Minnesota e-Health Bridging Information & Care Work Group

February 27, 2026

DEPARTMENT OF HEALTH

health.state.mn.us

Land Acknowledgement

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

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

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

Housekeeping

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

Agenda

10:00 – 10:10 a.m.	Welcome and housekeeping
10:10 – 10:20 a.m.	Review work group tasks and status
10:20 – 10:50 a.m.	Prioritization criteria and methodology
10:50 – 11:50 a.m.	Use Case Inventory
11:50 a.m. – noon	Looking ahead and next steps

Work group activities (from charge)

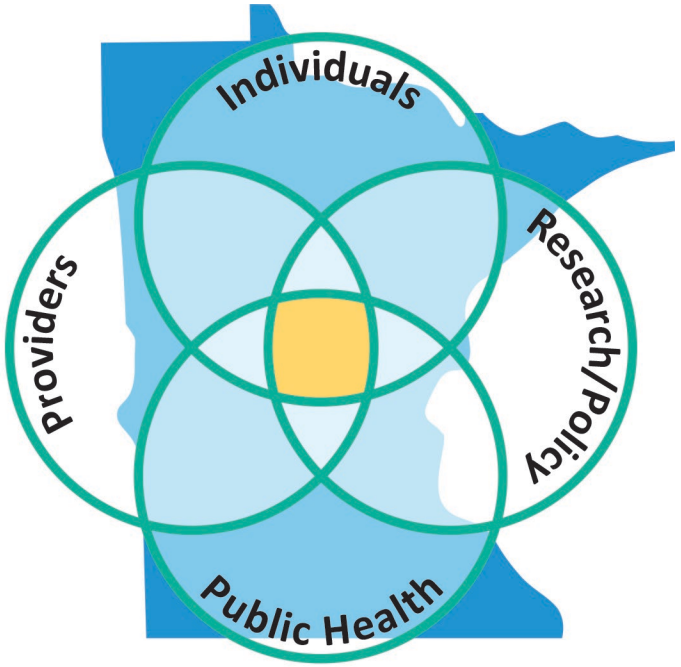
- Develop inventory of use cases where exchanged information is supporting care and where there are gaps and/or challenges
- Prioritize use cases, with an initial focus on high priority use cases, and identify opportunities to address gaps
- Review and discuss past efforts and lessons learned on root causes for the lack of interoperability in Minnesota
- 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
- 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)

Work group tasks and status (from charge)

Proposed Activities, Tasks and Deliverables

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

Prioritization



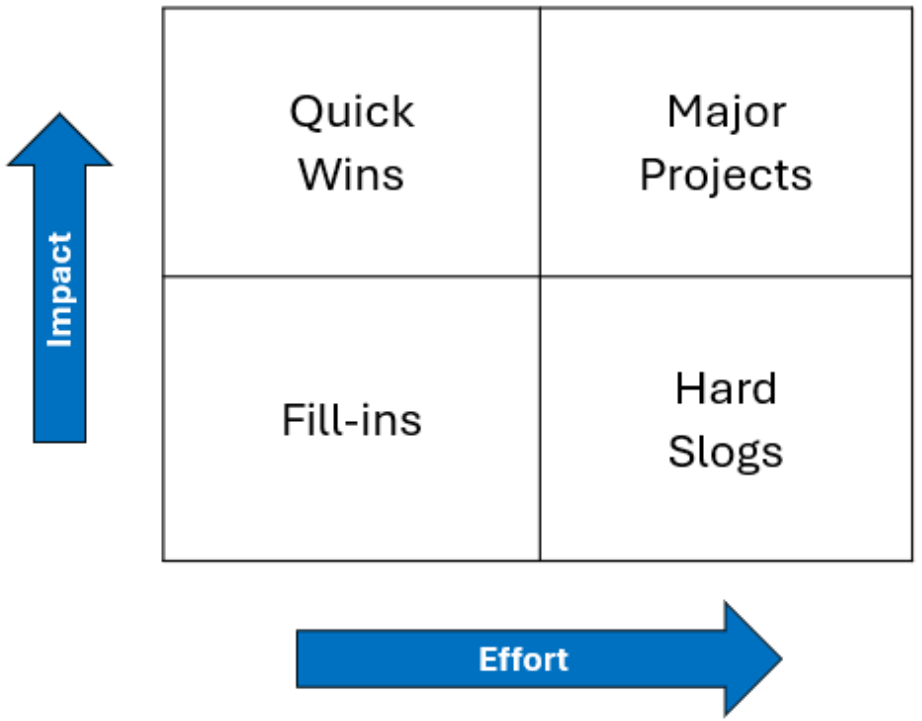
- Review use cases to ensure alignment with Minnesota e-Health Initiative priorities
- Assess potential impact and effort (feasibility and resources needed) for each use case
- Quantify impact and effort to help guide selection of priority use cases

Priority matrix

Quantify the impact, feasibility and resources needed for use cases

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

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



How to “quantify” use case potential impact

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

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

Sources: CyncHealth and Brett Marquard for sharing prioritization criteria

How to “quantify” potential effort

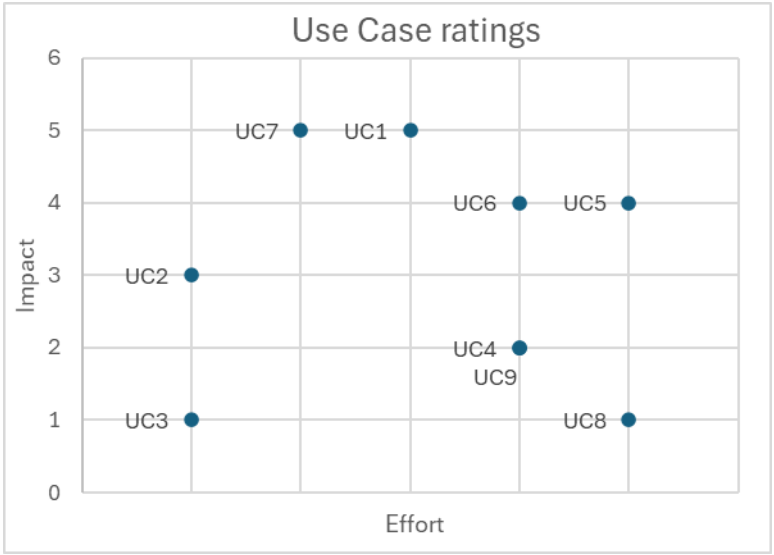
Assess what the feasibility and resource costs (e.g., financial, staff) are, considering the questions below, and quantify that as potential effort.

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

Sources: CyncHealth and Brett Marquard for sharing prioritization criteria

Rating survey

- Collect input from work group members, e-Health Advisory Committee and broader audience to generate:
  - Scatter diagram showing the average impact and effort ratings of all responses
  - Bar chart of average impact ratings, sorted high to low
  - Bar chart of average effort ratings, sorted high to low
  - Comments



Use case inventory

- Refer to use case inventory spreadsheet- linked in chat or shown here

https://www.health.state.mn.us/facilities/ehealth/workgroups/bic/docs/022726bicusecase.xlsx

Use case inventory categories

January 16 version (deferred items in red)

- Use case example
- Brief description of need and/or problem it solves
- Potential impacts
- 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? –will come back to this after prioritization

February 27 version (expanded or new in red)

- Use case example/name
- Use case description/Notes from work group discussion
- Expected outcomes / Potential impact
- Preconditions / Assumptions
- Legal or regulatory requirements and details
- Existing national technical standards, TEFCA exchange purpose (XP) SOP or other exchange process
- Senders
- Receivers
- Barriers (e.g., policy implications)

Use cases under consideration

1) Pharmacists/Pharmacies receive ADT notifications and other actionable-useful information e.g., discharge summaries
2) Long term and post-acute care providers and hospitals achieve bi-directional exchange of information needed for hospital to nursing home transition or nursing home to hospital transitions.
3) Providers can send and receive information needed in a useable format for patient transitions
4) Providers receive/obtain death "confirmation" more quickly/automatically from Minnesota Department of Health (MDH) death record data to allow cancellation of reminders/notifications
5) Improve death registration process for hospitals/health systems by implementing bi-directional electronic exchange with Minnesota Registration and Certification system (MDH).
6) Public Health Use Case: Increase number of facilities sending Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) data to MDH using an HIO
7) Public Health Use Case: Increase Newborn Screening Electronic Test Orders and Results (MDH Public Health Lab) using an HIO
8) Public Health Use Case: Increase Infectious Disease Electronic Test Orders and Results (MDH Public Health Lab) using an HIO
9) Smaller organizations (e.g., rural, independent, public health) receive health information electronically regardless of which EHR they use
10) Disability benefit determinations
11) Prior authorizations
12) Patient Access API (health plan/payer information available to patients)
13) Provider Access API (health plan/payer information available to providers)

Discussion by use case

- What is missing?
- What needs adjusting or context?
- Anything to add that would help assessing the impact or effort?

1) 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 & 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

2) Long term and post-acute care providers and hospitals achieve bi-directional exchange of information needed for hospital to nursing home transitions 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
- **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 requirements**: 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. Structure of information sent is not standardized; order of the discharge form is not standardized for ease of use.

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

- **Use case description:** 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
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: 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)
- **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)

4) Providers receive/obtain death confirmations more quickly/automatically from MDH death record data

- **Use case description:** Improve process for health systems to receive death conformations to allow for cancellation of reminders to family members about the deceased.
- **Expected outcomes/Potential impact:**
  - Increased patient family satisfaction
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: None
- **Existing technical standards or other:** None
- **Senders:** MDH Vital Records (Minnesota Records and Certification)
- **Receivers:** Providers and health plans/payers
- **Barriers:** Possible Minnesota legal issues, timeliness of death certification data entry

5) Improve death registration process for hospitals/health systems by implementing bi-directional electronic exchange

- **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.
- **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.
- **Legal or regulatory requirements**:
- **Existing technical standards or other:** Pilot- HL7 project 'fact of death' exchange-FHIR APIs
- **Senders:** Hospitals, health systems
- **Receivers:** Minnesota Vital Records and Certificates
- **Barriers:** Proof of concept adopted; funding to update MDH systems

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

- **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.
- **Expected outcomes/Potential impact:**
  - Improved MDH TBI/SCI program staff workflows
  - Increased patient satisfaction
  - Better long-term outcomes
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: Yes, required to send data (method not specified)
- **Existing technical standards or other:** HL7 automated ADT feed using an HIO; MDH TBI/SCI Data Specifications.
- **Senders:** Hospitals
- **Receivers:** MDH TBI/SCI program
- **Barriers:** Limited number of hospitals currently participating; information from other sources has 3-6 month delay

7) 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, & 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.
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: Yes, required to send data (method not specified)
- **Existing technical standards or other:** HL7 automated feed using an HIO; MDH Newborn Screening Electronic Test Orders and Results Data Specifications Data Specifications.
- **Senders:** Hospitals
- **Receivers:** MDH Public Health Lab
- **Barriers:** Significant hospital recruitment efforts needed as well as sustainable incentives from MDH

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

- **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.
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements:** Yes, required to send data (method not specified)
- **Existing technical standards or other:** HL7 automated feed using an HIO; MDH Infectious Disease Lab Electronic Test Orders and Results Data Specifications.
- **Senders:** Hospitals
- **Receivers:** MDH Public Health Lab
- **Barriers:** Significant hospital recruitment efforts needed as well as sustainable incentives from MDH

9) Smaller organizations 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.
- **Expected outcomes/Potential impact:**
  - Better care coordination
  - Increased patient safety
  - Reduced readmissions
  - Decreased repeat testing
  - Workload reductions
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: 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)
- **Senders:** Health systems, Clinics, hospitals, nursing homes, assisted living, public health etc.
- **Receivers:** Health systems, Clinics, hospitals, nursing homes, assisted living, public health etc.
- **Barriers:** Cost for smaller organizations, workforce training

10) Process for submitting health information for disability benefit determinations

- **Use case description:** Improve process for obtaining and submitting a patient's medical records for disability benefit determinations.
- **Expected outcomes/Potential impact:**
  - Increased patient and family satisfaction
- **Preconditions/Assumptions:** Agreement
- **Legal or regulatory requirements**: None
- **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; need to parse unstructured notes

11) Prior authorizations

- **Use case description:** All payers in the state are required to stand up prior authorization APIs by January 1, 2027, 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
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: CMS Interoperability Rule 0057-F
- **Existing technical standards or other:** FHIR (Da Vinci PAS)
- **Senders:** Health systems, hospitals, providers
- **Receivers:** Health plans, payers
- **Barriers:** Vendor readiness for Da Vinci standards

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

- **Use case description:** Patients can receive their health information from health plans and payers through APIs
- **Expected outcomes/Potential impact:**
  - Increased patient satisfaction
  - Patient empowerment
  - Better self-management
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: CMS Interoperability Rule 0057-F
- **Existing technical standards or other:** FHIR (Patient Access API)
- **Senders:** Health plans, payers
- **Receivers:** Patients
- **Barriers:** Patient digital literacy; security/privacy concerns

13) Provider 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
- **Preconditions/Assumptions:**
- **Legal or regulatory requirements**: CMS Interoperability Rule 0057-F
- **Existing technical standards or other:** Da Vinci Payer Data Exchange (PDex)
- **Senders:** Health plans, payers
- **Receivers:** Providers, clinics, hospitals, health systems
- **Barriers:** Patient matching accuracy; legal/contractual agreements

Out-of-scope use cases for the prioritization process

Criteria for why proposed use case may be out of scope:

- Current information access method is working well; electronic health information exchange (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 underway (keep in alignment, not get ahead of these)

Alternate recommendations for future consideration may include:

- Monitor and respond to rulemaking, policy, or other federal and state government activities
- Expand organizations able to participate with current process
- Explore opportunities directly with health systems

Proposed alternate recommendations for out-of-scope use cases (1 of 3)

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

- **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 (https://www.health.state.mn.us/facilities/ehealth/polst/docs/013124report.pdf).

- **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. (References: Minnesota Provider Directory Feasibility Study (https://www.health.state.mn.us/facilities/ehealth/pdstudy/index.html) and https://defacto.health/2025/06/25/how-will-the-cms-national-directory-affect-health-plans/)

- **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.

Proposed alternate recommendations for out-of-scope use cases (2 of 3)

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

- 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)

- **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.

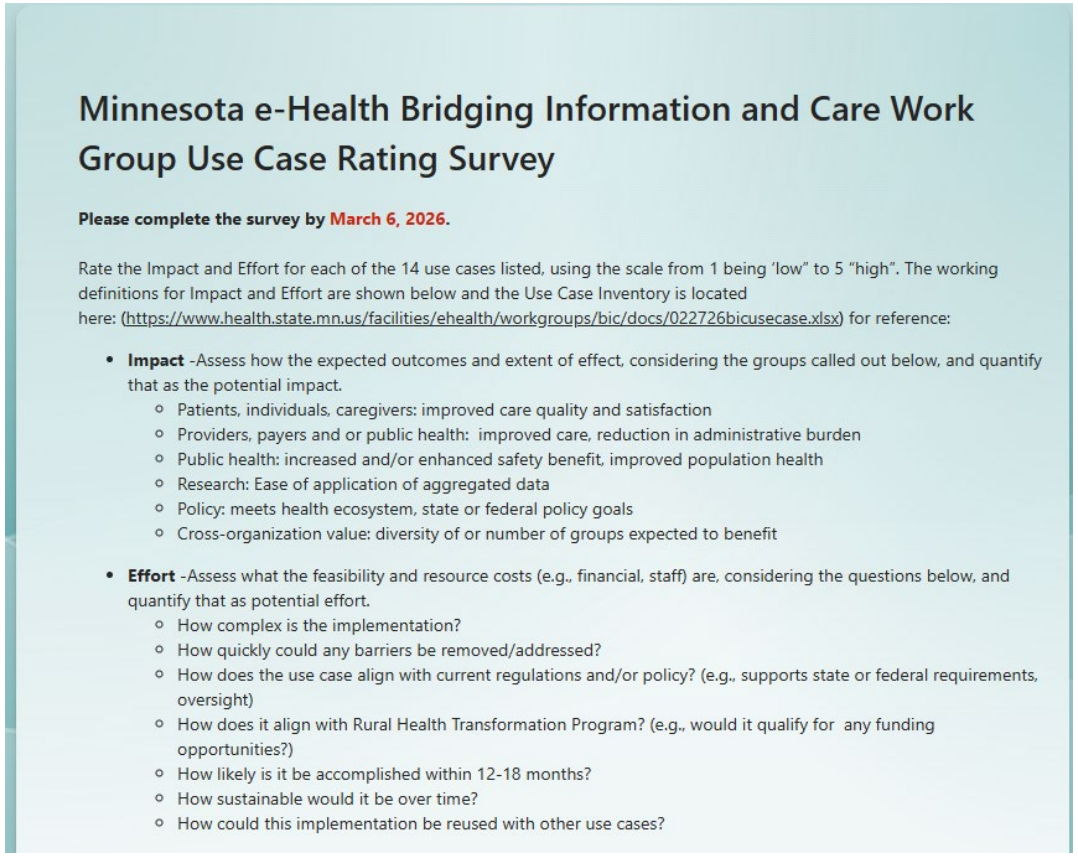
Proposed alternate recommendations for out-of-scope use cases (3 of 3)

Encourage organizations to participate with current information sharing process

- **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 (https://mn.gov/oems/data-center/hospital-hub/). 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).
- **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.

Use case rating survey tool

https://forms.office.com/g/AcLP4RyN5g



Minnesota e-Health Bridging Information and Care Work Group Use Case Rating Survey

Please complete the survey by March 6, 2026.

Rate the Impact and Effort for each of the 14 use cases listed, using the scale from 1 being 'low" to 5 "high". The working definitions for Impact and Effort are shown below and the Use Case Inventory is located here: (https://www.health.state.mn.us/facilities/ehealth/workgroups/bic/docs/022726bicusecase.xlsx) for reference:

- **Impact** -Assess how the expected outcomes and extent of effect, considering the groups called out below, and quantify that as the potential impact.
  - Patients, individuals, caregivers: improved care quality and satisfaction
  - Providers, payers and or public health: improved care, reduction in administrative burden
  - Public health: increased and/or enhanced safety benefit, improved population health
  - Research: Ease of application of aggregated data
  - Policy: meets health ecosystem, state or federal policy goals
  - Cross-organization value: diversity of or number of groups expected to benefit
- **Effort** -Assess what the feasibility and resource costs (e.g., financial, staff) are, considering the questions below, and quantify that as potential effort.
  - How complex is the implementation?
  - How quickly could any barriers be removed/addressed?
  - How does the use case align with current regulations and/or policy? (e.g., supports state or federal requirements, oversight)
  - How does it align with Rural Health Transformation Program? (e.g., would it qualify for any funding opportunities?)
  - How likely is it be accomplished within 12-18 months?
  - How sustainable would it be over time?
  - How could this implementation be reused with other use cases?

Looking ahead

March meeting (March 13!)

- Review survey results and prioritize use cases
- Review past efforts and lessons learned on root causes for the lack of interoperability in Minnesota (2010- current)
- Begin developing recommendations for priority use cases

Next steps

- Complete use case rating survey by March 6!!!
- Send additional comments and resources to the work group input form at https://forms.office.com/g/3Cc6VBRApA
- Reminder - please email mn.ehealth@state.mn.us to be added to the work group list to get all the meeting invitations and materials
- Add future meetings on calendar: https://www.health.state.mn.us/facilities/ehealth/workgroups/index.html
- If you are not receiving emails/not a participant, please join us by emailing anne.schloegel@state.mn.us
- Sign-up for MN e-Health Updates at https://www.health.state.mn.us/facilities/ehealth/updates/index.html

Upcoming meetings

- Bridging Information & Care Work Group
  - March 13, 2026
  - April 17, 2026
  - May 22, 2026
  - June 26, 2026
- Minnesota e-Health Advisory Committee
  - March 19, 2026 (10:00 a.m. – 12:00 p.m.)
- AI Work Group
  - March 23, 2026 (11:00 a.m. – 1:00 p.m.)

Thank you!