



2025-2026 Minnesota e-Health Initiative Bridging Information and Care Work Group Report

JULY 21, 2026

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Introduction

The Minnesota e-Health Initiative (Initiative) is a public-private collaborative to advance the adoption and use of electronic health records (EHRs) and other health information technology, including health information exchange (HIE). The Initiative is guided by a legislatively authorized 27-member advisory committee that provides recommendations, insight, and a connection to the health care community in Minnesota. Activities of the Initiative are coordinated by the Minnesota Department of Health (MDH), Center for Health Information Policy and Transformation (CHIPT). The scope of the Initiative includes providers, public health, consumers, and policy/research across the state who take collective action to advise the commissioner of health and provide guidance to the community. The Initiative's vision is that *all communities and individuals benefit from and are empowered by information and technology that advances health equity and supports health and wellbeing*. The mission and principles are available at:

[Minnesota e-Health Initiative \(www.health.state.mn.us/facilities/ehealth/initiative/index.html\)](http://www.health.state.mn.us/facilities/ehealth/initiative/index.html)

The Initiative identified a need to provide expert input on actions to advance the sharing and use of health and health-related information to support individual health care and public health in Minnesota. As a result the Minnesota e-Health Advisory Committee recommended the Minnesota e-Health Initiative Bridging Information and Care Work Group (work group) be chartered.

The purpose of the Minnesota e-Health Initiative Bridging Information and Care Work Group was to provide expert input on actions to advance the sharing and use of health and health-related information to support individual health care and public health in Minnesota. Interoperability and other health data exchange activities play an important role in bridging information and care and will be a key focus of this work group. The work group deliverables include:

- **Use case inventory:** Complete an inventory of assets, successes and information sharing needs (e.g., not able to get information, information not easily useable) and identify ways to address unmet needs.
- **Recommendations:** Recommend actions that are trusted, practical, achievable, and sustainable to address the information sharing needs identified in the inventory, ensuring that any recommended actions align with, federal, and state-level activities.

See Appendix A for more information on the work group charge.

Process and activities

The work group was led by co-chairs Steve Johnson, University of Minnesota, and Laura Topor, Granada Health. Together with CHIPT staff, they facilitated seven work group meetings from December 19, 2025, to June 12, 2026. Participation ranged from 26 to 34 individuals in a meeting.

The work group learned from MDH and national experts to help inform and develop the use case inventory and recommendations for the subsequent prioritized use cases. In particular, [Civitas Networks for Health \(https://civitasforhealth.org/about\)](https://civitasforhealth.org/about), “a leading voice and convener for organizations working to use data to improve health in communities across the country” provided information on national and other state HIE activities as potential considerations for strategies in Minnesota.

Deliverable 1: Use case inventory

The work group reviewed and discussed current successes and information sharing needs in Minnesota. Current assets and successes were highlighted as part of an environmental scan of the Minnesota HIE landscape. Work group members then identified information sharing needs (use cases) for consideration. A total of 19 use cases were put forward. Thirteen were deemed appropriate for further consideration and prioritization. The remaining six were considered “out of scope.”

See Appendix B for more detail on the use case inventory.

Work group members rated the impact and effort for each of the 13 use cases identified for consideration and came to consensus on a focus on two groupings of use cases, a total of six use cases:

Expanded/enhanced bi-directional exchange use cases (most impact)

- **UC02** - LTPAC & hospitals bi-directional for transitions
- **UC03** - Useable format for transitions bi-directional
- **UC09** - Bi-directional exchange regardless of EHR

Public health reporting uses cases (least effort, already moving forward)

- **UC06** - TBI/SCI data to MDH using an HIO
- **UC07** - Newborn Screening - test orders and results to MDH Public Health Lab using an HIO
- **UC08** - Infectious Disease - test orders and results to MDH Public Health Lab using an HIO

See Appendix C for more details on the use case prioritization process.

Deliverable 2: Recommendations

Work group members proposed recommendations for the two use case groupings:

- Expanded/enhanced bi-directional exchange (e.g., long-term care transitions)
- Public health reporting to MDH using an HIO (TBI, newborn screening, infectious disease)

The proposed recommended actions were categorized into four overarching objectives with 17 corresponding recommendations. The level of support for each recommendation was gathered. Each recommendation had its level of support grouped into one of the following categories.

- Highest level of support: >90% support/strongly support (8 of 17 recommendations)
- High level of support: > 80% support/strongly support (4 of 17 recommendations)
- Moderate level of support: >70% support/strongly support (5 of 17 recommendations)

The level of support is listed after each recommendation in this section.

See Appendix D for more detail on the level of support for use case recommendations.

Objective 1: Drive adoption of statewide HIO services for clinical data exchange, public health reporting, quality measurement and other use cases

1. The state and e-Health Advisory Committee strongly encourage healthcare organizations participate with an HIO for exchange of individual clinical information and public health reporting, and other allowed uses to secure a critical mass of users and close connectivity gaps, which is essential for both data quality and financial sustainability. *(highest level of support)*
2. The state and e-Health Advisory Committee promote participation in national networks, including TEFCA through QHINs. Health organizations may also connect through an HIO and/or EHR. *(high level of support)*
3. The HIOs, state and e-Health Advisory Committee work with partners such as MN HIMSS, Minnesota Hospital Association, Minnesota Medical Association, Minnesota Health Information Management Association, licensing boards and others to develop educational resources and identify ways to increase health information exchange. *(highest level of support)*
4. The state identifies state government incentives to drive health information exchange and fill interoperability gaps by monitoring and reporting activity. *(highest level of support)*
5. The state and e-Health Advisory Committee recommend Minnesota statutes be more explicit in requirements and consider incentives or potential enforcement authority/penalties for non-compliance with Interoperable Electronic Health Record Requirements. See [Minnesota Statute, 62J.495 Electronic Health Record Technology \(www.revisor.mn.gov/statutes/cite/62j.495\)](http://www.revisor.mn.gov/statutes/cite/62j.495). *(moderate level of support)*
6. The e-Health Advisory Committee develops shared messaging for all Advisory Committee members and work groups to use in engaging their organizations and partners. *(high level of support)*
7. The state and e-Health Advisory Committee explore funding sources (e.g., federal sources such as Centers for Medicare and Medicaid Services [CMS], Rural Health Transformation Program, etc.) to support onboarding, modernization and potentially ongoing support for less-resourced organizations to improve patient care and reporting efficiency through electronic health information exchange. *(highest level of support)*
8. The state and e-Health Advisory Committee monitor implementation of use cases and establish key metrics to measure success and communicate the impact of bidirectional health information exchange. *(highest level of support)*

Objective 2: Establish an implementation work group to advance and support use cases by developing statewide guidance and best practices

9. The state, HIOs, and e-Health Advisory Committee convene one or more health system and skilled nursing facility to develop an implementation plan to deploy nationally developed standard (e.g., [PACIO \(Post-Acute Care InterOperability\) Project \(https://pacioproject.org\)](https://pacioproject.org) for “usable transitions of care” guidance for hospital to skilled nursing facility transitions. Use the resulting implementation plan to execute a pilot. Promote pilot results as a model for hospital to skilled nursing facility transitions and for other transitions of care (e.g., home care transitions). *(high level of support)*
10. The state, HIOs, and e-Health Advisory Committee communicate best practices for exchanging information for hospital – skilled nursing facility transitions. *(moderate level of support)*

Objective 3: MDH, with partner input, develops an interoperability roadmap for the agency that includes strategies for public health reporting, FHIR, TEFCA

11. MDH develops and implements an agency interoperability roadmap and establishes clear roles, priorities, and decision processes so data exchange efforts are aligned, transparent, and not fragmented, including reporting pathways through an HIO to minimize program-by-program interfaces that aligns with state, federal and national activities. *(highest level of support)*
12. MDH develops and publishes an Implementation Guide for each use case (TBI, newborn screening, infectious disease reporting) with best practices and success stories, including but not limited to, how TEFCA may be leveraged. *(moderate level of support)*
13. MDH develops and delivers targeted communication to increase statewide awareness and progress on the MDH interoperability roadmap, priority use cases, implementation guides, and onboarding process so health data exchange partners (e.g., health systems, hospitals, clinics, local health departments, and others) understand expectations and available services. *(moderate level of support)*
14. MDH should implement a required process for MDH programs to assess data needs (e.g., why data is being collected, how it will be used and how often it is needed, to eliminate requests for data that are not actively used. *(moderate level of support)*

Objective 4: Evaluate the state policy landscape and identify what's needed for a coordinated state agency strategy to move toward a model that supports a fully functioning and sustainable statewide Health Data Utility (HDU) in alignment with the Minnesota e-Health Initiative vision

Working definition: A health data utility (HDU) is a not-for-profit organization or state government entity with information exchange at its core and multi-stakeholder governance which, through its mission and function, seeks to meet the comprehensive health data delivery and analytics needs of a state's public and private sectors.

[What is a Health Data Utility? \(https://thecsri.org/health-data-utility\)](https://thecsri.org/health-data-utility)

15. The state and e-Health Advisory Committee complete an environmental scan of HIE-related statutes in Minnesota and across the country to identify opportunities or places where Minnesota legislation or informal policy may need to be updated or added to create and support an HDU (e.g., HIE Oversight, Minnesota Health Records Act, CMS aligned networks). *(highest level of support)*
16. The state, e-Health Advisory Committee, and partners leverage/align the HDU with existing Minnesota health information exchange infrastructure (e.g., HIO services, encounter alerting services [EAS]) to support transitions, but ensure the next step is bidirectional clinical context and details about patient care and what is needed next, beyond notifications. *(high level of support)*
17. The state, e-Health Advisory Committee, partners and HIOs explore how an HDU could support health information exchange necessary to support eligibility determinations (e.g., Medicaid enrollment, paid family medical leave), access to social supports, and addressing social determinants of health (social drivers of health, upstream drivers of health) among others. *(highest level of support)*

Though deemed “out of scope” or not prioritized, the work group also proposed alternate recommendations for those use cases.

See Appendix E for proposed alternate recommendations for use cases not prioritized or deemed out of scope.

Conclusion and next steps

The work group endorsed the final recommendations at the June 2026 meeting and forwarded them to the Minnesota e-Health Advisory Committee. The recommendations were presented at the June 2026 Minnesota e-Health Advisory Committee meeting and endorsed.

The next steps will be to present the recommendations to the Commissioner of Health and develop methods to address the implementation and monitoring use cases.

Appendix A: 2025-2026 Bridging Information and Care Work Group Charge

Work group charge

The purpose of this work group is to provide expert input on actions to advance the sharing and use of health and health-related information to support individual health care and public health in Minnesota. Interoperability and other health data exchange activities play an important role in bridging information and care and will be a key focus of this work group. The work group will also serve as the forum to discuss and respond to any related issues from the e-Health Advisory Committee, MDH, other state agencies, and care partners.

Context

The goal of interoperability and health data exchange is to help make health information available, when and where it is needed, to improve the quality and safety of health and health care. In Minnesota, many efforts are underway to help achieve the secure electronic exchange of clinical information between organizations using nationally recognized standards.

Minnesota's approach has been to support a market-based strategy that allows health information organizations (HIOs) and other HIE service providers to bring innovation and initiative to the state, while maintaining state government oversight to ensure fair practices, sustainability and compliance with state and federal privacy, security and consent protections.

In recent years, federal and national efforts have greatly advanced health data exchange throughout the state and country. The development, adoption and increasing use of the Trusted Exchange Framework and Common Agreement™ (TEFCA™) is a nationwide framework for health information sharing. TEFCA is intended to remove barriers for sharing health records electronically among healthcare providers, patients, public health agencies, and payers.

Although TEFCA is gaining momentum and other interoperability and health data exchange mechanisms are widely used, gaps remain particularly for exchange between organizations using the Epic EHR and non-Epic using organizations, and between non-Epic users. This work group is charged with identifying opportunities and strategies to increase the electronic exchange of health information in Minnesota to enhance the use of information to bridge and support both individual and public health.

Key activities and tentative timeline

December 2025 - February 2026

- Review and provide input on environmental scan/status of current data sharing environment in Minnesota, including, but not limited to, the following:
 - Transitions of care and care coordination across the health ecosystem paying particular attention to specialists, long-term care and other smaller providers
 - Public health data reporting and case management
 - Health-related social needs information and referrals
- Review and discuss past efforts and lessons learned on root causes for the lack of interoperability in Minnesota
- Develop inventory of use cases where exchanged information is supporting care and where there are gaps and/or challenges

March - April 2026

- Prioritize use cases, with an initial focus on high priority use cases, and identify opportunities to address gaps
- Learn about and discuss options for information sharing and use/reuse including HIOs, community information exchanges (CIEs), Qualified Health Information Networks (QHINs), health data utilities (HDUs), networks of networks, and other examples
- Review strategies used by other states to address information sharing needs and identify strategies that could be adapted for use in Minnesota

April - May 2026

- Develop recommendations that are trusted and sustainable to meet identified needs to bridge information and care including, but not limited to:
 - Support for entirety of health ecosystem, specifically smaller, independent providers including specialty clinics, long-term and post-acute care, pharmacies, and others
 - Getting organizations connected for health information sharing (consider options such as a Minnesota HIO, QHIN, TEFCA, Minnesota Department of Human Services Encounter alerting service (EAS) or other)

Ongoing related activities

- Monitor and respond to rulemaking, policy, and other federal and state government activities (e.g., progress of TEFCA implementation and QHIN use, and CMS – “Make Health Tech Great Again”)
- Provide updates to the Minnesota e-Health Advisory Committee

Deliverables

Any materials created are expected to be widely shared and used by the Minnesota e-Health Advisory Committee, the MDH, and other local and state partners.

- Complete an inventory of assets, successes and information sharing needs (e.g., not able to get information, information not easily useable) and identify ways to address unmet needs.
- Recommend actions that are trusted, practical, achievable, and sustainable to address the information sharing needs identified in the inventory, ensuring that any recommended actions align with, federal, and state-level activities.

Timeframe and expectations

Meetings will begin by December 2025 and every 4-6 weeks thereafter. All members of the community and advisory committee are welcome to join the work group.

Work group participants are expected to:

- Attend and participate in work group meetings and activities.
- Review meeting materials and be prepared to contribute insights and expertise; engage your network as needed to provide additional expertise.
- Bring the perspective of the represented stakeholder group (for AC members) and/or your expertise to discussions and decision-making.
- Act as the liaison between work group and related groups or partners, sharing reports and information as directed.
- Keep the statewide interests of the Initiative foremost in decisions and recommendations, in particular health equity.
- Communicate with others in a professional manner.

Leadership

Co-chairs:

Steve Johnson

University of Minnesota

Laura Topor

Granada Health

MDH lead staff:

Anne Schloegel

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Definitions

Health Information Organization (HIO) - An HIO is an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in Minnesota Statutes, section 144.291, subdivision 2, paragraph (i), to improve coordination of patient care and the efficiency of health care delivery.

MDH issues Certificates of Authority to operate in Minnesota as an HIO to qualified organizations in accordance with all of the duties and privileges afforded to such HIOs pursuant to [Minnesota Statutes, chapter 62J, sections 498-4982 \(www.revisor.mn.gov/statutes/cite/62J.498\)](https://www.revisor.mn.gov/statutes/cite/62J.498).

Qualified Health Information Network (QHIN) - To the extent permitted by applicable SOP(s), a Health Information Network that is a U.S. Entity that has been Designated by the RCE and is a Party to the Common Agreement countersigned by the RCE. Source: Common Agreement Version 2.0 and Participant/Subparticipant Terms of Participation Version 1.0.

Source:

TEFCA Glossary can be found in the [RCE Resource Library \(https://rce.sequoiaproject.org/tefca-and-rce-resources\)](https://rce.sequoiaproject.org/tefca-and-rce-resources)

Trusted Exchange and Common Agreement (TEFCA) - The overall goal for the TEFCA is to establish a universal floor for health care information technology (health IT) interoperability across the country.

Source:

[Advancing Nationwide Interoperability of Electronic Health Information with TEFCA \(https://rce.sequoiaproject.org\)](https://rce.sequoiaproject.org)

Centers for Medicare and Medicaid Services - “Make Health Tech Great Again” - Initiative focus is on two broad areas: promoting a CMS Interoperability Framework (www.cms.gov/health-technology-ecosystem/interoperability-framework) to easily and seamlessly share information between patients and providers and increasing the availability of personalized tools so that patients have the information and resources they need to make better health decisions.

Source:

[Health Technology Ecosystem \(www.cms.gov/priorities/health-technology-ecosystem/overview\)](http://www.cms.gov/priorities/health-technology-ecosystem/overview)

Appendix B: Use case inventory

Current assets and successes:

The deliverable language was to develop an inventory of assets, successes and information sharing needs (e.g., not able to get information, information not easily useable) and identify ways to address unmet needs.

The current assets and successes were highlighted in a presentation of the environmental scan of health information exchange (HIE) landscape in Minnesota and are detailed here:

Health Information Organizations (HIOs)

Koble MN

- Entered Minnesota market in November 2014
- 140 connections to hospital/health systems, county public health, payers, long-term care facilities, behavioral health, laboratories, ambulatory clinics
- MDH Public health reporting contractor
- National syndromic surveillance program (NSSP) 125 of 129 (97%) eligible hospitals
- Electronic lab reporting (ELR) - 51 of 129 (40%) NSSP eligible hospitals
- Traumatic Brain Injury (TBI) - 37 of 129 (29%) NSSP eligible hospitals
- Additional use cases in process include immunizations and newborn screening

CyncHealth

- Entered Minnesota market in July 2024
- No connections to date

Epic EHR “Care Everywhere”

- Hospitals: 109 of 135 (81%) using Epic; anticipated to be 121 (90%) in two years
- Clinics: approximately 67% of health system and primary care clinics using Epic
- Specialty clinics (includes behavioral health) for the most part do not

Minnesota Department of Human Services - Encounter Alert Service (EAS)

Table B1. Minnesota Department of Human Service EAS

EAS participant organization type	EAS participants	Estimated total organizations	% EAS participants
Hospital/health system	128	135	95%
FQHC or similar	16	18	89%
Primary care clinic (part of health system or other)	122	682	18%
Specialty care clinic	5	662	1%
Behavioral/mental health clinic	30	120	25%
Nursing homes	17	338	5%
Community-based organization	17	?	?
County governments	36	78	46%
Tribal governments	1	11	9%
Health plan/insurer/payer	8	12	67%

Potential QHIN connections

- Organizations using the Epic EHR are anticipated to participate with the Epic-Nexus QHIN
- Koble MN and CyncHealth - possible connection with the eHealth Exchange QHIN
- Some state HIEs are not planning to participate in TEFCA/QHIN

Information sharing needs: Use cases identified and considered for prioritization process

Work group members presented use cases for consideration during the January 2026 and February 2026 work group meetings and via post-meeting input surveys. A total of 19 use cases were put forward. Thirteen were deemed appropriate for further consideration and were part of the prioritization process. The other six were considered “out of scope” for one of the following reasons:

- Current information access method is working well; HIE may not significantly advance the use case
- Does not represent HIE in the same way other use cases do
- Organizations involved are already moving towards bi-directional exchange; working on standards
- Past studies and efforts have addressed and recommended actions for use case
- Current national or federal efforts are already underway

Though not considered for prioritization, proposed alternate recommendations for the six use cases considered “out of scope” are detailed in Appendix E.

Work group members provided details on the thirteen use cases identified reviewed in the prioritization process.

Use case details

UC01 - Pharmacists/pharmacies receive ADT notifications

Use case description: Pharmacists/pharmacies receive ADT notifications and other actionable-useful information (e.g., discharge summaries to help with care transitions and medication reconciliation).

Expected outcomes/potential impact:

- Increased patient safety
- Reduced readmissions
- Reduced drug adverse events
- Workload reductions

Preconditions/assumptions: If pharmacies/pharmacists receive ADTs and discharge summaries (likely a cost for this service), there is expectation/need for pharmacist to get reimbursed for providing a clinical service such as medication reconciliation/counsel.

Legal or regulatory requirement: None

Existing technical standards or other: HL7 v2 ADT

Senders: Health systems, Hospitals

Receivers: Pharmacies

Barriers:

- Awareness and pharmacy system readiness
- Reimbursement
- Legal agreements (e.g., shared practice agreements or other pieces that need to be in place)
- Verifying established pharmacy/pharmacist relationship

UC02 - 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.

Use case description: Information will help support safe transitions of patients from a hospital to nursing home or other long-term care facility. Information on current forms is not always what's needed to describe "whole episode of care;" the information needed is not currently in a structured format (nursing notes are usually unstructured and more challenging to capture). An example, the discharge summary may indicate that the patient was able to stand up but not the additional context needed which is more like "when was the last time this person walked independently." Detailed descriptions of what a patient's true functional status is are needed to accomplish "a warm hand off" and help ensure a safe transition for the patient.

Expected outcomes/potential impact:

- Increased patient safety
- Reduced readmissions
- Workload reductions

Preconditions/assumptions: Agreement on what additional unstructured data (e.g., from nursing notes) should be included.

Legal or regulatory requirement: None

Existing technical standards or other: Direct 360X; C-CDA; USCDI v3, TEFCA XP: TEFCA Required Treatment (T-TRTMNT); TEFCA Care coordination XP (T-HCO-CC), Plus- additional information from nursing notes

Senders: Health systems, hospitals, nursing homes

Receivers: Skilled nursing facilities, assisted living, hospitals

Barriers:

- Current exchange format for a discharge summary is generally fax, direct electronic exchange or even paper in rare instances from the hospital (must upload fax/ electronic file into LTC EHR or task system which is extra work).
- Structure of information sent is not standardized; order of the discharge form is not standardized for ease of use.
- Information on current forms is not always what's needed to describe "whole episode of care;" information needed is not currently in a structured format (nursing notes are usually unstructured and more challenging to capture).
- Detailed descriptions of what a patient's true functional status is are needed to accomplish "a warm hand off" and help ensure a safe transition for the patient (e.g., discharge summary may indicate that the patient was able to stand up but not the additional context needed which is more like "when was the last time this person walked independently."

UC03 - Providers can send and receive information needed in a useable format for patient transitions

Use case description: Example of "...make shared information more useful in provider-to-provider patient record sharing (e.g., transitions of care such as primary care to specialty care)."

Expected outcomes/potential impact:

- Increased patient safety
- Reduced readmissions
- Workload reductions

Legal or regulatory requirement: No

Existing technical standards or other: Direct 360X; C-CDA; USCDI v3, TEFCA XP: TEFCA Required Treatment (T-TRTMNT); TEFCA Care coordination XP (T-HCO-CC)

Senders: Health systems, hospitals, clinics (primary care, specialty, mental health) LTPAC

Receivers: Health systems, Hospitals, Clinics (primary care, specialty, mental health) LTPAC

Barriers: Data quality (unstructured vs structured data)

UC04 - Providers receive/obtain death confirmations more quickly/automatically from MDH death record data to allow cancellation of reminders/notifications

Use case description: Allow notifications to health systems to cancel appointments and medication reminders to family members about the deceased. No easy way to go from Minnesota Vital Records and Certificates (MDH) back to all organizations that cared for that patient to let them know that patient is now deceased. Death records are public; challenge is in developing an automated way to inform providers. The Minnesota Registration & Certification system--the vital records system does provide an easy way for facilities that have registered the death to pull data about the death records they completed- this is not for deaths the facility did not register. Additional need to retrieve all death record data even when a patient may have died in a different facility/health and was registered by a medical certifier not associated with the health care facility/primary care provider. These institutions can order statewide death reports (\$15 each under Minnesota Administrative Rule 4601.0400). Additional suggestion that an organization's EHR could cancel all open orders for the deceased patient (e.g., cancel order for prescriptions)

Expected outcomes/potential impact: Increased patient family satisfaction

Senders: MDH Vital Records (Minnesota Records and Certification)

Receivers: Providers and health plans/payers

Barriers: Minnesota legal issues, timeliness of death certification data entry

UC05 - Death registration process for hospitals/health systems by implementing bi-directional electronic exchange with Minnesota Registration and Certification system (MDH)

Use case description: Improve process for providing the cause of death information needed for a death record (certification must be provided by a licensed APRN, PA, or MD). For deaths that occur in a hospital there is currently no mechanism to "autofill" the death certificate using information already in the hospital EHR. 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).

Expected outcomes/potential impact:

- More timely, accurate, and complete death records
- Availability of death certificates for families more quickly
- Less work for funeral establishments to identify a/the medical certifier

Preconditions/assumptions: Licensed APRNs, PAs, and MDs are associated with the death record and must provide the cause of death information--their license is part of the death record--needs to be structured so the licensee is aware and actually provides the cause of death information.

Existing technical standards or other: Pilot: Fact of death" interoperability (HL7 project 'fact of death' exchange) with funeral home case management systems--get the legal and demographic information about a decedent registered to establish a death record. Hospitals and clinics and medical certifiers provide only the cause of death information right now? No national standards or implementation guides yet for this--some states have put this into production--early adopters and are using HL7-FHIR APIs.

Senders/receivers: Hospitals, health systems, MDH - Minnesota Registration and Certification system

Barriers: Proof of concept adopted more widely, funding to update MDH systems

UC06 - Public Health Use Case: Increase number of facilities sending Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) data to MDH using an HIO

Use case description: Increase the number of hospitals (currently 29%) sending TBI/SCI case notifications using the established reporting connection (HIO) to allow for timely referral to free TBI recovery services to help patients navigate recovery, find rehabilitation services, and transition back to work, school, and community life. MDH TBI team is requiring hospitals make progress towards implementation by Fall 2027.

Expected outcomes/potential impact:

- Improve MDH TBI/SCI program staff workflows through centralized data collection and storage process
- Need to get information out to people who may not even know they've had TBI (may have not heard that term for their injury)
- Increased patient satisfaction
- Better long-term outcomes

Legal or regulatory requirement: Yes

Existing technical standards or other: HL7 automated ADT feed using an HIO; MDH TBI/SCI Data Specifications

Senders: All Minnesota hospitals

Receivers: MDH TBI/SCI program

Barriers: Limited number of hospitals currently participating; information from other sources has a 3-6 month delay

UC07 - Public Health Use Case: Increase Newborn Screening Electronic Test Orders and Results (MDH Public Health Lab) using an HIO

Use case description: Increase the number of hospitals (currently 2%) using the automated electronic test orders and results workflow to help enable quicker diagnosis, treatment and follow up for newborn screening tests (e.g., sickle cell disease, cystic fibrosis, and muscular dystrophy).

Expected outcomes/potential impact:

- Reduce hospital FTEs from 5+ to 1
- Improve MDH Public Health Lab workflows
- Enable faster diagnosis, treatment, and follow up for newborns and their families

Existing technical standards or other: HL7 automated feed using an HIO; MDH Newborn Screening Electronic Test Orders and Results Data Specifications Data Specifications

Senders: All Minnesota hospitals

Receivers: MDH Public Health Lab

Barriers: Hospital recruitment for the use case. Need sustainable incentives from MDH for hospital partners.

UC08 - Public Health Use Case: Increase Infectious Disease Electronic Test Orders and Results (MDH Public Health Lab) using an HIO

Use case description: Increase the number of hospitals (currently one pilot hospital) using the automated electronic test orders and results to enable quicker diagnosis, treatment and follow up for infectious conditions (e.g., RSV, Influenza/SARS-COV-2, and salmonella).

Expected outcomes/potential impact:

- Reduce hospital FTEs from 5+ to 1
- Improve MDH Public Health Lab workflows
- Quicker diagnosis, treatment, and follow up for Minnesotans and their families

Existing technical standards or other: HL7 automated feed using an HIO; MDH Infectious Disease Lab Electronic Test Orders and Results Data Specifications

Senders: All Minnesota hospitals

Receivers: MDH Public Health Lab

Barriers: Hospital recruitment for the use case. Need sustainable incentives from MDH for hospital partners.

UC09 - Smaller organizations (e.g., rural, independent, public health) receive health information electronically regardless of which EHR they use

Use case description: Improve the ability of smaller, rural and/or independent providers to receive information from the other facilities that their patients have received care to improve care coordination.

Expected outcomes/potential impact:

- Better care coordination
- Increased patient safety
- Reduced readmissions
- Decreased repeat testing
- Workload reductions

Legal or regulatory requirement: No

Existing technical standards or other: Direct 360X; C-CDA; USCDI v3, TEFCA XP: TEFCA Required Treatment (T-TRTMNT); TEFCA Care coordination XP (T-HCO-CC)

Senders/receivers: Health systems, Clinics, hospitals, nursing homes, assisted living, public health etc.

Barriers: Cost for smaller organizations and workforce training

UC10 - Process for submitting health information for disability benefit determinations

Use case description: Potential for TEFCA Exchange purposes (XP) government benefits determination SOP to help.

Expected outcomes/potential impact: Increased patient satisfaction

Legal or regulatory requirement: No

Existing technical standards or other: TEFCA Exchange purposes (XP) government benefits determination (T-GOVDTRM) SOP

Senders: Patients, hospitals, clinics, health systems

Receivers: Social Security Administration

Barriers: Provider response time limits; Parsing unstructured notes

UC11 - Prior authorizations

Use case description: All payers in the state are required to stand up prior authorization APIs by January 1, 2027 (CMS Interoperability Rule 0057-F) to help support improving the prior authorization process

Expected outcomes/potential impact:

- Better long-term outcomes
- Reduction in authorization turnaround time
- Reduced provider burden
- Faster speed to therapy

Legal or regulatory requirement: Yes, CMS Interoperability Rule 0057-F

Existing technical standards or other: FHIR (Da Vinci PAS)

Senders: Health systems, providers

Receivers: Health plans, payers

Barriers: DHS – can they make portal bi-directional –look at family leave; Vendor readiness for Da Vinci standards

UC12 - Patient Access API (health plan/payer information available to patients)

Use case description: Patients can receive their health information through APIs

Expected outcomes/potential impact:

- Increased patient satisfaction
- Patient empowerment
- Better self-management

Legal or regulatory requirement: Yes, CMS Interoperability Rule 0057-F

Existing technical standards or other: FHIR (Patient Access API)

Senders: Health plans and payers

Receivers: Patients

Barriers: Patient digital literacy; security/privacy concerns

UC13 - Access API (health plan/payer information available to providers)

Use case description: Sharing claims data and care gaps with clinicians

Expected outcomes/potential impact:

- Better care coordination
- Value-based care success
- Holistic patient view

Legal or regulatory requirement: Yes, CMS Interoperability Rule 0057-F

Existing technical standards or other: Da Vinci Payer Data Exchange (PDex)

Senders: Health plans and payers

Receivers: Providers, clinics, hospitals, health systems, etc.

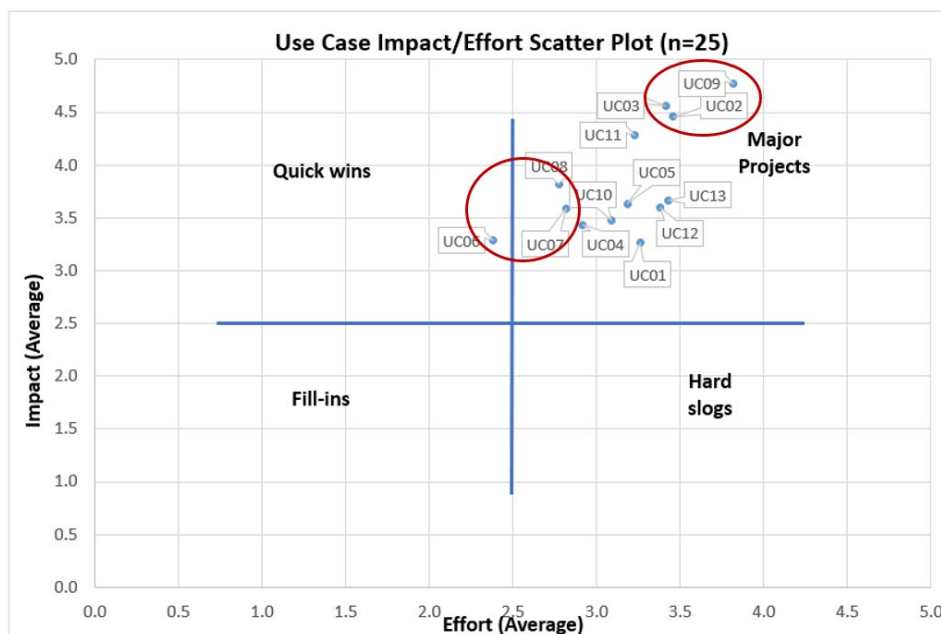
Barriers: Patient matching accuracy; Legal/Contractual agreements

Appendix C: Use case prioritization process

Work group members were asked to complete a survey and “rate” these qualities for each of the 13 use cases identified in Appendix B above:

- Use case impact (on a scale of 1-5, 1 being lowest and 5 being highest) -how this might impact the state
- Use case effort (on a scale of 1-5, 1 being lowest and 5 being highest) - resources needed to achieve

Table C1. Use case impact and effort



Survey responses were compiled and presented at the March 2026 meeting. Work group participants discussed where the 13 use cases fell on the impact/effort scale; all but one of the use cases fell into the “Major Projects” quadrant of high impact/high effort. Work group consensus was to focus on six use cases clustered in two groups that represented the most impact and least effort as shown above in Figure C1 and Table C1 and detailed here:

Expanded/enhanced bi-directional exchange use cases (most impact)

- **UC02** - LTPAC & hospitals bi-directional for transitions
- **UC03** - Useable format for transitions bi-directional
- **UC09** - Bi-directional exchange regardless of EHR

Public health uses cases (least effort, already moving forward)

- **UC06** - TBI/SCI data to MDH using an HIO
- **UC07** - Newborn Screening - test orders and results to MDH Public Health Lab using an HIO
- **UC08** - Infectious Disease - test orders and results to MDH Public Health Lab using an HIO

Table C1. Use case impact and effort details

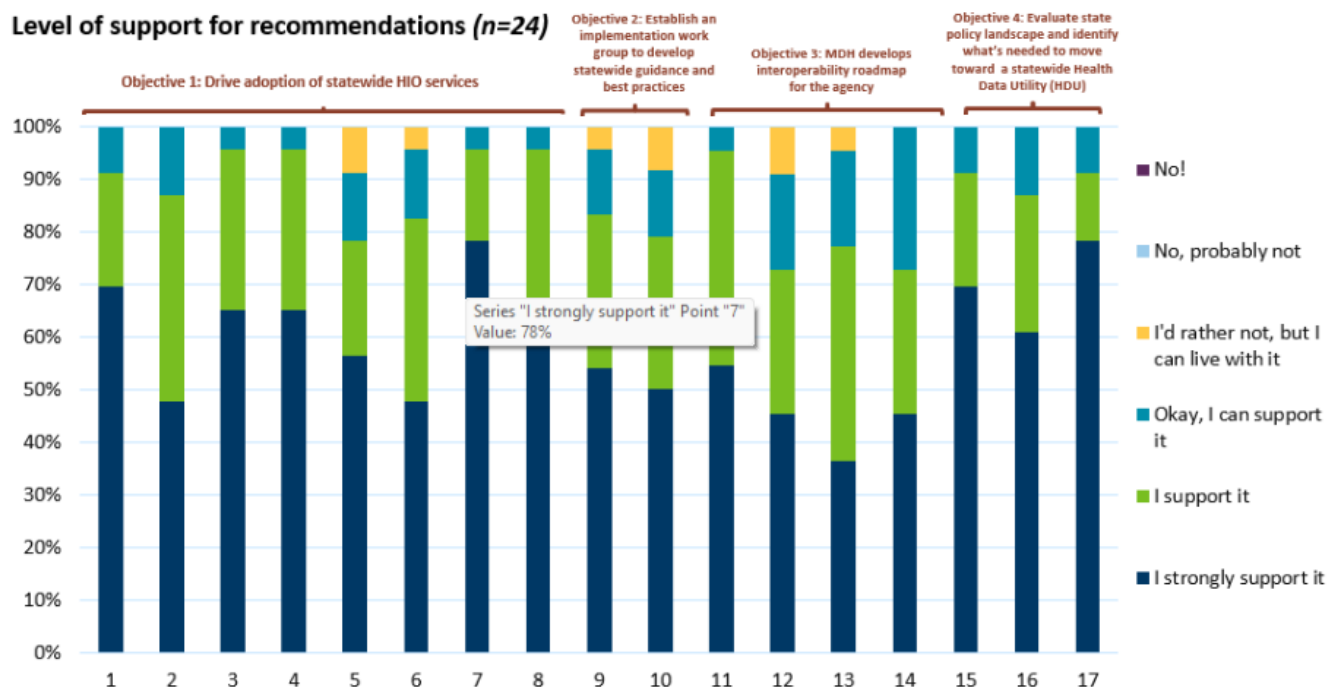
Use Case #	Use Case Description	Impact Average <i>Scale from 1-5 1 lowest, 5 highest (min,max)</i>	Impact Rank <i>Ranked 1-13 1 most, 13 least</i>	Effort Average <i>Scale from 1-5 1 lowest, 5 highest (min,max)</i>	Effort Rank <i>Ranked 1-13 1 least, 13 most</i>
UC01	Pharmacists/pharmacies receive ADT notifications and other actionable-useful information. (e.g., discharge summaries)	3.25 (1,5)	13 (least impact)	3.26 (1,5)	8
UC02	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	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	Providers receive/obtain death "confirmation" more quickly/automatically from MDH death record data to allow cancellation of reminders/notifications.	3.43 (1,5)	11	2.91 (1,5)	4
UC05	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	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	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	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	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	Process for submitting health information for disability benefit determinations.	3.45 (1,5)	10	3.09 (1,5)	5
UC11	Prior authorizations	4.23 (3,5)	4	3.23 (1,5)	7
UC12	Patient Access API (health plan/payer information available to patients).	3.57 (2,5)	9	3.38 (1,5)	9
UC13	Provider Access API (health plan/payer information available to providers).	3.64 (2,5)	7	3.43 (1,5)	11

Appendix D: Level of support for use case recommendations

The Bridging Information and Care Work Group spent several months identifying use cases, prioritizing use cases and developing recommended actions to advance prioritized use cases. The proposed recommended actions were categorized into four overarching goals/objectives with 17 corresponding recommendations, note that some actions support both use case groups. The May 2026 meeting concluded with an assessment of the level of support the members indicated for each recommendation. Live polls were used to gauge the level of support on a scale of 0-5 for each recommended action. Members not in attendance were given an opportunity to weigh in with a survey sent after the meeting. The overall results are summarized here and in Figure D1 below.

- All recommendations had 90+ percent support (Strongly support, Support, Okay, I can support it)
- Strongest support for all Objective 4 recommendations
- No recommendations with “No” votes; only a few votes were “I’d rather not, but I can live with it”

Figure D1. Level of support for use case recommendations



Appendix E: Proposed alternate recommendations for use cases not prioritized or deemed out of scope

Use cases not prioritized

Monitor and respond to evolving organizational or national pilots or other best practices

UC01 - Pharmacists/pharmacies receive ADT notifications and other actionable-useful information (e.g., discharge summaries)

- Continue to follow the work of [The Sequoia Project - Pharmacy Care: Use Cases for Health Information Exchange, March 2026](https://sequoiaproject.org/interoperability-matters/pharmacy-workgroup) (<https://sequoiaproject.org/interoperability-matters/pharmacy-workgroup>) and others to move forward with this use case

UC04 - Providers receive/obtain death "confirmation" more quickly/automatically from MDH death record data to allow cancellation of reminders/notifications

UC05 - Improve death registration process for hospitals/health systems by implementing bi-directional electronic exchange with Minnesota Registration and Certification system (MDH).

- 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).

Monitor current status of processes via TEFCA or other federal requirements

UC10 - Process for submitting health information for disability benefit determinations

- Monitor use and success of the TEFCA Standard Operating Procedure: Exchange Purposes Government Benefits Determination (T-GOVDTRM) which can be found in the [RCE Resource Library](https://rce.sequoiaproject.org/tefca-and-rce-resources) (<https://rce.sequoiaproject.org/tefca-and-rce-resources>)

UC11 - Prior authorizations

- Follow completion/fulfillment of requirements for [2024 CMS Interoperability and Prior Authorization Final Rule \(CMS-0057-F\)](https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f) (www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f)

UC12 - Patient Access API (health plan/payer information available to patients)

- Follow completion/fulfillment of requirements for [2020 CMS Interoperability and Patient Access Final Rule \(CMS-9115-F\)](https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-patient-access-final-rule-cms-9115-f) (www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-patient-access-final-rule-cms-9115-f)
- [Patient Access API](https://www.cms.gov/priorities/burden-reduction/overview/interoperability/frequently-asked-questions/patient-access-api) (www.cms.gov/priorities/burden-reduction/overview/interoperability/frequently-asked-questions/patient-access-api)

UC13 - Provider Access API (health plan/payer information available to providers)

- Follow completion/fulfillment of requirements for [2024 CMS Interoperability and Prior Authorization Final Rule \(CMS-0057-F\)](https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f) (www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f)

Use cases deemed out-of-scope

Monitor and respond to rulemaking, policy, or other federal and state government activities

UC14 - Registry for Provider Order for Life Sustaining Treatment (POLST) forms

- In 2024 MDH completed a study that included recommendations for action; legislature has not advanced any POLST proposals in prior years
 - [Minnesota POLST Registry Study](https://www.health.state.mn.us/facilities/ehealth/polst/docs/013124report.pdf) (www.health.state.mn.us/facilities/ehealth/polst/docs/013124report.pdf)

UC15 - Onboard new providers (Credentialing)

- There are state and national efforts to address the administratively burdensome credentialing process for hospitals and health systems. Current related efforts around centralized or shared provider directories may also ease the credentialing burden
 - [Minnesota Provider Directory Feasibility Study](https://www.health.state.mn.us/facilities/ehealth/pdstudy/index.html) (www.health.state.mn.us/facilities/ehealth/pdstudy/index.html)
 - [Defacto Health - How will the CMS National Directory affect health plans?](https://defacto.health/2025/06/25/how-will-the-cms-national-directory-affect-health-plans/) (<https://defacto.health/2025/06/25/how-will-the-cms-national-directory-affect-health-plans/>)

UC16 - Medicaid redeterminations

- The Minnesota Department of Human Services has a manual process in place to help address this issue; unclear whether there will be additional actions at federal or state level.

Identify best practices for comprehensive, longitudinal records including opportunities for patients to store and manage their records

UC17 - Working definition for comprehensive longitudinal patient record

- Single, integrated, and normalized electronic record containing a patient's entire (lifetime) health history compiled from multiple sources-diagnoses, medications, labs, imaging, and notes.

Explore opportunities directly with health systems (EHR use case)

UC06 - Send resources for traumatic brain injury (TBI)

- Work with health systems to develop "automated" messages to patients with TBI diagnosis code from the patient portal that include resources (e.g., attachments, links) or develop way to include resources as part of the discharge summary.

Encourage organizations to participate with current information sharing process

UC18 - Emergency Medical Services (EMS) information sent directly to hospital or nursing home receiving patient

- Currently, hospitals have access through MNSTAR Hospital Hub exchange portal that provides secure access to electronic patient care reports (ePCRs) submitted by EMS. Skilled nursing facilities may request to receive EMS ePCRs (data sharing agreement required). ePCRs may contain information more detailed or descriptive of patient/resident functional status (to allow for improved transitions).
 - [MNSTAR Hospital Hub \(https://mn.gov/oems/data-center/hospital-hub\)](https://mn.gov/oems/data-center/hospital-hub)

UC19 - Bed availability at nursing homes/transitional care units

- Current MDH MNTrac system (portal) provides hospital and skilled nursing bed tracking. The system allows nursing home to participate; however, training resources to onboard nursing homes may be limited.