Summary: Minnesota e-Health Advisory Committee Meeting | October 13, 2026

Objectives

- Strengthen connections and foster collaboration between new and returning Advisory Committee members.
- Orient members to and establish context for the committee's proposed work plan.
- Engage with and provide input on key e-health activities occurring in the state: MNSHINE, the Rural Health Transformation Program (RHTP), and Minnesota Department of Health (MDH) data modernization efforts.
- Discuss and shape the work plan by identifying feasible priority activities, opportunities and barriers, what success looks like, and any learning needs.

Summary

Motion to approve the 2026-27 Advisory Committee Charge: Bryan Jarabek and Lindsey Sand (Co-chairs)

The 2026-27 Advisory Committee Charge was approved.

Framing today's meeting: Kari Guida (MDH), Bryan Jarabek and Lindsey Sand (Co-chairs)

Kari Guida provided an overview and context for the meeting presentations and activities.

- Meeting was guided by the Artificial Intelligence (AI) Work Group and Bridging Information and Care (BIC) Work Group recommendations, the desire of Advisory Committee members to take action on the recommendations, and current developments in Minnesota's e-health ecosystem.
- These activities were illustrated using five pillars (federal and national activities, AI recommendations, BIC recommendations, MDH interoperability, and the RHTP), across these pillars members have an opportunity to take action, support learning, and build relationships.
    - Presentations align with these pillars.
- After presentations, members participated in small group discussions to shape their work plan through June 2027. Several considerations were presented for their planning:
    - There is more work than MDH staff and Advisory Committee time.
    - The BIC and AI recommendations do not have a specific timeframe.

    - Changes in the ecosystem may require us to pivot.
    - Prioritization is needed to ensure the work does not get diluted.
- Worksheets were provided for members to record what actions should be taken by June 2027, learning needs for both the Advisory Committee and the broader community, relationships to build, challenges and concerns, what success looks like, and personal interest in serving as a lead or co-lead for that area.
- A tentative timeline was shared to illustrate how progress could look through June, mapping out when several activities could take place. Members were invited to provide input on the timeline.
- Bryan encouraged members to think about where they can contribute to the work and consider being a lead or co lead so that work can happen in between meetings.

MNSHINE: Liz Cinqueonce and Chad Peterson (MNSHINE)

- MNSHINE (Minnesota Statewide Health Information Network and Exchange) brings together Minnesota Community Measurement, Koble Minnesota, and the Minnesota EHR Consortium to advance a more coordinated statewide health data ecosystem.
- Minnesota's health data landscape faces challenges related to fragmented data-sharing networks, duplicative infrastructure and reporting, evolving interoperability requirements, and financial and workforce pressures.
- MNSHINE is exploring a Health Data Utility (HDU)—a trusted, member-governed, nonprofit organization that would provide shared infrastructure, data stewardship, and coordination across Minnesota's health data ecosystem.
- The proposed HDU would support inclusive membership, representative governance, transparency, shared accountability, and collaboration while complementing existing organizations rather than replacing them.
- The model aims to establish common standards, connect clinical, claims, public health, government program, and community data, reduce duplication, and support reusable data services. Examples include streamlining clinical quality measurement and eligibility determination for public programs.
- Work is progressing on MNSHINE's organizational structure, the HDU's financial and operational business model, and policy and regulatory alignment.

Discussion

Presenters posed three questions for the Advisory Committee:

1. What aspects of this vision are most important for strengthening Minnesota's statewide health information ecosystem – and where do you see gaps or risks we should address?
2. How should MNSHINE complement and connect with Minnesota's existing e-health governance, infrastructure, and initiatives without creating unnecessary duplication?
3. What policy, regulatory, or interoperability changes would be most important to enable this future-state vision for Minnesota?

A member asked why do we think this model will work now and if MNSHINE as a public-private entity jeopardizes a statewide HDU being a public utility? Another member asked about funding.

- Approach is different now because of lessons learned with past HIE efforts. Market-based approach has not worked with multiple entities entering and leaving the market, resulting in lost momentum. Other approaches were not well-received and Minnesota now has one state certified HIO.
- The goal is to create a collaborative public-private model that builds on national standards, allows both Epic-based and non-Epic data exchange, and avoids dictating a single, mandated solution.
- Aims to bring the public and private sectors together early so solutions are codesigned.
- Proposing a structured process for identifying future data-sharing needs as new programs emerge (e.g., Paid Family Medical Leave, H.R. 1).
- Thinking about efficiency and affordability – new solutions should not be built unnecessarily when existing assets can be connected or repurposed.
- Funding will need to be from both public and private sources to ensure sustainability.
- Much of the needed infrastructure already exists, so work will often involve connecting existing components.

There were additional member comments regarding funding. One stating from a patient/provider perspective, it seems logical for the state to invest financially in unified, statewide solutions, and another wondering whether Minnesota should fund more of the infrastructure directly to achieve the benefits frequently discussed by the committee. One member noted that given H.R. 1, we should consider reducing state spending in this area.

Rural Health Transformation Program update: Zomi Bloom (MDH)

- Minnesota received approximately $193 million for federal fiscal year 2026 through the federal Rural Health Transformation Program (RHTP), which provides $50 billion nationally over five federal fiscal years (2026-2030).
- Minnesota's program focuses on community-based preventive care and chronic disease management; rural workforce recruitment and retention; sustaining access to care close to home; regional care models; and technology, infrastructure, and collaboration to support rural provider financial viability.
- The fifth initiative includes potential investments in data management tools, technical assistance and workforce skill-building, artificial intelligence applications, a secure statewide rural health data network, cybersecurity, and revenue cycle management.
- Listening sessions identified patient portals, access to health records, interoperability, referrals, and telehealth as helpful tools. Challenges included inconsistent internet access, accessibility and language barriers, culturally responsive care, and maintaining a human-centered experience.
- MDH described plans for technical assistance and performance measurement to help rural providers implement technology investments and evaluate their impact.

Discussion

Committee members were invited to share perspectives on patient technology use and measuring HIT investments.

- What are members hearing from their teams and communities about using technology to manage health needs? What is most helpful, most challenging, and where are the greatest opportunities?
    - A member highlighted results from a survey that older adults have strong internet access and comfort using technology, but experience challenges navigating fragmented services such as housing, healthcare, and mental health.
    - Importance of designing solutions around the patient experience, not just technology infrastructure, and the importance of simplifying service navigation.
    - Telehealth is convenient, but there are concerns about maintaining continuity and relationships with primary care providers.
- Evaluating technology investments: Considering common health information technology investments at members' facilities or in the broader health care market, what outcomes or indicators are most useful for determining whether those investments are successful?
    - Members shared that relevant metrics include patient satisfaction with technology tools, provider/staff efficiency, and measures tied to care coordination such as whether referrals are completed and follow-through on imaging/labs.

Members also asked questions related to funding.

- What percentage of the grant funding has been distributed so far, and how much is going to hospitals/health systems versus infrastructure or administration?
    - MDH applied for $200 million and is close to obligating a substantial portion, though many contracts are still being finalized. In Budget Period 1, about 70% of funds were allocated to hospitals; smaller amounts went to CCBHCs, tribal partners, and FQHCs. Approximately 97% of funds will ultimately go out as grants/contracts, with around 3% retained for MDH administrative costs. Presenters acknowledged that procurement and timing complexities have delayed implementation, but funds are on the way.
- Will future funding cycles more directly target long-term care and community-based organizations, rather than relying on funding to trickle down?
    - Beginning in Budget Period 2, MDH plans to shift to a more competitive application pool, which may open opportunities for additional provider types. Applications must still align with federally approved priorities, but MDH intends to encourage regional partnerships between hospitals and community-based organizations. Future investments may emphasize social determinants, public health collaboration, and chronic disease prevention in rural areas.

MDH data modernization update and discussion: Blen Shoakena, Elisabeth Atherly, Tim Jenkins, Kari Guida (MDH)

- The MDH Office of Data Strategy and Interoperability (DSI) is advancing MDH's data modernization efforts in alignment with the Minnesota e-Health Advisory Committee's vision. DSI works with health care, community organizations, Tribal and local public health, MNIT, and the state HIO (now MNSHINE) to improve data sharing and interoperability.
- MDH is moving toward a more coordinated, enterprise-wide data environment to improve data quality and usability of data, reduce administrative burden, and support health equity, data equity, and data sovereignty.
- MDH is working on several use cases: CMS Promoting Interoperability use cases (syndromic surveillance, electronic lab reporting, electronic case reporting, and immunizations) and other MDH use cases which includes three use cases identified in the BIC Work Group (traumatic brain injury/spinal cord injury, newborn screening electronic test orders and results, and infectious disease electronic test orders and results).
- Presenters highlighted progress made with syndromic surveillance and the three BIC use cases. MDH reported that 99% of Minnesota hospitals contribute real-time data to the National Syndromic Surveillance Program. Efforts are underway to expand electronic data exchange for traumatic brain injury and spinal cord injury notifications, newborn screening, and infectious disease testing.
- Presenters noted that expanding data exchange requires better communication and coordination between health system interoperability teams and operational program staff, as well as greater organizational prioritization of public health data exchange.

Discussion

Committee members were asked to help advance public health data exchange by:

- Identifying appropriate interoperability and information technology contacts within their health systems to support priority public health use cases.
- Facilitating coordination between health system interoperability teams and operational program staff to clarify the need for modernized data exchange.
- Elevating public health data exchange as an organizational priority alongside other enterprise initiatives.
- Providing guidance on communication strategies that would resonate with health system leadership and encourage engagement.

Discussion of these occurred during the small group discussion agenda item.

Work plan development and small group discussion: Bryan Jarabek and Lindsey Sand (Co-chairs)

In addition to discussing DSI's requests, members discussed priorities and potential actions for advancing the AI and BIC recommendations through June 2027 in small groups. Members attending online discussed advancing the AI recommendations in a breakout room. Members identified opportunities for education, collaboration, policy development, implementation planning, and engagement with partners.

AI

- Members discussed continuing to build AI literacy and promote the AI Resource Catalog, with an emphasis on accessible guidance on AI governance, risks, safety, and mitigation strategies.
- Members also identified opportunities to learn from other states, engage experts, and explore guidance or policy approaches for AI use in health care.
- Focusing on a specific use case, such as ambient listening and AI scribes, was identified as a potential way to develop and share practical guidance.

BIC

- Members discussed advancing HIE and increased participation in HIOs and the importance of communication and guidance for less-resourced settings.
- Members wanted to explore funding opportunities and policy to support adopting HIO services.
- Many members expressed interest in starting the hospital-to-skilled nursing facility transitions pilot and outlined next steps to do so, including better understanding information sharing needs, identifying potential partners, and the need to communicate value.
- Additional discussion focused on exploring policy and governance for a statewide HDU.

Closing remarks: Bryan Jarabek and Lindsey Sand (Co-chairs)

Co-chairs thanked members for their time and engagement and reminded members to consider being a lead or co-lead to help continue the momentum of this work.

Comments submitted through survey form

- It was very hard to follow the discussions in the room, the small group discussions. I do not recommend this scenario going forward. It appeared that you had more people virtual than in the room so you should have gone full virtual. Very hard to follow.

Attendance

Members present

Bryan Jarabek, MD, PhD, Chief Medical Informatics Officer, M Health Fairview
Co-chair; Representing: Large Hospitals

Lindsey Sand, LNHA, HSE Independent Consultant, Health & Community, Humble Hill Consulting
Co-chair; Representing: Health Care Administrators

Wendy Abrahamson, LPN, Epic Ambulatory Optimizer, Astera Health
Representing: Nurses

Brett K. Anderson, PhD, MS, RN, PHN, NE-BC, President & CEO, Ebenezer Senior Living; Post-Acute Executive & President of Senior Services, Fairview Health Services
Representing: Long-Term & Post-Acute Care

Stacie Christensen, Deputy Commissioner & General Counsel
Representing: Department of Administration

Jill Ender, PharmD, Associate Vice President, Ancillary Clinical Services, Winona Health
Representing: Small/Critical Access Hospitals

Carolyn Heine
Representing: Consumer Members

Matt Hoenck, Director of IT & Analytics, South Country Health Alliance
Representing: Health Plans

Steve Johnson, PhD, Associate Director, CTSI Health Informatics Program, University of Minnesota
Representing: HIT Training & Education

George Klauser, Executive Director – Community Services-ACO/Healthcare Consultant, Lutheran Social Services of Minnesota
Representing: Social Services

Andy Levesque, Director of Enterprise Architecture, Chief Enterprise Architect, Gillette Children's
Representing: Experts In Emerging Technology & Innovation

John Li, Chief Data & Analytics Officer
Representing: Department of Health

Genevieve Melton-Meaux, MD, PhD, Senior Associate Dean, Health Informatics & Data Science, University of Minnesota
Representing: Academics & Clinical Research

Nathan Moracco, Technology Director
Representing: Direct Care & Treatment

Jane Pederson, MD, MS, Chief Medical Quality Officer, Stratis Health
Representing: Experts in Quality Improvement

Charles Peterson, Chief Executive Officer, The Koble Group
Representing: Health IT Vendors

Megan Polzer, Epidemiologist, Dakota County Public Health
Representing: Local Public Health

Mathew Spaan, Manager, Care Delivery & Payment Reform
Representing: Department of Human Services

Adam Stone, Practice Leader, Zaviant
Representing: Experts in Health IT

Laura Topor, President, Granada Health
Representing: Pharmacy

Tyler Winkelman, MD, MSc, Director, Research & Evaluation Data Analytics Core, Hennepin Healthcare Research Institute
Representing: Physicians

Members absent

Jon Eichten, Commissioner
Representing: Minnesota IT Services

Greg Hanley, Director of Quality Management, Blue Cross Blue Shield of Minnesota
Representing: Health Plans

Eric Maurer, MHA, MHI, Chief Innovation & Strategy Officer, Community-University Health Care Center
Representing: Community Clinics/Fed Qual. Health Centers

Ashley Setala, Director of Regulation & Policy Strategy
Representing: Department of Commerce

Designated alternates present

Todd Bergstrom, Director of Research & Data Analysis, Care Providers of Minnesota
Representing: Long Term & Post-Acute Care

Justine Mrosak, MD, Clinical Informatics Medical Director, Hennepin Healthcare System
Representing: HIT Training & Education

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To obtain this information in a different format, call 651-201-5979.