

LPH Data Modernization SCHSAC Workgroup September 2026 Meeting Minutes

INTEROPERABILITY & DATA ACCESS: MONDAY SEPTEMBER 14TH, 2026
| 10:00AM-11:00AM

DATA QUALITY/USABILITY & DATA CAPACITY: WEDNESDAY
SEPTEMBER 2ND, 2026 | 3:00PM-4:00PM

SHARED GOVERNANCE & DATA RELATIONSHIP: MONDAY SEPTEMBER
14TH, 2026 | 11:05AM-12:00PM

FULL LPH DATA MODERNIZATION SCHSAC WORKGROUP: THURSDAY
SEPTEMBER 17TH, 2026 | 1:05PM-2:30PM

MINUTES PREPARED BY: GABBY CAHOW, MDH DATA MODERNIZATION PLANNER
LOCATION: VIRTUAL, MICROSOFT TEAMS

Attendance

▪ Interoperability & Data Access Subgroup:

Members

Melanie Countryman-Dakota County Public Health, **Rob Prose**-St. Louis County Public Health, **Lisa Klotzbach**-Dakota County Public Health

MDH Subject Matter Experts

Kari Guida-MDH Center for Health Information Policy and Transformation (CHIPT), **Dawn Huspeni**-MDH Infectious Disease Epidemiology, Prevention, and Control (IDEPC) Division

Facilitators/Guest Attendees

Gabby Cahow-MDH Public Health Strategy and Partnership Division (PHSP)

▪ Data Quality/Usability & Data Capacity Subgroup:

Members

Shelly Aalfs-Countryside Public Health, **Angel Korynta**- Polk-Norman-Mahnomen Public Health, **Alyssa Johnson**-Faribault-Martin CHB

MDH Subject Matter Experts

Abby Stamm-MDH Office of Data Strategy and Interoperability (DSI), **Emily Styles**-MDH Health Promotion Chronic Disease (HPCD)

SEPTEMBER 2026 LPH DATA MODERNIZATION SCHSAC WORKGROUP MEETING
NOTES

Facilitators/Guest Attendees

Gabby Cahow-MDH Public Health Strategy and Partnership Division (PHSP)

▪ Shared Governance & Data Relationship Subgroup:

Members

De Malterer-Le Sueur- Waseca Counties SCHSAC Elected, **Tina Jordahl**-Olmsted County Public Health Services

MDH Subject Matter Experts

An Garagiola, MDH Office of American Indian Health (OAIH), **John Li**- MDH Chief Data & Analytics Officer Executive Office

Facilitators/Guest Attendees

Gabby Cahow-MDH Public Health Strategy and Partnership Division (PHSP), **Chelsie Huntley**- MDH Public Health Strategy and Partnership Division (PHSP)

▪ Full LPH Data Modernization SCHSAC Workgroup Meeting:

Members

Shelly Aalfs-Countryside Public Health, **Angie Hasbrouck**-Horizon Public Health, **Melanie Countryman**-Dakota County Public Health, **Lisa Klotzbach**-Dakota County Public Health, **Tina Jordahl**-Olmsted County Public Health Services, **Rob Prose**-St. Louis County Public Health, **Sarah Grosshuesch**-Wright County Public Health,

MDH Subject Matter Experts

Jessie Carr-MDH Environmental Health Division, **Kari Guida**-MDH Center for Health Information Policy and Transformation (CHIPT), **Abby Stamm**-MDH Office of Data Strategy and Interoperability (DSI), **John Li**- MDH Chief Data & Analytics Officer Executive Office, **Emily Styles**-MDH Health Promotion Chronic Disease (HPCD)

Facilitators/Guest Attendees

Gabby Cahow-MDH Public Health Strategy and Partnership Division (PHSP), **Deanna White**-MDH Center for Public Health Practice (PHP)

Purpose

- In September 2026 the Workgroup met in Subgroups to continue to brainstorm ideas for recommendations and as a full Workgroup to provide collective feedback on the recommendations developed so far.

Subgroup Agenda

- Meeting Kick-Off
- Recommendation Idea Generation
- Meeting Wrap-Up

Full Workgroup Agenda

- Meeting Kick-Off
- Review and Provide Feedback on Draft Recommendations for Data Capacity, Data Sharing, and Data Relationship in Breakout Rooms
- Large Group Discussion
- Meeting Wrap-Up

Decisions made

- None at this time

Action items

- **Interoperability & Data Access Subgroup:**
 - Review the first draft of recommendations for Interoperability (Sent separately to subgroup)
- **Data Quality/Usability & Data Capacity Subgroup:**
 - Review the first draft of recommendations for Data Quality/Usability (Sent separately to subgroup)
- **Shared Governance & Data Relationship Subgroup:**

- Review the first draft of recommendations for Share Governance (Sent separately to subgroup)

Talking Points

- The LPH Data Modernization SCHSAC Workgroup members met in Subgroups to continue to generate ideas and draft language for recommendations for the issue statements identified under each topic area/vision statement.

Meeting notes

- Subgroup Meetings: Recommendation Idea Generation
- **Background/Context:**
 - Members were asked to consider the following prompts as they were brainstorming ideas for recommendations:
 - What system-level change do we want to see to address this problem and achieve our vision?
 - Changes can include things like implementing programs, projects, policies, initiatives, activities, events, ventures, plans, systems, and models.
 - Who is implementing that change? MDH, LPH, TPH? MDH & LPH together? SCHSAC?
 - What processes need to be initiated or what decisions need to be made to address this issue and achieve our vision?
 - Once the Subgroup has completed generating ideas for a vision area, the facilitator will take the information collected during the brainstorm and the subsequent discussion and draft recommendations for the Subgroup to provide feedback and edit once idea generation is complete.
- Below are the Issue Statements for each vision statement/topic area.
 - **Interoperability:** Data flows securely and seamlessly across systems and organizations ensuring information is available for timely insight, coordinated action, and ultimately measurably healthier communities.

1. Challenges to creating an interoperable governmental public health data system include technical issues (ex. differences in interoperability capabilities and IT infrastructure across LPH, TPH, and MDH) and policy issues (ex. data privacy, security, legal, and regulatory compliance).

a. Recommendation Ideas:

- i. drive adoption of and participation in statewide HIO services and TEFCA (Trusted Exchange Framework and Common Agreement)
- ii. Understand the policy, regulations, security, legal, and regulatory landscape that is inhibiting interoperability-MDH and LPH

2. The scope and focus of public health interoperability efforts has been between public health and healthcare organizations and has yet to include or address the importance of expanding interoperability efforts with social needs serving entities.

a. Recommendation Ideas:

- i. DHS and Healthcare Medicare Work Requirement could give an example of interoperable data exchange that could inform future improvements
- ii. Analyze and propose policy changes around language that compel public health and healthcare sharing data - Example Fatality Review- Law enforcement, VA
- iii. U of M Extension collaboration for policy review?
- iv. What and how are social service providers reporting to DHS
 1. (HL-7 messaging as an example for healthcare)
- v. Agency to Agency agreements to support data sharing between human services/social service serving agencies (DCT, DHS, DOC) that enable LPH also get access to data

3. Buy-in across the system for investment in interoperable systems has been impacted by a lack of understanding the value of interoperability

a. Recommendation Ideas:

- i. Move toward sharing more provisional/preliminary data between MDH and LPH (automated or just sharing?)
 - 1. Increase knowledge and skills around the use of preliminary data for public health decision making
 - ii. Leverage tools like data lakes to increase interoperability (or another tool for LPH to easily access data)
 - 4. Resources and expertise have already been invested in sustaining and improving legacy IT systems that may not have interoperable functionalities.
 - a. **Recommendation Ideas:**
 - i. LPH must be involved in MDH's interoperability plans (whole system roadmap)
 - ii. MDH should move towards not investing in siloed systems, and invest in whole public health system real time EHR data
 - 5. In order to create interoperable systems local, Tribal, and state health agencies would need to develop shared standards and/or align with existing standards such as FHIR or HL-7.
 - a. Recommendation Ideas:
- **Data Quality & Usability:** All stages of the data lifecycle are transparent, rigorous, and responsive to the needs of the public health system, communities, and partners. Data systems are designed with end users in mind and data are available in user-friendly and easy to understand formats.
 - 1. Data priorities and needs across the governmental public health system haven't been assessed to identify the most important and relevant data from existing data sets and sources.
 - a. **Recommendation Ideas:**
 - i. There is a lot of focus on "need" - what is a want vs. what is a need - do we have a definition?
 - ii. Priorities may differ by capacity (staff, funding, time) to complete - how do we weight MDH/LPH/TPH priorities to ensure that all groups have an equal footing

- iii. Environmental scan of MDH/LPH/TPH needs and priorities with a clear definition of both
 - iv. Are we assuming that the end-user is the same across existing data sources and sets?
 - v. Related, specific measures and what the best data sources are for each
 - vi. Environmental scan of data sources used and what they are used for, whether data should be line or summary level, capacity to clean and summarize themselves
- 2. Significant lags in data timeliness limits its useability for public health decision-making and action.
 - a. **Recommendation Ideas:**
 - i. What needs to be public facing/available vs requested for decision making
 - ii. Creating better relationships between LPH and MDH Data stewards
 - iii. Reduce barriers to access for LPH (when appropriate)
 - iv. Leverage interoperability to improve data timeliness
 - v. Are there data sets that would take priority over others in regards to cleaning/weighting/disseminating? Does this get addressed when identifying the data priorities and needs?
 - vi. tension between up-to-yesterday and data cleanliness, validation
 - vii. Identify which data sources are most important/ Identify where there may be data sets/sources that are behind but critical
 - viii. access to preliminary data (when is appropriate and feasible)
 - 1. Can data stewards share preliminary data (clearly defined) and validation code with LPH who have capacity?
 - 2. Difference between data for decision making and action (preliminary can be good enough) and data for assessment (final)

3. Governmental public health partners (LPH, TPH, and MDH) have shared data needs and data needs that are unique to their role in the public health system, which prevents a one-size-fits all approach to data usability.
 - a. **Recommendation Ideas:**
 - i. Can we define what is meant by usability... filtering abilities, viewing data sets, etc.?
 - ii. Are there sets of needs, for CDC grants, state reporting, CHAs, and for individual community projects? (like defined roles/personas)
4. Limited data user engagement during the data design process impacts useability for governmental public health partners.
 - a. **Recommendation Ideas:**
 - i. This one feels more like a capacity issue (staffing/time)
 - ii. Who is the end user in these design processes? Does it stop at LPH/TPH or does it extend to the communities served?
 1. For the purposes of this workgroup and these recommendations LPH is the “end user” rather than community/the general public
 - iii. What does the design process look like? Does it include specific considerations for defined user roles? General requests could overwhelm.
 - iv. Include/engage/gather feedback from LPH in data design process
 - v. Data available at the CHB level whenever feasible that includes the city CHBs such as Minneapolis
 - vi. Work towards geocoding data when appropriate/feasible
 1. Milestone from the MDH Data Vision and Roadmap: Establish a centralized geocoding system and support geographic data
5. Lack of transparency related to data quality assurance methodology and information on available data accuracy and completeness.
 - a. **Recommendation Ideas:**

- i. Proposed Recommendation: MDH should develop standards for technical notes for data available publicly and by request that include information on data collection and analysis methodology, data limitations, bias within data, data citations (when from a secondary source), a data dictionary when applicable, and interpretation guidance. These technical notes should be easily accessible on MDH website for public data and provided with requested data.
 - 1. Include data prep, cleaning, validation methodology
 - ii. Include technical notes in data catalog
 - iii. Better disseminated, technical documentation for datasets (share data prep scripts?)
 - iv. List the primary data source in data catalog and/or technical notes
 - v.
 - 6. Lack of clarity of roles and responsibilities on maintenance of state data infrastructure, data tools, and IT systems between public health data staff/data stewards and county-based IT/MN-IT.
 - a. **Recommendation Ideas:**
 - i. clarity on technical assistance related to IT
 - 1. Example: MDH cannot provide data storage recommendations
- **Shared Governance:** Local, Tribal, and state public health agencies work within a mutually developed governance structure that ensures decisions about data policies, processes, and standards are transparent and made and implemented collaboratively.
- 1. There are no shared data governance/decision-making bodies that include Tribal, local, SCHSAC, and state representation with the authority or dedicated resources (staffing/time/funding) to determine governmental public health shared data modernization priorities, policies, or implementation approaches.

a. Recommendation Ideas:

- i. Shared data governance to address Tribal Data Sovereignty issues (Data catalog and Tribal data in program and grant data)
- ii. Two sides: how data are collected and used and how we decide how to invest resources (example IT systems) into data priority
- iii. High level decision making (right level and infrastructure)
- iv. As human services work to modernize, how does public health fit in or get needs met?
- v. Alignment with AMC leg priorities
- vi. dedicated body, space, forum
- vii. Need a way to agree on a strategic plan

2. Updating and maintaining modern IT infrastructure at the local, Tribal, and state level to enable interoperability requires dedicated funding.

a. Recommendation Ideas:

- i. good policy + good relationship = good governance
- ii. Examples of things that are working well (data collaboration and shared decision making) Injury prevention (overdose and opioid for fatality review), OVR, Sys (willingness to share data and to work together) Acting in partnership- Data relationship?
- iii. Data Fact Sheet: Example from Washington DOH to create more transparency (resource in the works)
 - 1. Data Technical Assistance (Data, Data Use, and Data Sharing) for Tribes
- iv. LPH/TPH representation and engagement in internal MDH data modernization decisions
 - 1. Need to get specific about the kinds of decision that LPH/TPH need to be involved in
 - a. Go to LPHA regions for feedback
 - b. Identify test questions to identify opportunities
 - i. who has the data, who gets the data, how they get the data
 - ii. whole public health system implication

- c. Identify technical assistance requests from LPH that have been requested multiple time to identify opportunities
 - d. Explore via data set to identify opportunities
 - 3. Updating and upgrading data systems, process, and policies requires a significant investment of resources and there is no governmental public health system approach (Tribal, local, and state) to making decisions about what and how data modernization priorities are funded.
 - a. **Recommendation Ideas:**
 - i. review systems to identify areas of investment
 - ii. Look across how data and technology infrastructure is being funded and look for opportunities for economies of scale
 - iii. Identify priorities/criteria for investments: need data sets that are updated at this interval unifying look
 - 4. The siloed nature of public health funding has caused data collection, assessment, surveillance, and sharing to be disjointed, funding specific/dependent, and has made a whole system approach to data challenging.
 - a. **Recommendation Ideas:**
 - i. sustainable state funding for data modernization
 - ii. Capital investments in MN-IT. MN-IT serving the whole system
 - iii. Currently responding to issues and requests, rather than building a whole system infrastructure/universal
 - 5. Current funding approaches allocate limited resources for staffing, data tools/software, and training which are foundational for building data capacity.
 - a. **Recommendation Ideas:**
- **Full LPH Data Modernization SCHSAC Workgroup Meeting Notes:**
 - **Background/Context:**

- The Subgroups finished brainstorming around the topic areas of Data Capacity, Data Relationship, and Data Sharing in August 2026. The workgroup facilitator translated the ideas into draft recommendation language. The Subgroups were able to provide feedback and edits to the recommendation language. The workgroup facilitator refined the recommendations based on Subgroup member feedback to bring to the full workgroup meeting in September for the other Subgroup members to provide feedback.
- **Activity and Discussion:**
 - The Workgroup was broken into Subgroups and put into breakout rooms to review and provide feedback on the draft recommendation language of the two areas the other Subgroups have been working on. After the Workgroup members had the opportunity to provide feedback, the group came back together to have a short discussion on the recommendations as a whole.
- **Recommendation Language**

Recommendation 2: Improve visibility and access to data at MDH for Local and Tribal Public Health

Vision: Data are shared and accessed easily, enabling consistent, reliable, and timely access to locally relevant information across state, local, and Tribal public health

1. MDH should work with local and Tribal health departments to identify any legal barriers to MDH sharing data with local and Tribal health departments and work to address through policy and/or legislation.
2. MDH should formally define their relationship with local and Tribal public health as it relates to data sharing and adopt department-wide policies and practices consistent with the definition. Specifically, MDH should articulate:
 - a. When a data use agreement is necessary for sharing data.
 - b. What statutes, policies, legal review/interpretation, may limit data sharing between LPH and MDH.
3. When data use agreements are necessary for data sharing, MDH should:
 - a. Articulate the legal rationale for requiring a data use agreement.
 - b. Provide easily accessible documentation related to the data use agreement.
 - c. Provide outreach/training when new data use agreements are implemented and notify all local and Tribal public health when changes are made to data use agreements.

4. MDH should develop and maintain a data catalog that is accessible to local and Tribal public health. At a minimum, the data catalog should:
 - a. Recognize local and Tribal public health as governmental public health entities that share the responsibility of protecting and promoting the health of the public with MDH that require different consideration in data sharing and access as compared to the public or community partners.
 - b. Include clear classifications of data that indicate what data are available to local and Tribal public health. If data are not available to local and Tribal health, the reason must be listed.
 - c. Identify what data contains Tribal Data and requires additional data sharing agreements with Tribes for local public health to access.
 - d. When data are added, removed, or updated, these changes must be communicated to local and Tribal public health.
5. When access to data requires local or Tribal public health to make a request to MDH, MDH should streamline and simplify the data request process by:
 - a. Providing clear and specific guidelines for requesting data.
 - b. Developing a standardized data request method for local and Tribal public health that can be used across multiple areas and is automatically routed to the appropriate MDH data steward.
 - c. Engaging local and Tribal public health in continuous improvement processes related to data requests between LPH and MDH.
6. When MDH denies a data request by a local or Tribal public health department, that denial must be based on statutory or legal limitations and MDH must provide documentation of the reason the data request was denied.
 - **Workgroup Feedback:**
 - Language consistency: switch from data to information confused me
 - Are there recommendations for bi-directional sharing/exchange of data elsewhere? Do we need to rec to make data flowing from LPH to MDH easier?
 - Under data catalog, include if data can be made available in a different data format or aggregation, or with some variables removed
 - Under 5, are there complementary recommendations about guidelines for MDH providing data, like usable format, timeline, documentation?

- What are the roles/duties/ expectations of LPH and TH for data sharing?
- I'm unclear how 3 and 5 are different
- In the data catalog, included reference to any suppression guidelines or best practice coding/cleaning requirements.
- special attention needs to be made to combine HHS agencies with LPH and how data sharing occurs including technical assistance that is supportive to their governance model
- Where would ongoing regular requests fit in here? Or real-time API sharing?
- How would we determine if our datasets contain tribal data and what to do with it?
- Where is the interoperability?
- Overall: health care partners sometimes require funding to submit/share data with public health. (Sharing)
- Overall: No mention of health care systems/partners. Is that intentional should that be part of it? (sharing)

Recommendation 4: Increase capacity to meaningfully use data across the entire public health system

Vision: Local, Tribal, and state public health agencies have the knowledge, skills, staffing, tools, and funding to effectively collect, analyze, interpret, share, and use data to identify and take action around community health priorities and emerging health issues.

1. MDH and local public health should leverage existing data and conduct an assessment to identify gaps in data capacity to fulfil the Foundational Public Health Responsibilities across state, local and Tribal health departments.
2. Together, MDH, local public health, and Tribal public health should develop a strategic plan on how to ensure data capacity across the state.
3. MDH and SCHSAC should support the development and maintenance of Regional Data Models by:
 - a. Evaluating the impact of Regional Data Models on increasing capacity across the state
 - b. Studying the cost to develop and sustain Regional Data Models to determine appropriate funding levels

- c. Developing and implementing policies that support sharing data across counties and regions.
 - d. Working to secure long-term sustainable funding for Regional Data Models
- 4. MDH local and Tribal public health should collaboratively develop core data and informatics competencies for common public health positions such as data analysts, epidemiologists, public health strategists, and informaticians.
- 5. MDH should provide regular training opportunities (live and asynchronous) to local and Tribal public health that build knowledge and skills related to:
 - a. Data storytelling, visualization, and communication.
 - b. Core data and informatics competencies, such as data collection, analysis, validation, and interpretation.
 - c. Programming and data coding basics for biostatistics and epidemiology
 - d. Data reliability and data suppression
 - e. How data and informatics connects and supports other foundational public health areas and capabilities
- 6. MDH should support peer learning spaces related to data and informatics that are open to MDH, local and Tribal public health.
- 7. MDH and local public health should collaborate to develop onboarding education and materials for new public health staff that includes:***
 - a. Information on data stewardship and security
 - b. The importance of data informed public health practice
 - c. An overview of MDH datasets and support/technical assistance resources
 - d. An overview of data sharing and access between LPH, MDH, and Tribal public health
 - e. Information on how/where to make MDH data requests
 - f. Tribal Data Sovereignty
- 8. MDH, LPH, and SCHSAC should support the development of academic partnerships with universities and colleges to support workforce development and training related to data, informatics, and research.
- 9. Once the MN public health system has addressed the differences in data capacity across the state, LPH and MDH should focus capacity building, education, and training efforts on supporting community (decision-makers, community partners, and community members) access, use and understanding of public health data and information. ***

*Notes: ***Tribal public health should also be invited to participate-looking for workgroup guidance on how to word that within the recommendations*

▪ **Workgroup Feedback:**

- there needs to be linkage text for 1 and 2
- tribals is missing ensure consistent language
- We have learned in the last 2 years that core system capacity funding can be at risk and there should be something not just about gaps but about how we maintain the core and fund the core
- 5.c. not a lot of staff will need this/not a lot of LHD (sharing)
- Address capacity within MDH as well to support capacity for LPH, Tribal, and within MDH. (Maybe this is outside scope though).
- It might be good to be more explicit on the meaning of data capacity. (people, training, infrastructure, all of the above?)
- The regional data model is not beneficial to all LDHs equally. The criteria is too strict. Does not address the root causes for all LHDs around data capacity (sharing)
- 1-4 requires new staff for LPH. What is needed will vary be LHD/regions? (sharing)
- #4 could create more inequities (sharing)
- Accessibility needs to be part of this discussion (sharing)

Recommendation 6: Develop stronger relationships and role clarity between state, local, and Tribal public health.

Vision: Local, Tribal, and state public health agencies are rooted in shared history and embrace working across systems and with partners to build trust, communication, and collaboration supporting progress towards improving the health of Minnesotans.

1. As LPH and MDH collaborate on data modernization strategies, every decision should uphold Tribal Data Sovereignty and any decision that may impact Tribes must be done in consultation with Tribal governments.
 - a. As MDH implements a Tribal Data Sovereignty Policy and develops data use agreements with Tribes, a mirrored process should also be implemented between LPH and Tribes.
 - b. As LPH, MDH, and SCHSAC work with Tribal partners around data modernization, they must allow adequate time in the process for trust and relationship building.

- c. LPH and MDH should commit to implementing the CARE (Collective benefit, Authority to control, Responsibility, Ethics) Principles of Indigenous Data Governance.
- 2. LPH, MDH, and SCHSAC should begin a process to explore and define roles and responsibilities for Foundational Public Health Responsibilities related to data and informatics. These conversations should also aim to address MDH's role in:
 - a. Articulating what data MDH will make available to address the Foundation Areas of Communicable Disease Control, Chronic Disease and Injury Prevention, Environmental Public Health, Maternal, Child, and Family Health, and Access to and Linkage with Clinical Care.
 - b. Facilitating/managing cross-state data sharing that enables out-of-state data access for LPH and Tribal public health.
 - c. Supporting the data capacity and modernization of Tribal public health and smaller capacity CHBs that cannot meet the Foundational Public Health Responsibilities independently.
- 3. MDH should develop a more centralized communication strategy to ensure crucial data and informatics updates and information reach LPH and Tribal public health partners. This communication strategy should include engagement and communication with relevant communities of practice and regional groups such as LPHA regional meetings or Regional Data Models.
- 4. MDH and LPH should work together to tell the story of Minnesota public health data modernization to help policymakers and community understand the value and importance of investing in public health data infrastructure and foundational data capacity by
 - a. Creating consistent messaging and unified narrative across Tribal, local, and state partners about the value of data and the need to modernize our system
 - b. Communicating the value of near real-time data and the need to invest in it
 - c. Engaging policymakers through regular briefings to build stronger relationships
 - d. Aligning Minnesota's needs to national priorities to increase credibility
 - e. Making data modernization a permanent fixture on legislative agendas
- **Workgroup Feedback:**
 - 2.b. will/may require policy and legislation changes (Sharing)
 - I second #3. I'd love a place to post my news relevant to LPH instead of tracking down lots of LPH groups separately.

- #4 Template so people are saying the same message but addresses the complexity of presenting to elected officials (sharing)
- Is formal "consultation" what is meant in #1?
- #4 Look at lessons learned from social services success in getting funding to update legacy systems (sharing)
- MDH is working on part of #2 internally. I haven't heard if or how they plan to share with or include LPH/TH.

Garden Plot

The "Garden Plot" is a place for topics, ideas, and questions that came up during the meeting that still need to be "tended" to at a future meeting.

Next meeting

Subgroup Meetings:

Agenda items: Continue recommendation brainstorm

- Interoperability and Data Access: Monday, October 12th | 10:00am-11:00am | Virtual, Microsoft Teams
- Data Usability/ Quality and Data Capacity Subgroup: Wednesday, October 7th | 3:00pm-4:00pm | Virtual, Microsoft Teams
- Shared Governance and Relationship Subgroup: Monday, October 12th | 11:05am-12:00pm | Virtual, Microsoft Teams
- Full LPH Data Modernization SCHSAC Workgroup: Thursday, October 15th | 1:05pm-2:30pm

Minnesota Department of Health
Public Health Strategy and Partnership Division

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