Minnesota e-Health Bridging Information & Care Work Group

March 13, 2026

DEPARTMENT OF HEALTH

health.state.mn.us

Land Acknowledgement

Every community owes its existence and vitality to generations from around the world who contributed their hopes, dreams, and energy to making the history that led to this moment. Some were brought here against their will, some were drawn to leave their distant homes in hope of a better life, and some have lived on this land for more generations than can be counted. Truth and acknowledgment are critical to building mutual respect and connection across all barriers of heritage and difference.

We begin this effort to acknowledge what has been buried by honoring the truth. We are standing on the ancestral lands of the Dakota people. We want to acknowledge the Dakota, the Ojibwe, the Ho Chunk, and the other nations of people who also called this place home. We pay respects to their elders past and present. Please take a moment to consider the treaties made by the Tribal nations that entitle non-Native people to live and work on traditional Native lands. Consider the many legacies of violence, displacement, migration, and settlement that bring us together here today. Please join us in uncovering such truths at any and all public events.*

*This is the acknowledgment given in the USDAC Honor Native Land Guide - edited to reflect this space by Shannon Geshick, MTAG, Executive Director Minnesota Indian Affairs Council

Housekeeping

- The meeting will be recorded for notetaking purposes.
- Cameras may be turned off to preserve bandwidth.
- Please mute your microphone when not speaking.
- Use the “raise hand” feature and say your name before speaking. Please feel free to turn camera on when speaking.
- Feel free to use the chat to share content, comments, questions and/or share thoughts in the work group input form https://forms.office.com/g/3Cc6VBRApA.
- If you’re experiencing technical problems, use chat or email Susie Blake at Susie.Blake@state.mn.us.

Agenda

10:00 - 10:10 a.m.	Welcome and housekeeping
10:10 - 11:40 a.m.	Use case rating survey results and prioritization
11:40 - 11:55 a.m.	Prior Minnesota interoperability efforts
11:55 a.m. - noon	Looking ahead and next steps

Work group tasks and status (from charge)

Proposed Activities, Tasks and Deliverables

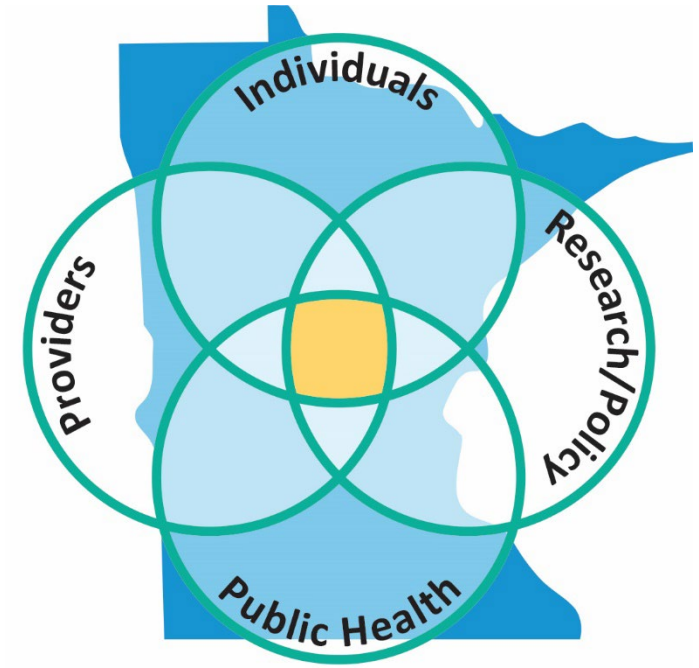
	Status	Workgroup Meetings						
December 2025 - February 2026		Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Review and provide input on environmental scan/status of current HIE environment		X	X					
Develop inventory that identifies use cases/areas where exchanged information is supporting care and where there are gaps and/or challenges		X	X	X				
March - June 2026								
Prioritize use cases and identify for which ones the WG will draft recommendations				X	X			
Review prior work to address root causes of lack of interoperability in Minnesota					X			
Learn about and discuss options for information sharing and use/reuse (e.g., HIOs, QHINs etc)						X		
Review strategies used by other states and identify any strategies that could be used or built upon in Minnesota						X		
Develop recommendations to help achieve priority use cases						X	X	X

 **Completed**

 **In process**

 **Not yet started**

Prioritization



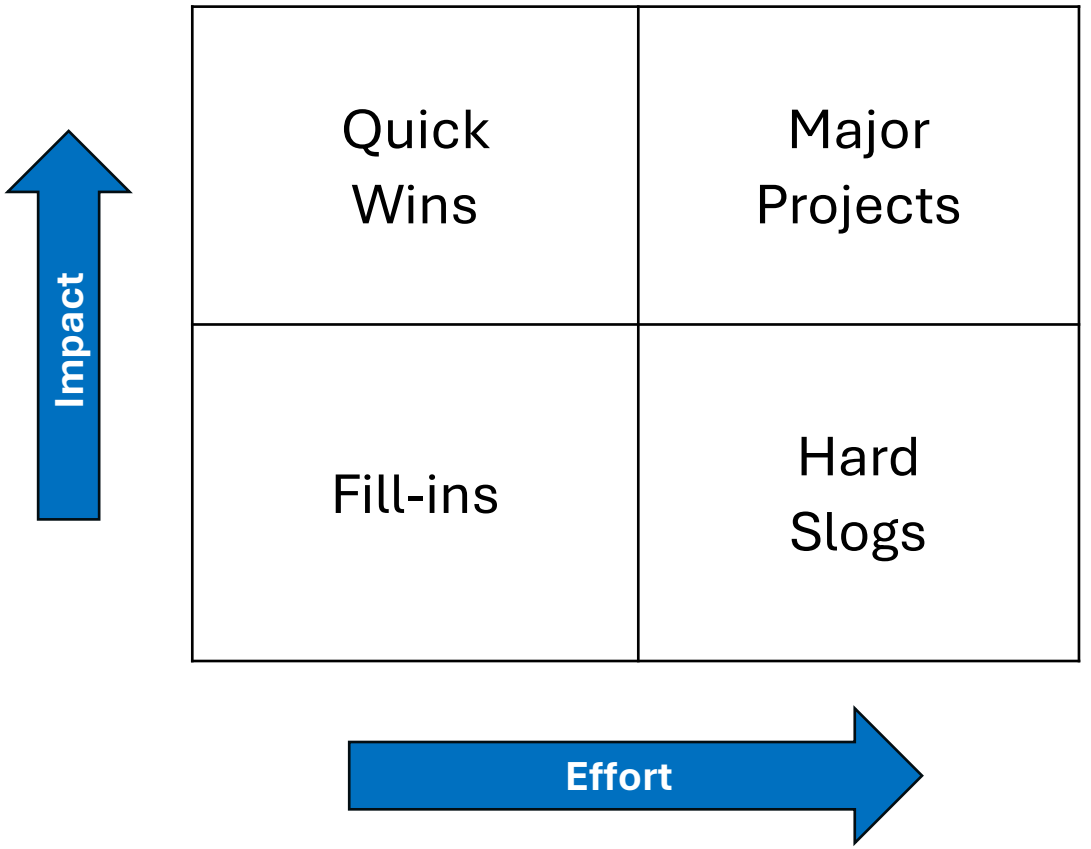
- Review use cases to ensure alignment with Minnesota e-Health Initiative priorities
- Assess potential impact and effort (feasibility and resources needed) for each use case
- Quantify impact and effort to help guide selection of priority use cases

Priority matrix

Quantify the impact, feasibility and resources needed for use cases

- **Effort:** Feasibility, resources required
- **Impact:** Expected outcomes

Graph and create a “Priority matrix” to help support or identify use cases to move forward



How to “quantify” use case potential impact

Assess how the expected outcomes and extent of effect, considering the groups called out below, and quantify that as the potential impact.

- Patients, individuals, caregivers: improved care quality and satisfaction
- Providers, payers and or public health: improved care, reduction in administrative burden
- Public health: increased and/or enhanced safety benefit, improved population health
- Research: Ease of application of aggregated data
- Policy: meets health ecosystem, state or federal policy goals
- Cross-organization value: diversity of or number of groups expected to benefit

Sources: CyncHealth and Brett Marquard for sharing prioritization criteria

How to “quantify” potential effort

Assess what the feasibility and resource costs (e.g., financial, staff) are, considering the questions below, and quantify that as potential effort.

- How complex is the implementation?
- How quickly could any barriers be removed/addressed?
- How does the use case align with current regulations and/or policy? (e.g., supports state or federal requirements, oversight)
- How does it align with Rural Health Transformation Program? (e.g., would it qualify for any funding opportunities?)
- How likely is it be accomplished within 12-18 months?
- How sustainable would it be over time?
- How could this implementation be reused with other use cases?

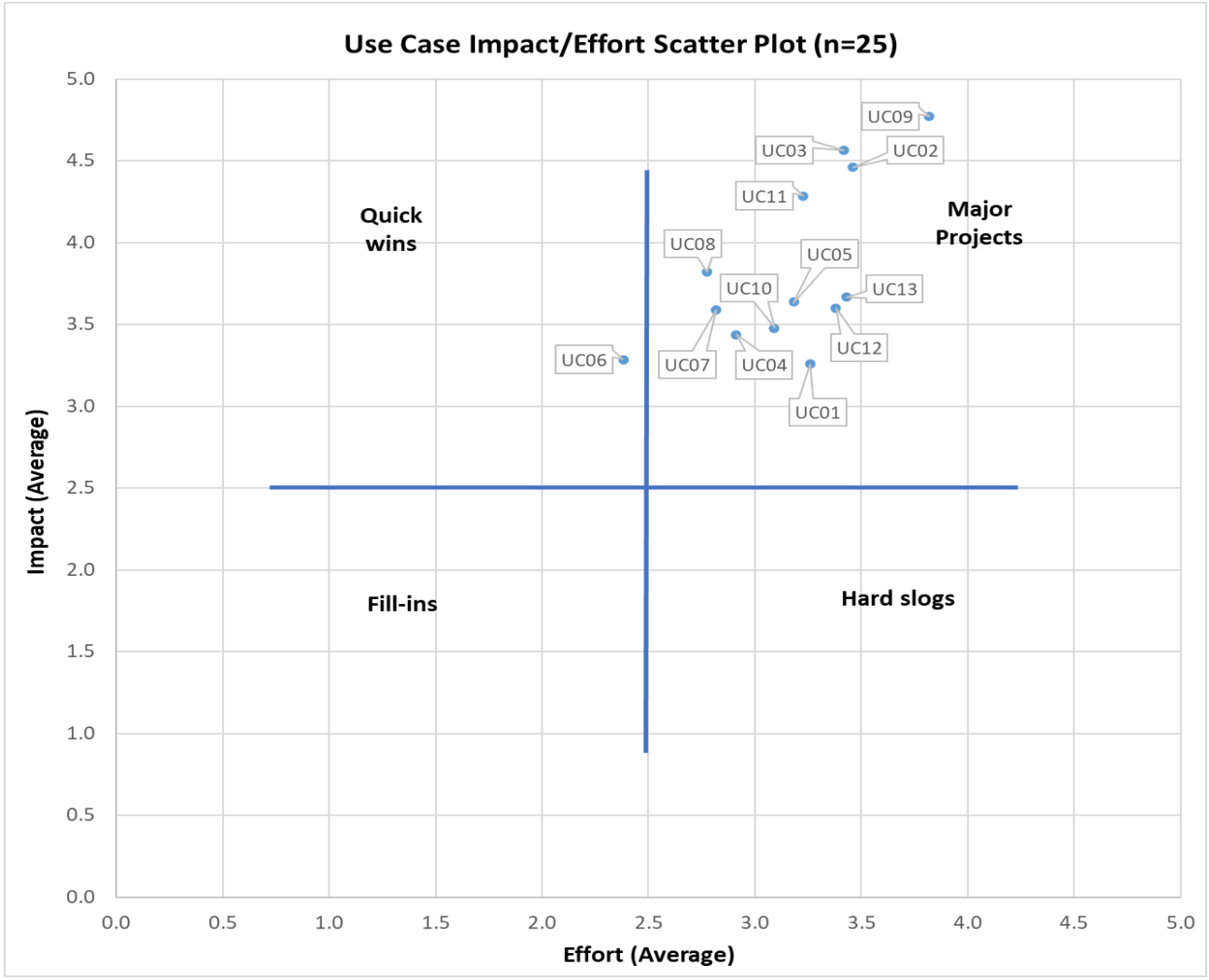
Sources: CyncHealth and Brett Marquard for sharing prioritization criteria

Use case rating survey results

- Collected input from work group members, e-Health Advisory Committee and broader audience to generate
  - 25 responses received (work group members, Advisory Committee members, large health systems, rural hospitals, local public health etc.)
  - Results compiled and summarized (*see Results summary handout*)
    - Scatter diagram showing the average impact and effort ratings of all responses
    - Scatter diagram expanded for easier viewing
    - Bar chart of average impact ratings, sorted high to low
    - Bar chart of average effort ratings, sorted high to low
    - Table of results
    - Comments compiled as separate handout (*see Comments handout*)

Use case rating survey results

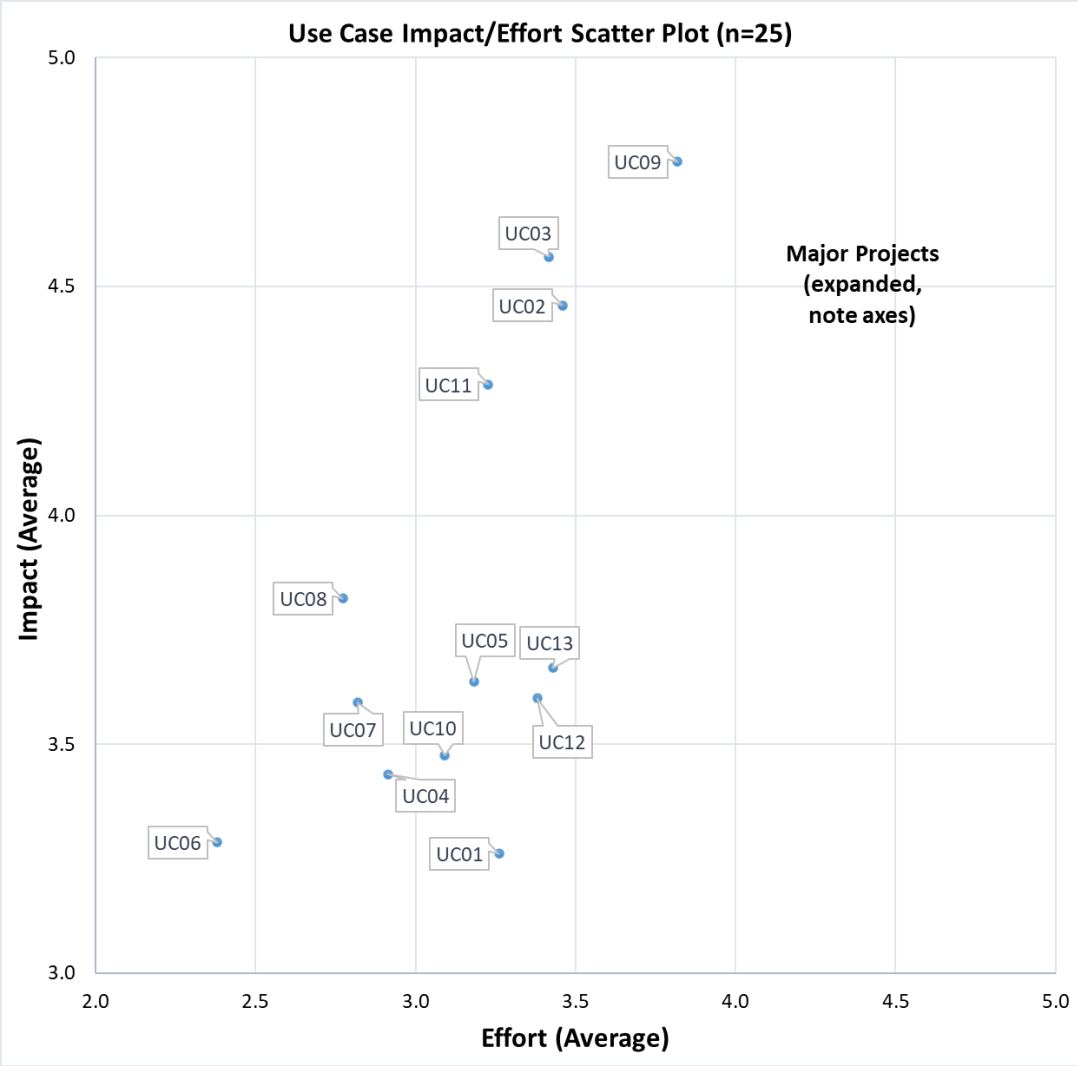
Scatter diagram showing the average impact and effort ratings of all responses



UC01 - Pharmacists ADTs
UC02 - LTPAC & hospitals- bi-directional for transitions
UC03 - Useable format for transitions bi-directional
UC04 - Death notifications from MDH
UC05 - Death registration -bi-directional with MDH
UC06 - TBI/SCI data to MDH using HIO
UC07 - Newborn Screening- test orders & results to MDH Public Health Lab using HIO
UC08 - Infectious Disease- test orders & results to MDH Public Health Lab using HIO
UC09 - Bi-directional exchange regardless of EHR
UC10 - Disability benefit determinations
UC11 - Prior authorizations
UC12 - Patient Access API (payer info)
UC13 - Provider Access API (payer info)

Use case rating survey results

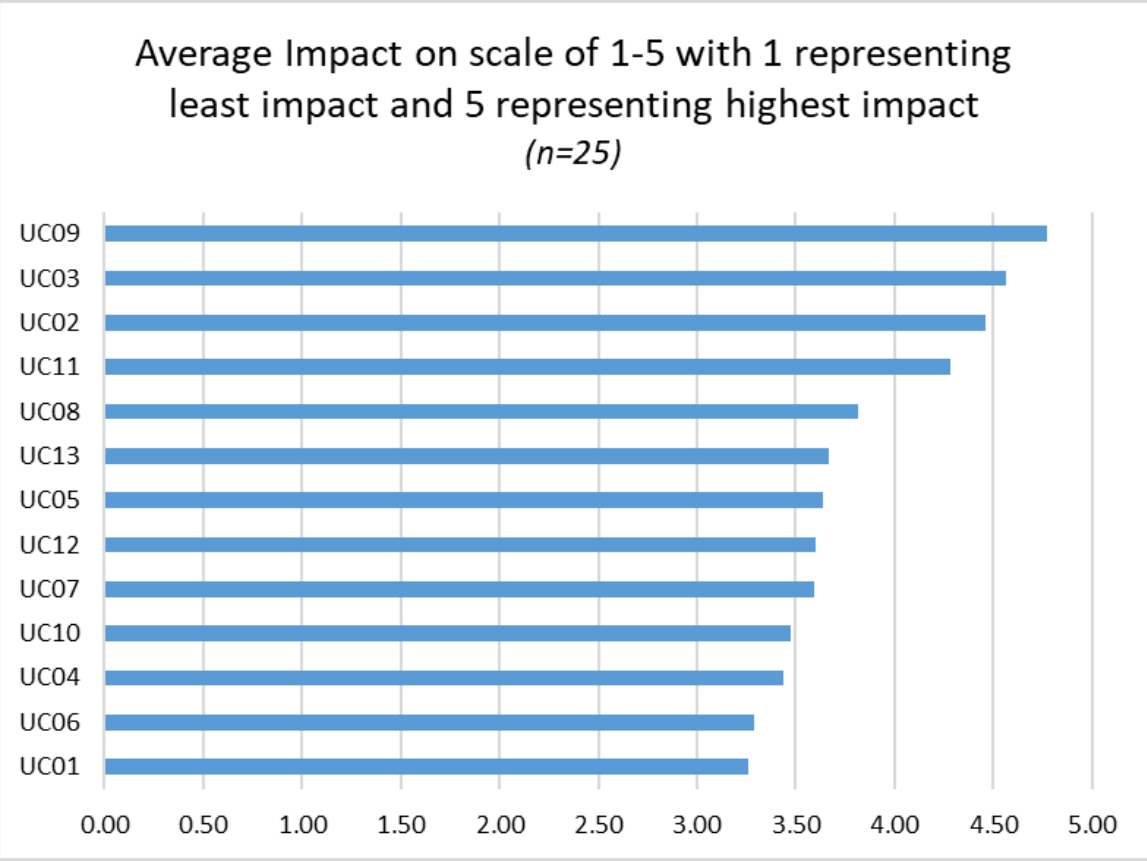
Scatter diagram showing the average impact and effort ratings of all responses; all show strong ratings, axes are adjusted to reflect this



UC01 - Pharmacists ADTs
UC02 - LTPAC & hospitals- bi-directional for transitions
UC03 - Useable format for transitions bi-directional
UC04 - Death notifications from MDH
UC05 - Death registration -bi-directional with MDH
UC06 - TBI/SCI data to MDH using HIO
UC07 - Newborn Screening- test orders & results to MDH Public Health Lab using HIO
UC08 - Infectious Disease- test orders & results to MDH Public Health Lab using HIO
UC09 - Bi-directional exchange regardless of EHR
UC10 - Disability benefit determinations
UC11 - Prior authorizations
UC12 - Patient Access API (payer info)
UC13 - Provider Access API (payer info)

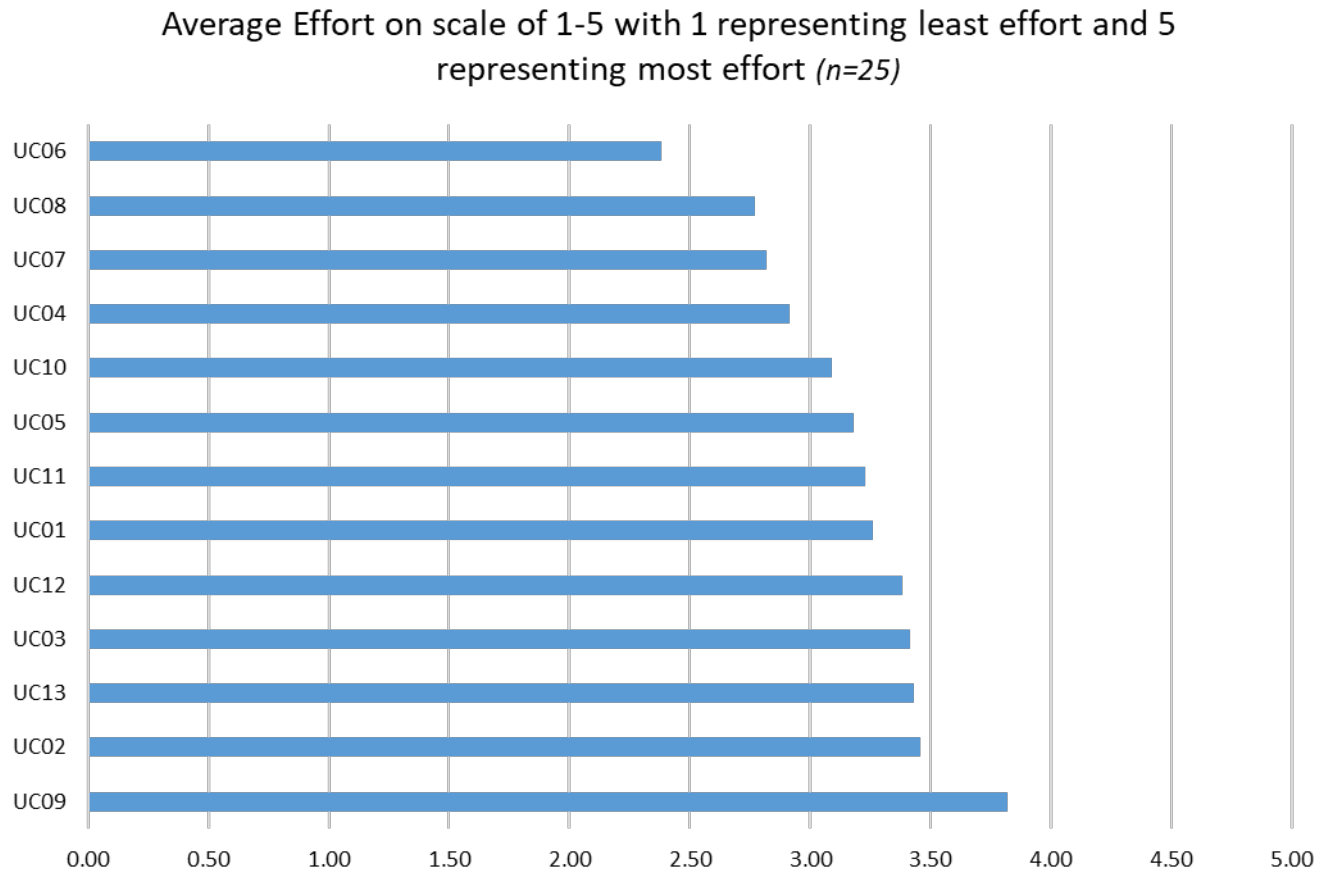
Use case rating survey results - Impact

- Bar chart of average impact ratings, sorted high to low



Use case rating survey results - Effort

- Bar chart of average effort ratings, sorted low to high



Use case rating survey results - Combined table

Use Case #	Use Case Description	Impact Average Scale from 1-5 1 lowest, 5 highest (min, max)	Impact Rank Ranked 1-13 1 is most impact, 13 is least impact	Effort Average Scale from 1-5 1 lowest, 5 highest (min, max)	Effort Rank Ranked 1-13 1 is least effort, 13 most effort
UC01	1. Pharmacists/pharmacies receive ADT notifications and other actionable-useful information. (e.g., discharge summaries)	3.25 (1,5)	13 (least impact)	3.26 (1,5)	8
UC02	2. Long term and post-acute care providers and hospitals achieve bi-directional exchange of information needed for hospital to nursing home transition or nursing home to hospital transitions.	4.46 (1,5)	3	3.46 (2,5)	12
UC03	3. Providers can send and receive information needed in a useable format for patient transitions.	4.50 (3,5)	2	3.42 (2,5)	10
UC04	4. Providers receive/obtain death "confirmation" more quickly/automatically from Minnesota Department of Health (MDH) death record data to allow cancellation of reminders/notifications.	3.43 (1,5)	11	2.91 (1,5)	4
UC05	5. Improve death registration process for hospitals/health systems by implementing bi-directional electronic exchange with Minnesota Registration and Certification system (MDH).	3.64 (1,5)	6	3.18 (1,5)	6
UC06	6. Public Health Use Case: Increase number of facilities sending Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) data to MDH using an HIO.	3.29 (1,5)	12	2.38 (1,4)	1 (least effort)
UC07	7. Public Health Use Case: Increase Newborn Screening Electronic Test Orders and Results (MDH Public Health Lab) using an HIO.	3.59 (1,5)	8	2.82 (1,5)	3
UC08	8. Public Health Use Case: Increase Infectious Disease Electronic Test Orders and Results (MDH Public Health Lab) using an HIO.	3.82 (1,5)	5	2.77 (1,5)	2
UC09	9. Smaller organizations (e.g., rural, independent, public health) receive health information electronically regardless of EHR used.	4.77 (3,5)	1 (most impact)	3.82 (2,5)	13 (most effort)
UC10	10. Process for submitting health information for disability benefit determinations.	3.45 (1,5)	10	3.09 (1,5)	5
UC11	11. Prior authorizations	4.23 (3,5)	4	3.23 (1,5)	7
UC12	12. Patient Access API (health plan/payer information available to patients).	3.57 (2,5)	9	3.38 (1,5)	9
UC13	13. Provider Access API (health plan/payer information available to providers).	3.64 (2,5)	7	3.43 (1,5)	11

Use case rating survey results - Comments

- Collected input/comments
  - See handout of ***Use Case Rating Survey Responder Comments***

Selected survey comments for use case #1

Pharmacist ADTs and discharge summaries

- Pharmacists are busy and may not have time to review discharge information.
- It will take a significant amount of effort for pharmacy systems who are not connected to a HISP to receive Event Notifications via the Direct Standard.
- Effort is lower only if ADT can be received outside the pharmacy system, high effort of need pharmacy software changes.
- Ranked lower impact due to a smaller set of population that would benefit, higher effort due to reimbursement issues and potential lack of readiness for pharmacists to take this on.
- HIOs have this as a core service.

Selected survey comments for use case #2

Long term and post-acute care providers and hospitals achieve bi-directional exchange of information needed for hospital to nursing home transition or nursing home to hospital transitions

- Consider a pilot with a few systems and LTC groups to map out the best way to then share with other systems across Minnesota.
- This is a major gap in today's ecosystem. Long-term care settings often receive discharge information that is lengthy, non-standardized, and difficult to operationalize, despite having limited clinical resources on site.
- Critical elements for safe transitions such as clear med reconciliation, what changed during the encounter, pending tests, follow-up needs, and DME/treatment orders etc. are frequently buried in compliance-driven documents.
- From the nursing home provider side, we send the current medication and treatment lists, careplans, and any other info they need to provide care. When the residents returned to skilled care, they often are restarted on medications that had been discontinued previously. Med reconciliation is a significant issue from nursing home to acute care.
- Conversely, information sent from LTC to acute and ambulatory settings is often not available as a usable clinical summary, resulting in incomplete histories, duplicative testing, avoidable medication changes, and missed follow-up.

Selected survey comments for use case #3

Providers can send and receive information needed in a useable format for patient transitions

- Like other use cases, but more focused on referrals to specialists.
- Could have a big impact for rural areas that don't have a lot of specialists. And for specialty referrals between systems.
- Not just data availability that is the end goal but making information available and readily usable within the provider's native workflow. Interoperability ideally should be invisible to the clinician and delivered into their EHR in a concise, context-aware format that supports transitions without adding navigation burden.
- Bigger challenge when you are changing health organization, could be an area to look at maternal health outcomes.
- Acute care EHRs should support this according to the ASTP/ONC Transitions of Care certification criterion 170.315(b)(1). LTPAC facility EHRs that do not yet support these standards will require a significant investment to do so.

Selected survey comments for use case #4

Providers receive/obtain death "confirmation" more quickly/automatically from Minnesota Department of Health (MDH) death record data to allow cancellation of reminders/notifications

- Address the current HL7 framework, request process, and $15 per request fee structure to replace it with a more interoperable API interface that gets this death information out to everyone who had been caring for a given patient automatically.
- Would need investment from the state to supplement fees and improve the structure.
- Epic is currently investigating some work on this for consumption of death certificates.
- MDH OVR currently sends select health systems a monthly statewide death file. Is the ask to send the file more frequently?

Selected survey comments for use case #5

Improve death registration process for hospitals/health systems by implementing bi-directional electronic exchange with Minnesota Registration and Certification system (MDH)

- Review/monitor draft HL7 Vital Records Death Reporting (VRDR) FHIR Implementation Guide which is beginning to be piloted.
- Common and high-value use case across states.
- Requires bi-directional exchange so clinical data can pre-populate the death certificate and verified death information can flow back to update the longitudinal record for care delivery and quality reporting.
- Consider expanding capacity to allow Licensed Registered Nurses who can implement a provider order to complete this process.
- MDH piloted with EPIC in Summer 2025 for a "proof of concept" which moved cause of death information through APIs using HL7-FHIR to an S3 bucket at MDH. Significant changes need to be made to the vital records electronic death registration for this to work well and significant change must occur in the death registration "culture" where deaths get registered in a two-part fashion almost exclusively being initiated by a mortician and then a record moving to the medical certifier to complete the cause of death (finish the record).

Selected survey comments for use case #6

Public Health Use Case: Increase number of facilities sending Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) data to MDH using an HIO

- Framework established that needs expansion.
- Needs health system and provider engagement and education as well as resourcing to help it be more of a priority for health systems.
- Think this can be achieved through education
- Limited impact based on volume of TBI patients but very helpful to those people; don't see this has having a widespread impact, although important for those affected.
- Opportunity to scale timely, standardized public health reporting through a shared HIE-enabled pathway rather than separate hospital recruitment and interface efforts for each program
- Use cases 6, 7, and 8 all represent a single opportunity to scale timely, standardized public health reporting through a shared HIE-enabled pathway rather than separate hospital recruitment and interface efforts for each program. Leveraging an HIE as the established reporting connection allows hospitals to use interfaces they have already implemented, eliminating program-specific builds and significantly reducing the FTE lift required to participate.

Selected survey comments for use case #7

Public Health Use Case: Increase Newborn Screening Electronic Test Orders and Results (MDH Public Health Lab) using an HIO

- Framework established that needs expansion.
- Needs health system and provider engagement and education as well as resourcing to help it be more of a priority for health systems.
- Higher workflow effort on health care side of things, but may be worthwhile, provider side effort is high
- Possible to start with buy-in recruitment at major birthing facilities and show savings? Can the ETOR effort be combined with the Infectious Disease use case?
- High impact as this could reduce hospitals FTEs from 5 to 1. High effort as it takes about 6 months to a year to implement.
- Use cases 6, 7, and 8 all represent a single opportunity to scale timely, standardized public health reporting through a shared HIE-enabled pathway rather than separate hospital recruitment and interface efforts for each program. Leveraging an HIE as the established reporting connection allows hospitals to use interfaces they have already implemented, eliminating program-specific builds and significantly reducing the FTE lift required to participate.

Selected survey comments for use case #8

Public Health Use Case: Increase Infectious Disease Electronic Test Orders and Results (MDH Public Health Lab) using an HIO

- Framework established that needs expansion.
- Needs health system and provider engagement and education as well as resourcing to help it be more of a priority for health systems.
- Use cases 6, 7, and 8 all represent a single opportunity to scale timely, standardized public health reporting through a shared HIE-enabled pathway rather than separate hospital recruitment and interface efforts for each program. Leveraging an HIE as the established reporting connection allows hospitals to use interfaces they have already implemented, eliminating program-specific builds and significantly reducing the FTE lift required to participate.
- High impact as this could reduce hospitals FTEs from 5 to 1. High effort as it could take a year or more to implement. Pilot sites are starting with a small list of 10 or so tests out of the 120--Northfield-Meditech and Fairview-Epic.

Selected survey comments from use case #9

Smaller organizations receive health information electronically regardless of HER (e.g., rural, independent, public health)

- Major benefits to healthcare, especially for rural Minnesotans, need to help smaller health systems and clinics get on TEFCA and better understand their barriers, also need to determine why EHR's at smaller locations are not making the shared data more available to the providers and nurses doing the care within their workflows and try to impact those groups or help smaller health systems and clinics advocate for themselves.
- This is foundational HIE/HIO functionality.
- Could look at specific use case example such as maternal health and good opportunity for TEFCA.
- Is this something that could be funded through the Rural Health Transformation Program?

Selected survey comments from use case #10

Process for submitting health information for disability benefit determinations

- Conceptually this is a straightforward use case because the required information already exists within source EHRs; however, the level of effort varies widely based on vendor capability, local configuration, and the extent to which key content resides in unstructured notes. For some organizations this will be a light lift, while for others it may be complex and costly to structure, extract, and transmit the information in a standardized, computable format.

- The process must also incorporate clear consent management and privacy controls given the sensitivity of the data and the external recipient (SSA).

- Leveraging TEFCA government benefits determination workflows can help normalize exchange and reduce provider burden, but overall success will depend on EHR functionality and the ability to automate record compilation and submission.

- This is where an HIE/HIO can provide significant value by serving as the intermediary that normalizes data, compiles the appropriate longitudinal record, and manages routing in alignment with TEFCA workflows. An HIE can also centralize consent management and apply consistent privacy controls, reducing administrative and technical burden on individual providers. This approach levels EHR capability differences, improves timeliness for SSA determinations, and enables participation without requiring custom extraction and submission processes.

Selected survey comments from use case #11

Prior authorizations

- Effort is slightly easier because there is public policy requiring some of this and it is a major focus of ongoing reform so our recommendations may lead to implementations and the focus would be more on education and recommendations than the implementation itself although could give feedback.
- Would need appropriate insurance involvement in the committee from multiple insurers. The main 4 outcomes and potential committee influence could be:
  - Prior Authorization Requirements, Documentation, and Decision (PARDD) API: Payers must implement FHIR-based APIs to automate prior authorization, with decisions required within 7 days for standard requests (previously 14+) and 72 hours for urgent requests. (This will happen without the committee.)
  - Improved Patient Access API: Expands the existing Patient Access API to include information about prior authorization decisions (would be a huge improvement allowing patients to track this through an API). (Committee could give advice on how this could get to patients and providers efficiently and be useful in improving the process.)
  - Payer-to-Payer Data Exchange: Requires payers to exchange patient clinical and claims data when a patient switches insurance plans to ensure continuity of care. (This will happen without the committee but will be good for patients and providers to see if improvements are noted with insurance transitions.)
  - Reduced Provider Burden: A new MIPS measure for clinicians and hospitals for using Electronic Prior Authorization, intended to reduce administrative burnout. (This is where the committee could have the most impact connecting this provider process update with the payer process updates directly to patients.)
  - There are also a significant standards and dependency on the level of versioning. PAS is based on FHIR R4 and must function across multiple US Core implementation guide versions tied to different stages of USCDI adoption.
- While Da Vinci is designed to span these releases, many EHRs are not yet fully operational on USCDI v3 and will need to advance quickly. Payer-specific constraints and use of data elements not yet supported in US Core introduce additional variability, creating a gap between regulatory expectations and real-world vendor readiness. Our organizational data specifications are aligned to USCDI v3, with active movement toward v5 to stay ahead of required versioning, but ecosystem readiness for USCDI and FHIR remains uneven.
- A trusted intermediary can help normalize connectivity, manage version translation, and provide a consistent integration model so providers are not maintaining multiple, version-dependent payer connections. Without that alignment, this may meet technical compliance but deliver limited real-world reduction in provider burden or improvement in speed to therapy.

Selected survey comments from use case #12

Patient Access API (health plan/payer information available to patients)

- While this use case advances API-based data availability, the intended patient use case is not clearly defined. It is unclear what specific decisions patients are expected to make with the information or how it will meaningfully improve care navigation, coverage comparison, cost transparency, or self-management. Most payers already offer member portals, so the incremental value depends on whether patients can access a longitudinal, cross-plan view in a tool they actually use and trust.

- Populations most likely to benefit from improved access including rural residents, individuals with lower income, older adults, people with limited English proficiency, and those with intermittent coverage are the least likely to use standalone apps or manage multiple payer-specific experiences. Without a consistent, consumer-friendly access model including support for proxy access, language access, and low-barrier identity verification the risk is widening rather than narrowing disparities.

- In addition, without clarity on the patient-facing application approach and how raw FHIR data will be translated into usable, consumer-friendly information, the result may be technical compliance with limited real-world adoption.

Selected survey comments from use case #13

Provider Access API (health plan/payer information available to providers)

- The value of this use case will depend on whether payer data is delivered in a longitudinal, patient-matched, and EHR-integrated format that supports action at the point of care.
  - Variation in PDex implementation across payers risks forcing providers to manage multiple connections and data views, shifting rather than reducing administrative burden.
  - Differences in data completeness, refresh frequency, attribution logic, and care gap definitions will affect trust and usability as well. This data is most effective when it complements and doesn't attempt to duplicate HIE clinical exchange by adding coverage context, cost and utilization history, and attributed care gaps not available in clinical feeds.
  - To be clinically useful, claims information must be available in a timeframe that supports encounters and care management. Retrospective data has limited point-of-care value. Accurate patient matching and clear legal and contractual frameworks would be essential and foundational. A trusted intermediary can normalize multi-payer data and present a consistent view, so providers are not maintaining separate integrations for each plan. Without that alignment and workflow integration, the risk is creating a technically compliant feed with limited impact on coordination, value-based care performance, or a holistic patient view.
- Follow/track federal or MN requirements, federal requirement by Jan 2027.
- While this work should be underway, my sense is that providers aren't well-informed about what it involves and how it could be used, hence the higher effort rating.

Discussion and considerations

Note: The results summary is intended to be a discussion tool, not a decision tool.

- Do the survey results affirm the work group's prior discussions?
- Are there any surprises or concerns?
- Is there need for clarification or strengthening of any use case?
- Can any use case(s) be eliminated?
- Can some use cases be grouped together?
- What kind of effort is needed?
  (e.g., technical, policy, marketing/encourage participation or other lever)

Selection of priority use cases

- Which use cases should be the focus recommendations?
  - Balance of impact and effort?
  - Most impact?
  - Least effort?
  - Already in process or have requirement
- Which can be grouped together based on similar strategies
  - Use cases # 3 and 9? And maybe 2 as well
    (Information not moving for transitions of care, referrals and disparate EHRs)
  - Use cases 4 and 5 - research into death notifications
  - Use cases 6, 7, & 8 - support all three public health uses cases; education/promotion; learn from pilots
  - Use cases 11-13 - already in process
- Monitor EHIgnite Challenge (current ASTP/ONC activity - Transforming raw Electronic Health Information (EHI) into actionable insights for patients and clinicians)

Minnesota interoperability activities since 2004

Minnesota e-Health Initiative, Advisory Committee, Minnesota Department of Health and partners have leveraged state and federal resources to address interoperability.

- Engaged broad community to develop guidance and policies to include the entire care continuum (including long-term and post-acute, specialty, pharmacy, dental, public health and address health equity)
- Implemented legislation to move e-health and health information exchange forward while protecting Minnesotans
  - e-Prescribing and interoperable EHR mandates
  - HIE oversight law (Minnesota Statutes, chapter 62J.498 through 62J.4982)
- Conducted legislative studies and task forces on HIE
  - *2016 - 2018* HIE Study (www.health.state.mn.us/facilities/ehealth/hie/study/index.html)
  - *2018 - 2019* HIE Task Force publishes Advisory Committee endorsed recommendations for Minnesota Connected Networks (www.health.state.mn.us/facilities/ehealth/hie/taskforce/index.html)

Minnesota e-Health and HIE History www.health.state.mn.us/facilities/ehealth/initiative/index.html

Minnesota interoperability activities since 2004 (continued)

- MDH disbursed state and federal funds with a primary focus on rural and safety-net providers through grant and loan programs for:
    - EHR adoption: 2007 - 2010 – state funds
    - HIE: 2011 - 2015 - federal funds (HITECH and SIM)
    - Policy support (e.g., Minnesota Health Records Act - Foundations in Privacy Toolkit January 2017 developed by Gray Plant Mooty)
  - Supported pilot projects to understand what could be replicated or what doesn't work
- Ongoing monitoring of federal and state activities, aligning with requirements and pivoting often in response to changes in strategy, policies and rules.

Minnesota interoperability successes

- Two certified HIOs (Koble-MN and CyncHealth) that can provide HIE services www.health.state.mn.us/facilities/ehealth/hie/certified.html
- Minnesota Department of Human Services establishes Encounter Alerting Service (EAS) - *Nearly every hospital sending admission, discharge, and transfers (ADTs) through the EAS*

# EAS participants	# EAS participants	Estimated total # organizations	% EAS participants
Hospital/Health system	128	135	95%

- Streamlined public health reporting from health providers to MDH using an HIO
  - National syndromic surveillance program (NSSP) 104 of 129 (81%) NSSP ***eligible*** hospitals
  - Electronic lab reporting (ELR) - 51 of 129 (40%) NSSP eligible hospitals
  - Traumatic Brain Injury (TBI) - 37 of 129 (29%) NSSP eligible hospitals

Lessons learned and ongoing challenges

- There is no one size fits all, but full participation is needed to achieve the most value for all.
- At least one HIO is needed to fill HIE connectivity gaps and be a connection to national gateway.
- Requires up-front and ongoing funding for all organizations.
- Minnesota's health care ecosystem is continually evolving and can be difficult to navigate.
- e-health standards are not static and require ongoing resources to keep up to date.
- Funding and technology solutions alone do not remove all barriers; policies, people, workflows competing priorities are part of the equation.
- Information moves at the speed of trust (technology is usually not the roadblock).
- Critical to keep aligned with both state and federal strategies and regulations – don't get ahead or fall behind.

Looking ahead - April meeting

April meeting

- Learn about and discuss options for information sharing and use/reuse including HIOs, TEFCA/Qualified Health Information Networks (QHINs), Health Data Utilities and others
- Review strategies used by other states to address information sharing needs and identify strategies that could be adapted for use in Minnesota
- Start to develop recommendations for priority use cases

Upcoming meetings

- Bridging Information & Care Work Group
  - April 17, 2026
  - May 15, 2026
  - June 12, 2026
- Minnesota e-Health Advisory Committee
  - March 19, 2026 (10:00 a.m. - 12:00 p.m.)
- AI Work Group
  - March 23, 2026 (11:00 a.m. - 1:00 p.m.)
  - April 27, 2026 (11:00 a.m. - 1:00 p.m.)

Next steps

- Submit additional comments and resources to the work group input form at https://forms.office.com/g/3Cc6VBRApA
- Reminder - please email mn.ehealth@state.mn.us to be added to the work group list to get all the meeting invitations and materials
- Add future meetings on calendar: www.health.state.mn.us/facilities/ehealth/workgroups/index.html
- If you are not receiving emails/not a participant, please join us by emailing anne.schloegel@state.mn.us
- Sign-up for MN e-Health Updates at www.health.state.mn.us/facilities/ehealth/updates/index.html

Thank you!