MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1360 Energy Park Drive, Suite 220
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mn.gov/boards/hpsp

PROGRAM COMMITTEE MEETING MINUTES

Date: 8/18/2026

Location: Virtual and In-Person at 335 Randolph in Minnehaha

Time: 10:00 AM CST

I. **Meeting called to begin at 10:00AM by Chair Mary Noble**

II. **Introductions:**

Board	Name	In Attendance?
Behavioral Health and Therapy	Bharati Acharya	✓
Chiropractic Examiners	Mary Noble	✓
Dentistry	Samuel Ankrah	✓
Dept of Health	Robert Dehler/Daphne Ponds/Debbie Thao	-
Dietetics & Nutrition	Susan Estes	✓
Long Term Services & Supports	Deb	✓
Marriage & Family Therapy	Jennifer Mohlenhoff	Chilah Brown
Medical Practice	Averi M. Turner	✓
Nursing	Tracy Sonterre-Rieger	Kate Reimers
Occupational Therapy	Christine Hoepner	✓
Office of Emergency Medical Services	Amber Lage	Pattie Forsberg Tanya Armstrong
Optometry	Britt Heglund	-
Pharmacy	Ben Maisenbach	✓
Physical Therapy	Allen Rasmussen	✓
Podiatry	Cyndee Fields	✓
Psychology	Michael Thompson	✓
Social Work	Linda Gustafson	✓

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Veterinary Medicine	Jody Grote	✓

Other Attendees: Kim Navarre (HPSP – Director), Kerry Gibbons (HPSP – Office Manager), Tracy Erfourth (HPSP – Case Manager), Nicky Williams (HPSP – Case Manager), Andrew Leinen (HPSP – Case Manager), Johanna Gangl (HPSP – Case Manager), Pang Yang (HPSP – Case Manager)

III. **Review: Minutes from meeting (Chair) –** Moved by Allen Rasmussen, 2nd by Chilah Brown

IV. **Review: Proposed agenda (Chair)**

V. **Public comments (Chair) – None**

VI. **HPSP Updates** – The HPSP team remains steady with a staff of 10, managing a significant and complex caseload. On average, each case manager oversees approximately 80 individuals, with roughly 550 participants active in the program at any given time. Of these, about 75 individuals are in the determination phase, while more than 400 are progressing under Participation Agreements. Approximately 30% of all referrals received do not result in monitoring, reflecting both the diversity of referral reasons and HPSP's careful criteria for determining eligibility.

VII. **Presentation: HPSP – Case Manager Review**

The HPSP Staff Members (Nicky Williams, Andrew Leinen, Johanna Gangl, Pang Yang, and Tracy Erfourth) reviewed and discussed two fictional case scenarios illustrating the processes and decision-making practices of the Health Professionals Services Program (HPSP). Case managers highlighted their current and past roles, their values and how they align with HPSP's Value Statements (Integrity, Respect, Informed, Accountability, Excellence), and our monitoring approach, emphasizing patient safety, strong collaboration with treating providers, and individualized participant support.

Objectives Covered

- Understanding HPSP's referral pathways, monitoring structure, and clinical decision-making.
- Applying HPSP procedures through real-world scenarios.
- Highlighting the complexities faced by participants referred for medical, mental health, or substance use concerns.

Case Scenario A: Medical Condition (TBI) A self referred participant reported cognitive challenges following a head injury. HPSP requested a neuropsychological evaluation and a temporary refrain from practice. Evaluation revealed executive function deficits, leading to an 18-month Participation Agreement with occupational therapy, neurology follow-up, and ongoing assessments. Despite limited improvement and eventual job loss due to extended

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leave, providers felt the participant could safely manage their condition independently. HPSP determined successful completion with recommendation to continue treatment.

Case Scenario B: Substance Use & Mental Health A therapist submitted a confidential third-party referral regarding substance use involving alcohol, cannabis, and Kratom. Assessment confirmed multiple substance use disorders and recommended intensive outpatient treatment, abstinence, therapy, and support group engagement. A 36-month Participation Agreement was established.

The participant initially struggled with compliance, prompting an initial report to the licensing board. Later concerns—including missed appointments, diluted toxicology results, and a positive PEth and Kratom screen—resulted in further investigation through a Toxicology Director Opinion. Findings showed levels inconsistent with incidental exposure, and due to continued denial despite evidence, the participant was unsuccessfully discharged.

General Themes Discussed

• Importance of clinical data and provider recommendations in decision-making.
• Workflow for weekly team case consultations.
• Reporting requirements, statutory obligations, and when non-compliance necessitates board notification.
• Assessing insight, practice safety, and readiness for completion or discharge.

Questions from Committee Members:

Q: How do you determine end date for Participation Agreements when it is something like a TBI, a life changing diagnosis in which progress and the future are so unknown?

A: For conditions like traumatic brain injury where recovery is unpredictable, HPSP sets a Participation Agreement end date based on provider recommendations and the minimum time needed to evaluate stability. The end date doesn't imply full recovery—it marks a point to assess whether the participant can safely self-manage their condition.

If the participant is stable, follows treatment, and shows insight into their limitations, HPSP may close the case. Because these conditions can change over time, the participant is instructed to contact HPSP ***before returning to practice*** *so monitoring can resume if needed.*

In essence, HPSP is not monitoring to resolve the illness—we are monitoring whether the participant can manage their condition in a way that protects the public.

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Q: In these cases, would you ask the providers to refer the Licensee back to the program when they have approved the licensee's return to practice?

A: In situations like this, we may ask providers to refer the licensee back to HPSP when they approve a return to practice—but it isn't automatic. Each provider sees HPSP through their own professional lens, and their comfort level with monitoring varies. Ideally, we want them to notify us, and it's often a conversation we initiate when we see that a participant's condition may require future oversight. Ultimately, the goal is to ensure a smooth handoff and maintain public safety, while recognizing that provider engagement can differ case by case.

Q: What about cognitive decline due to aging? How do you determine monitoring needs?

A: When a licensee's cognitive decline progresses from mild to moderate or severe, HPSP cannot continue monitoring. Our program is designed to support individuals who can still safely manage their condition with guidance, which typically aligns only with mild impairment. Once a treating provider determines the condition has advanced beyond mild, the licensee is no longer eligible for monitoring, and the case is discharged unsuccessfully to the board.

At that point, the provider's evaluation usually states that the licensee is unable to practice safely. This clinical determination is what triggers the report—not HPSP deciding the severity itself. Our role remains focused on monitoring only when an illness can be safely self managed with oversight; when it cannot, responsibility shifts to the board for further action.

Q: What about if a licensee is referred to HPSP but does not cooperate and provide you the medical documents or assessments you need?

A: When a licensee is referred to HPSP but does not cooperate—meaning they decline evaluations, do not return authorizations, or otherwise prevent HPSP from assessing their condition—we cannot determine eligibility for monitoring. Because our decisions rely heavily on treatment provider evaluations and recommendations, lack of cooperation leaves us without the clinical information needed to establish safety.

In these situations, HPSP must discharge the case to the licensing board. This is not a determination of illness severity—it is simply the result of being unable to complete an

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assessment. Without provider input, HPSP cannot ensure public safety through monitoring, and the board becomes responsible for next steps.

VII. **Adjourn: Chair** – Motion to Adjourn – by Susan Estes, 2nd by Averi M. Turner

Next Meetings:
November 10, 2026
February 9, 2027
May 11, 2027