

LPH Data Modernization SCHSAC Workgroup March 2026 Meeting Minutes

DATE: MARCH 19TH 2026 | 1:05PM-2:30PM

MINUTES PREPARED BY: GABBY CAHOW, MDH DATA MODERNIZATION PLANNER

LOCATION: VIRTUAL, MICROSOFT TEAMS

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, **Shelly Aalfs**-Countryside Public Health, **Tina Jordahl**-Olmsted County Public Health Services, **Sarah Grosshuesch**-Wright County Public Health,
- MDH Subject Matter Experts
- **Jessie Carr**-MDH Environmental Health Division, **Abby Stamm**-MDH Office of Data Strategy and Interoperability (DSI), **Kari Guida**-MDH Center for Health Information Policy and Transformation (CHIPT), **Liana Schreiber**- MDH Office of Statewide Health Improvement Initiatives (OSHII),
- Facilitators/Guest Attendees
Gabby Cahow-MDH Public Health Strategy and Partnership Division (PHSP), **Chelsie Huntley**-MDH Public Health Strategy and Partnership Division (PHSP)

Purpose

- The March 2026 meeting was focused on prioritizing the factors, issues, and barriers to vision statements that were developed and finalized in February. The factors, issues, and barriers identified will become the focus of workgroup recommendations. The prioritization activity will help the workgroup focus on which topics and issues to develop recommendations on and indicate which recommendations are most important for governmental public health data system transformation.
- The Workgroup also gained two new MDH subject matter experts from the Office of Statewide Health Improvement Initiatives (OSHII), Jacob Walker-Swaney and Liana Schreiber. The Workgroup did an introduction and ice-breaker activity to help welcome them to the team.

Agenda

- Meeting Kick-Off
- Introductions and Icebreaker
- Prioritization Activity (Small Group)
- Prioritization Activity (Large Group)
- Meeting Wrap-Up

Decisions made

- None

Action items

- Share the final vision statements with your regional and divisional partners and networks.

Talking Points

- The Workgroup began prioritizing the issues/factors/barriers for each vision statement to guide the recommendations using a matrix activity.

Meeting notes

- Identifying Objectives:
- **Background/Context:**
 - At the in-person strategic planning meeting (February 2nd, 2026), the Workgroup members brainstormed in small groups around the question “What are the factors, conditions, issues, or things getting in the way of this vision?” for each vision statement.
 - The Workgroup reviewed all the ideas generated and then had a discussion that allowed them to ask questions, share feedback, and provide additional ideas and insight.
 - The Workgroup facilitator took the information and ideas generated to recreate the in-person whiteboard in a virtual environment, which allows the Workgroup members to continue the strategic planning process virtually.
- **Meeting/Discussion Summary**
 - The Workgroup participated in a small group prioritization matrix activity that asked the small groups to focus on two of the vision statements and use the matrix to determine

how each barrier/issue/factor identified at the previous in-person strategic planning meeting should be prioritized.

- LPHDMSW: Strategic Planning Part 2 Virtual • Data Modernization Planner
 - The matrix was designed with the X-axis or horizontal axis indicating impact (smaller to greater impact). The small groups were asked to consider the following questions when determining impact:
 - Which ones provide the most significant long-term benefits?
 - Which ones do our stakeholders (LPH/TPH/MDH) respond to and value the most?
 - The matrix was designed with the Y-axis or vertical axis indicating scope and influence (outside of scope or lesser influence to within scope and greater influence). The small groups were asked to consider the following questions when determining scope and influence:
 - Which are easiest to change?
 - Which require the least amount of resources (time, energy, money, etc.)?
 - Which ones get the most immediate, visible results?
- Below is a summary of how the small groups categorized/prioritized the factors/issues/barriers to each vision statement:
 - **Interoperability:** Data flows and is integrated securely and seamlessly across systems and organizations ensuring shared information is available for timely insight, coordinated action, and supporting measurably healthier communities.
 - Within Scope/High Influence and Greater Impact
 - Lack of trust if the data is accurate
 - Not understanding the value of interoperability
 - Legal or statutory barriers
 - Funding
 - Lack of trust the data is secure
 - Need interoperability w/ social needs serving entities
 - Lack of trust on how data will be used
 - Interoperability access issues
 - Time and expertise already invested into existing systems (Examples: EHR systems and MEDSS)
 - Within Scope/High Influence and Smaller Impact

- Following Standards/ shared standards
- Outside Scope/Low Influence and Greater Impact
 - Many of the EHR systems used are privately owned- less control over functionality
 - Healthcare organizations are not always compelled to share data with public health
- Outside Scope/Low Influence and Smaller Impact
 - Different systems are not open or compatible with API integration
- **Data Access:** Data are shared and accessed easily, enabling consistent, reliable, and timely access to locally relevant information across state, local, and Tribal public health
 - Within Scope/High Influence and Greater Impact
 - Data access. need technical notes and data limitations explained
 - Need knowledge on how to use data
 - lack of shared understanding why something is or isn't shared
 - lack of standardized ways to access data
 - Inability to describe why data is used/needed
 - Within Scope/High Influence and Smaller Impact
 - You have to know who to contact to access data
 - Data sharing agreements
- Outside Scope/Low Influence and Greater Impact
 - No Factors Identified in this Area
- Outside Scope/Low Influence and Smaller Impact
 - No Factors Identified in this Area
- **Data Quality & Usability:** All stages of the data lifecycle are transparent, rigorous, and responsive to the needs of the public health system, communities, and partners. Data systems are designed with end users in mind and data are available in user-friendly and easy to understand formats.
 - Within Scope/High Influence and Greater Impact

- How do we know data is accurate? What quality checks are in place? Who does them? When? (data literacy, community transparency)
 - Data designers do not connect or communicate with the end user to understand needs (opportunity for 2-way communication or feedback from user. can SCHSAC recommend such opportunities/methods?)
 - Data is not always timely (MDH scope, but SCHSAC could advocate for it)
- Within Scope/High Influence and Smaller Impact
 - No Factors Identified in this Area
- Outside Scope/Low Influence and Greater Impact
 - End users: many different levels need shared data different systems how do we know what to share? (data usability)
 - Who is responsible for maintenance? (data stewards? IT?)
 - Need to meet end users needs. When community is the end user. How do we help them understand how to use? (data usability - how to share data with public)
 - Too much data (reword: difficulty isolating relevant data that we have?) teach developers how to make their data displays useful
- Outside Scope/Low Influence and Smaller Impact
 - No Factors Identified in this Area
- **Data Capacity:** Local, Tribal, and state public health agencies have the knowledge, skills, staffing, tools, and funding to effectively collect, analyze, interpret, share, and use to identify and take action around community health priorities and emerging health issues.
 - Within Scope/High Influence and Greater Impact
 - Workforce development: Need for education and training to build capacity- Lack of trainers and time to attend trainings (certifications? specific training needs? advocate for data literacy to be a requirement in FPHR)
 - Lack of formal workforce development - Need for informatics trained staff (advocate for informatics to be part of FPHR requirements)
 - Lack of funding. Agencies patch together grants. County board do not value or support data capacity (require data capacity to address data needs as mandated requirement for LPH - need MDH support - hard to operationalize)
 - Resources to maintain systems- Agencies do not funding to keep systems going (SCHSAC help to secure funding? or encourage MDH prioritize it?)

- Need money for data tools, staff and training
- Need to build capacity around story telling and communicating with community (SCHSAC to train or work with MPPH or other venue to offer trainings)
- Within Scope/High Influence and Smaller Impact
 - No Factors Identified in this Area
- Outside Scope/Low Influence and Greater Impact
 - holes in staffing
 - High staff turnover- skills walk out the door. Staff learn systems and then leave. (staff retention)
 - difficult to make data and information accessible to community (data literacy? data access?)
- Outside Scope/Low Influence and Smaller Impact
 - Too many different tools -How to decide which software to use for what?
- **Shared Governance:** Local, Tribal, and state public health agencies work within a mutually developed governance structure that ensures decisions about data policies, processes, and standards are transparent and made and implemented collaboratively.
 - Within Scope/High Influence and Greater Impact
 - Must include MDH, LPH, TPH, and SHCSAC
 - privacy
 - Lack of leadership buy in(not lack of buy-in of importance but of the "how")
 - Question who has fiscal responsibility? Who pays for what?
 - laws/legal framework
 - Insufficient capacity to implement
 - Burdensome data use agreement process and inconsistent data rules
 - No dedicated funding or staffing on governance- not prioritized
 - No coherent governance group (who has authority to recommend policy)
 - Determining who has control and how to share authority
 - Within Scope/High Influence and Smaller Impact

- Ethics
- Outside Scope/Low Influence and Greater Impact
 - Liability and risk tolerance around data collection and sharing
 - Uncertainty about future of federal data collection
- Outside Scope/Low Influence and Smaller Impact
 - Siloed funding and data collection
- **Relationships:** Local, Tribal, and state public health agencies are rooted in shared history and embrace working across systems and with partners to build trust, communication, and collaboration supporting progress towards improving the health of Minnesotans.
 - Within Scope/High Influence and Greater Impact
 - Tension between control/ownership and capacity to do the work
 - Need shared understanding of roles and responsibilities
 - Roles not clearly articulated - no clear swim lanes between locals and state
 - Within Scope/High Influence and Smaller Impact
 - No Factors Identified in this Area
 - Outside Scope/Low Influence and Greater Impact
 - Differences in government to government relationships-tribes + State, locals + State, Locals + tribes
 - Outside Scope/Low Influence and Smaller Impact
 - Insufficient channels of communication across public health agencies

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, April 16, 2026

Time: 1:05pm-2:30pm

Location: Virtual, Microsoft Teams

Agenda items: Continue strategic planning, come to consensus around priority issues, begin building a workplan (If there are additional agenda items, please email them to gabby.cahow@state.mn.us)

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Public Health Strategy and Partnership Division

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