LPH Data Modernization SCHSAC Workgroup February 2026 In-Person Strategic Planning Meeting Minutes

DATE: FEBRUARY 2ND 2026 |10:00AM-4:00PM

MINUTES PREPARED BY: GABBY CAHOW, MDH DATA MODERNIZATION PLANNER

LOCATION: ROOM B149 ORVILLE L. FREEMAN BUILDING, 625 ROBERT STREET NORTH, SAINT PAUL, MN 55155

Attendance

- **Members**

  De Malterer-Le Sueur- Waseca Counties SCHSAC Elected, **Angie Hasbrouck-**Horizon Public Health, **Melanie Countryman-**Dakota County Public Health, **Lisa Klotzbach**-Dakota County Public Health, **Alyssa Johnson**-Faribault-Martin CHB, **Richard Scott**-Carver County Public Health, **Rob Prose**-St. Louis County Public Health, **Angel Korynta-**Polk-Norman-Mahnomen Public Health,

- **MDH Subject Matter Experts**

  Jessie Carr-MDH Environmental Health Division, **Dawn Huspeni**-MDH Infectious Disease Epidemiology, Prevention, and Control (IDEPC) Division, **Abby Stamm**-MDH Office of Data Strategy and Interoperability (DSI), **An Garagiola**, MDH Office of American Indian Health (OAIH), **Lindsey Krueger**- Interim 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), **Phyllis Brashler-**MDH Public Health Strategy and Partnership Division (PHSP)

Purpose

- The purpose of the February In-Person Strategic Planning Meeting was to take the insight the Workgroup has gained during the shared learning phase and identify and set priorities for data system transformation. The goal of the meeting was to develop vision statements and begin to identify objectives for each vision statement.

Agenda

- Meeting Kick-Off
- Visioning/Goal Setting
- Lunch
- Visioning/Goal Setting
- Identifying Objectives
- Break
- Identifying Objectives
- Meeting Wrap-Up

Decisions made

- None

Action items

- Share the draft vision statements below with your regional or divisional partner to get their feedback:
  - **Why/Values:** A robust, user-friendly public health data system ensures data is used to advance healthier, more equitable communities by supporting strategic goals, creating a better understanding of community needs, improving programs and services, supporting faster action when health issues emerge, and helping tell the story of public health in Minnesota.
  - **Interoperability:** Public health data flows securely, seamlessly, and responsibly across systems and organizations ensuring shared information is used for timely insight, coordinated action, and supporting measurably healthier communities.
  - **Data Access:** Across the public health data system data are shared easily and multi-directionally, enabling consistent, reliable, and timely access to locally relevant information.
  - **Data Quality & Usability:** Data systems are designed with end users in mind and data are available in user-friendly, accurate, timely, and relevant formats.
  - **Data Capacity**: Local, Tribal, and state public health agencies have the data capacity (knowledge, skills, staffing, funding, and tools) they need to address community health priorities and emerging health issues.

- **Shared Governance:** Local, Tribal, and state public health agencies work within a mutually developed decision-making structure that oversees and standardizes how data are obtained, shared, used, and maintained.
- **Relationships:** Local, Tribal, and state public health agencies are rooted in shared history and embrace working across systems and with partners to build trust and make progress towards improving the health of Minnesotans.

Talking Points

- The Workgroup met in-person at the MDH Office in St. Paul to identify and set priorities for data system transformation and begin the process of developing a workplan.
- The Workgroup developed draft vision statements and identified barriers to achieving those vision statements, which will be used to create objectives for the workplan.
- The LPH Data Modernization SCHSAC Workgroup has the authority to develop recommendations, which are then reviewed and approved by SCHSAC. SCHSAC provides the approved recommendations to the Commissioner of the Minnesota Department of Health.

Meeting notes

- **Visioning and Goal Setting:**
- The Workgroup members brainstormed around the question “What would it look, sound, and feel like if we were successful at creating a modernized, seamless, responsive, and publicly supported governmental public health data system?”
- The Workgroup members worked together to identify themes. 7 main themes emerged:
  - Why/Values
  - Interoperability
  - Data Access
  - Data Quality & Usability
  - Data Capacity
  - Shared Governance
  - Relationships

- The Workgroup members broke into small groups to develop draft vision statements for each theme. The whole Workgroup was able to provide feedback and come to consensus around the following draft vision statements:
  - **Why/Values:** A robust, user-friendly public health data system ensures data is used to advance healthier, more equitable communities by supporting strategic goals, creating a better understanding of community needs, improving programs and services, supporting faster action when health issues emerge, and helping tell the story of public health in Minnesota.
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- **Identifying Objectives:**
- The Workgroup members brainstormed around the question “What are the factors, conditions, issues, or things getting in the way of this vision/goal?” for each vision statement. Below are the barriers, conditions, and issues they identified that will inform the workplan objectives
  - **Why/Values**
  - **Interoperability**

- not understanding the value of interoperability
- Different systems are not open or compatible with API integration
- Interoperability security issues
- Healthcare organizations may not have the expertise to share data with public health
- Many of the EHR systems used are privately owned- less control over functionality
- Lack of trust if the data is accurate
- Lack of trust on how data will be used
- Lack of trust the data is secure
- funding
- Time and expertise already invested into existing systems (Examples: EHR systems and MEDSS)
- Need interoperability w/ social needs serving entities
- Legal or statutory barriers

- **Data Access**
  - Need knowledge on how to use data
  - Inability to describe why data is used/needed
  - Data sharing agreements
  - lack of shared understanding why something is or isn't shared
  - lack of standardized ways to access data
  - You have to know who to contact to access data
  - Data access. need technical notes and data limitations explained
- **Data Quality & Usability**
  - End users: many different levels need shared data different systems. How do we know what to share?
  - Too much data
  - who is responsible for maintenance?
  - Data is not always timely
  - How do we know data is accurate? What quality checks are in place? Who does them? When?

  - Data designers do not connect or communicate with the end user to understand needs
  - Need to meet end user's needs. When community is the end user, how do we help them understand how to use?
- **Data Capacity**
  - Workforce development: Need for education and training to build capacity- Lack of trainers
  - holes in staffing
  - difficult to make data and information accessible to community
  - Need to build capacity around story telling and communicating with community
  - Need money for data tools, staff and training
  - High staff turnover- skills walk out the door. Staff learn systems and then leave
  - Lack of formal workforce development - Need for informatics trained staff
  - Resources to maintain systems- Agencies do not funding to keep systems going
  - Lack of funding. Agencies patch together grants. County board do not value or support data capacity
  - Too many different tools -How to decide which software to use for what?
- **Shared Governance**
  - "volun-telling" implementation responsibilities- those involved, not feeling a sense of ownership
  - Determining who has control and how to share authority
  - Burdensome data use agreement process and inconsistent data rules
  - LPH activities ahead of MDH rules (Example regional data models)
  - Must include MDH, LPH, and TPH
  - Lack of leadership buy in
  - Siloed funding and data collection
  - Uncertainty about future of federal data collection
  - Insufficient capacity to implement
  - Difficulty aligning or agreeing on priorities
  - Ethics

- Local differences in resources and needs (one size fits all won't work)
- Question who has fiscal responsibility? Who pays for what?
- No dedicated funding or staffing on governance- not prioritized
- Privacy
- Liability and risk tolerance around data collection and sharing
- laws/legal framework
- No coherent governance group (who has authority to recommend policy)
- Too many different tools -How to decide which software to use for what?

- **Relationships**
  - Tension between control/ownership and capacity to do the work
  - Need shared understanding of roles and responsibilities
  - Insufficient channels of communication across public health agencies
  - Differences in government to government relationships-tribes + State, locals + State, Locals + tribes
  - Equity
  - Roles not clearly articulated - no clear swim lanes between locals and state

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.

- None at this time

Next meeting

Date: Thursday, February 19, 2026

Time: 1:05pm-2:30pm

Location: Virtual, Microsoft Teams

Agenda items: Continue strategic planning, finalize vision statements, objectives and brainstorm action steps (If there are additional agenda items, please email them to gabby.cahow@state.mn.us)

Minnesota Department of Health
Public Health Strategy and Partnership Division

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