fast track are those deemed most serious by the board, those requiring automatic suspension by statute for tax or child support delinquencies or certain court orders, and those involving applicants for licensure and reregistration.

¹ *Minnesota Statutes* 2014, 214.103, subd. 1a(e).

² Minnesota Board of Nursing, *Complaint Handling Procedures and Coding* (Minneapolis, August 2, 2012).

The Minnesota Board of Nursing has generally resolved complaints within prescribed timeframes, but it has not always acted quickly enough when public safety is at risk.

Exhibit 2.1 shows the average number of days for the nursing board to resolve complaints in fiscal years 2009 through 2014. While average resolution times have fluctuated widely over the last several years, it took the board, on average, 135 days to resolve complaints in fiscal year 2014. Dismissed complaints averaged 107 days, and complaints resolved through disciplinary or other actions averaged 218 days.³

Exhibit 2.1: Average Number of Days to the Minnesota Board of Nursing's First Action on Complaints, Fiscal Years 2009 through 2014

Type of Action	Average Number of Days					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Dismissal	162	144	111	192	197	107
Nondismissal ^a	327	283	221	235	226	218
Total	206	189	139	201	204	135

NOTES: We excluded complaints related to tax and child support delinquencies from this analysis. Because state law requires the Minnesota Board of Nursing to automatically suspend nurses who fail to pay taxes or child support, these complaints should take almost no time to resolve. We calculated averages based on the fiscal year the action was taken, not the fiscal year in which the complaint was filed.

^a Nondismissals are complaints resolved through nondisciplinary or disciplinary actions.

SOURCE: Office of Legislative Auditor, analysis of Minnesota Board of Nursing data.

While statutes require that all complaints be resolved within a year, it is important for the board to act quickly in cases where the public could be at risk. As shown in Exhibit 2.2, compared to fiscal year 2009, the board increased the percentage of complaints resolved through disciplinary or nondisciplinary actions within a year of receipt. The vast majority of complaints were resolved within a year in all years between 2011 through 2014, and the board has steadily reduced the percentage taking over a year to resolve. Nevertheless, in 2014, the board took longer than a year to resolve 15 percent of complaints that were not dismissed.⁴

³ These figures exclude automatic child support and tax suspensions because those suspensions take virtually no time to resolve and are automatically issued. Average times for complaint resolution, including automatic suspensions, were 132 days for all complaints, 107 days for dismissals, and 198 days for nondisciplinary and disciplinary actions in fiscal year 2014.

⁴ These figures also exclude automatic child support and tax suspensions.

Exhibit 2.2: Minnesota Board of Nursing Time-to-Resolution for Complaints Resolved through Nondisciplinary or Disciplinary Actions, Fiscal Years 2009 through 2014

Time-to-Resolution ^a	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
2 months or less	11%	11%	15%	11%	13%	15%
More than 2 months through 6 months	32	34	42	42	36	39
More than 6 months through 1 year	20	24	26	26	35	31
More than 1 year through 1.5 years	18	18	8	15	11	10
More than 1.5 years through 2 years	9	11	5	4	4	3
More than 2 years	10	3	4	2	2	2

NOTES: We also refer to complaints resolved through nondisciplinary or disciplinary actions as nondismissals. We excluded complaints related to tax and child support delinquencies from this analysis. Percentages may not total 100 percent due to rounding.

^a Time categories are less than 60 days; 61 through 182 days; 183 through 365 days; 366 through 547 days; 548 through 730 days; and more than 730 days.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing data.

Board policy requires complaints coded fast track to be resolved within six months.⁵ While fast track complaints include the most serious complaints, those complaints are very rare. Most complaints coded fast track are not any more serious than other complaints, but they must be expedited for administrative reasons or because they require automatic suspensions for child support or tax delinquency.⁶ Average times for fast track complaints were within six months in all fiscal years from 2009 through 2014. Some fast track complaints were not resolved within the board policy of six months. Between 2009 through 2014, the board took longer than six months to resolve 16 percent of fast track complaints; 92 percent were resolved within one year.

We looked at whether the board acted in a timely way when there was evidence that a nurse's continued practice could constitute a serious risk of harm to the public. Since 1989, the board has had authority under the *Nurse Practice Act* to issue a temporary suspension when there is probable cause to believe the nurse violated the act and "continued practice by the nurse would create a serious risk of harm to others."⁷ Under this provision, the board must hold a hearing within 30 days of issuing the suspension.

⁵ Minnesota Board of Nursing, *Complaint Handling Procedures and Coding*.

⁶ As previously discussed, fast track complaints also include those involving applicants for licensure and reregistration.

⁷ *Laws of Minnesota* 1989, chapter 194, sec. 13; and *Minnesota Statutes* 2014, 148.262, subd. 3.

Although the Minnesota Board of Nursing has recently begun to issue more temporary suspensions, it has often taken the board too long to do so.

The Minnesota Board of Nursing issued temporary suspensions only 11 times in fiscal years 2009 through 2014, with 7 of the 11 temporary suspensions issued in 2014. However, the board issued temporary suspensions within four months of receiving a complaint in only 6 of the 11 cases. We read public orders and key documents in these 11 temporary suspension cases. In only one case did the board temporarily suspend a nurse within one month of receiving a complaint. Board staff told us that they do not issue a suspension until the Office of the Attorney General says the board has met evidentiary standards.

In some temporary suspension files we reviewed, it appeared the board had the evidence it needed early on and should have used its temporary suspension power more quickly. For example, in one case, a nurse admitted to Health Professionals Services Program (HPSP) staff that he had substituted saline for fentanyl and had been impaired at work. He was found ineligible for HPSP and reported to the board. Three months later, he admitted the allegations to the nursing board. Despite his tape-recorded admissions, the board did not temporarily suspend him for another five months, or about eight months after the initial complaint was filed. Board staff stated that the nurse seemed to be cooperating with the board, but after months of waiting for the nurse to sign a *Stipulation and Consent Order* for his suspension, the board eventually chose to use their temporary suspension authority.

The Minnesota Board of Nursing has not acted quickly enough to suspend nurses when public safety is at risk.

We also looked at the time to resolve cases where the nurses' actions were serious enough that the board issued a suspension. As shown in Exhibit 2.3, about half of the suspensions issued in fiscal year 2014 were issued within six months of receiving the complaint. In fiscal years 2009 through 2014, it took the board more than six months to issue suspensions in 37 to 57 percent of the complaints. On average, it took the board over 200 days to suspend nurses in each of these years.

Board staff told us that some complaints resulting in suspensions took much longer due to the contested case hearing process. We evaluated how long it took for the board to suspend nurses in cases where the board scheduled contested case pre-hearings or hearings. We measured the time required for the board to (1) schedule its first discipline conference and (2) issue a suspension after the first discipline conference in fiscal years 2009 through 2014.⁸ We found that, over the last several years, it took the board an average of 235 days to schedule the first discipline conference in these cases. It took an additional 267 days after the first scheduled discipline conference to finally impose a suspension. In 2014, it took an average of 201 days for the board to schedule its first discipline conference and an additional 197 days for the nurse to be suspended.

⁸ We looked at the first discipline conference scheduled, regardless of whether the nurse appeared at it. We could not specifically evaluate the time it took to hold a contested case pre-hearing or hearing or whether one was held because of missing or questionable board data.

Exhibit 2.3: Minnesota Board of Nursing Time-to-Resolution for Suspensions Issued, Fiscal Years 2009 through 2014

Time-to-Resolution ^a	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
2 months or less	6%	11%	16%	11%	12%	4%
More than 2 months through 6 months	37	37	42	51	45	49
More than 6 months through 1 year	23	19	19	18	25	21
More than 1 year through 1.5 years	18	20	13	14	10	16
More than 1.5 years through 2 years	4	12	6	4	7	6
More than 2 years	12	2	4	1	1	4
Average number of days	318	284	233	212	224	258

NOTES: These figures exclude tax, child support, and other automatic suspensions as well as removals of stays of suspensions and temporary suspensions. Percentages do not total 100 percent due to rounding.

^a Time categories are less than 60 days; 61 through 182 days; 183 through 365 days; 366 through 547 days; 548 through 730 days; and greater than 730 days.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing data.

We also used our review of a random sample of 214 board files to evaluate whether the board had information indicating that the public was at risk, yet took too long to issue suspensions. There were 22 complaint files in our sample that resulted in suspensions in fiscal years 2009 through 2014. In some cases, we were concerned about how long it took the board to suspend the nurses given the evidence it had in its file that the nurse presented an extraordinary risk to the public. In some files we reviewed, the board's internal process greatly contributed to delays, even in the cases that went on to a contested case hearing. We describe four of these cases in Exhibit 2.4.

When we asked the board about delays in processing some of these cases, they stated that sometimes protracted negotiations with the nurse contributed to the length of time it took to suspend. In some cases, the nurse agreed to a suspension, but did not sign the *Stipulation and Consent Order* in a timely way. Board staff stated that the state government shutdown in July 2011 as well as a threatened nurses' strike in 2010 (which resulted in a surge of nurses from other states applying for licensure) affected case resolution times in those years. Board staff acknowledged that some delays were unexplainable. For example, in several cases it took months to draft allegations so that a discipline conference could be scheduled.

Exhibit 2.4: Cases of Serious Risk to the Public Where the Minnesota Board of Nursing Did Not Act Quickly Enough

Days from Complaint Receipt to Board Action	Case Description
463	<p>Nurse was previously suspended for opiate and alcohol dependence and a number of practice issues. He successfully petitioned for reinstatement and was placed on a stay of suspension and required to participate in HPSP. After nearly 16 months of monitoring, he was discharged from HPSP for not notifying his case manager of new prescriptions for opiates, missing toxicology screens, and testing positive on toxicology screens. HPSP notified the board about the nurse's problems three times before discharging him, including that the nurse had been terminated from work after a physical altercation with, and injury of, a resident. He also threatened a coworker and was the subject of a number of patient complaints.</p> <p>It took five months to draft a notice to the nurse after the board received the allegations. Although he was under a stayed suspension, the Office of the Attorney General advised the board shortly before the case was to be considered by the full board that the nurse's waiver of his right to a contested case hearing may have been invalid. Consequently, the board could not unilaterally lift the stay and impose a suspension. The board did not suspend him until he defaulted at a contested case proceeding. The nurse was able to practice after discharge from HPSP monitoring for 13 months before he was suspended.</p>
602	<p>Nurse was fired for suspected diversion from two jobs a year apart. Both employers submitted complaints to the board. The nurse self enrolled in HPSP after his second termination. He told HPSP staff that he did not divert drugs. HPSP reported him to the board after a positive toxicology screen two months after enrollment. HPSP consulted with the board regarding discharge. HPSP case notes state, "Spoke with [staff] at the Board of Nursing...I explained that we had concerns about him working if we discharged him to the board, given his illness instability, financial situation, and desperation to make money.... We thought that we could continue to monitor to ensure safety while the board investigated and took necessary action. [Board staff] explained that they had the means to stop him from practicing if needed and felt comfortable with us discharging him." Nonetheless, the board did not take disciplinary action to remove the nurse from practice for another four months.</p> <p>The board did not take disciplinary action based on the employer complaints until after the HPSP discharge, although well over a year had elapsed since the first complaint. While seeking an agreement for a suspension, board staff learned that the nurse had moved to another state and applied for licensure there. After issuing the suspension, the board learned the nurse had also been charged with possession of narcotics (and pled guilty to a lesser charge) while it was processing the complaints.</p>
541	<p>Nurse substituted saline for a patient's morphine, leaving the patient in pain. The board received notice and evidence from the Department of Health supporting a finding of maltreatment for diverting drugs. The board had all employment records within six weeks of receiving the complaint, but did not send a <i>Notice of Conference</i> for another eight months. The nurse defaulted at the conference, but appeared later at the Office of Administrative Hearings. The board agreed to continue negotiating with the nurse in a discipline conference rather than proceeding to a contested case hearing. The board eventually suspended the nurse for a tax liability—541 days after receiving the diversion complaint. The board continued to process the diversion complaint after the nurse was suspended for her tax delinquency. Her final suspension for diverting drugs did not occur until 758 days after the complaint was received. During the 18 months she was able to practice after receipt of the complaint, she was charged with several thefts.</p>
343	<p>HPSP reported to the board that the nurse had requested pain medication from a doctor she worked with and secretly had multiple pain medication prescriptions from several different providers. Separately, the nursing board received two different complaints that the nurse had called prescriptions in under another nurse's name and committed other fraud to obtain prescriptions. Despite being discharged from HPSP after two months for lying to the program and abusing pain medication, the board took almost a year to suspend the nurse. The nurse's registration expired about five months after the board received the complaints. While the nurse could not work in Minnesota after her registration expired, during those months she could have applied for licensure in another state without a disciplinary action from Minnesota on her record.</p>

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing complaint data.

RECOMMENDATION

The Minnesota Board of Nursing should make greater use of its authority to temporarily suspend nurses' licenses when it determines that the public is at serious risk of harm, and it should suspend nurses in a more timely manner.

The Minnesota Board of Nursing has often acted too slowly to suspend nurses, especially when the board has received substantial documentation from other sources regarding nurses' public safety risks. We recognize that, given staff's limited authority to investigate complaints without convening a discipline conference, it may be difficult to gather enough evidence to impose a suspension in a timely manner. Other recommendations in this chapter could, if implemented, help the board move more swiftly and frequently to impose temporary suspensions.

RECOMMENDATION

The Legislature should clarify state law to allow the Minnesota Board of Nursing to continue to temporarily suspend nurses under the *Nurse Practice Act* rather than using legislation adopted in 2014.

Unlike some other health-related licensing boards, the nursing board has long had the authority to temporarily suspend a nurse's license prior to holding a hearing if his or her continued practice would create a serious risk of harm to others.⁹ In 2014, the Legislature extended this authority to all health-related licensing boards, including the nursing board.¹⁰ According to the Office of the Attorney General, the new law, which includes the nursing board, generally takes precedence over the law specifically directed at the nursing board. However, the new law is ambiguous in some respects.

A primary concern relates to language in the new law that requires the suspension be lifted if the nursing board has not issued a final order (or lifted the suspension) within 30 days. The new law is not clear what time period the 30 days covers. For example, the 30 days could start from the board or contested case hearing date, after an administrative law judge has issued his or her report, or from the date of suspension. The board's "old" law did not call for an automatic lifting of the temporary suspension after a set period of time, but rather unambiguously states that the temporary suspension remains in effect until the board stays the suspension, issues a final order after a hearing, or mutually settles the matter with the nurse. Thus, the board's "old" law potentially gave the board more time for issuing suspensions and holding hearings.

We think that it is important for the board to be able to act quickly in these cases. Staff told us that the health-related licensing boards will be asking the Legislature to clarify the new temporary suspension law in the 2015 legislative session. We agree that clarification is needed.

⁹ *Minnesota Statutes* 2014, 148.262, subd. 3.

¹⁰ *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 46.

Factors Affecting Timeliness

Over the last few years, the board has taken steps to resolve complaints more quickly. For example, in 2013, it initiated a “Kaizen” exercise to help streamline administrative practices.¹¹ Staff reported that one outcome of this process—scheduling closed board meetings on discipline cases every month rather than every other month—helped decrease resolution times. In the last several years, the board has also hired legal staff to do some legal drafting in-house rather than relying on the Office of the Attorney General for drafting of all notices required in the complaint resolution process.

Three factors have adversely affected the Minnesota Board of Nursing’s ability to resolve complaints in a timely manner: (1) expanded criminal background questions, (2) limited investigation authority, and (3) reliance on discipline conferences.

We discuss each of these problems in the following sections. Although we make recommendations below to address timeliness problems stemming from the nursing board’s limited authority to investigate complaints, other recommendations later in this chapter should help address the remaining two factors.

Expanded Criminal Background Questions

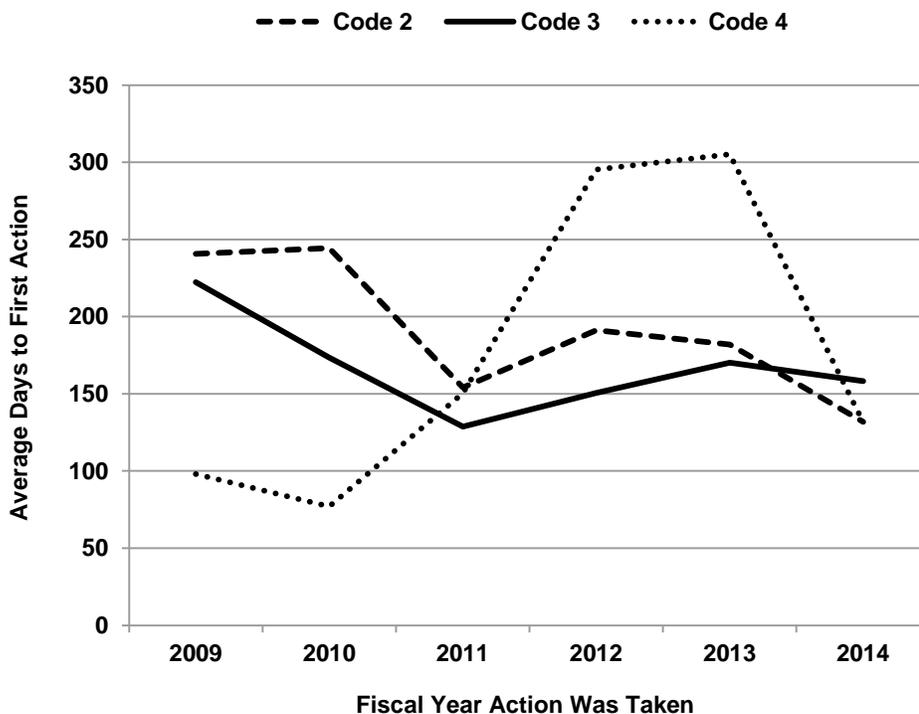
As shown earlier in Exhibit 2.1, complaints resolved in fiscal year 2014 have taken less time, on average, than those resolved in 2009, but about the same amount of time as complaints resolved in 2011. A major reason for the variation in resolution times since 2011 was the board’s 2010 decision to change its licensure forms to ask new and renewing nurses whether they had *ever been convicted of any crime*. Previously, the board only asked if they had *been convicted of a felony or gross misdemeanor in the previous five years*.

Because the board triages complaints as they come into the office, complaints involving minor criminal backgrounds, which generally resulted in dismissals, often took the board a long time to resolve in fiscal years 2012 and 2013. These longer dismissal times affected the overall resolution times of all complaints, including more serious complaints. As shown in Exhibit 2.5, the least serious (code 4) complaints resolved in fiscal years 2012 and 2013 showed a marked increase in resolution times. However, more serious complaints (codes 2 and 3) also showed a noticeable increase in resolution times during this period.¹² For example, complaints coded “serious” (code 2) took an average of 154 days in fiscal year 2011, but increased to 191 days and 182 days in 2012 and 2013.

¹¹ Kaizen is continuous improvement philosophy based partly on the belief that (1) good processes bring good results and (2) big results come from many small changes accumulated over time.

¹² Board policy directs staff to code complaints as extremely serious (code 1), serious (code 2), moderately serious (code 3), and not serious (code 4). We did not include code 1 complaints (extremely serious) in our analysis because staff rarely use this code. Seriousness codes are based on various factors: effect on patient, the nurse’s response to the incident, the number of alleged incidents, and the nurse’s intent (i.e., whether the nurse intended harm or if the action was accidental). Minnesota Board of Nursing, *Complaint Handling Procedures and Coding*.

Exhibit 2.5: Time-to-Resolution for Complaints by Seriousness Code, Fiscal Years 2009 through 2014



NOTES: Lower codes are designated as more serious than higher codes. Code 1 (extremely serious) was used only 12 times in fiscal years 2009 through 2014 and was, therefore, excluded from this exhibit. Code 2 represents complaints coded by the board as “serious.” Code 3 represents complaints that are “moderately serious,” and Code 4 represents complaints that are “not serious.”

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing data.

Limited Investigation Authority

As discussed earlier, statutes require that the Minnesota Board of Nursing forward complaints requiring investigation to the Office of the Attorney General. While statutes do not define what constitutes an investigation, the board has generally interpreted investigation to include fieldwork and interviews with complainants and nurses. The board limits its investigatory powers to those specifically laid out in law regarding subpoenaing records.¹³

As a result, staff do not conduct interviews or visit where an incident is alleged to have occurred. Some staff told us they could potentially conclude an investigation with a ten-minute phone interview, but they believe state law

¹³ *Minnesota Statutes* 2014, 214.103, subds. 2-3; and 148.191, subd. 2. Although the 2014 Legislature added language allowing the executive director to “authorize a field investigation to clarify the nature of the allegations and the facts that led to the complaint,” the extent to which the board can investigate a complaint—as opposed to simply clarify one—is unclear. *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 48, subd. 2.

prevents them from doing this. Instead, interviews with nurses and others are sometimes conducted by investigators from the Office of the Attorney General prior to the discipline conference.¹⁴ However, the board rarely uses them to look into complaints. In fiscal years 2009 through 2014, the board forwarded an average of 1 percent of complaints each year to the Office of the Attorney General for investigation.

Instead, for many of the complaints that require investigation, board staff use discipline conferences to interview nurses and learn about current employers and healthcare providers.¹⁵ In fiscal years 2009 through 2014, about 39 percent of the complaints that resulted in disciplinary or nondisciplinary actions were resolved through discipline conferences. At times, staff learn information at the conferences that requires them to do more investigation afterwards. For example, while statutes allow staff to subpoena a nurse's employment records, staff do not always learn about a nurse's current or former employers until the discipline conference. This, in turn, curtails staff's ability to subpoena employment records in a timely manner. At other times, staff learn information at the conference that, if known earlier, might have allowed them to dismiss a complaint without going through a discipline conference.

RECOMMENDATIONS

The Legislature should:

- **Clarify statutes to explicitly give Minnesota Board of Nursing staff greater authority to investigate complaints.**
 - **Amend statutes to give the Minnesota Board of Nursing access to the quarterly unemployment insurance reports employers are required to file with the Minnesota Department of Employment and Economic Development.**
-

Giving staff more investigative authority to investigate and resolve complaints is in keeping with National Council of State Boards of Nursing (NCSBN) guidelines for effective regulatory programs.¹⁶ These guidelines say that effective boards are able to hire their own investigators and attorneys and manage their work. Furthermore, investigatory staff are seen as integral parts of the complaint resolution process. Several other states have granted their regulatory agencies more authority than Minnesota to conduct investigations and resolve complaints. For example, investigatory staff in South Carolina's Department of Labor, Licensing, and Regulation (which regulates nursing along with 40 other occupations) issue subpoenas, collect records, and conduct interviews, which

¹⁴ *Minnesota Statutes* 2014, 214.04, subd. 1; 214.10, subd. 2; and 214.103, subd. 5. As discussed in Chapter 1, the board is required to use the Office of the Attorney General in cases involving sexual contact with a patient. Such complaints are relatively rare. *Minnesota Statutes* 2014, 214.10, subd. 8(a).

¹⁵ In addition to using discipline conferences to help investigate complaints, the board also uses them to educate nurses and discuss possible actions to resolve the complaints.

¹⁶ National Council of State Boards of Nursing, *Evidence-Based Regulation: A Regulatory Performance Measurement System* (Chicago: NCSBN, 2004), 29.

culminates in a written summary report submitted to the nursing board's complaint review panel. Furthermore, several Minnesota state agencies, including the departments of Human Services and Health, routinely interview individuals and visit sites as part of their complaint investigation processes.

Also, granting the nursing board access to Department of Employment and Economic Development (DEED) employment records would give the board more tools to protect the public in a timely manner. Acquiring information on nurses' work histories can be time consuming for board staff and often ends up being done at discipline conferences, which may be too late for staff to verify their accuracy. In addition, nurses do not always inform staff about their previous employers. Minnesota employers must file quarterly reports with DEED identifying their employees and the number of hours they worked. Although these records do not specifically identify whether a nurse has a nursing versus a nonnursing job, the data could be a useful tool for board staff.

Reliance on Discipline Conferences

In fiscal year 2014, complaints that resulted in disciplinary or nondisciplinary action took, on average, 99 days longer to resolve when the board held discipline conferences than when it did not.¹⁷ While the discipline conference process affects the timeliness of complaint resolution, the board is hesitant to make agreements on discipline without using a conference. In the past, the board resolved more discipline cases by agreements through the mail without holding discipline conferences. However, the Office of the Attorney General advised the board that doing so could circumvent nurses' due process rights. Consequently, the nursing board began using discipline conferences more frequently to ensure that nurses have some type of hearing. The board used discipline conferences to resolve 31 percent of complaints resulting in discipline and nondisciplinary actions in fiscal year 2009; that figure rose to 42 percent in 2014.

Four procedural protections built into the discipline conference process affect how quickly the Minnesota Board of Nursing can schedule discipline conferences. First, the board must inform nurses about the allegations against them. The board does this in a *Notice of Conference* that staff cannot draft until they review nurses' records. Second, the board must give nurses adequate notice of their conference date.¹⁸ Third, the board allows nurses an opportunity to be heard in the discipline conference. As a result, if nurses or their attorneys make reasonable requests to reschedule a conference, the board generally accommodates those requests. Lastly, nurses have a right to a hearing before impartial adjudicators. Although infrequent, board members sometimes discover

¹⁷ One might expect the most serious complaints to be heard in discipline conferences. We could not systematically review whether complaints that resulted in disciplinary or nondisciplinary actions and were reviewed in a discipline conference were more serious than complaints in which actions were imposed without a discipline conference. However, based on our observations of discipline conferences, the seriousness of complaints reviewed in conferences varied greatly. For example, several conferences we attended dealt with nurses not disclosing minor criminal convictions. Other conferences we attended involved complaints alleging serious patient harm.

¹⁸ While there is no set amount of time established as "adequate" notice, the Office of the Attorney General and the nursing board have decided that nurses should be notified about 30 days before the date of their discipline conferences.

they have a conflict of interest (for example, they work at the same facility as the nurse appearing before them) and must cancel a scheduled appearance. Board staff may have to reschedule the conference if they cannot find another board member to sit on the review panel.

The board generally schedules five discipline conferences per day, three to four days per week. It cannot schedule concurrent conferences or more conferences each week for two main reasons. First, board members have limited availability to serve on conference review panels. Second, considerable staff time is required to prepare conference notices and materials.

Besides using discipline conferences to protect nurses' due process rights, the board also uses discipline conferences to settle cases and avoid lengthy and costly contested case hearings. However, reaching settlements with nurses can take a long time for a variety of reasons. In our file review, some of the longest cases to resolve were those where it took many months to negotiate agreements with the nurse and where nurses did not promptly sign the agreements they made. The full board also sometimes rejects a settlement. Nurses are generally able to practice without restriction while settlements are negotiated and before the full board approves the final outcomes.

CONSISTENCY

Consistency means that similar complaints are treated similarly. Minnesota Board of Nursing policy establishes consistency as a principle guiding its complaint resolution process.¹⁹ To measure consistency of complaint outcomes, we analyzed board data on review panel recommendations, interviewed board members and staff, observed discipline conferences, and examined a random sample of nursing board complaint files.

Board Members' Effect on Consistency

In practice, the Minnesota Board of Nursing's complaint review panels are the de facto decision makers in disciplinary cases. In the board meetings we attended, there was very little deliberation or disagreement with review panel recommendations. Over the last year, the board has accepted review panel recommendations over 95 percent of the time. Furthermore, cases are generally decided through a consent agenda, with little consideration of individual cases. There is also little, if any, questioning of review panel recommendations or of nurses during full board hearings. However, panel decisions are made by only one board member who may or may not be a nurse.

¹⁹ Minnesota Board of Nursing, *Complaint Resolution Philosophy* (Minneapolis, August 2, 2012).

Because board members serving on review panels are the de facto decision makers in resolving complaints, we looked at the consistency of review panel recommendations. In looking at the board's data overall, we noted a marked difference in review panel recommendations to dismiss complaints, depending on whether panel members were public or professional members of the board. To explore this further, we used logistic regression to analyze the likelihood of a review panel recommending to dismiss a complaint based on whether a public or professional board member was on the panel.²⁰ If review panels are consistent, a nurse's likelihood of being disciplined should be independent of which board member happened to be serving on his or her review panel. We analyzed discipline review panel recommendations from fiscal years 2009 through 2014.

Nurses were more likely to have complaints against them dismissed when professional members of the Minnesota Board of Nursing served on their discipline review panels.

Over the last several years, the Minnesota Board of Nursing's review panel decisions have not always been consistent, with public board members less likely to dismiss complaints than professional members. After controlling for different factors, including types of cases more likely to be reviewed by public or professional board members, we found that the odds of having a complaint dismissed were 41 percent higher when a professional member served on the review panel than when a public member served on the panel.²¹

Some board members and staff told us that professional members, because of their knowledge about what nursing entails, may have a better understanding of nurses' actions. Public members may, on the other hand, tend to focus more on the experience of the patient and risk to the general public.

RECOMMENDATION

The Minnesota Board of Nursing should require that an additional board member review and approve discipline review panel recommendations before they are sent to the full board for final action.

As noted in Chapter 1, state policy requires that health-related licensing boards composed of both professional and public members regulate their professions. Ideally, review panels should consist of more than one board member. Unlike the nursing board, several other Minnesota health-related licensing boards use semi-permanent complaint review panels to hear complaints and propose settlements. These panels generally consist of two to three board members, including at least one professional and one public member who serve in this

²⁰ We analyzed dismissals to ensure that we had enough cases in our statistical model. There were not enough cases to evaluate differences among board members' use of each specific disciplinary or nondisciplinary action.

²¹ We controlled for several variables: the seriousness of the complaint; whether it involved practice-related issues, a criminal conviction, drugs, alcohol, or other health problems, or whether the panel considered multiple complaints at the time. We also controlled for whether the nurse was represented by an attorney or had been the subject of previous complaints to the board.

function for at least a year. For example, the Minnesota Board of Medical Practice has two complaint review committees, each consisting of two board member physicians and one public member. Committee members are appointed to one-year terms. The Minnesota Board of Physical Therapy also uses a semi-permanent complaint review committee comprised of one public and two professional board members to hear complaints and make recommendations for the full board's consideration.

Given that the nursing board's discipline panels are the de facto decision makers, we think that panel decisions should be the product of at least two board members—one nurse member and one public member. While using two board members on review panels is likely "best practice," the sheer volume of complaints heard in the board's discipline conferences prevents it from having more than one board member on a review panel. We think the next best option would be for another board member to independently review and approve the discipline review panel's recommendation before sending it on to the full board. This "second" board member would not need to attend the discipline conference, but review the record.²² Because discipline conference materials are electronically available to board members, the second member would not have to travel to the board's office to do this. Further, professional board members (nurses) should review the recommendations from panels made up of public members and vice versa. If the two board members disagree with one another regarding the review panel's recommendation, the full board should review the complaint.

Taken alone, this recommendation may increase the workload of individual board members. However, other recommendations that we make throughout this chapter, such as giving staff more responsibility to dismiss complaints and propose settlements, may reduce the amount of time individual members must spend on board activities and reduce the use of discipline conferences to resolve complaints.

Types of Complaints

We also used our file review, observations of discipline conferences, and interviews with board staff and members and nurses' attorneys to determine whether the nursing board has acted consistently in resolving the different types of complaints it has received.

The Minnesota Board of Nursing's actions to resolve practice-related complaints, while reasonably related to the nurses' violations, have not always been consistent.

In complaints involving practice problems, we observed that the nursing board sometimes used lower-level penalties (such as administrative *Agreements for Corrective Action* or disciplinary actions such as imposing conditions,

²² The Minnesota Board of Nursing should also electronically make available its recordings of discipline conferences so the "second" board member could review them, if necessary. Because review of these conferences could be time consuming, we would expect the board to compensate members for their time reviewing and approving review panel decisions.

limitations, or civil penalties) interchangeably.²³ In some cases, we could not determine why the board dismissed some complaints but imposed administrative or disciplinary actions in others. For example, in reviewing board files, we read allegations of nurses violating the *Health Insurance Portability and Accountability Act* (HIPAA).²⁴ In one file, a nurse accessed her nephew's medical records for no medical purpose. In another file, a nurse accessed her friend's child's medical records in violation of HIPAA. The board dismissed one complaint, but issued an *Agreement for Corrective Action* in the other. Although neither of these actions involves discipline, the *Agreement for Corrective Action* is public information and posted on the nurse's public record forever.

In our file review of complaints resolved in fiscal years 2009 through 2014 and our observations of discipline conferences, we also evaluated whether complaint outcomes seemed reasonable based on the nurses' actions and culpability. Despite inconsistency in practice-related outcomes, we did not find any case where the action imposed by the board seemed grossly disproportionate (that is, either too lenient or too strict) to the act committed. Furthermore, although some board actions were inconsistent, the individual outcomes were reasonably related to the basis of the complaint.²⁵

The Minnesota Board of Nursing has been highly consistent in resolving complaints alleging drug diversion.

While we found that practice-related complaints were sometimes resolved inconsistently, the board was highly consistent in imposing suspensions in complaints related to drug diversion. In reviewing files and observing conferences, we learned that, when the board has clear evidence of diversion (for example, when the nurse has admitted diverting drugs), it will suspend the nurse and require at least one year of abstinence before the nurse can return to practice. Staff and board members we spoke with confirmed that it is the board's unofficial policy to suspend nurses, generally for a year, when they divert drugs. Board staff told us that they also consider aggravating and mitigating circumstances. For example, in complaints alleging diversion, staff will consider the quantity of drugs diverted, the timespan of the diversion, whether the nurse was impaired at work, and patient harm, among others.

²³ See Exhibit 1.3 in Chapter 1 where we define possible actions the board may take in response to a complaint.

²⁴ The federal *Health Insurance Portability and Accountability Act of 1996* guarantees, in part, privacy of medical records from individuals with no medical purpose for viewing them. Pub. L. No. 104-191, 110 Stat. 1936.

²⁵ We discuss the overall reasonableness of complaint outcomes at the end of this chapter.

In our review of a random sample of 214 nursing board files from fiscal years 2009 through 2014, 24 complaints alleged drug diversion.²⁶ In 13 of these cases, the board had clear evidence of diversion, mostly because the nurses admitted doing so. Twelve of these 13 cases resulted in a suspension.²⁷

In the remaining 11 cases, the board did not have sufficient evidence to impose discipline for diversion. Some allegations were false or appeared to be diversion when in actuality the nurse had problems documenting drugs correctly. Others were suggestive of diversion but could not be proven. In such cases, the board imposed conditions and limitations on the nurses or referred them to HPSP for monitoring. Some of these nurses were later suspended when they did not comply with conditions imposed on their licenses or were noncompliant with HPSP requirements.

Board Tools to Assure Consistency

One way to help ensure consistency is to use policies, procedures, guidelines, or administrative rules to help structure the decision-making process. Attorneys from the Office of the Attorney General have consistently advised all health-related licensing boards that they must promulgate administrative rules rather than develop guidelines for handling complaints.²⁸

The Minnesota Board of Nursing has not adopted or implemented clear policies, guidelines, or administrative rules to help ensure consistency in resolving complaints.

Although the board has a policy regarding its complaint resolution philosophy, it does not give any practical guidance on how to consistently resolve any given type of complaint.²⁹ With the exception of civil penalties, the board generally does not list factors to consider when deciding whether to dismiss a complaint or what type of disciplinary or nondisciplinary action to impose.

²⁶ We used our file review rather than board data to evaluate consistency in these cases because the board's code for diversion is very limited. The code does not track whether there was direct patient harm, whether the nurse documented falsely in patient charts, stole from "waste," adulterated medication, or denied patients medication. In addition, board staff do not consistently update codes when new information comes to light during an investigation.

²⁷ The one complaint involving admitted diversion that did not result in suspension was not a straightforward diversion complaint. That case involved a nurse who was discharged from HPSP, although she was not enrolled in the program because of her diversion. While in HPSP, she told the program that she had diverted medication in another state in the past. Upon receiving a complaint from HPSP discharging the nurse, the board issued the nurse a stayed suspension and referred her back to the program. However, the nurse's license was suspended one month later for violating the stay of suspension.

²⁸ Administrative rules have the force and effect of law, while guidelines do not. In addition, the rulemaking process offers people and organizations affected by the rules opportunities to participate in their formulation.

²⁹ Minnesota Board of Nursing, *Complaint Resolution Philosophy*.

While the board has developed guidelines for issuing civil penalties, the guidelines are too vague to be useful in consistently setting fine amounts.³⁰ For example, the policy states a civil penalty of “up to \$5,000” should be issued in moderately serious cases, including sleeping at work, boundary violations, accessing pornography at work, and other violations. Board members are also asked to consider several factors in deciding how much of a civil penalty to impose, including patterns of at-risk behavior and the degree of the nurses’ insight into their behavior. But the Office of the Attorney General has, at times, discouraged the board from using its civil penalty policy.³¹ Over the last several years, the board has levied few civil penalties against nurses. In fiscal year 2014, about 15 percent of disciplinary actions taken by the board included civil penalties. While other board actions are much more common, the board does not have guidelines or rules for imposing other types of disciplinary or administrative actions.

As we showed in Chapter 1, the largest category of complaints reported to the board involves practice problems. In dealing with this type of complaint, the Minnesota Board of Nursing has adopted the principles of “Just Culture” into board policy.³² Just Culture seeks to distinguish among human error, at-risk behavior, and intentional reckless behavior. The principle seeks to avoid disciplining nurses when institutional failures or other factors outside of nurses’ control caused *Nurse Practice Act* violations or patient harm. Just Culture requires nursing boards to evaluate the culpability of the nurse when problems occur and avoid discipline when errors were unavoidable.

The board’s discipline conference room includes a resource binder with a structured decision-making tool based on the principles of Just Culture. However, when we observed discipline conferences, we saw this tool used only once. Board members and staff stated that board members had different levels of familiarity with Just Culture principles as well as different levels of agreement with its principles. Some also stated that the tool was of limited use in resolving many types of complaints.

We attended nearly 40 discipline conferences. We felt that, in several of the conferences we attended, resolution would be more efficient and consistent if the board had some tools or guidance to help resolve complaints. In particular, we attended several discipline conferences where at least some of the alleged violations involved nurses not disclosing their criminal backgrounds. For

³⁰ Minnesota Board of Nursing, *Guidelines for Assessment of Civil Penalties* (Minneapolis, February 3, 2011).

³¹ For example, in one discipline conference we attended, the assistant attorney general advised the board member on the panel that she or he could not actually use the civil penalty guidelines, but could levy any penalty from \$1 to \$10,000 for the violation, based on statutes regarding unpromulgated rules.

³² Minnesota Board of Nursing, *Complaint Resolution Philosophy*.

example, in one conference, the nurse had failed to disclose two convictions for failing to pay for gas.³³

In some cases, board members have wanted to recommend a civil penalty for failing to disclose a criminal conviction. However, there was no meaningful guidance regarding how much of a civil penalty to impose. In addition, each nondisclosure case has been reviewed independently regarding whether the crime was directly related to nursing and whether the nurse had been rehabilitated. While this independent review is required in most cases by the *Criminal Rehabilitation Act*, the board panel has no guidance from any resource listing past board decisions in similar cases or any presumptions about whether discipline is merited for certain types of crimes.³⁴

The board has developed an unofficial list of factors to help it decide whether to open complaints based on criminal history—that is, whether the criminal history is within the board’s jurisdiction to act. Staff used the list when they were beginning to process the flood of criminal history complaints received after changing the initial licensure and renewal application questions in 2010. Although having a list of factors to consider may be helpful, simply identifying factors without additional detail cannot guarantee that persons with similar circumstances are treated similarly.³⁵

RECOMMENDATIONS

The Minnesota Board of Nursing should:

- **Develop policies, guidelines, or administrative rules to help members and staff determine what actions are generally appropriate for certain types of complaints.**
 - **Grant staff more authority to propose settlements in some cases instead of using discipline conferences.**
-

The Minnesota Board of Nursing needs to develop documents that describe violations of the *Nurse Practice Act* and the range of board actions appropriate for each. Guidelines or administrative rules are especially needed given the inconsistencies we found in handling practice-related complaints and the increased number of complaints the board will have to handle once it fully implements criminal background checks.

³³ When a nurse has been convicted of theft, the board will open a complaint to resolve the matter. *Minnesota Statutes* 2014, 214.10, subd. 2a.

³⁴ *Minnesota Statutes* 2014, 364.01-364.10.

³⁵ The board’s Discipline Resources Committee is developing guidelines to help the board as it implements criminal background checks required in *Minnesota Statutes* 2014, 214.075. Although statutes do not require the board to implement the checks until 2018, the board plans to do so in 2015.

The board has been discussing the advantages and disadvantages of having guidelines for criminal background checks within the past year, but has not yet developed any guidelines. While the individual review of circumstances in most cases is required by the *Criminal Rehabilitation Act*, we feel that the board could use guidelines or rules to: (1) guide board members in issuing civil penalties for nondisclosure of criminal background, (2) set forth presumptions for whether a crime is directly related to nursing, (3) list aggravating and mitigating circumstances to be considered, and (4) set forth probable disciplinary actions.

Several nursing boards in other states have adopted guidelines or matrices to help them decide appropriate sanctions for different types of violations. Furthermore, these and other related documents often are available not only to board members, but all nurses via the boards' websites. For example, the Texas Board of Nursing's disciplinary matrix chart identifies four levels or tiers of substance abuse violations, each with their respective sanctions.³⁶ The Wyoming Board of Nursing uses a simpler matrix that identifies various categories of violations (for example, abuse or neglect, substance abuse, and criminal convictions), the extent to which complaint allegations have been substantiated, and recommended actions, including whether the complaint should be heard by a disciplinary committee.³⁷ The California Board of Registered Nursing lists minimum and recommended sanctions for various violations identified in its *Nurse Practice Act*.³⁸

Using guidelines may also result in fewer discipline conferences, which adds considerable time to the board's complaint resolution process. Development of guidelines or rules will allow the board to delegate some types of cases to staff. Staff can use their expanded investigatory authority to investigate complaints outside of discipline conferences and to propose settlements to nurses and the board. For example, complaints that involve nurses not disclosing past criminal convictions on their applications and low-level practice issues that require remediation, such as taking a course or working under supervision, could be easily handled by staff based on guidelines developed by the board.

Nurses would still retain many protections of their due process rights in making agreements proposed by staff. If they so choose, nurses would still have the right to meet with a board review panel in a discipline conference or have a contested case hearing. Disciplinary actions would not become final until the full board gives its approval. As we will discuss later, staff must also assure that nurses understand the process, their rights, and the agreements they sign.

³⁶ Texas Board of Nursing, *Disciplinary Matrix Chart* (Austin, undated).

³⁷ Wyoming State Board of Nursing, *Discipline Decision Matrix* (Cheyenne, April 2013).

³⁸ State of California Board of Registered Nursing, *Recommended Guidelines for Disciplinary Orders and Conditions of Probation* (Sacramento, May 2003).

RECOMMENDATION

The Minnesota Board of Nursing should maintain an electronic log of its actions that lists the aggravating and mitigating circumstances in each case that led it to impose the action that it did.

We think the nursing board should maintain an electronic log to help board members walk through how board policies have been applied in individual cases. Complaint outcomes and the aggravating and mitigating circumstances that were considered should be public in order to give guidance to other nurses and board members.

Unlike the Minnesota Board of Nursing, nursing boards in some states identify circumstances that board members should consider when taking action on complaints. For example, Illinois state law identifies several aggravating factors that licensing boards must consider when imposing discipline, including the seriousness of the offense, presence of multiple offenses, prior disciplinary history, lack of contrition, and impact on the injured party.³⁹ The law also lists mitigating factors to be considered, including whether the conduct was self-reported, voluntary remedial action taken, and cooperation with the board.

RECOMMENDATION

The Minnesota Board of Nursing should meet at least annually to review and discuss “mock” complaints to help identify and sort out differences in how individual board members arrive at their recommendations for action.

According to NCSBN, nursing boards with the best outcomes in discipline have formal mechanisms in place to ensure consistency in applying disciplinary sanctions. The Minnesota Board of Nursing has implemented very few of NCSBN’s recommended practices to help ensure consistency. For example, the nursing board does not regularly review its enforcement practices to ensure consistency. Nor has it developed formal mechanisms to review proposed sanctions for consistency with previous actions for similar complaints. We also looked at how the nursing board compares with best practices for regulatory agencies developed by the Texas Sunset Advisory Commission.⁴⁰ As with NCSBN’s guidelines, the Minnesota Board of Nursing falls short of Texas’s best practices in terms of implementing mechanisms to help ensure consistency in imposing sanctions.

When we talked with the executive directors of other health-related licensing boards in Minnesota, some said they use “mock” cases as a training device to help sort out consistency problems among board members. For example, the Minnesota Board of Dentistry’s two semi-permanent complaint review

³⁹ *Illinois Civil Administrative Code* 2015, Title 20, sec. 2105-130.

⁴⁰ Texas Sunset Advisory Commission, *Sunset Occupational Licensing/Regulation Model* (Austin, January 18, 2014), 23-32.

committees meet jointly once a year to discuss common issues. During these sessions, dentistry board staff submit “mock” complaints that board members discuss with one another to help identify any consistency issues the board might have. Other state boards also told us that they use the mock complaint approach to help ensure that board members are applying sanctions consistently. We think the nursing board should include more mock cases as part of an ongoing training program for board members.

FAIRNESS

In this section, we discuss fairness issues associated with complaint resolutions. First, we discuss fairness in the board’s internal hearing process, particularly fairness issues associated with discipline conferences. Second, we discuss the lack of retirement options for nurses with illnesses or disabilities. Finally, we discuss data privacy issues.

The Internal Hearing Process

As discussed earlier, the Minnesota Board of Nursing seeks to avoid using contested case hearings and instead uses discipline conferences to reach mutual agreements with nurses regarding their discipline. The board has taken many steps to ensure nurses’ due process rights in the absence of a contested case hearing. While much of the board’s internal process and use of *Stipulation and Consent Orders* were upheld in a 2012 Minnesota Court of Appeals case, we believe that some elements of the internal hearing process that may be unfair to nurses could be remedied without major changes.⁴¹

Almost two-thirds of nurses attending discipline conferences do not have an attorney. In the absence of an attorney to explain and protect a nurse’s rights, it is important that the board ensures that its process is fair. In this section, we discuss the fairness of discipline conference practices and procedures. We specifically examine whether nurses understand the process and their rights.

Although Minnesota Board of Nursing’s discipline review panels are the de facto decision makers in its discipline conferences, the board has done little to help ensure that nurses understand the process.

Nurses scheduled for discipline conferences receive a *Notice of Conference* from the board that outlines the allegations against them and their rights in the discipline process. However, the notice is lengthy and overly legalistic. For example, the first paragraph begins by notifying the nurse of the time and place of the conference and states the conference is being held “to discuss activities alleged below that could affect the status of your license as a [nurse].” Only in section 7 of the notice, after several pages of additional information, is the nurse informed more specifically about the nature and purpose of the conference. Yet even this description is hard to understand:

⁴¹ In the Matter of Judnick, #A12-1673 (Minn. Ct. App. 2013).

*YOU ARE FURTHER NOTIFIED that you may choose to be, though you are not required to be, represented by an attorney at this conference, that the Review Panel will tape-record the conference, and that anything you say may be used as evidence against you should the matter proceed to a contested case proceeding at a later time. You are further notified that the conference is designed to permit the Panel to seek and clarify information, to provide you an opportunity to clarify possible misunderstanding, and to allow the Panel and you to seek resolution and remedy of an alleged problem without the necessity of instituting a contested case proceeding. Please allow a minimum of two hours for the conference.*⁴²

No part of the mailing sent to nurses clarifies what a “Review Panel” or “contested case proceeding” is. The board does not send any information about the disciplinary process or specific information about the possible disciplinary actions the board may take and their consequences. The board has information on its website, but the information can be hard to find and understand.

We asked staff and board members whether they thought nurses understood the *Notice of Conference*, the process, and their rights. They felt that many nurses did not understand or even read the entire notice. They reported that many nurses call the board asking for an explanation of what the notice means. In some of the discipline conferences we attended, it appeared that some nurses did not understand all of what the notice contained.

In the discipline conference itself, the assistant attorney general reads a statement regarding the investigative purpose of the conference and explains that the panel will offer a settlement. The assistant attorney general then asks if the nurse understands his or her rights and, if not represented by an attorney, the nurse is asked to waive his or her right to have an attorney present. In the conferences we observed, these notices were read very fast; some assistant attorneys general put little effort into reading the notice in a way that nurses could understand them. It appeared to us that many nurses did not understand the boilerplate statement. Staff and board members we interviewed agreed it is unlikely that many nurses could follow or understand the statement as it is read to them during the discipline conference.

We observed that nurses sometimes did not seem to understand that the review panel recommendation was not the final disposition of their case or that they could negotiate with the panel regarding its settlement offer. At the same time, review panels never asked nurses to accept or reject an agreement that day. The board always mailed the proposed agreements to nurses, which gave them an opportunity to carefully review the document before signing (or rejecting) it.

Discipline conferences do not offer nurses all the due process rights of a full hearing at OAH or in court. Because discipline conferences are considered part of the board’s investigation, state law prevents nurses from seeing the evidence

⁴² Minnesota Board of Nursing, *Notice of Conference with Board of Nursing Review Panel* (Minneapolis, undated).

against them, as the data are classified as active investigatory data.⁴³ We attended some discipline conferences where nurses disputed allegations, stating that they did not know where the board received its information. Although all employees have rights to their human resources file, the board sometimes receives information about nurses from other sources that may not be available to nurses. The nurses may not know the source or quality of this evidence, or whether the evidence would be admissible in a contested case hearing.

RECOMMENDATION

To improve transparency, the Minnesota Board of Nursing should use “plain” English in its communications and dealings with nurses during the complaint resolution process.

More specifically, the board should: (1) provide more information about the discipline conference process on its website and make it easier for nurses to find, (2) include a cover sheet with its *Notice of Conference* explaining the process in “plain” language, and (3) consistently use “plain” language during review panel conferences. This would be in keeping with Governor Dayton’s executive order issued in March 2014 requiring state agencies to use “plain” language when dealing with the public.⁴⁴

Practically speaking, the discipline conference is the only time nurses have to talk with staff or board members about their alleged behavior. The majority of nurses come to the conference without an attorney to help them understand the process. The board’s *Notice of Conferences* is not written in plain English. Most nurses have never had a complaint filed against them, and most have never appeared at a discipline conference. Although we observed that the review panels treated nurses with respect throughout the discipline hearing, the process can still be very intimidating.

Lack of Minnesota Board of Nursing guidelines or administrative rules related to the complaint resolution process and lack of access to past Office of Administrative Hearings’ findings can disadvantage nurses.

As we discussed previously, the board does not have official guidelines or administrative rules to help it make decisions (although it does have unofficial and informal guidelines for certain cases). We think the board’s lack of formal guidelines or administrative rules is unfairly disadvantageous to nurses. We observed during discipline conference deliberations that staff often shared with the board member what the full board would normally do and how factors should be considered. For example, in one diversion case we observed, the board member wanted to send the nurse to HPSP. During discipline conference deliberation, staff told the board member that normally the remedy in a diversion case was suspension and the fact that a nurse did not suffer from chronic pain

⁴³ *Minnesota Statutes* 2014, 13.41, subd. 4.

⁴⁴ Governor Mark Dayton, Executive Order 14-07, “Implementing Plain Language in the Executive Branch,” March 4, 2014.

was an aggravating factor.⁴⁵ However, nurses who are the subject of complaints do not have access to information on these informal guidelines and factors that inform discipline review panels' decisions.

In addition, board staff and members rely on their knowledge of complaints they have litigated at OAH to know what they can impose discipline for and what evidence is sufficient. However, OAH's findings, conclusions, and recommendations in nursing board discipline cases are classified as "not public." This can be disadvantageous to nurses because they have no access to past OAH decisions as they weigh whether to accept a review panel's settlement offer.⁴⁶

RECOMMENDATION

The Legislature should amend statutes to require the Minnesota Board of Nursing to classify Office of Administrative Hearings' findings and recommendations as public data after it has redacted information identifying specific nurses.

The Minnesota Department of Human Services makes documents related to its fair hearing appeals public information after redacting personal information about litigants. Furthermore, the department's fair hearings database is searchable online.

Retirement Due to Illness or Injury

Nurses who are too ill or disabled to practice safely or have a disability that prevents them from safely practicing may choose to voluntarily surrender their registration to practice. Voluntary surrender is a disciplinary action that must include findings of fact and is permanently on the nurse's public record.⁴⁷

The Minnesota Board of Nursing does not have an administrative tool that allows nurses to "retire" their licenses when an illness makes it impossible for them to practice safely.

Nurses can allow their authorization to work in Minnesota (their registration) lapse, but the board still considers them licensed, and they are licensed in the view of other states. Therefore, if the board becomes aware of a nurse who is unable to practice safely due to health concerns, the board uses the disciplinary process to take action against their license.

We read files and attended discipline conferences involving nurses who agreed that, due to illness or disability, they were unable to practice nursing safely.

⁴⁵ Nurses and their attorneys are asked to leave the room while the review panel deliberates. Also, staff do not record the panel's deliberations.

⁴⁶ While the board's final actions accepting or rejecting OAH findings are public, the board cannot publish facts that were not proven to be true when accepting an administrative law judge's decision. *John Doe, M.D. v. Minnesota State Board of Medical Examiners*, 435 N.W.2d 45 (Minn. 1989).

⁴⁷ The board does not discipline nurses who have an illness or a disability but demonstrate they are effectively managing their health conditions and do not pose a risk to the public.

Some nurses objected to having public discipline placed on their record simply because they were ill. For example, one nurse with a brain injury indicated to board members that she would have appreciated a little empathy from them and should have been asked to turn over her license in a gentler, less legal, manner, without having disciplinary action taken against her since she had done nothing wrong.

RECOMMENDATION

The Legislature should authorize the Minnesota Board of Nursing to grant emeritus status to nurses in good standing who wish to retain their licenses and titles, but voluntarily give up their right to practice.

We think the actions available to the board to help nurses who have an illness or disability retire from practice are unduly harsh and disrespectful. Staff and board members we spoke with as well as HPSP staff agreed that it would be preferable to allow some nurses to retire their licenses without placing a disciplinary action on their records.

Other health-related licensing boards in Minnesota grant emeritus status to some retiring licensees. For example, the boards of Chiropractic Examiners, Medical Practice, and Pharmacy grant emeritus status to licensees retiring in good standing. This allows licensees to retain their titles without being subject to disciplinary proceedings. Their public records do not indicate that their retirement was the result of disciplinary action.

Some other state boards of nursing issue emeritus licenses to retiring nurses. For example, in Arkansas, nurses in good standing who wish to retire for any length of time from nursing but retain the title of nurse can apply for a “retired nurse” license. A retired license can be renewed every two years as long as the nurse submits the necessary application and fee. Idaho also allows certain retiring nurses to obtain emeritus licenses. We think Minnesota should likewise have a nondisciplinary option for nurses retiring in good standing. We think the Minnesota Board of Nursing should determine the circumstances under which it could be used.

Data Privacy

When a nurse is disciplined or signs an *Agreement for Corrective Action* in Minnesota, that information becomes public data and remains so forever.

State law may be unduly harsh in making all disciplinary and certain nondisciplinary actions public information indefinitely.

Some advocates for nurses told us that nurses can have difficulty finding employment years after having signed an *Agreement for Corrective Action* and remediating their practice. In contrast to *Agreements for Corrective Action* (which are considered nondisciplinary actions), nondisciplinary referrals to HPSP

are not made public. Even in some cases of discipline, it may not serve a public safety purpose to keep all actions public forever.

The 2012 Legislature passed a law requiring all health-related licensing boards to post on their websites the name and address of licensees who have “any disciplinary or corrective action or restriction of privileges taken against their licenses.”⁴⁸ We found that the nursing board complies with this requirement. However, not all of the eight other health-licensing boards we spoke with post nondisciplinary actions on their website. For example, the Minnesota Board of Dentistry prefers to use the threat of public disclosure connected with discipline as an incentive to get licensees to sign nondisciplinary *Agreements for Corrective Action*. While the Minnesota Board of Podiatry posts board actions on its website, the public must pay a fee to view an individual license online.⁴⁹

RECOMMENDATION

The Legislature should give the Minnesota Board of Nursing the authority to develop administrative rules or guidelines for expunging certain actions from nurses’ public records after a given period of time has passed and no additional violations have occurred.

There are many good reasons for publicizing board actions against nurses (and other health professionals). For example, healthcare providers check the licensing status of nurses before hiring them. In addition, certain healthcare facilities licensed by the state must ensure that their staff are properly licensed to maintain their licenses. Finally, the public has a right to know the status of the nurses that help treat them. Having the information readily available online is an easy-to-use resource for all concerned.

Yet, we think state law is unduly harsh in making most administrative and all disciplinary actions available to the public for all time. Although statutes currently provide for the dismissal of complaints after nurses have completed the requirements outlined in their *Agreements for Corrective Action*, licensing records available to the public identify all corrective actions that nurses have entered into, no matter how old.⁵⁰

Unlike some other states, Minnesota does not have a system that expunges nurses’ licenses so that the public cannot see some actions taken against them.⁵¹ For example, state law allows the Kentucky Board of Nursing to determine

⁴⁸ *Laws of Minnesota* 2012, chapter 278, art. 2, sec. 24. This provision became effective July 1, 2013.

⁴⁹ According to the executive director, telephone callers can receive a verbal report on a podiatrist without paying a fee.

⁵⁰ *Minnesota Statutes* 2014, 214.103, subd. 6(a)(2). The 2014 Legislature amended state law to allow for the expungement of some criminal convictions from the public record. *Laws of Minnesota* 2014, chapter 246.

⁵¹ Expungement means that a nurse’s public record no longer lists certain actions, and the board cannot report the action for any purpose other than statistical. In effect, expungement keeps certain portions of a nurse’s license from public view; the expunged actions are still available to the nursing board.

whether certain actions should be expunged from nurses' public records.⁵² Upon written request from the nurse, the Kentucky nursing board can consider expunging the record when a nurse has met all conditions outlined in: (1) a consent decree at least five years old, (2) an order or decision at least ten years old that resulted in a reprimand, if there has been no subsequent disciplinary action, or (3) an agreed upon order or decision at least 20 years old, if there has been no subsequent disciplinary action.⁵³

Expunging nurses' public records in Minnesota would not affect the board's responsibility to report all disciplinary actions it takes to the *National Practitioners Data Bank*, as required in federal law.⁵⁴ While Minnesota's public record on some nurses would differ somewhat from the confidential data maintained in the national databank (which is not available to the general public), we think the benefits from expunging records under certain circumstances would outweigh any disadvantages. Furthermore, according to board staff, Minnesota Board of Nursing records, not national databanks, are the primary source that employers use to verify the licensure status of nurses.

REASONABLENESS

The previous sections have discussed the concerns we have with the timeliness and consistency of some board disciplinary decisions and the fairness of certain board processes. In this section, we look at the reasonableness of the nursing board's decisions in meeting the board's mission to protect public safety. First, we discuss whether the board's high dismissal rate impacts public safety. Next, we discuss the board's focus on public safety when it imposes disciplinary or nondisciplinary actions.

The Minnesota Board of Nursing's final complaint resolution decisions have been generally reasonable.

Board decisions to dismiss or take other actions to resolve complaints have been reasonable—that is, decisions have generally been appropriate given the nurses' violations or offenses. Complaint outcomes have adequately protected the public. The board has generally imposed its most serious actions—license suspension or revocation—in situations where the public has been at risk. If anything, the board has tended to err on the side of public safety in disciplining nurses.

⁵² *Kentucky Revised Statutes* 2014, 314.131 (1), (9).

⁵³ 201 *Kentucky Administrative Regulations* 2015, 20:410. The board may also expunge actions resulting from nonpayment of funds, practicing without a current license, and failing to complete continuing education requirements in a timely manner.

⁵⁴ *Patient Protection and Affordable Care Act of 2010*, Pub. L. No. 111-148, 124 Stat. 119.

Dismissal Rate

Public safety could be impacted by a board that dismisses too many complaints or dismisses them without sufficient review. As discussed in Chapter 1, the board has a high complaint dismissal rate.

The high complaint dismissal rate reported by the Minnesota Board of Nursing is misleading.

As discussed in Chapter 1, the vast majority of actions that the board has taken on complaints have been dismissals—72 percent in fiscal year 2014. However, this high rate of dismissal does not demonstrate that the board is failing to protect public safety or is unreasonable in its actions. For example, more than a quarter of all dismissals were done without the need for an investigation, mostly because the complaints (1) were duplicative, (2) were not violations of the *Nurse Practice Act* or did not make an allegation regarding a nurse, (3) did not include sufficient evidence to investigate, (4) did not involve nurses practicing in Minnesota, or (5) involved a minor incident for which the nurse or employer had already taken corrective action.

RECOMMENDATION

The Minnesota Board of Nursing should improve the accuracy and consistency of information in its complaint management database so that it can use the information to better report on and evaluate its complaint resolution process.

Throughout our evaluation, we noted problems with the board's complaint management database. These problems often resulted in (1) misleading information, such as the board's overall dismissal rate; (2) codes that do not contain sufficient information to be useful, such as its code that combines all drug and alcohol complaints into the same category; and (3) codes that are not updated throughout the complaint resolution process, such as the code for diversion. Overall, we think improvements in the board's data management system and how staff code information could help the board better assess its performance. Improvements could also result in the board providing more meaningful information to the Legislature and the general public.

Another problem contributing to the board's high dismissal rate is that the board has not issued any guidance for employers regarding their reporting of minor incidents. In our interviews with board staff, we learned that some employers routinely report all violations—no matter how small—to the board, regardless of whether the nurse or employer involved had already taken corrective action. Other employers do not do this. Not only can this be unfair to nurses, but reporting all minor incidents can clog the board's complaint resolution process, preventing it from focusing on more serious complaints. As we discussed in Chapter 1, the board receives, and ultimately dismisses, many complaints about violations that had already been addressed locally by nurses or employers.

RECOMMENDATION

The Minnesota Board of Nursing should adopt guidelines or administrative rules related to mandated reporters' reporting of minor incidents.

To help ensure that nursing boards are not inundated with complaints alleging minor violation of state laws, NCSBN's *Model Act* says that nursing boards should adopt rules related to mandated reporters' reporting of minor incidents.⁵⁵ Under certain circumstances—when a nurse's continuing practice does not pose a risk of harm and the minor incident in question can be addressed through corrective action by the nurse's employer—employers should not have to report the incident.

To help employers and other mandated reporters identify when practice issues must be reported to the board, the North Carolina Board of Nursing developed a complaint evaluation tool commonly referred to as CET.⁵⁶ This tool provides a framework through which employers, nursing leaders, and board members can consistently and justly analyze and evaluate clinical practice events and errors. The tool helps distinguish among practice issues resulting from human error, at-risk behavior, and reckless behavior. In addition, the Georgia Board of Nursing is currently developing rules and guidelines to help Georgia nurses and employers better understand their reporting requirements.

Overall, Minnesota Board of Nursing staff thoroughly review complaints before complaints are dismissed or actions imposed.

Although the majority of complaints are dismissed without convening a review panel, our file review showed that staff carefully reviewed these cases prior to dismissing them.⁵⁷ Staff examined records and other evidence and crafted inquiry letters specific to the issues at hand. Inquiry letters were also clearly reviewed and, at times, staff consulted with other staff prior to dismissing complaints. When a nurse's response to an inquiry letter did not address all of staff's concerns, the nurse would be scheduled for a discipline conference.

Minnesota Board of Nursing staff are diligent in assuring they have the whole picture when they evaluate complaints. They request and review voluminous records to ascertain whether a complaint is valid and whether there are any *Nurse Practice Act* violations not part of the complaint. Board staff also use their expertise as nurses to help them understand the circumstances surrounding complaints and to assist them in conducting discipline conference interviews.

⁵⁵ National Council of State Boards of Nursing, *NCSBN Model Act* (Chicago: NCSBN, 2012).

⁵⁶ North Carolina Board of Nursing, "*Just Culture*" in *Nursing Regulation Toolbox*, <http://www.ncbon.com/myfiles/downloads/cet-booklet.pdf>, accessed January 2, 2015.

⁵⁷ Two board members must also review and approve these dismissals.

Many board dismissals involve simple errors that nurses or their employers have already addressed and pose no future risk of harm to the public.⁵⁸ The board seeks to dismiss cases where nurse discipline would serve no public protection purpose. We saw many of these simple error cases in the files we reviewed, and we were comfortable that such dismissals did not negatively impact public safety. For example, in one case a nurse documented giving a patient medication prior to administering it, a common but erroneous practice. After ensuring the nurse understood the importance of proper documentation, the complaint was dismissed.

More complex issues may be dismissed after careful review by staff determines that the circumstances leading to the incident fell outside of the nurse's control. Some dismissals we reviewed involved serious incidents, but the board found that nurse discipline would serve no purpose or be unfair. For example, in one file we reviewed, a vulnerable adult died after leaving the assisted living facility where he resided in the winter. The board found that the facility's policy of allowing residents to routinely use an alarmed emergency exit and understaffing at the facility were the main contributors to the man's death. It would have been unfair and not protected public safety to discipline the nurse who could not check the door each time the alarm went off without neglecting other patients. At the time the resident left the facility, the nurse was handling another resident's very serious medical issue. The board dismissed the complaint.

Many complaints are also dismissed after review by staff and a board member in a discipline conference. Thirty-nine percent of complaints reviewed in discipline conferences between fiscal years 2009 through 2014 were dismissed.

RECOMMENDATION

The Legislature should amend statutes to give Minnesota Board of Nursing staff greater authority to dismiss some complaints without requiring the approval of two board members.

Allowing staff greater authority to dismiss complaints is in keeping with NCSBN's guidelines for effective regulatory agencies, which call for board staff to have the authority to resolve selected discipline cases without full board review.⁵⁹ We think board staff should be able to dismiss complaints without involving the expressed approval of board members, especially in cases where violations do not pose a serious risk to the public. Expanding staff's authority to investigate and dismiss complaints may also (1) decrease the time required to resolve complaints, (2) reduce the number of discipline conferences needed, and (3) reduce some of the workload and time required of board members. As we noted in Chapter 1, being an effective board member requires a huge commitment of time.

⁵⁸ Employers are not required to report these types of events, yet they frequently do. This contributes to the high number of complaints the nursing board receives and dismisses.

⁵⁹ National Council of State Boards of Nursing, *Evidence-Based Regulation*, 28.

Currently, two board members must review and approve all complaint dismissals.⁶⁰ One board member told us that reviewing dismissed complaints takes time from the other work board members could be doing, especially since members rarely disagree with staff decisions to dismiss. Given the quality of staff's investigations, we think this would be a logical move. To ensure that board members agree with actions taken by staff, the board could periodically review a random sample of staff actions.

Board Focus on Public Safety

The mission of the Minnesota Board of Nursing is to protect public safety. Any evaluation of the reasonableness of the board's actions must determine whether its disciplinary processes are appropriately focused on serving the board's mission.

Making information public is one way the board protects public safety. As we discussed in Chapter 1, all disciplinary actions are reported to national databanks that can only be accessed by certain regulatory agencies and healthcare providers. In addition, as required by state law, the board publishes most nondisciplinary and all disciplinary actions on its website, which is accessible to the general public.⁶¹

Attorneys who represent health professionals, including nurses, stated that, compared to other boards, the nursing board is stricter in disciplining licensees. In fiscal year 2014, 24 percent of the complaints that the board resolved resulted in disciplinary action. In comparison, about 9 percent of the complaints closed by the Minnesota Board of Medical Practice and about 14 percent of the complaints closed by the Minnesota Board of Dentistry resulted in some type of disciplinary action.⁶² Our impression in reviewing files was that the nursing board processed complaints with great concern for public safety. In reviewing individual complaint files and attending board meetings and discipline conferences, we found only one case where we thought a nurse needed remediation or discipline, but the board failed to act.⁶³

As we previously discussed, the board frequently suspends nurses when it determines the nurses' continued practice constitutes a risk to the public. This includes cases of diversion and nurses who are unable to complete HPSP monitoring for drug or alcohol dependence.

⁶⁰ State law requires that two board members review and approve all complaint dismissals. *Minnesota Statutes* 2014, 214.10, subd. 1.

⁶¹ *Minnesota Statutes* 2014, 214.072. This law excludes nondisciplinary referrals to HPSP.

⁶² Minnesota Health Licensing Boards, *Biennial Reports July 1, 2012 to June 30, 2014* (Minneapolis, 2015), 41 and 73. While Minnesota Board of Medical Practice data are for fiscal year 2014, Minnesota Board of Dentistry data are for the biennium.

⁶³ This case involved a failure to document a patient fall and an initial denial the fall occurred; it was unclear in the board file why the case was dismissed.

Few nurses return to practice after being suspended by the Minnesota Board of Nursing.

As we discussed in Chapter 1, suspension has been the most common disciplinary action taken by the board. Individuals who return from suspensions must petition the board for reinstatement and provide ample documentation of their ability to practice safely. We looked at nurses who were suspended in fiscal years 2003 and 2004 to see if they had returned to practice by the end of fiscal year 2014. Only 30 percent of the 110 nurses suspended in this timeframe returned to practice during the next 10 to 11 years.⁶⁴ Furthermore, less than a quarter of nurses who were removed from practice during 2003 and 2004 returned to work at some point by the end of fiscal year 2014.⁶⁵

Nurses must meet all requirements in their suspension orders prior to petitioning to return to practice. Most suspended nurses must meet with a review panel and show that they are safe to practice. The board reinstates almost all suspended nurses by issuing stayed suspensions or placing conditions or limitations on their licenses, such as being monitored at work. Any violation of the stays, conditions, or limitations can result in an immediate suspension and a streamlined and speedy board hearing process regarding the suspension.

We used the board's data to examine the extent to which suspended nurses were also subject to earlier board actions. It has been argued that the nursing board waits too long before suspending nurses—that is, the board has “let nurses off easy” before finally suspending them.

Most nurses suspended by the Minnesota Board of Nursing over the last six years had no previous disciplinary or nondisciplinary actions taken against them by the board.

Overall, we found that, of the 582 nurses the board suspended in fiscal years 2009 through 2014, 53 percent had no previous disciplinary or nondisciplinary actions imposed on them prior to their suspensions. While 24 percent of the nurses had one previous board action taken against them prior to being suspended, that previous action was a stay of a suspension for almost one-fourth of these nurses.

Five percent of nurses had four or more previous actions by the board before finally being suspended. We saw in our file review that the board sometimes did not have the evidence to suspend some nurses when it first received complaints. At times, however, the board reached agreements with nurses that allowed the board to monitor the nurses and impose conditions and limitations on their

⁶⁴ Due to data limitations, it was not possible to ascertain the extent to which the remaining nurses might have sought reinstatement—some may have chosen to quit nursing altogether. In addition, disciplinary actions taken by the board in 2003 and 2004 do not accurately reflect the board's current philosophy on suspensions. Because the board suspended fewer nurses in the early 2000s, they would have likely been more serious than some of the cases that result in suspensions today.

⁶⁵ There were 181 nurses who were removed from practice through stipulations to cease practicing, suspensions, revocations, and voluntary surrenders in fiscal years 2003 and 2004.

licenses. In some cases the board's monitoring of these nurses led to evidence that eventually supported suspending them.

The Minnesota Board of Nursing has tended to err on the side of public safety in imposing disciplinary actions, especially when complaints involved drug diversion.

The Minnesota Board of Nursing has erred on the side of caution by generally imposing at least 12-month suspensions in complaints involving theft of narcotics. Board staff told us that, in these cases, it is disciplining nurses not for their chemical dependency problem, but for theft, which is criminal behavior independent of the nurses' illness. But some advocates for nurses have complained that the nursing board errs too much on the side of public safety in disciplining nurses who suffer from chemical dependency. As we previously discussed, outcomes in cases involving nurses' theft of drugs from work are highly consistent, most often resulting in at least a one-year suspension with a requirement of one year of continuous sobriety. Some nurse advocates told us they felt that the board failed to consider individual circumstances in imposing these suspensions, that suspensions can be detrimental to nurses' recovery and return to practice, and that suspensions are unnecessary in situations where the nurse's theft of drugs did not harm patients. Advocates also pointed out that many nurses with addictions who divert are high-achievers with no nursing performance issues.

RECOMMENDATION

The Legislature should amend state law to allow nurses who have had their licenses suspended for substance abuse or other health-related problems to participate in the Health Professionals Services Program at their own expense without board referral.

We think that it could be advantageous to some suspended nurses to allow them to participate in HPSP while under suspension, but at their own cost. Currently, state law does not allow nurses under discipline to participate in HPSP unless specifically referred by the nursing board.⁶⁶ Although the board refers nurses to HPSP under discipline, it does not do so when that discipline is a suspension.

Allowing nurses to self refer while under suspension also makes sense because the board generally requires, as a condition of lifting its suspensions, one year of sobriety. The board also asks for evidence that nurses have participated in many of the activities typically called for in HPSP monitoring agreements.⁶⁷ Once nurses are reinstated, the board frequently requires them to participate in HPSP as a condition of regaining their license.

Although not able to practice, these nurses would be expected to abide by the conditions laid out in monitoring agreements, including attending treatment, taking random toxicology screens, and participating in chemical dependency and

⁶⁶ *Minnesota Statutes* 2014, 214.32, subd. 4(3).

⁶⁷ Chapter 3 discusses HPSP participation requirements in greater detail.

other support groups. At the same time, HPSP records for these nurses should be fully available to the nursing board. The program's monitoring provides high quality evidence of nurses' sobriety prior to their return to practice.

Some alternative programs that operate independent of their state boards of nursing, such as Georgia's program, allow nurses under suspension to enroll in their monitoring programs. These nurses are required to pay all treatment and monitoring costs.

RECOMMENDATION

The Minnesota Board of Nursing should consider, on an individual basis, referring nurses suspended for substance abuse or other health-related problems to the Health Professionals Services Program.

It makes good sense for the board to refer nurses under suspension to HPSP, when appropriate, rather than wait until they petition for reinstatement (often a year later). It would not place the public at risk, because the nurses would not be allowed to practice while in HPSP without the board first approving the nurses' reinstatement. Under these circumstances, we think the board should pay HPSP's monitoring costs, as the board currently does for all nurses that it refers to the program.

Chapter 3: Health Professionals Services Program

Health professionals have long recognized the need to address issues related to nurses with addiction problems. It is estimated that substance-use disorder—defined as the continued use of mood-altering, addictive substances despite adverse consequences—affects approximately 10 to 20 percent of nurses nationwide.¹ Perhaps more so than many other health professionals, nurses are susceptible to substance abuse by the very nature of the work they do. According to the research literature, workplace risk factors include easy access to controlled substances and a work environment where drugs are viewed as an acceptable way to promote healing or cope with problems.²

This chapter discusses Minnesota’s use of an alternative-to-discipline program, the Health Services Professionals Program (HPSP), to protect the public from nurses with substance abuse or other physical or mental problems. As we discussed in Chapter 1, one of the largest categories of complaints filed with the Minnesota Board of Nursing over the last several years has involved allegations of substance abuse or other health problems among nurses.

ALTERNATIVE-TO-DISCIPLINE PROGRAMS

It was not until the early 1980s that most states began investigating some type of “alternative-to-discipline” program for nurses—mainly for those with chemical dependency problems. The National Council of State Boards of Nursing (NCSBN) defines alternative-to-discipline programs as voluntary, nonpublic,³ nondisciplinary approaches that nursing boards can use in lieu of imposing traditional disciplinary actions.⁴ The programs are designed primarily for nurses

¹ For example, see National Council of State Boards of Nursing, *Substance Use Disorder in Nursing*, (Chicago: NCSBN, 2011), 1-3; “Substance Use Disorders and Accessing Alternative-to-Discipline Programs,” *Journal of Nursing*, vol. 3, issue 2 (July 2012): 16; “Treating Nurses and Student Nurses with Chemical Dependency: Revising Policy in the United States for the 21st Century,” *International Journal of Mental Health Addiction*, vol. 7 (2009): 530; and “Addressing Chemically Dependent Colleagues,” *Journal of Nursing Regulation*, vol. 2, issue 2 (July 2011): 10.

² For example, see “Substance Use Disorders and Accessing Alternative-to-Discipline Programs,” *Journal of Nursing Regulation*, vol. 3, issue 2 (July 2012): 17.

³ According to NCSBN, “nonpublic” means that participation in the program is not disclosed to the general public, but may be disclosed to nursing boards, treatment providers, and employers. Alternatively, some programs are “confidential,” which means that participation records are not shared with others without the consent of the licensee. National Council of State Boards of Nursing, *Substance Use Disorder in Nursing*, 3.

⁴ National Council of State Boards of Nursing, *Substance Use Disorder in Nursing*, 235. Many states also use alternative-to-discipline programs in combination with disciplinary actions. For example, nurses in Minnesota and Indiana, among others, can be referred to an alternative program as a nondisciplinary or disciplinary action.

suffering from substance abuse, but who do not pose a significant risk to the public. The programs' goals are to promote early intervention, diagnosis, and treatment of nurses before substance abuse affects their practice.

Alternative-to-discipline programs are monitoring programs designed primarily to protect the public, not treatment programs for nurses.

Alternative-to-discipline programs' main focus is public safety, not nurse rehabilitation or treatment. They are not treatment programs for nurses, such as the Nurse Professional Program at Hazelden Betty Ford Foundation in Center City, Minnesota, nor are they nurse support groups. At the same time, the alternative programs generally require that treatment and support components be built into nurses' recovery programs. To participate in alternative programs, nurses must generally sign monitoring agreements that lay out specific assessment, treatment, toxicology screening, supervision, and reporting requirements as well as worksite limitations. The alternative programs then monitor nurses' adherence to these agreements.

The nursing literature cites numerous advantages of alternative-to-discipline programs over traditional disciplinary methods. Perhaps most importantly, nurses can continue to practice if they comply with their monitoring agreements rather than have their licenses suspended or revoked. Also, alternative programs, because they are generally viewed as voluntary programs, can forgo the extensive investigation, documentation, and hearings processes characteristic of nursing board proceedings. Consequently, they may be able to remove nurses from practice more quickly than nursing boards, thereby offering a faster response to public safety concerns. Finally, allowing nurses to report themselves to alternative programs instead of their nursing boards may encourage them to proactively seek help for their problems, thereby protecting the public.

At the same time, alternative-to-discipline programs may have some disadvantages. For example, depending on how the alternative programs are designed, confidentiality aspects can appear overly protective of nurses and an unnecessary risk to public safety. Also, because alternative program staff may not be licensed nurses, they may be less able to detect nurse practice issues among participants than nursing board staff, which may put the public at risk. Finally, it is argued that few nurses voluntarily report themselves to alternative programs, and that most nurses who self report are doing so under pressure from others, particularly their employers. This is important because it may mean that nurses are not seeking help before they have problems with their practice.

At least 39 states, including Minnesota, have alternative-to-discipline programs for nurses, but programs vary regarding their administrative structures, participant confidentiality, and eligibility requirements.

Unlike Minnesota's approach, alternative-to-discipline programs in many other states are statutorily part of their state boards of nursing. According to NCSBN,

about half of the alternative programs nationwide function in this manner.⁵ Some of these states, including Arizona and North Carolina, have board staff managing their alternative programs and their discipline programs for nurses with substance abuse problems. For example, the North Carolina Board of Nursing operates two distinct monitoring programs for nurses with substance abuse problems—one for nurses participating under discipline and another for nurses not under discipline. Other states have one joint program for nurses with substance abuse problems, with slightly different participation requirements for nurses participating under discipline than for those not participating under discipline.

Nursing boards in other states, such as Kansas and South Carolina, contract with outside groups for monitoring services. For instance, the South Carolina Board of Nursing contracts with the Recovering Professionals Program for monitoring services for board-referred nurses. The program, which operates independent of the state board and professional nursing associations, also accepts nurses who self refer to the program. In still other states, including Georgia, Indiana, and New Jersey, nursing boards use programs operated by professional nursing associations.⁶ For example, the Georgia Board of Nursing works with the Georgia Nurses Association to administer the Georgia Nurse Association Intervention Program, which serves both nurses who self refer and those referred by their nursing board.

Finally, some states, including Minnesota, operate alternative programs jointly across several health-related licensing boards. For example, various health-related boards in Michigan work together to offer or contract for monitoring services for their licensees.

State boards of nursing vary in their access to information about nurses in alternative-to-discipline programs. According to NCSBN, nursing boards in 19 percent of the states with alternative programs are notified when nurses self refer or are referred by third parties to the alternative programs; nursing boards are not notified in 51 percent of the states with alternative programs.⁷ In some states where nursing boards operate the alternative programs, such as Arizona, the boards have built a “firewall” between their regulatory and alternative monitoring program functions. This firewall helps ensure that the identity of nurses who self refer to the alternative program is not made known to staff who license and process complaints. In some states, including Nevada and North Carolina, nurses who self refer must temporarily inactivate or temporarily surrender their licenses with their nursing boards. Still other states, such as Minnesota and Michigan, do not inform their nursing boards about nurses who self refer or are referred by third parties unless those nurses are unsatisfactorily

⁵ National Council of State Boards of Nursing, *Comparison of Discipline and Alternative Program Survey* (Chicago: NCSBN, May 2010), 2.

⁶ Many states, including Minnesota, also have nurse support groups operated by professional nursing organizations that are not connected to their respective state nursing boards.

⁷ National Council of State Boards of Nursing, *Comparison of Discipline and Alternative Program Survey*, 12. In 24 percent of the states, the question is not applicable because the nursing boards in these states operate the alternative programs.

discharged from the program, do not comply with program requirements, or are ineligible (or become ineligible) for the program.⁸

States' alternative programs also vary in terms of reporting participants' practice violations to their respective state boards. In some states where nursing boards operate their own alternative programs, the boards know when participating nurses have violated their nurse practice acts, regardless of whether the violations are related to their illnesses. This may not be the case when nursing boards do not directly operate the alternative programs. For example, Minnesota law requires that its alternative program only report practice issues unrelated to a nurse's illness to the nursing board.⁹

Finally, states' alternative-to-discipline programs vary substantially in terms of eligibility requirements. While substance abuse may affect nurses' practice, other health or physical conditions may likewise affect their practice and place the public at risk. Minnesota's alternative-to-discipline program covers physical, mental, and other health problems in addition to substance abuse, but programs in most other states are not that inclusive. For example, according to NCSBN, alternative programs in 25 states (including Minnesota and the District of Columbia) also monitor mental health issues, and programs in 12 states (including Minnesota) also monitor physical or other health problems.¹⁰

ALTERNATIVE-TO-DISCIPLINE IN MINNESOTA

Florida established the first alternative-to-discipline program for nurses in 1983. Since then, other states, including Minnesota, have created similar programs. Although the individual approaches taken by states vary, their overall goals are similar—to protect the public from unsafe or potentially unsafe nurses.

The 1994 Legislature created the Health Professionals Services Program to protect the public by monitoring health professionals unable to practice with reasonable skill and safety due to illness, substance abuse, or other health conditions.

As established in state law, HPSP is managed by a 17-member committee known as the Health Professionals Services Program Committee.¹¹ Each of the 16 health-related licensing boards designated in state law, plus the Emergency Medical Services Regulatory Board, appoint one member to serve on the

⁸ For the most part, alternative-to-discipline programs routinely report program discharges for reasons other than successful completion to their respective licensing boards.

⁹ *Minnesota Statutes* 2014, 214.33, subd. 3(10). As we discuss later in this chapter, it may be difficult to distinguish between practice issues that are related to a nurse's illness and those that are not.

¹⁰ National Council of State Boards of Nursing, *Member Board Profiles: Discipline/Continued Competence/Assistive Personnel/Practice* (Chicago: NCSBN, undated), 28.

¹¹ *Minnesota Statutes* 2014, 214.32.

program committee.¹² Each participating board has one vote, regardless of the number of their licensees being monitored by the program.¹³ The program committee designates one of the participating boards to manage administrative aspects of the program.¹⁴ This includes hiring a program manager and staff (with the approval of the full program committee).¹⁵ In accordance with state law, HPSP also has an advisory committee that consists of 17 representatives from various health-related professional associations and 2 public members appointed by the Governor. Although not specifically authorized in statute, HPSP's program manager has also appointed an ad hoc member to the advisory committee, which brings the advisory committee's total membership to 20.¹⁶

Eligibility to participate in HPSP is limited to persons regulated by one of the participating health-related licensing boards. State law further denies admission to licensees (including persons who have applied for or are planning to apply for licensure) who: (1) have diverted controlled substances for other than self-administration;¹⁷ (2) have been previously terminated from the program (or another similar program) for noncompliance and not referred back by their licensing board; (3) are currently under licensing board discipline, unless referred by their board;¹⁸ (4) are regulated under the state's human immunodeficiency virus, hepatitis B virus, and hepatitis C virus prevention program, unless referred by the board or the Minnesota Department of Health; (5) have been accused of sexual misconduct; or (6) would create a serious risk of harm to the public if allowed to practice.¹⁹

¹² *Minnesota Statutes* 2014, 214.01, subd. 2. The health-related boards designated in state law include the Minnesota boards of Behavioral Health and Therapy, Chiropractic Examiners, Dentistry, Dietetics and Nutrition, Marriage and Family Therapy, Medical Practice, Nursing, Nursing Home Administrators, Optometry, Pharmacy, Physical Therapy, Podiatric Medicine, Psychology, Social Work, and Veterinary Medicine, the Emergency Medical Services Regulatory Board, and the Minnesota Department of Health (which serves on the committee in lieu of the Office of Unlicensed Complementary and Alternative Health Care Practice).

¹³ As part of HPSP's strategic planning efforts, staff are reviewing HPSP's current governance structure and identifying areas that may warrant changes.

¹⁴ The Minnesota Board of Dentistry has fulfilled this role for the last several years.

¹⁵ During fiscal year 2014, HPSP had eight staff, including a program manager and five case managers.

¹⁶ The program manager created this position as a way to allow a nurse to continue serving as an advisory committee member after she retired from nursing. Prior to her appointment as an ad hoc member, she served on the committee as the official representative of one professional nursing association.

¹⁷ Although not specifically defined in state law, the term "diversion" generally describes a variety of activities used to obtain drugs illegally. According to NCSBN, diversion most commonly refers to misappropriating drugs from a patient, healthcare employer, or other source. National Council of State Nursing Boards, *Substance Use Disorder in Nursing*, 237.

¹⁸ Although the phrase "alternative-to-discipline programs" implies that these programs only serve nurses that are not under board discipline, many states' programs, including HPSP, also monitor nurses who have been referred to the program as a form of discipline by their respective nursing boards. When the nursing board refers nurses to HPSP under discipline (as opposed to a nondisciplinary referral), the board has greater control over the nurses' participation and receives information about the nurses' status in the program.

¹⁹ *Minnesota Statutes* 2014, 214.32, subd. 4.

The Health Professionals Services Program is funded by the health-related licensing boards it serves, with the Minnesota Board of Nursing paying the largest share of its costs.

For the most part, each health-related licensing board (and the Department of Health) pays an annual participation fee of \$1,000 and a pro rata share of program expenses based on the number of its licensees referred to or participating in the program. In fiscal year 2014, the health-related licensing boards paid an average annual cost of \$1,334 per licensee. Exhibit 3.1 shows the amounts each of the 17 participating agencies paid to HPSP in fiscal year 2014. The Minnesota Board of Nursing paid the lion's share of HPSP's costs—nearly \$433,000 in 2014, which reflects the large number of nurses in the program.

The Health Professionals Services Program's monitoring services are free to participants; the nursing board pays the cost of monitoring nurses in the program. Nurses, however, are responsible for the costs of their assessments, treatment, and, if required, toxicology screens. As we discuss later in this chapter, participating in HPSP can be costly for nurses.

Exhibit 3.1: Health-Related Licensing Boards' Costs to Participate in the Health Professionals Services Program, Fiscal Year 2014

Participating Boards or Departments	Fiscal Year 2014		
	Total Costs	Average Number of Licensees Referred or Monitored	Average Cost per Licensee Referred or Monitored
Nursing	\$432,769	326	\$1,329
Medical Practice	147,994	112	1,320
Pharmacy	40,780	29	1,394
Dentistry	31,778	32	993
Behavioral Health and Therapy	21,345	16	1,377
Emergency Medical Services	20,439	15	1,394
Chiropractic Examiners	19,875	14	1,379
Physical Therapy	19,623	14	1,393
Social Work	17,050	12	1,411
Psychology	11,302	8	1,490
Veterinary Medicine	8,560	6	1,489
Marriage and Family Therapy	5,918	4	1,614
Dietetics and Nutritional Practice	3,199	2	2,020
Nursing Home Administrators	2,425	1	2,238
Optometry	1,761	1	3,523
Podiatric Medicine	1,000	0	0
Department of Health	4,188	2	1,733
Total	\$790,004	592	\$1,334

NOTES: Total costs include: (1) a \$1,000 fee charged to all participating boards, (2) each board's share of monitoring costs based on the number of licensees referred or monitored by the program, and (3) a fee to cover the Minnesota Board of Dentistry's costs to administer HPSP. In lieu of acting as HPSP's administrating agent, the dentistry board is not assessed the latter administrative fee.

SOURCE: Health Professionals Services Program data, 2014.

Referral Rates

Nurses can enter HPSP in one of four ways: (1) self referral, (2) third-party referral, (3) nursing board nondisciplinary referral, and (4) nursing board disciplinary referral. The referral source is important because it affects the confidentiality of nurses' participation in the program and the amount of control the board can exercise over the nurses while in HPSP.²⁰

There are two ways in which nurses can enroll in HPSP without going through the board. First, both the *Nurse Practice Act* and enabling legislation for HPSP require nurses to report themselves to either the nursing board or HPSP if their practice is or may be adversely affected by a health condition.²¹ When nurses self report to HPSP and subsequently enroll in the program, the fact that the nurses have a problem that may affect their practice is "off the board's radar" as long as the nurses comply with program requirements. That is, the board does not know that the nurses have sought help from HPSP, nor does HPSP notify the board that the nurses have contacted the program.²² Second, state law allows employers, nurses, and other mandated reporters to refer nurses to HPSP in lieu of reporting them to the nursing board.²³ These third-party referrals also stay "off the board's radar" regarding their enrollment in HPSP as long as the nurses comply with HPSP requirements.

The Minnesota Board of Nursing may also refer nurses to HPSP. As discussed in Chapter 1, the board can make nondisciplinary referrals to HPSP to either determine nurses' program eligibility or as a follow up to diagnosis and treatment. In these situations, HPSP informs the board whether the nurses so referred have enrolled in the program, but it releases additional information about the nurses' participation in the program only if the nurses give written permission. The board may also refer nurses to HPSP as a form of discipline. In these circumstances, HPSP informs the board of the nurses' enrollment and status in the program and provides the board with compliance documentation throughout the nurses' participation in the program.

²⁰ As used here, "confidential" simply means that HPSP participation records are not shared with others without the consent of the licensee.

²¹ *Minnesota Statutes* 2014, 148.263, subd. 3; and 214.33, subd. 1.

²² If self-referred nurses do not subsequently enroll in HPSP, or if HPSP determines they are not eligible to participate, HPSP notifies the board of the nurses' inquiry.

²³ *Minnesota Statutes* 2014, 148.263, subd. 3; and 214.33, subd. 1. Mandated reporters are persons who, as a result of their professions, are more likely to be aware of violations of the *Nurse Practice Act*. When they observe possible violations, they are obligated to report the violations to the nursing board or HPSP, depending on the individual circumstances surrounding the violation.

About 500 health professionals, including nearly 250 nurses, were referred to the Health Professionals Services Program in fiscal year 2014.

Exhibit 3.2 shows the number of health professionals referred to HPSP by each participating health-related licensing board in fiscal years 2009 through 2014. In total, 501 individuals were referred to the program in 2014, which is less than the number referred in fiscal years 2011 and 2013. Over the last six fiscal years, HPSP received, on average, about 498 referrals a year.

Exhibit 3.2: Referrals to the Health Professionals Services Program by Health-Related Licensing Board, Fiscal Years 2009 through 2014

Participating Boards or Departments	Number of Referrals					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Nursing	277	282	277	259	277	248
Dentistry	35	53	56	49	55	77
Medical Practice	73	59	61	74	72	54
Chiropractic Examiners	15	16	14	17	20	23
Behavioral Health and Therapy	5	21	19	26	26	18
Emergency Medical Services	6	13	30	12	20	17
Pharmacy	21	17	22	20	14	16
Social Work	11	11	14	8	10	15
Veterinary Medicine	2	4	3	4	5	9
Marriage and Family Therapy	3	2	2	4	3	6
Physical Therapy	7	6	14	12	8	5
Psychology	3	4	5	3	6	5
Department of Health	6	3	1	2	3	4
Nursing Home Administrators	2	0	0	0	1	2
Dietetics and Nutritional Practice	0	0	0	0	2	1
Optometry	0	1	0	0	0	1
Podiatric Medicine	<u>0</u>	<u>0</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total	466	492	519	490	522	501

SOURCE: Health Professionals Services Program, *Fiscal 2012 Report* (St. Paul, 2012), 4; and *Fiscal 2014 Report* (St. Paul, 2014), 5.

Overall, the majority of referrals to HPSP in fiscal year 2014 were not disciplinary in nature, and they were most often made by the licensing boards themselves—36 percent in 2014—followed closely by self referrals at 32 percent. Referrals as a form of discipline comprised 16 percent of total referrals.

Although nurses have comprised the majority of HPSP referrals over the last several years, Minnesota Board of Nursing referrals to HPSP have dropped considerably since fiscal year 2009, reaching a six-year low of 248 in fiscal year 2014. With the exception of the boards of Medical Practice and Physical Therapy, referrals to HPSP from other health-related licensing boards in 2014 were not substantially lower than their referral rates in previous years.

Unlike other health-related licensing boards, the percentage of nurses referred under disciplinary action to the Health Professionals Services Program by the Minnesota Board of Nursing has steadily increased since fiscal year 2009.

Exhibit 3.3 shows that the percentage of nurses referred to HPSP under discipline has steadily increased over the last several years, going from 16 percent in fiscal year 2009 to 26 percent in 2014. During this timeframe, the percentage of nurses referred to HPSP in nondisciplinary actions fluctuated between 12 and 18 percent.

In contrast, the overall percentage referred under discipline for the other health boards remained around the 6 percent level for the same time period. For example, disciplinary referrals by the Minnesota Board of Medical Practice dropped from 7 percent in 2009 to 4 percent in 2014. At the same time, the overall percentage of other health professionals referred in nondisciplinary actions by their licensing boards increased from 43 to 56 percent.

Exhibit 3.3: Referrals to the Health Professionals Services Program, Fiscal Years 2009 through 2014

Type of Referral	Number and Percentage of Referrals					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Nurses						
Nondisciplinary referral from MBN	18%	17%	12%	12%	13%	17%
Disciplinary referral from MBN	16	17	17	21	26	26
Self	45	48	48	51	44	38
Third-party	21	17	23	16	17	19
Number of referrals	277	282	277	259	277	248
Other Health Licensed Professionals						
Nondisciplinary referral from other licensing boards	43%	51%	50%	44%	46%	56%
Disciplinary referral from other licensing boards	6	6	4	3	9	6
Self	31	33	31	39	35	27
Third-party	20	10	15	13	10	12
Number of referrals	189	210	242	231	245	253
Total						
Nondisciplinary referral from all licensing boards	28%	32%	29%	27%	29%	36%
Disciplinary referral from all licensing boards	12	12	11	13	18	16
Self	39	42	40	46	40	32
Third-party	20	14	19	15	14	15
Total number of referrals	466	492	519	490	522	501

NOTE: MBN refers to the Minnesota Board of Nursing.

SOURCES: Health Professionals Services Program, *Fiscal 2009 Report* (St. Paul, 2009), 4; and *Fiscal 2014 Report* (St. Paul, 2014), 8.

Participation Rates

Simply being referred to HPSP—or referring oneself—does not necessarily mean that HPSP will accept the nurse into the program or that the nurse will actually enroll in the program. The Health Professionals Services Program requires that certain diagnostic assessment information be collected before enrolling a nurse (or any other licensee).²⁴ This information helps staff determine: (1) whether a nurse has an illness, (2) the severity of that illness, and (3) whether the illness warrants monitoring. After the assessment is completed and HPSP determines that the nurse has an illness it can monitor, HPSP requires the nurse to sign a contract and monitoring plan, at which time the nurse becomes a program participant.

In fiscal year 2014, nurses accounted for 55 percent of HPSP's total enrollment. The next largest group of participants was Minnesota Board of Medical Practice licensees at 18 percent. Licensees from the boards of Dentistry and Pharmacy each made up about 5 percent of HPSP enrollment. Each of the remaining health-related licensing boards comprised 3 percent or less of HPSP's 2014 enrollment.

Exhibit 3.4 shows the number of licensees participating in HPSP from each health-related licensing board per 1,000 licensees regulated in fiscal year 2014. Nurses participated in HPSP at a rate of 2.73 per 1,000 nurses licensed, which was lower than participation rates for the boards of Chiropractic Examiners (4.92 per 1,000 licensed), Behavioral Health and Therapy (4.82), and Medical Practice (3.74).

Over the last several years, the overwhelming majority of the Health Professionals Services Program's participants, including nurses, have had substance-abuse problems.

We looked at the clinical diagnoses of nurses discharged (for any reason) from HPSP in fiscal years 2010 through 2014. During this timeframe, 79 percent of nurse participants were diagnosed with a substance-abuse disorder, 71 percent had a psychiatric disorder, and 14 percent had a medical disorder. Overall, 54 percent of nurse participants suffered from substance-use disorders in combination with medical or psychiatric disorders.

Lower percentages of nurses had a diagnosis of alcohol abuse (as opposed to drug abuse) than did most other health professionals. Whereas 47 percent of nurses had a diagnosis of alcohol abuse, 53 percent of other health professionals had this diagnosis. In contrast, 30 percent of nurses abused prescription drugs compared with 22 percent of other health professionals; 10 percent of nurses abused illicit street drugs compared with 7 percent of other health professionals in HPSP.

²⁴ At times, staff will monitor some individuals while their diagnostic information is being obtained, which may take a long time if licensees have multiple or complicated problems to assess.

In fiscal year 2014, the majority of individuals participating in HPSP for drug diversion were nurses. According to HPSP, diversion is “the inappropriate acquisition of controlled or other potentially abusable substances.”²⁵ About a fifth of HPSP participants (mostly nurses) admitted diverting prescription drugs prior to their enrollment in the program. Of those diverting drugs, nearly three-fourths said they did so at their workplace—often by taking drugs from inventory or waste or forging prescriptions for their personal use.²⁶ Diversion unrelated to their workplace usually involved individuals taking drugs from family or friends.

Exhibit 3.4: Health-Related Licensing Boards’ Participation in the Health Professionals Services Program, Fiscal Year 2014

Participating Boards or Departments	Number of Licensees or Registrants	Number of HPSP Participants	Number in HPSP per 1,000 Licensees or Registrants
Chiropractic Examiners	2,641 ^a	13	4.92
Behavioral Health and Therapy	3,527 ^a	17	4.82
Medical Practice	28,319	106	3.74
Nursing	117,892	322	2.73
Psychology	3,800	9	2.37
Veterinary Medicine	2,681	6	2.24
Physical Therapy	6,300	13	2.06
Dentistry	17,169	31	1.81
Pharmacy	20,000	32	1.60
Dietetics and Nutritional Practice	1,655	2	1.21
Marriage and Family Therapy	2,495	3	1.20
Nursing Home Administrators	872	1	1.15
Social Work	12,350	14	1.13
Optometry	1,074	1	0.93
Emergency Medical Services	32,000	18	0.56
Department of Health	6,836 ^a	2	0.29
Podiatric Medicine	235	0	0.00
Total	257,991	590	2.28

NOTE: Number of HPSP participants reflects the number enrolled on July 2, 2014.

^a Data refer to the number licensed or registered in fiscal year 2013.

SOURCE: Health Professionals Services Program, *Fiscal 2014 Report* (St. Paul, 2014), 8.

Terms of Participation

When nurses enroll in HPSP, they must sign participation agreements and monitoring plans that list program compliance requirements. Nurses who are unwilling to sign the agreements are reported to the nursing board.

²⁵ Health Professionals Services Program, *Fiscal Year 2014 Report* (St. Paul, August 2014), 14.

²⁶ Diverting from inventory means that drugs were taken from storage or supply rooms; diverting from waste means that nurses took excess drugs not administered to patients for their own use rather than destroying any amounts not administered to patients.

The Health Professionals Services Program may act much faster than the Minnesota Board of Nursing to protect public safety by requiring nurses to refrain from practice immediately upon learning of problems.

One key feature of HPSP's monitoring plans is that nurses must agree to refrain from work when required to by program staff. The Health Professionals Services Program routinely asks nurses to stop practicing when they first contact the program. Staff do not approve nurses to return to practice until their treatment providers determine that the nurses are safe to resume working. Also, HPSP staff frequently place conditions on nurses' monitoring plans limiting the type of work they can do and the hours they can work. For example, HPSP may limit nurses to employment where they do not have access to narcotic drugs, or staff may bar nurses from working overtime.

In addition to requiring nurses to refrain from work upon enrollment, HPSP case managers may require them to refrain from work at any point during their participation in the program. For example, if a nurse admits to using drugs or alcohol or has a positive toxicology screen for drugs or alcohol, HPSP requires the nurse to stop working until he or she is assessed safe to return by his or her treatment provider.

The program's ability to immediately request that nurses refrain from work serves to protect public safety in a way that the Minnesota Board of Nursing does not.²⁷ As discussed in Chapter 2, the board takes, on average, over six months to resolve complaints through disciplinary or other actions. During that time, nurses can practice. If the nurses do not refrain from practice at HPSP's request, HPSP discharges them and reports them to the board.

At the same time, it is important to note that, unlike nurses under a disciplinary order, nurses who self refer to HPSP or are referred by third parties (as well as nursing board nondisciplinary referrals) do not have practice restrictions placed on their licenses by the board. Because their participation in HPSP is considered not-public data, the general public—including current and future employers—may not be aware that the nurses are participating in HPSP. There is no record of HPSP participation on the nurses' licenses at the Minnesota Board of Nursing.²⁸ Likewise, there is no public record when HPSP asks nurses to refrain from practice. Also, if nurses continue or return to work without HPSP's permission, HPSP may not be aware that the nurses have done so.²⁹ While HPSP obtains

²⁷ The board can immediately suspend, on a temporary basis, a nurse's license if there is a serious or imminent risk of harm to others. However, as discussed in Chapter 2, the nursing board rarely uses this authority. *Minnesota Statutes* 2014, 148.262, subd. 3; and 214.077.

²⁸ To address this issue, NCSBN guidelines for alternative-to-discipline programs say that, as a condition of being accepted into an alternative program, nurses must agree to "inactivate" their licenses until or unless approved to continue or return to practice by their treatment providers and the alternative program. National Council of State Boards of Nursing, *Substance Use Disorder in Nursing*, 207.

²⁹ In January 2012, HPSP tried to address this problem by asking treatment providers about nurses' employment changes in its treatment provider report forms.

releases from nurses to contact their employers, HPSP does not know if the nurses have reported all of their jobs to the program.

RECOMMENDATION

The Legislature should give the Health Professionals Services Program access to the quarterly unemployment insurance reports employers are required to file with the Minnesota Department of Employment and Economic Development.

We think expanding HPSP's access to employment records could help them monitor nurses when it asks them to refrain from practice. In reviewing a random sample of 75 HPSP files as well as the HPSP files of nurses whose board files we reviewed, we noted instances where HPSP had no knowledge that nurses had returned to practice without its approval. Minnesota employers must file quarterly reports with the Department of Employment and Economic Development identifying their employees and the number of hours they worked. While these records do not specifically identify whether a nurse has a nursing versus a nonnursing job, having access to these data could be a useful monitoring tool for HPSP. We made a similar recommendation in Chapter 2 regarding nursing board access to employment data.

The Health Professionals Services Program is a very rigorous monitoring program, and success in the program can be difficult, time-consuming, and costly.

A common perception among some members of the general public—and state officials—is that nurses entering an alternative-to-discipline program such as HPSP are “getting off easy.” Some people view alternative programs as overly protective of nurses and an unnecessary risk to public safety. While there may be some validity to these perceptions, depending on how the program is operated, HPSP is a very difficult program to successfully complete.

Exhibit 3.5 shows the standard monitoring agreement for nurses with substance-abuse problems, which comprise the bulk of the diagnoses that HPSP monitors. As shown, participation requirements are rigorous and time-consuming. For the most part, successful completion requires a three- to five-year commitment. During this time, participants must refrain from all alcohol and drugs (unless prescribed by an approved healthcare practitioner) and attend over 140 meetings or appointments each year with treatment or other support providers.³⁰

While nurses do not pay to have HPSP monitor them, they must pay the cost of their toxicology screens, which cost between \$15 and \$45 per screen. At one screen per week, the cost to nurses can range between \$780 and \$2,340 per

³⁰ On occasion, HPSP staff have concerns about the drugs prescribed by a licensee's doctor, especially if a drug is prone to abuse or may be unnecessary. In these cases, HPSP informs the prescriber of its concern. At times, HPSP has required licensees to work with another prescriber (for example, a physician who specialized in addiction medicine).

year.³¹ In addition, nurses must pay for their treatment, healthcare provider visits, and any other assessments that HPSP may require. This can be a hardship for many nurses, some of whom may not be employed when they enter HPSP or may lack insurance coverage. Also, nurses must telephone HPSP's "toxicology line" every day except Sunday, generally for three years, to see if they must submit a urine sample that day. Although participants have a window of time to submit samples (generally 6 a.m. to 6 p.m.), screening locations may not be close to their work or home.

Exhibit 3.5: Typical Monitoring Agreement for Nurses with Substance Abuse Problems

In order to participate in the Health Professionals Services Program, nurses agree to:

- Abide by HPSP requests to cease practicing.
- Refrain from all alcohol and drug use, unless a drug is prescribed by an approved healthcare provider.
- Identify and use only approved healthcare providers.
- Undergo, at nurses' cost, all assessments required by HPSP.
- Attend Alcoholics Anonymous-type meetings at least twice a week.
- Attend at least one professional support group meeting a month.
- Call HPSP's "toxicology line" daily (excluding Sundays).
- Pass 6 to 12 random drug and alcohol screens every three months.
- Enroll in and complete an approved treatment program.
- Meet with an approved therapist at least twice a month after completing a treatment program.
- Meet with an approved psychiatrist at least quarterly after completing a treatment program.
- Identify a worksite monitor to observe their job performance and report back to HPSP.
- Undergo a random audit of their administration of controlled substances at least three times a month.
- Submit quarterly reports to HPSP.
- Ensure their worksite monitors and treatment providers submit quarterly reports to HPSP.

SOURCE: Office of the Legislative Auditor, summary of Health Professionals Services Program monitoring plans for health professionals with substance abuse problems.

Outcomes from HPSP Participation

Nurses enrolled in HPSP can be discharged from the program for a variety of reasons: successful completion, voluntary withdrawal, noncompliance, death, becoming ineligible while being monitored, or failing to contact or cooperate with HPSP. About a third of nurses discharged from HPSP later return to the program. Although 69 percent of all HPSP nurse participants between fiscal years 2010 through 2014 were enrolled in HPSP only once, 24 percent were enrolled twice, and 7 percent were enrolled three or more times.

³¹ The Health Professionals Services Program may be able to work with nurses to help reduce costs, including the number or type of drug screens required. However, HPSP must require drug or alcohol screens when nurses are diagnosed with substance-abuse disorders. If nurses cannot afford the screens, HPSP reports them to the nursing board.

Overall, nurses were less likely to successfully complete the Health Professionals Services Program than were other health professionals in fiscal years 2010 through 2014.

Exhibit 3.6 shows outcomes for nurses and other health professionals that were discharged from HPSP (for any reason) in fiscal years 2010 through 2014.³² As these data show, 48 percent of nurses discharged during this time period successfully completed the program—that is, the nurses completed the terms of their monitoring plans.

Exhibit 3.6: Discharges from the Health Professionals Services Program, Fiscal Years 2010 through 2014

Type of Discharge	Number and Total Percentage of Discharges					Total Percentage
	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	
Nurses						
Successful completion	98	111	90	100	91	48%
Noncompliance	74	70	67	68	74	34
Voluntary withdrawal	11	21	19	28	18	9
Became ineligible	16	20	17	17	14	8
Deceased	0	1	0	1	0	>1
Other Health Licensed Professionals						
Successful completion	76	66	51	62	63	59%
Noncompliance	16	24	23	26	30	22
Voluntary withdrawal	7	11	9	6	10	8
Became ineligible	7	7	9	16	19	11
Deceased	1	1	1	0	2	1
Total						
Successful completion	174	177	141	162	154	52%
Noncompliance	90	94	90	94	104	30
Voluntary withdrawal	18	32	28	34	28	9
Became ineligible	23	27	26	33	33	9
Deceased	1	2	1	1	2	<1

NOTE: Percentages may not total 100 percent due to rounding.

SOURCES: Health Professionals Services Program, *Fiscal 2012 Report* (St. Paul, 2012), 7; and *Fiscal 2014 Report* (St. Paul, 2014), 9.

For the most part, a higher percentage of other health-related professionals discharged from HPSP successfully completed the program than did nurses. As noted above, nurses had a 48 percent success rate in fiscal years 2010 through 2014. This compares with a 59 percent success rate for other health professionals. Nurses also had a higher discharge rate for noncompliance than did other health professionals—34 percent compared with 22 percent.³³

³² These data do not include nurses or other health professionals referred to HPSP who did not enroll in the program or sign monitoring agreements.

³³ The remaining 19 percent of nurses and 20 percent of other health professionals were dismissed from HPSP because they voluntarily resigned from the program, became ineligible for monitoring, or died while in the program.

When asked about the differences in success rates, HPSP and nursing board staff told us that one factor affecting nurses' success rates is that the nursing board expects HPSP to discharge nurses when they do not comply with monitoring requirements. Other health-related licensing boards are more likely to allow their licensees to remain in the program. Another factor is that nurses are more likely to have difficulty paying for toxicology screens and treatment than other health professionals such as doctors and dentists.

Nineteen percent of the nurses who successfully completed the Health Professionals Services Program in fiscal years 2000 through 2004 later reenrolled in the program, and a similar percentage were later removed from practice by the Minnesota Board of Nursing.

We looked at the number of times individual nurses returned to HPSP after successfully completing the program in fiscal years 2000 through 2004.³⁴ Of the 283 nurses successfully completing HPSP during this timeframe, 81 percent did not reenroll at a later date.³⁵ Nineteen percent referred themselves back to HPSP or were referred by the nursing board, their employers, or others.

We also looked at the extent to which nurses who successfully completed the program later faced disciplinary actions at the Minnesota Board of Nursing. As Exhibit 3.7 shows, of the 129 nurses who were self- and third-party referred and successfully completed HPSP in fiscal years 2000 through 2004, 76 percent had no future actions taken against them by the board. The remaining 24 percent had at least one future action against them. Perhaps more important, 84 percent had no future actions related to chemical dependency or other health-related problems—issues that likely led to their enrollment in HPSP in the first place. In total, about 17 percent had one or more future actions taken against them that resulted in their removal from practice—a suspension, revocation, voluntary surrender, or stipulation to cease practicing.

Exhibit 3.7 also shows the percentage of nurses referred to HPSP by the board (either through nondisciplinary or disciplinary action) who successfully completed the program and had subsequent board actions against them. Results of this analysis were similar to our results for self- and third-party referrals—82 percent of board-referred nurses had no future actions related to chemical dependency or other health-related problems, and 18 percent had one or more related actions taken against them. Of the 154 nurses referred to HPSP by the board who successfully completed the program, 17 percent were subsequently removed from practice (either temporarily or permanently).

³⁴ We looked at nurses successfully completing HPSP in fiscal years 2000 through 2004 to give nurses an adequate period of time to return to the program if needed—10 to 14 years.

³⁵ Although 81 percent of nurses did not return to HPSP after successfully completing the program, this does not necessarily mean that their illnesses remained well-managed. For example, some of these nurses may have quit nursing altogether.

Exhibit 3.7: Percentage of Nurses with Board Actions After Successfully Completing the Health Professionals Services Program in Fiscal Years 2000 through 2004

	No Actions	One or More Actions
Self- or Third-Party Referred Nurses (N=129)		
Total with actions	76%	24%
Actions related to drugs, alcohol, or health	84	16
Actions removing the nurses from practice ^a	83	17
MBN-Referred Nurses (N=154)		
Total with actions	80%	20%
Actions related to drugs, alcohol, or health	82	18
Actions removing the nurses from practice ^a	83	17

NOTES: MBN refers to the Minnesota Board of Nursing. Percentages may not total 100 percent due to rounding.

^a Actions resulting in removal from practice include suspensions, revocations, voluntary surrenders, and stipulations to cease practicing.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing and Health Professionals Services Program data.

CONFIDENTIALITY ISSUES

In theory, the Minnesota Board of Nursing has no knowledge of nurses who self refer to HPSP or are referred there by third parties, such as employers. The board only learns about their participation if HPSP (1) notifies the board when nurses do not comply with program requirements or (2) discharges the nurses for any reason other than successful completion.

The Minnesota Board of Nursing has several concerns about nurses who enroll in HPSP without its knowledge. First, the board may receive complaints about nurses while they are enrolled in HPSP. If board staff are not aware that the nurses are participating in HPSP, they may not be able to thoroughly investigate the complaints. Further, board and HPSP staff may be more effective if each were more aware of the other agency's actions. Second, nurses who self refer may be doing so in lieu of being reported to the nursing board by their employers, which suggests that the nurses' problems have already affected their practice. Third, board staff believe it is simply good public policy that the agency responsible for regulating nursing—the Minnesota Board of Nursing—be informed whenever problems or concerns about nurses' ability to practice arise. In this respect, they point out that NCSBN's model guidelines for alternative-to-discipline programs do not include nurse confidentiality, and alternative programs in some other states likewise do not contain confidentiality provisions for self-referred nurses or those referred by third parties. Fourth, nursing board staff have greater investigatory authority than HPSP staff, which allows them to more widely examine issues related to nurses' practice. Finally, allowing some nurses to participate in HPSP without the board's knowledge may result in nurses

who have engaged in the same behavior being treated inconsistently in terms of complaint outcomes.

On the other hand, nurse advocates and HPSP staff argue that removing confidentiality may deter nurses from enrolling in HPSP and seeking help. Fewer nurses may choose to undergo monitoring if they are automatically reported to the nursing board, which could compromise public safety.

Scope of Confidentiality Problem

To evaluate the potential scope of the confidentiality problem, we first looked at the referral sources for all nurses who were monitored by HPSP and discharged for any reason in fiscal years 2010 through 2014. As shown in Exhibit 3.8, of the 927 nurses discharged during this time period, 48 percent (444) were referred by the board. Theoretically, the board did not know the remaining 52 percent (483) of nurses had enrolled in HPSP. These nurses either referred themselves to HPSP or were referred by third parties.³⁶ We examined whether the board learned that these nurses were participating in the program during this period.

Over the last five years, the Minnesota Board of Nursing became aware of over half of all nurses who enrolled in the Health Professionals Services Program without board knowledge.

Of the 483 nurses participating in HPSP without board knowledge, 56 percent (270) eventually came to the nursing board's attention due to HPSP complaints regarding unsuccessful discharge or noncompliance.³⁷

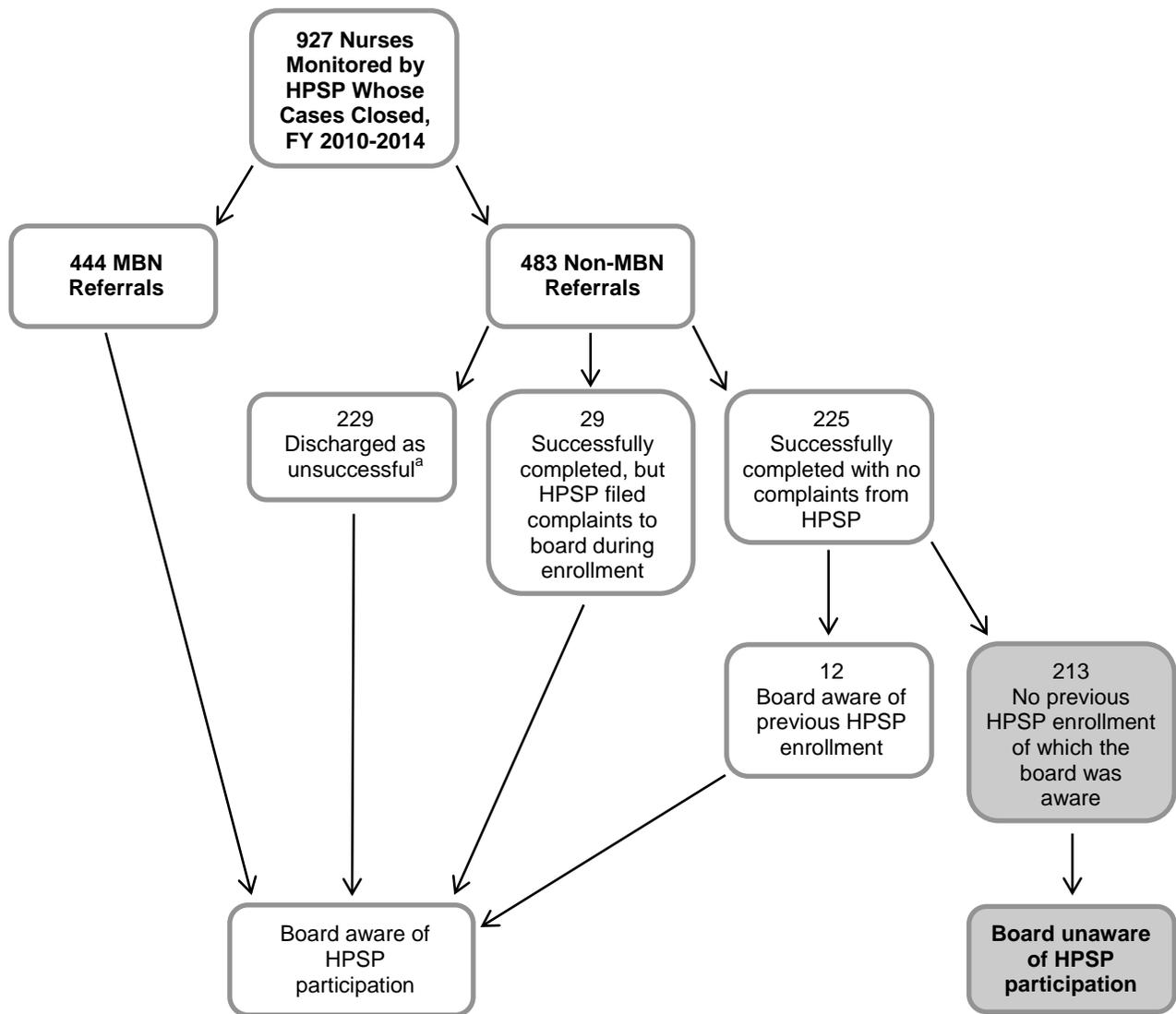
The Health Professionals Services Program provides valuable information to the Minnesota Board of Nursing when it reports noncompliant or discharged nurses to the board.

When nurses with substance-abuse problems enroll in HPSP, part of their recovery process is to tell the truth about how their substance use has affected their lives and work. If nurses later fail to comply with HPSP requirements, HPSP sends the board the nurses' entire file—including their admissions about the extent of their substance abuse and any impact it had on their nursing practice. Thus, HPSP is sometimes a valuable source of information in the board's disciplinary process.

³⁶ The number of nurses referred to HPSP by third parties may decrease in the future. Effective July 1, 2014, employers must report nurses who have diverted narcotics or other controlled substances from their workplace to the nursing board rather than reporting them only to HPSP. Employers may still report nurses to HPSP as well as the nursing board. There is no mandate for nurses or other third parties to report nurses who have diverted to the board. *Laws of Minnesota 2014*, chapter 291, art. 4, sec. 55.

³⁷ As shown in Exhibit 3.8, the 270 nurses also includes 12 nurses who had self-referred and successfully completed without a complaint from HPSP during this time period, but the board was aware of a previous HPSP enrollment.

Exhibit 3.8: Minnesota Board of Nursing’s Knowledge of Nurses Monitored by the Health Professionals Services Program, Cases Closed in Fiscal Years 2010 through 2014



NOTES: There were 149 nurses with multiple enrollments in HPSP that closed between 2010 and 2014. Many nurses also have multiple referral sources for one enrollment. Nurses are categorized based on all referral sources for all enrollments closing from 2010 to 2014. Any nurse with multiple different referral sources where one referral source was the board are classified as a board referral. For example, if a nurse referred themselves in one enrollment, but were board referred for another enrollment, they are classified as a board referral in this chart. MBN refers to the Minnesota Board of Nursing.

^a This includes one person who both successfully completed and was unsuccessfully discharged during this period.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Board of Nursing and Health Professionals Services Program data.

Impact of Confidentiality on Complaint Resolution

To look at the extent to which confidentiality provisions might compromise or affect the board's complaint resolution process, we looked at the number of complaints filed against nurses participating in HPSP without the board's knowledge.³⁸ These were nurses who: (1) referred themselves or were referred to HPSP by third parties, (2) successfully completed HPSP, (3) did not have any complaints filed by HPSP with the board while the nurses were in the program, and (4) had not, to the board's knowledge, previously enrolled in the program.

In some cases, the Minnesota Board of Nursing has resolved complaints without knowing the nurses had been enrolled in the Health Professionals Services Program.

First, we examined complaints filed against nurses who successfully completed HPSP in fiscal years 2010 through 2014. While 83 percent of these nurses had no complaints filed against them while they were in HPSP, 17 percent (36) had one or more complaints. Thirty-three nurses had one complaint, two had two complaints, and one nurse had four complaints filed against them while in the program without the board's knowledge.³⁹

Second, we looked at nurses who had successfully completed HPSP without the board's knowledge between fiscal years 2000 and 2004. We then examined how many complaints the board received about these nurses between their successful discharge and the end of fiscal year 2014. Overall, 77 percent of the nurses had no complaints filed against them after successfully completing HPSP. However, the board processed complaints against 23 percent (28) of these nurses without knowing they had been enrolled in HPSP. Eighteen nurses had one complaint filed against them, eight nurses had two complaints, and two nurses had three complaints.⁴⁰

³⁸ In some cases, the board may learn indirectly of HPSP participation. For example, in our board file review, the board sometimes saw HPSP worksite monitor reports in nurses' employment files. Some nurses also told the board that they had enrolled in HPSP.

³⁹ Simply having a complaint filed against them does not necessarily mean that the nurses in question actually violated the *Nurse Practice Act*. Multiple complaints may also not reflect multiple different allegations. Finally, complaints may not be related to substance abuse or other health conditions.

⁴⁰ We also looked at the extent to which this group completed HPSP multiple times without the board's knowledge during the ten-plus years between their successful discharge in fiscal years 2000 through 2004 and the end of fiscal year 2014. Of the 124 nurses in the group, 8 successfully completed HPSP twice, and 1 successfully completed HPSP three times. About the same percentage of these 124 nurses were diagnosed with substance-abuse disorders (79 percent) as the general HPSP population.

RECOMMENDATION

The Legislature should amend statutes to allow the Minnesota Board of Nursing to routinely submit a list of nurses with complaints filed against them to the Health Professionals Services Program, where staff would identify whether any of those nurses were enrolled in their program.

Although the scope of the confidentiality problem is smaller than it would initially appear—the nursing board generally knows when most nurses are participating in HPSP—a sizeable number are participating in the program without the board’s knowledge. In addition, a significant proportion of the nurses who have participated in HPSP without board knowledge have complaints filed against them while they are in the program or after completing it. To resolve these complaints in a thorough and reasonable manner, board staff should have access to information about the HPSP participation of nurses who are the subjects of complaints. Although nurses sometimes reveal their HPSP participation or board staff discover it in nurses’ employment files, the board should not have to learn about HPSP participation by happenstance. Finally, HPSP staff may benefit from this type of information-sharing in that its monitoring staff would automatically learn whether any of their nurse participants were under board investigation.

Statutes should allow the nursing board to learn if nurses with complaints filed against them are enrolled in, or have ever been enrolled in, HPSP. We do not recommend that the statute be retroactive (that is, cover nurses who have already signed participation agreements) due to the disclosures and agreements nurses made when they voluntarily enrolled in the program in the past. However, going forward, HPSP should revise its contracts and participation agreements to make it clear to nurses that their participation would be reported to the nursing board if the board receives any complaints against them in the future.⁴¹

At the same time, it is not necessary that the board know the identity of all nurses who are successfully participating in HPSP if the board or HPSP has not received any complaints or reports against their practice. As we discuss in the next section, HPSP does a good job monitoring nurses; nurses who comply with the program likely do not pose a risk to public safety. Thus, we think HPSP’s confidentiality provisions should continue, as long as the participating nurses do not have complaints filed against them. In this way, the public protection benefits that might accrue from allowing nurses to self refer or be referred by third parties without automatically coming to the board’s attention can continue.

LAPSES IN MONITORING

In this section, we discuss other concerns with the board’s use of HPSP that may have implications for public safety. First, we discuss the public safety risk presented between the time nurses are unsuccessfully discharged from HPSP and

⁴¹ As previously discussed, nurses sign contracts and participation agreements that lay out the circumstances under which their participation in HPSP may become known to the nursing board.

nursing board action. Second, we discuss board concerns about HPSP's reporting of problems nurses might have while participating in the program.

Time between Discharge and Board Action

In Chapter 2, we discussed several complaints where the public was at risk during the period between HPSP discharge to the Minnesota Board of Nursing and the board's subsequent action. Although HPSP monitors nurses' practice while they are participating in the program, no agency is monitoring the nurses' practice between the time of their discharge from HPSP and final action by the board. In these cases, HPSP notifies the board of the nurses' discharges, which results in complaints being filed against the nurses.

The Minnesota Board of Nursing has not acted in a timely manner when the Health Professionals Services Program discharges nurses to the board for noncompliance.

We evaluated the time it took the board to process HPSP discharges in our random sample of HPSP and nursing board file reviews.⁴² We identified 36 cases where the board disciplined a nurse at least partially based on an HPSP discharge in fiscal years 2009 through 2014. On average, the board took 160 days to impose disciplinary action in these cases, with a median time of 142 days. It took the board significantly less time (an average of 120 days) to impose disciplinary action in 2014 than in previous years though, most likely because the board began meeting more frequently to resolve complaints.

Statutory changes enacted in 2014 could help the board act more quickly in these types of cases. The 2014 Legislature established HPSP noncompliance and discharge as independent grounds for board discipline.⁴³ This change removes the necessity for the board to prove nurses returned to using drugs or alcohol and pose a threat to the public before taking action. The board can now impose disciplinary action solely based on the HPSP discharge or report of noncompliance. However, the board would still need to investigate to determine what discipline is appropriate.

RECOMMENDATION

The Legislature should enact legislation to allow the Health Professionals Services Program to continue to monitor a nurse after being unsuccessfully discharged until the Minnesota Board of Nursing acts on the complaint.

The board should continue to pay for HPSP monitoring of discharged nurses whom HPSP determines it can continue to monitor. This policy is consistent with the practices of some other health-related licensing boards in this state.

⁴² The board's information management system does not consistently differentiate between actions taken on HPSP complaints for noncompliance and HPSP discharges. Therefore, it was not possible to systematically evaluate the time between HPSP discharge and board action using board data.

⁴³ *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 56.

Other health-related licensing boards sometimes ask that their licensees not be immediately discharged so that HPSP can continue to monitor them while their boards process the complaints. As noted previously, staff told us that the nursing board is more likely to ask HPSP to discharge licensees for noncompliance than are other health-related licensing boards.

Allowing HPSP to monitor nurses after discharge protects public safety by keeping nurses in monitoring rather than letting these nurses practice without restrictions or monitoring for months until the board acts. The additional monitoring also can provide the board with more information that could inform the board's disciplinary decisions. Continued participation in the program can also serve to encourage the nurse to maintain sobriety and continue to comply with treatment requirements. Lastly, because the board would continue to pay for monitoring after discharge, it may encourage the board to act more quickly in HPSP discharges.

While not all nurses discharged from HPSP may agree to being monitored while they await action by the nursing board, some will. We attended a number of discipline conferences where nurses discharged from HPSP continued to see their treatment providers and attend support groups. In addition, the board often refers nurses back to HPSP after their discharge. We see no compelling reason why nurses who are willing to continue in HPSP while the board processes their HPSP discharge should not be able to continue in the program.

COMMUNICATION AND COOPERATION

While Minnesota Board of Nursing staff were generally complimentary of HPSP's work, they expressed concern regarding some of HPSP's policies and practices on reporting nurses' relapses, problem toxicology screens, and investigating practice problems. Further, they pointed out that statutes do not give HPSP investigatory authority. Finally, board staff questioned the quality of HPSP's worksite monitoring.

For example, board staff pointed out that HPSP does not have any nurses on staff or under contract to help identify nursing problems.⁴⁴ It can be difficult to ascertain whether a practice problem is related to the illness for which a nurse is being monitored, or even whether it is a nursing issue. A common example is tardiness or work absences. Case managers at HPSP may process these problems as related to a nurse's depression or substance-use disorder. However, absenteeism and tardiness can also create risk to patients and may be related to other practice-related problems; nursing board staff believe that all practice issues should be evaluated by the board.

Board staff are also concerned that HPSP's staff—mostly social workers and alcohol and drug counselors—do not have the medical expertise to understand whether a nurse's practice impacts patients or whether it is related to a nurse's illness. Consequently, HPSP staff may be unaware of issues that someone with

⁴⁴ Although HPSP has tried to hire nurses, few nurses have applied for job openings.

medical training might notice. For example, board staff told us that a medical procedure that one nurse had undergone indicated to them that the nurse had returned to drug use.

The Health Professionals Services Program has generally done a good job monitoring nurses, and it has complied with its internal policies and reported important practice issues to the Minnesota Board of Nursing when necessary.

In our HPSP and board file reviews, we assessed the rigor of HPSP's monitoring, including whether the program followed its own policies. Overall, we concluded from our review of the files of over 150 nurses that HPSP did a good job monitoring nurses.⁴⁵ For example, HPSP staff consulted with nurses' worksite monitors and treatment providers, as well as the monitored nurses, as needed. The program required assessments prior to allowing nurses to return to work and followed assessors' recommendations regarding imposing restrictions on work hours and practice settings.

We also found that HPSP relied on its policies to determine when cases should be sent to the board.⁴⁶ For example, noncompliance was reported to the board after a nurse had too many problem toxicology screens within one year.⁴⁷ Staff at HPSP reported nurses even where it appeared to them that the nurse had not purposely diluted or missed a screen. The program's reliance on policies helped staff make consistent and objective decisions regarding reporting noncompliance with program requirements.

We also looked at how HPSP identified and reported practice problems to the board. While HPSP did not have any medical professionals on staff, HPSP staff consulted medical professionals about practice issues. Case managers at HPSP consulted (sometimes without identifying the nurse) nursing board staff (who are nurses) to discuss whether a practice problem should be reported. The program also used medical consultants when needed, most often to help establish and review monitoring guidelines and protocols, provide opinions regarding ambiguous toxicology screening results, and help staff understand conflicting recommendations of treatment providers and assessors.

Case managers at HPSP also consulted nurses' treatment providers and pieced together information from various sources, including worksite monitors, to get a picture of how well nurses were doing and whether they could safely care for patients. Case managers at HPSP also relied on nurse supervisors who served as nurses' worksite monitors to report practice deficiencies that could impact patient safety. These supervisors also had an ongoing responsibility to report serious

⁴⁵ Seventy-five of these files were a random sample of HPSP files opened between January 1, 2010, and June 30, 2014. We also read the HPSP files of nurses whose nursing board files we had reviewed.

⁴⁶ Health Professionals Services Program, *Training Manual—Working Document* (St. Paul, December 2012). These policies are reviewed yearly for possible updates and revisions.

⁴⁷ A problem screen includes screens that were diluted, missed, or late. Positive screens are handled according to HPSP's relapse policy.

problems not related to the nurses' illnesses to the Minnesota Board of Nursing, regardless of whether the nurses they were supervising were enrolled in HPSP.

Overall, HPSP has generally reported nurse practice issues as required by law and policy. State law requires HPSP to report practice problems to the board if the problems are unrelated to nurses' illnesses or reasons for being in HPSP.⁴⁸ The 2014 Legislature amended statute to also require HPSP to report any person who unlawfully uses drugs or alcohol while on duty or on call, whether or not their use is related to their illness.⁴⁹

At the same time, we found some discrepancies when we reviewed case files. At times, HPSP was inconsistent in reporting nurses' impairment at work prior to their enrollment. Also, HPSP staff sometimes used the flexibility in HPSP policies to allow potential noncompliance to go on longer than it should have. In particular, they sometimes appeared too liberal in cancelling toxicology screens.⁵⁰ On the other hand, although we saw some errors, we also saw HPSP erring on the side of caution and reporting nurses to the board for noncompliance or discharging them even when the nurses likely did nothing wrong. In these cases, the board investigated HPSP's complaints and dismissed them.

Monitoring nurses with substance-abuse problems is difficult—no matter who does the monitoring. It can be hard to detect when people are lying about their return to use. Nurses may cheat on toxicology tests or lie about being out of town for a toxicology screen. In addition, many nurses suffer from chronic pain for which they receive prescriptions. When they abuse their pain medication, toxicology screens cannot be used to detect drug abuse. These cases are particularly difficult—for both the nursing board and HPSP.

Basic philosophical differences between staff at the Minnesota Board of Nursing and the Health Professionals Services Program have negatively affected their working relationship.

While the missions of both HPSP and the nursing board are to protect public safety, HPSP approaches public safety from an individual case-management perspective while the board approaches it from a regulatory perspective. For example, confidentiality provisions are important to HPSP because its staff believe those provisions encourage nurses to seek help when they need it and allow the program to monitor those individuals to ensure they can practice safely. However, to the board, the confidentiality provisions shield information that may be valuable in making decisions regarding whether a nurse can practice safely.

To address some of the strains these philosophical differences create, HPSP has developed policies in conjunction with HPSP's program committee. These policies provide a framework regarding when problems or concerns need to be reported to the respective licensing boards. However, the nursing board does not

⁴⁸ *Minnesota Statutes* 2014, 214.33, subd. 3(10).

⁴⁹ *Laws of Minnesota* 2014, chapter 291, art 4, sec. 54.

⁵⁰ Cancelling a screen excuses the licensee from submitting it. Cancelled screens are not counted as "missed" and, therefore, are not counted as "problem screens."

necessarily agree with how the policies have been operationalized, nor does it generally trust that HPSP always follows its policies or interprets them in the same way that the board would. As discussed previously, the board has only one vote on HPSP's 17-member program committee even though nurses make up the majority of HPSP participants and the nursing board pays the bulk of HPSP's costs.

One HPSP policy that some nursing board staff questioned relates to reporting participants' past criminal histories. It has been HPSP policy to check the Minnesota Court Information System (MNCIS), a database maintained by the state's judicial system, to learn about participants' past criminal histories regarding substance-related crimes.⁵¹ According to board staff, although HPSP reports practice issues unrelated to nurses' illnesses to the board, it has not always reported criminal convictions that it learns about to the nursing board. Also, board staff have some concerns that HPSP's policy on relapses does not clearly define a relapse. For example, it is not clear whether a weekend "binge" is considered a single relapse or multiple ones.⁵²

RECOMMENDATION

The Minnesota Board of Nursing and the Health Professionals Services Program should work together to develop nurse-specific policies, procedures, and mechanisms to help identify nurses that should be reported to the board.

Despite their philosophical differences, the board and HPSP should jointly develop policies and procedures that would allow staff to work together to address mutual concerns. The HPSP program committee has developed one set of policies for the licensees of all health-related licensing boards. However, nurses present unique risks to vulnerable patients in ways that some other health licensed professionals do not. For example, few other professions have the same level of access to patients' homes and to narcotic drugs as nurses. In addition, few professionals are as responsible for day-to-day and even minute-to-minute cares as nurses are. Due to the unique access to, and impact on, vulnerable people that nurses have, we feel that HPSP and the board must develop policies and practices that specifically apply to nurses. Having nurse-specific policies also makes sense since roughly half of all HPSP participants are nurses.

To some extent, implementing nurse-specific policies and practices is already happening on an informal, ad hoc basis. We noted in our file reviews that HPSP staff sometimes made "blind" calls to obtain the nursing board's advice on how to proceed in individual cases. Some executive directors of other health-related licensing boards also told us that HPSP routinely sought their advice on troublesome cases without identifying the licensee in question. However, we feel

⁵¹ Health Professionals Services Program, *Training Manual*, 25-26. As of November 20, 2014, HPSP stopped checking MNCIS for all participants because the checks were not revealing much useful information. Staff continue to check MNCIS on a case-by-case basis, as needed.

⁵² This is important because HPSP does not report first relapses for nurses who self refer or are referred by third parties if the nurses report their relapse to HPSP staff.

that a concerted effort to make clear nurse-specific policies is essential if the board is required by law to use HPSP to monitor nurses.⁵³

Because there has been a lack of trust between HPSP and the nursing board and because both parties sometimes interpret statutes and policies differently, we think additional tools are necessary to help ensure agreed-upon policies are satisfactorily implemented. Reliable reporting of practice issues based on jointly developed policies could be accomplished in a variety of ways, while still ensuring the confidentiality of nurses successfully participating in HPSP via self- or third-party referrals.

For example, HPSP or the board could contract with an outside nurse to regularly conduct blind reviews of HPSP files to help identify nurse practice issues that HPSP staff might have missed. Another option would be for the board and HPSP staff to meet regularly to discuss “mock” cases or cases where the identity of nurses have been redacted. Also, HPSP staff could develop a de-identified electronic log similar to what we recommended for the board. This log would identify the factors HPSP considered when deciding whether to report a practice issue to the board. The log would be available to board staff for review and would also serve as a useful resource to HPSP staff. The board could also help HPSP design worksite monitor forms or training materials to help monitors flag practice issues that must be reported to HPSP. The board and HPSP could also develop joint policies regarding nurses who enroll in HPSP multiple times without the board’s knowledge.

Lastly, HPSP and the board have had differing interpretations of statutes, particularly concerning instances of drug diversion prior to HPSP enrollment. Staff at HPSP told us that they treat diversion as an illness-related practice issue, which does not require reporting to the nursing board. Staff at the board stated that diversion is always accompanied by practice problems unrelated to drug use, such as committing purposeful and illegal errors in medication documentation. They also point out that diversion is a crime—that is, workplace theft. We think that the board and HPSP should consider developing a joint policy that allows a third party (preferably an assistant attorney general) to make final decisions regarding conflicting interpretations of state law. Should the board or HPSP disagree with the assistant attorney general, they should seek legislative clarification.

Legislation passed in 2014 partially addresses board concerns about nurses who enroll in HPSP after diverting. Employers can no longer report nurses who divert drugs from their workplace to HPSP in lieu of reporting to the board.⁵⁴ Instead, they must report the nurses to the nursing board if the employer discovers the diversion independent of the nurse’s enrollment in HPSP.⁵⁵ Although HPSP must report nurses who admit their diversion caused identifiable patient harm to

⁵³ As noted in Chapter 1, the 2014 Legislature required all health-related licensing boards to participate in HPSP for one year, a provision that expires in July 2015. *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 52.

⁵⁴ *Laws of Minnesota* 2014, chapter 291, art. 4, sec. 55.

⁵⁵ Nurses may still report themselves to the program after diverting drugs.

the board, board staff are concerned that the nurses may not accurately report the nature of their diversion to HPSP.⁵⁶ For example, the nurse may deny substituting saline for medication or giving patients less than full doses and admit only to diverting from “extra” medication that would otherwise be discarded. The board is concerned that, because HPSP cannot investigate nurses’ self reports of diversion, the program must rely solely on nurses’ self-reporting of their actions.

RECOMMENDATION

The Legislature should clarify statutes to require that employers report all instances of identifiable patient harm occurring as a result of nurses diverting drugs to the Minnesota Board of Nursing, regardless of whether those nurses are enrolled in the Health Professionals Services Program.

Current state law is unclear whether employers must report workplace diversion resulting in identifiable patient harm that they learned about after a nurse enrolled in HPSP. Clarifying statutes will help ensure that the nursing board is aware of nurses whose diversion caused patient harm, regardless of their HPSP enrollment. While HPSP reports nurses who have caused patient harm to the nursing board, this clarification would help ensure that the board learns of patient harm caused by nurses’ diversion even when nurses have been dishonest with HPSP.

⁵⁶ *Minnesota Statutes* 2014, 214.33, subd. 3(a)(5). In practice, HPSP finds nurses who report causing patient harm ineligible and reports them to the nursing board.

List of Recommendations

- The Minnesota Board of Nursing should make greater use of its authority to temporarily suspend nurses' licenses when it determines that the public is at serious risk of harm, and it should suspend nurses in a more timely manner. (p. 35)
- The Legislature should clarify state law to allow the Minnesota Board of Nursing to continue to temporarily suspend nurses under the *Nurse Practice Act* rather than using legislation adopted in 2014. (p. 35)
- The Legislature should:
 - Clarify statutes to explicitly give Minnesota Board of Nursing staff greater authority to investigate complaints.
 - Amend statutes to give the Minnesota Board of Nursing access to the quarterly unemployment insurance reports employers are required to file with the Minnesota Department of Employment and Economic Development. (p. 38)
- The Minnesota Board of Nursing should require that an additional board member review and approve discipline review panel recommendations before they are sent to the full board for final action. (p. 41)
- The Minnesota Board of Nursing should:
 - Develop policies, guidelines, or administrative rules to help members and staff determine what actions are generally appropriate for certain types of complaints.
 - Grant staff more authority to propose settlements in some cases instead of using discipline conferences. (p. 46)
- The Minnesota Board of Nursing should maintain an electronic log of its actions that lists the aggravating and mitigating circumstances in each case that led it to impose the action that it did. (p. 48)
- The Minnesota Board of Nursing should meet at least annually to review and discuss “mock” complaints to help identify and sort out differences in how individual board members arrive at their recommendations for action. (p. 48)
- To improve transparency, the Minnesota Board of Nursing should use “plain” English in its communications and dealings with nurses during the complaint resolution process. (p. 51)
- The Legislature should amend statutes to require the Minnesota Board of Nursing to classify Office of Administrative Hearings' findings and recommendations as public data after it has redacted information identifying specific nurses. (p. 52)

- The Legislature should authorize the Minnesota Board of Nursing to grant emeritus status to nurses in good standing who wish to retain their licenses and titles, but voluntarily give up their right to practice. (p. 53)
- The Legislature should give the Minnesota Board of Nursing the authority to develop administrative rules or guidelines for expunging certain actions from nurses' public records after a given period of time has passed and no additional violations have occurred. (p. 54)
- The Minnesota Board of Nursing should improve the accuracy and consistency of information in its complaint management database so that it can use the information to better report on and evaluate its complaint resolution process. (p. 56)
- The Minnesota Board of Nursing should adopt guidelines or administrative rules related to mandated reporters' reporting of minor incidents. (p. 57)
- The Legislature should amend statutes to give Minnesota Board of Nursing staff greater authority to dismiss some complaints without requiring the approval of two board members. (p. 58)
- The Legislature should amend state law to allow nurses who have had their licenses suspended for substance abuse or other health-related problems to participate in the Health Professionals Services Program at their own expense without board referral. (p. 61)
- The Minnesota Board of Nursing should consider, on an individual basis, referring nurses suspended for substance abuse or other health-related problems to the Health Professionals Services Program. (p. 62)
- The Legislature should give the Health Professionals Services Program access to the quarterly unemployment insurance reports employers are required to file with the Minnesota Department of Employment and Economic Development. (p. 75)
- The Legislature should amend statutes to allow the Minnesota Board of Nursing to routinely submit a list of nurses with complaints filed against them to the Health Professionals Services Program, where staff would identify whether any of those nurses were enrolled in their program. (p. 83)
- The Legislature should enact legislation to allow the Health Professionals Services Program to continue to monitor a nurse after being unsuccessfully discharged until the Minnesota Board of Nursing acts on the complaint. (p. 84)
- The Minnesota Board of Nursing and the Health Professionals Services Program should work together to develop nurse-specific policies, procedures, and mechanisms to help identify nurses that should be reported to the board. (p. 88)
- The Legislature should clarify statutes to require that employers report all instances of identifiable patient harm occurring as a result of nurses diverting drugs to the Minnesota Board of Nursing, regardless of whether those nurses are enrolled in the Health Professionals Services Program. (p. 90)



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March 3, 2015

James Nobles
Legislative Auditor
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Room 140 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155-1603

Dear Mr. Nobles:

Thank you for the opportunity to review and comment on your report, *Minnesota Board of Nursing: Complaint Resolution Process*. Thank you, also, for the rigor of the evaluation and the professionalism and thoroughness of the audit team. The Board is gratified that your office concluded the Board's decisions have been reasonable, appropriate, generally timely and consistent with the mandate to protect the public. Generally, the Board believes the report is accurate and agrees with the facts and findings.

The Board is appreciative of the suggestions aimed at improving its processes. As you noted is often the case, the audit validates many issues and suggestions the Board has identified and considered. For example, the Board of Nursing *FY2014-2016 Strategic Initiatives* includes activities to "provide fair, consistent, and efficient complaint resolution processes". Activities listed in the document are: "develop formal evaluation program for complaint review, resolution, and disciplinary processes; analyze and update internal procedures; evaluate best practices for case resolution and public protection; and propose any needed statutory changes."

Based on the Legislative Audit Commission directive to the Office of Legislative Auditor (OLA) to audit the Board's complaint resolution process, the Board delayed its self-evaluation pending the outcome of the OLA audit.

The Board appreciates and values the thorough audit completed by Jo Vos, KJ Starr and Sean Williams. Their efforts and outcomes far exceed the resources of the Board to conduct such a comprehensive evaluation and report and have provided the Board with data, analysis and recommendations for quality improvement.

Key Recommendations

1. The Legislature should:

- A. Allow the Board to continue using its authority under the Nurse Practice Act to suspend nurses.

Comment: The assumption is this is further elaborated on page 35, i.e. “The Legislature should clarify state law to allow the Minnesota Board of Nursing to continue to temporarily suspend nurses under the *Nurse Practice Act* (Minnesota Statutes section 148.262, subd. 3) rather than using legislation adopted in 2014.” (citation added) The OLA report states the Office of the Attorney General has advised the 2014 law is ambiguous in some respects, including the requirement for the Board to lift a temporary suspension if the board has not issued a final order within 30 days; however, the start of the 30-day-period is unclear. The OLA report asserts 148.262, subd. 3 is clearer and unambiguously states the temporary suspension remains in effect until the Board brings the matter to resolution. The Board agrees the requirements, process and procedures for issuing orders of temporary suspension included in Chapter 214 should be clarified. In collaboration with the Office of Administrative Hearings and the Office of the Attorney General, the health-related licensing boards have collectively proposed clarifying language for Chapter 214 to the Legislature for possible enactment in this legislative session.

- B. Give Board staff greater authority to investigate and dismiss complaints.

Comment: (pp. 37-39) The Board agrees the language in Minnesota Statutes 148.191, subd. 2 and 214.103, subd. 2-3 is unclear. The Board has previously sought explicit statutory authority to conduct field investigations and believes many complaints could be resolved more readily and more consistently if staff has greater authority to investigate and propose recommended action to the Board.

- C. Allow the Board to expunge certain information about actions it has taken from nurses’ public records, when appropriate.

Comment: (pp.53-55) The Board has considered expungement or the alternative of not publishing certain actions or removing them from public view after a certain time period. To that end, the Board includes the following in the *FY2014-2016 Strategic Initiatives: Evaluate current policy to publish individual disciplinary data considering such issues as, data practices, transparency, impact on public need to know and safety.*

It is important to note that all disciplinary actions must be reported to the federal National Practitioner Data Bank, which does not expunge records. In fact, the NPDB routinely reviews board websites to compare for data discrepancies and reconciliation. There is the potential for confusion depending on a user’s search of data bases. However, the Board has recognized this concern and is committed to considering a solution that meets the public’s need to know and the impact of certain disciplinary actions on nurses.

- D. Require the Board to send a list of nurses who have complaints filed against them to HPSP (Health Professionals Services Program), where staff would identify nurses enrolled in their program.

Comment: (pp. 82-83) The Board appreciates the data analysis regarding confidentiality, duality of HPSP participation and Board investigations, successful completion and noncompliance. The Board also appreciates that while both the Board and the HPSP are goal-directed to protect the public, the strength of HPSP staff is to monitor health care

professionals for management of their illness, and the Board's role is to investigate alleged violations of the law.

The Board has been a strong advocate of HPSP from its inception and collaborated with the Board of Medical Practice to propose the initial statutory authority to establish the program in 1994. The Board will continue to work closely with the HPSP to identify and implement approaches that minimize duplication of efforts, avoid gaps in surveillance and optimally protect the public.

2. The Minnesota Board of Nursing should:

- A. Make greater and quicker use of its authority to temporarily suspend nurses.

Comment: The Board generally agrees with this recommendation and has greatly increased its use of this authority in 2014. Additionally, the Board has increased the frequency of board meetings to monthly rather than bimonthly so it can bring complaints to resolution more quickly. The Board will continue to seek the advisement of the Office of Attorney General to be assured of the sufficiency of the evidence to issue an order of temporary suspension.

- B. Develop policies, guidelines or administrative rules to help board members and staff determine appropriate actions for certain types of complaints and delegate to staff greater responsibility to resolve some complaints.

Comment: The Board of Nursing is committed to ensuring due process rights of licensees are upheld in all of its processes. This compels the Board to consider cases on an individual basis, evaluating the unique circumstances of each case, while ensuring similarly situated licensees are treated in a similar manner.

Guidelines for case outcomes can be a useful tool to provide greater consistency among similar cases. The challenge is to develop guidelines that provide sufficient detail to give clear and unambiguous direction that is helpful yet are broad and inclusive enough to capture all relevant aggravating and mitigating circumstances. Nonetheless, the Board has already begun to develop guidelines for evaluating criminal histories of nurses.

Inevitably there is considerable policy debate when lines are being drawn and there are decisions to be made about consequences for behavior, whether that is in the context of Board of Nursing disciplinary cases, criminal convictions or substantiated maltreatment. The Board will consider how best to provide greater guidance to Board members to provide assurances of consistency in decision making.

The Board will also bear in mind the premise that determinations with general applicability may be considered a rule and should be promulgated using the legally required process for adoption of rules.

3. The Minnesota Board of Nursing and HPSP should develop joint policies and procedures to identify when nurses participating in HPSP must be reported to the Board.

Comment: (pp. 85-90) The Board appreciates that the evaluators recognize nurses work in situations that may present "unique risks to vulnerable patients in ways that some

other health-licensed professionals do not, such as access to patients' homes and narcotic drugs". The Board also appreciates the challenge to HPSP staff to have "nurse-specific" policies, procedures and mechanisms which may be different than monitoring of other health care professionals. The Board of Nursing is committed to collaborating with HPSP staff to arrive at effective and efficient reporting decisions that support public protection.

4. The Legislature should amend state law to allow nurses who have had their licenses suspended for substance abuse or other health-related problems to participate in the Health Professionals Services Program at their own expense without board referral. Additionally, The Minnesota Board of Nursing should consider, on an individual basis, referring nurses suspended for substance abuse or other health-related problems to the Health Professionals Services Program.

Comment: Although these two items were not identified as "key" recommendations, they are worthy of comment. The report does not contain rationale for the latter recommendation and does not cite any public safety benefit for either recommendation. There is no indication what criteria the Board would use to determine the circumstances under which the Board should fund the monitoring of a licensee removed from practice. The Board is supportive of licensees addressing the illness or condition that impacts or impairs their ability to practice safely by seeking treatment; however, the purpose of the HPSP is to provide assurances of public safety by monitoring individuals who are authorized to practice. It is not within the mandate of the Board to underwrite the cost of monitoring for a select few licensees, particularly when the Board has determined those individuals to be unsafe to practice for a period of time.

In conclusion, the Board of Nursing appreciates the significant effort of your team to conduct the audit and prepare this report. This letter comments only on the key recommendations. (Exception noted.) The Board will conduct a comprehensive review and study of the report's findings and proposed recommendations with the goal of meeting the identified strategic objective identified in the Board of Nursing *FY2014-2016 Strategic Initiatives* to "provide fair, consistent and efficient complaint resolution processes."

Thank you.

Sincerely,



Shirley A. Brekken, MS, RN
Executive Director

Health Professionals Services Program

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February 26, 2015

Mr. James R. Nobles
Legislative Auditor
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658 Cedar Street, Suite 140
St. Paul, MN 55155

Dear Mr. Nobles:

The Health Professionals Services Program (HPSP) appreciates the opportunity to review and respond to the findings of the *Minnesota Board of Nursing: Complaint Resolution Process* audit as it relates to the HPSP. Please extend our gratitude to your staff for their professionalism throughout the review. They sought to understand our processes and asked excellent clarifying questions. They produced a valuable, fair, and comprehensive report.

Thank you for acknowledging the rigorous requirements of the HPSP monitoring and how we collaborate with multiple parties throughout the monitoring process to protect the public. We are dedicated to program improvement. Relatedly, we recently developed a comprehensive strategic plan that focuses on all areas of program performance.

Minnesota's Health Professionals Services Program protects the public by providing monitoring services to regulated health care professionals whose illnesses may impact their ability to practice safely. With sincere dedication to this mission, we serve all of the sixteen health-related licensing boards and the Department of Health.

The report made specific recommendations which have been carefully considered, as indicated below.

Recommendation 1: *The Legislature should give the Health Professionals Program access to the quarterly insurance reports employers are required to file with the Minnesota Department of Employee and Economic Development.*

The HPSP supports this recommendation, as it will give us another tool to monitor participant employment, which will serve to enhance monitoring and public safety.

Recommendation 2: *The Legislature should amend statutes to allow the Minnesota Board of Nursing to routinely submit a list of nurses with complaints filed against them to the Health Professionals Services Program, where staff would identify whether any of those nurses were enrolled in the program.*

This recommendation would create one level of confidentiality for nurses and another level for all other regulated health professionals eligible for HPSP services. The HPSP does not support different levels of confidentiality based on board or profession. We support statutory language that consistently applies to all of the health-related licensing boards and the Department of Health.

The report implies that the Board of Nursing cannot investigate complaints effectively when licensees are enrolled in the HPSP without the board's knowledge. No other board has raised concerns that participation in HPSP impedes their investigations. Boards routinely ask licensees under investigation to sign authorizations to obtain HPSP data and licensees often want the boards to have this data to document that they are compliant with monitoring.

Recommendation 3: *The Legislature should enact legislation to allow the Health Professionals Services Program to continue to monitor a nurse after being unsuccessfully discharged until the Minnesota Board of Nursing acts on the Complaint.*

The HPSP believes that this can be accomplished without a legislative change, as similar processes are already in place with other health-related licensing boards. When HPSP reports licensee non-compliance with monitoring, HPSP is not obligated to discharge the licensee, as long as the licensee is amenable to continued monitoring. The report itself, rather than discharge of the licensee, provides the impetus for the regulatory board to initiate an investigation. A report of non-compliance does not need to lead to discharge unless so requested by the regulatory board.

Recommendation 4: *The Minnesota Board of Nursing and the Health Professionals Services Program should work together to develop nurse-specific policies, procedures, and mechanisms to help identify nurses that should be reported to the board.*

The HPSP is committed to working with the Board of Nursing and all of the health-related licensing boards to identify when participants should be reported to their regulatory boards. We do not believe these determinations should be profession-specific but, rather, behavior-specific. This ensures consistency in HPSP's criteria for reporting and provides a consistent basis for board investigations and discipline. All health-related licensing boards will have shared expectations of what will be reported and HPSP staff will apply a consistent standard for determining when to report.

There are varying degrees of non-compliance with HPSP monitoring and not all non-compliance represents symptom exacerbation or relapse. The HPSP is committed to continuing to work with the Board of Nursing and all of the health-related licensing boards to refine the threshold for reporting based on non-compliance. Currently, the HPSP and the boards, including the Board of Nursing, jointly use a consensus model to determine reporting thresholds.

We do not believe that reporting thresholds should be nurse-specific or profession-specific. Reporting thresholds should be behavior-specific. Absent practice restrictions that may be placed in a Monitoring Plan, the Plan is not specific to any profession, but the Plan is specific to the illness being monitored and as such is based on current monitoring guidelines for the specific illness. We are concerned that, if the threshold for reporting nurses is lowered, it will have a chilling effect on nurses self-reporting or reporting other nurses. It could undermine the basic premise of a diversion program, early intervention. We believe it would be unreasonable, for example, to report a nurse who has missed one toxicology screen (as the only evidence of non-compliance) vs. reporting other professionals after they have missed four toxicology screens within a 12-month period (the current threshold). As a point of comparison, some of the other professionals we monitor are employed in very high risk professions, such as anesthesiology or surgery; yet, the Board of Medical Practice has not seen the necessity to propose physician-specific reporting.

Recommendation 5: *The Minnesota Legislature should clarify statutes to require employers to report all instances of identifiable patient harm occurring as a result of nurses diverting to the Minnesota Board of Nursing.*

The HPSP supports this recommendation but believes it has been established through Minn. Stat. 214.33, Subd. 5.

Again, the HPSP appreciates the thorough review of its services. We are hopeful that this document will provide readers with a greater understanding of the HPSP.

Sincerely,



Monica Feider, MSW, LICSW
Program Manager

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Special Education, February 2013
K-12 Online Learning, September 2011
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Q Comp: Quality Compensation for Teachers, February 2009
Charter Schools, June 2008

Education, Postsecondary

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MnSCU System Office, February 2010
MnSCU Occupational Programs, March 2009

Energy

Renewable Energy Development Fund, October 2010
Biofuel Policies and Programs, April 2009
Energy Conservation Improvement Program, January 2005

Environment and Natural Resources

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DNR Forest Management, August 2014
Sustainable Forest Incentive Program, November 2013
Conservation Easements, February 2013
Environmental Review and Permitting, March 2011
Natural Resource Land, March 2010
Watershed Management, January 2007

Government Operations

Minnesota Board of Nursing: Complaint Resolution Process, March 2015
Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014

Government Operations (continued)

Helping Communities Recover from Natural Disasters, March 2012
Fiscal Notes, February 2012
Capitol Complex Security, May 2009
County Veterans Service Offices, January 2008

Health

Minnesota Health Insurance Exchange (MNsure), February 2015
Financial Management of Health Care Programs, February 2008
Nursing Home Inspections, February 2005

Human Services

Managed Care Organizations’ Administrative Expenses, March 2015
Medical Assistance Payment Rates for Dental Services, March 2013
State-Operated Human Services, February 2013
Child Protection Screening, February 2012
Civil Commitment of Sex Offenders, March 2011
Medical Nonemergency Transportation, February 2011
Personal Care Assistance, January 2009

Housing and Local Government

Consolidation of Local Governments, April 2012

Jobs, Training, and Labor

State Protections for Meatpacking Workers, 2015
State Employee Union Fair Share Fee Calculations, July 2013
Workforce Programs, February 2010
E-Verify, June 2009
Oversight of Workers’ Compensation, February 2009
JOBZ Program, February 2008
Misclassification of Employees as Independent Contractors, November 2007

Miscellaneous

The Legacy Amendment, November 2011
Public Libraries, March 2010
Economic Impact of Immigrants, May 2006
Liquor Regulation, March 2006
Gambling Regulation and Oversight, January 2005

Transportation

MnDOT Selection of Pavement Surface for Road Preservation, March 2014
MnDOT Noise Barriers, October 2013
Governance of Transit in the Twin Cities Region, January 2011
State Highways and Bridges, February 2008