Summary: Minnesota e-Health Bridging Information and Care Work Group Meeting

Meeting Date: January 16, 2026

The Bridging Information and Care Work Group meeting included 34 participants with co-chairs Steve Johnson and Laura Topor.

Meeting objectives

- Revisit environmental scan
- Develop use case inventory
- Discuss prioritization criteria

Welcome and agenda (slides 1-4)

Work group members were welcomed, land acknowledgement read, and meeting logistics reviewed. Co-chair Laura Topor reviewed the agenda and asked for any members who had not been at the December meeting to introduce themselves. New members shared their name, role and organization.

Advisory Committee updates (slides 5-16)

The co-chairs provided highlights from the Minnesota e-Health Advisory Committee meeting on January 15.

Co-chair Laura Topor reviewed the process for the coordinated response to the ASTP HTI-5 proposed rule. Instructions for sending comments are here: Minnesota e-Health Coordinated Responses (www.health.state.mn.us/facilities/ehealth/coordresponse/index.html). The Minnesota e-Health Initiative provides feedback on state and federal definitions, criteria, standards, and/or proposed regulations relating to e-health. Written comments are due by Friday, February 13, at 5:00 p.m.

ASTP/ONC fact sheet, chart, recorded information session on HTI-5 Proposed Rule webpage: HTI-5 Proposed Rule (www.healthit.gov/topic/laws-regulation-and-policy/health-data-technology-and-interoperability-astponc-deregulatory-actions-unleash-prosperity).

Co-chair Steve shared highlights from the Rural Health Transformation Program (www.health.state.mn.us/facilities/ruralhealth/ruraltrans.html) (Minnesota) update. Minnesota received $193 million award and MDH is in process of clarifying and revising budget. Continued funding after first year will be dependent on “satisfactory progress.”

Revisit environmental scan (slides 17-21)

A high-level overview of the care continuum that is within the purview of the work group as well as the current health care ecosystem (hospitals, clinics, nursing homes, etc.) in Minnesota.

The Minnesota Department of Human Services Encounter Alerting Service (EAS) admission, discharge transfer (ADT) alerts were updated with denominators to indicate to percentage of certain organization types receiving alerts. The public health reporting transactions were revised to include transaction volumes.

Develop Use Case Inventory (slides 22-24)

The co-chairs introduced the "Use Case Inventory" table. Discussion focused on the use cases identified at the December 19, 2025, meeting and a few new ones as well. A summary of the discussion is included below in addition to the inventory shared at the meeting (see Appendix A). The discussion input will be incorporated into a revised Use Case Inventory that will be shared prior to the February meeting.

Overall comments that may pertain to one or more use cases

- Where might there be opportunities to use AI in these use cases? AI can be helpful by collecting, summarizing and putting information in a desired format. Most EHRs are working on this, but standardization would be a best practice.
  - What relationships should be considered and are there any regulations that support or constrain the use case?
- Capture of care setting nuances (may be the "same" use case but differences exist based on setting).
- Expand the use case inventory "exchange type" details to include (e.g., bidirectional or one-way exchange or consider adding another column or row to capture directions).

Use case discussion notes

Pharmacists/Pharmacies receive ADTs and other actionable-useful information (e.g., discharge summaries)

- If pharmacies/pharmacists can receive ADTs and discharge summaries (likely a cost for this service), how can pharmacist get reimbursement for providing a clinical service such as medication reconciliation?
  - Concern that the information from long term care (LTC) may not be complete as LTC does not generally send prescriptions to retail pharmacies and patients whose records are not in an Epic EHR are sometimes left out. In addition, long term care and pharmacy workflows are different from outpatient.

Long term and post-acute care providers receive discharge information needed in useable format to safely transition a patient from a hospital to nursing home or other long-term care facility

- Current exchange format for a discharge summary is generally fax, Direct electronic exchange or even paper in rare instances from the hospital.
- LTC upload fax or electronic file into LTC EHR or our task system which is extra work.
  - Structure of information sent is not standardized
  - Form - specifically order of the form is not standardized for ease of use
- While there was a standard paper form previously, when organizations adopted EHRs, they generally built out their own electronic forms (e.g., after visit summaries).
- 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.

- Consider bringing all the health systems together with LTC facilities to develop standard for form/data for discharge to nursing home or other LTC facility.

Comprehensive, longitudinal record (new potential use case) - similar to LTC discharge/transition use case

- Need for organizations to receive information from all the organizations outside of their own organization in an "easy to digest" way - "the patient story." Concept of aggregating and parsing all information including from scanned paper documents, to know all the places they've been and what happened at each place to help the patient feel cared for and that they aren't responsible for sharing all that information. Rural providers are hit particularly hard regarding access to the longitudinal health data for their patients. HIOs can be that last mile of interoperability and inclusivity regardless of EHR used to provide longitudinal access to data across all participating providers.

Nursing bed availability (new potential use case)

- Suggestions to use MN*Trac* (www.health.state.mn.us/communities/ep/coalitions/mntrac.html) does some of this now "Minnesota system for Tracking Resources, Alerts and Communication) is a database-driven, password-protected web application designed to track bed capacity including National Disaster Medical System (NDMS) responses and pharmaceuticals and resources from all hospitals within the state to support surge capacity needs. Additionally, hospital diversion status, emergency incident planning, emergency communication, and emergency alert notifications are supported in real time." MN*Trac* includes: Hospitals, Emergency Medical Services (EMS), Local Public Health (LPH), Emergency Management (EM), regional caches, Medical Resource Control Centers (MRCC), Poison Control, Minnesota Department of Health (MDH), Emergency Medical Services Regulatory Board (EMSRB) and Skilled Nursing Facilities (SNF). Note: MN*Trac* can be used for bed availability in SNFs, but the practicality statewide is challenging from a support and training perspective.

Death notifications

- There is not a good interface to get a death certificate filled out with information that has already been entered - double work.
- No easy way to go from Minnesota Vital Records and Certificates (www.health.state.mn.us/people/vitalrecords/death.html) back to all organizations that cared for that patient to let them know that patient is now deceased. There could be statutory barrier that may prevent this.
  - Additional suggestion that EHR could cancel all open orders for the deceased patient (e.g., cancel order for prescriptions)
- Current exchange format is manual; preference for bi-directional Direct electronic exchange.

Provider Order for Life Sustaining Treatment (POLST) forms and/or advance directives (new potential use case)

- Generally need immediate access to a POLST or Advance Directive so traditional HIE query and response may not be adequate. MDH completed a study in 2024 with recommendations for a POLST registry.
- Minnesota POLST Registry Study (www.health.state.mn.us/facilities/ehealth/polst/docs/013124report.pdf)
- ePOLST and POLST in EHRs - POLST (https://polst.org/technology/epolst)

Resources to patients with traumatic brain injury (TBI) (potentially apply to other conditions)

- Needing to information out to people who may not even know they've had TBI (may have not heard that term for their injury).

- Discussion of how this could be automated in the health system in terms of an automated message sent from the patient portal to patients with TBI diagnosis code (consider other options instead of electronic notification for TBI patients).
- Many systems already use external vendor-supported directories to connect patient to resources (e.g., Findhelp, Unite Us as the "backbone" (Example: Fairview's Community Resource Connect (www.mhealthfairview.org/resources/community-resource-connect)) or would a statewide directory of community based organizations and their services be a goal?
- Barriers include that health systems may want resource materials "branded" and won't just send out others' materials.

Smaller organizations receive information regardless of EHR - not discussed

- How do we get data to the private care providers or to the specialty clinics in an effective way?
- Option: promote TEFCA, QHIN structure and make sure it's safe and reliable and get people to connect to it through our own through our own HIOs or whatever.
- Lab is an issue due to reference ranges etc.

Medical Assistance (MN Medicaid) eligibility redeterminations

- In 2027 Medicaid eligibility checks will need to be completed every six months instead of annually. That includes items such as verifying income, residency and other criteria. If clinics could receive the expiration date or the redetermination date from the Minnesota Department of Human Services (DHS), then we would be able to help the patients in advance so they don't lose coverage. Desire to have direct interface between DHS and the health system/clinic. (Have heard that Epic may begin working on this with other states by end of 2026).
- DHS created a report that looks out three months to see whose dates are coming up and that is sent to the counties. In addition, redetermination dates are sent to Integrated Health Partnership (IHP) program participants for the members attributed to those clinics/providers. Nevertheless, there is still a gap. Only attributed members are included, which is not all Medicaid members. DHS is only allowed to send out information for members with an established treatment relationship. The ideal would be a bidirectional exchange between DHS - MMIS and clinics/providers.
- May be able to build on what is happening with the new Paid Family Medical Leave (https://paidleave.mn.gov) program.

Disability benefit determinations - not discussed

Onboard new health care staff (credentialing) (new potential use case)

- Complete all the credentialing processes for providers, pharmacy, nursing using a bidirectional interface with DHS - barriers include getting approval by public boards to do this; one health system has set it up for the new staff to health system but not health system to DHS.

Prior authorizations - not discussed

Make shared information more useful in provider-to-provider patient record sharing (e.g., transitions of care such as primary care to specialty care) - not discussed

Third-party application data sharing - patient access through APIs - not discussed

Payer-to-provider patient record sharing (provide specific example) - not discussed

Prioritization criteria (slide 25)

The co-chairs introduced several criteria to consider as the work group efforts continue.

- What is the potential impact?
  - Impact could be efficiency; it could be outcomes or financial savings. Or consider rural health impact as part of this or separate.
- What is the feasibility/ease of implementation?
  - Linked to is there an existing standard, is anybody doing this? Places in the state or elsewhere in the country that we can learn from?
- What existing resources are available? (e.g., what infrastructure already exists)
- Which use cases should be lower priority? (e.g., use cases that require changes in law)
- What is within scope?
- What is out of scope?

Next steps and upcoming meeting (slides 26-27)

Use Case Inventory template (with use cases added today) will be sent out for work group members to help populate. Work group members are encouraged to edit (add to, delete, correct) and return it before the next meeting. All submissions will be compiled so that a productive discussion can happen at the next work group meeting on February 27, 2026, from 10:00 a.m. – noon.

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2/17/2026

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

Appendix A
Use Case Inventory - *working draft for discussion only*

MINNESOTA E-HEALTH BRIDGING INFORMATION AND CARE WORK GROUP

Use case example	Brief description of need and/or problem it solves	Type of exchange (direct/ query/FHIR)	Is there an existing solution or existing standards?	Who needs to participate (senders and receivers)	Barriers (e.g., policy implications)	How can success be measured?	Potential impacts
Pharmacists/Pharmacies receive ADTs and other actionable-useful information (e.g., discharge summaries)	Notifications to help with care transitions & medication reconciliations	Direct	Yes? EAS, HIO, TEFCA QHIN	Health systems, pharmacies	Awareness and pharmacy system readiness, reimbursement	Number of pharmacies receiving notifications, other information and number of discontinued prescriptions	Reduced readmissions, adverse events
Long term and post-acute care providers receive information needed in useable format	Data needed to support patient transitions (timeliness, relevancy and usability issues)						
Nursing bed availability							
Death notifications	Notifications to health and care providers						
Provider Order for Life Sustaining Treatment (POLST) forms and/or advance directives (see Minnesota POLST Registry Study)							
Resources to patients with TBI (potentially larger use case for other conditions)	Resources with services and supports to traumatic brain injury (TBI) patients based on their care needs						

Use case example	Brief description of need and/or problem it solves	Type of exchange (direct/ query/FHIR)	Is there an existing solution or existing standards?	Who needs to participate (senders and receivers)	Barriers (e.g., policy implications)	How can success be measured?	Potential impacts
Smaller organizations receive information regardless of EHR	Fill the gap in what smaller organizations receive/exchange to match more significant sharing among large health systems						
Medicaid redeterminations							
Onboard new providers							
Disability benefit determinations							
Prior authorizations	All payers in the state are required to stand up prior auth APIs by January 1, 2027						
Make shared information more useful in provider-to-provider patient record sharing (e.g., transitions of care such as primary care to specialty care)							
Third-party application data sharing - patient access through APIs	Patients can receive their health information through APIs						
Payer-to-provider patient record sharing (provide specific example)							