Summary: Minnesota e-Health Advisory Committee Meeting

Date: 10/22/2025

Objectives

- Welcome and introduce new committee members
- Review and gather input on the draft work group charges and discuss next steps
- Provide an update on the Rural Health Transformation Program

Summary

New members

- Nathan Moracco, Technology Director
  Representing: State of Minnesota, Direct Care and Treatment
- Laura Topor, President, Granada Health
  Representing: Rotating Professionals - Pharmacy
- Kari Majors, Vice President and Executive Director, CyncHealth
  Representing: Health IT Vendors (designated alternate)
- Emilie Maxie, DNP, CCRN, ICU Enterprise Staffing Pool RN, Mayo Clinic
  Representing: Nurses (designated alternate)

Rural Health Transformation Program Update

Diane Rydrych, Director of the Health Policy Division at MDH, presented an overview of the Rural Health Transformation Program (RHTP) grant. Zora Radosevich, Director of the Office of Rural Health and Primary Care at MDH also joined the meeting to answer questions. [Note: As of writing this meeting summary, the application has been submitted and the press release can be found on MDH's website: State health officials submit federal Rural Health Transformation Program application (https://www.health.state.mn.us/news/pressrel/2025/ruralhealth110625.html).

In September 2025 the Centers for Medicare & Medicaid Services (CMS) released a notice of funding opportunity for the RHT Program as an attempt to encourage innovative forms of care delivery in rural areas. This is a one-time effort to fund rural health priorities over the next five years.

- $25 billion will be distributed to states over five years through annual payments between Federal Fiscal Years 2026-2030. For Minnesota, this translates to $100 million per year if approved.
- Another $25 billion will be distributed among at least one-fourth of the states with approved applications, at the discretion of the CMS Administrator.

- Proposals due November 5; Minnesota is planning to submit a proposal on November 3. The proposal process is a multi-agency effort, including the Governor's office, and MDH is the lead agency.
- The intent of this program is not to simply fill behind Medicaid cuts, but to transform how health care is delivered in rural areas.
- Awardees have up to 24 months to spend a year's allocation. Unspent money will be clawed back.
- MDH has conducted extensive external engagement via a public comment period and one-on-one meetings. Input has been provided from individuals and organizations in 77 of 87 counties.
- Minnesota is proposing five RHTP Initiatives, outlined in the bullets below. Technology is viewed as a means to achieve each initiative.
    - Improve health outcomes for rural Minnesotans with or at risk of developing cardiovascular disease, diabetes and chronic kidney disease (cardiometabolic disease).
    - Build education pathways and promote training opportunities in rural communities to sustainably expand the health care workforce in rural Minnesota.
    - Expand health care access in rural communities by creating new entry points for community-based screenings, preventive care and chronic disease management through technology-enabled care delivery, mobile care and increased use of community-based frontline workers.
    - Strengthen partnerships between providers to enable delivery of expanded services in rural areas through shared learning, collaborative approaches and advanced technology interventions.
    - Strengthen and stabilize rural provider financial health through strategic investments in technology, data infrastructure and collaborative mechanisms to address unique needs of rural providers.

One committee member asked if for-profit organizations are eligible for this funding. Diane responded that, based on guidance available to date (which changes) they have not seen any restrictions for non-profit organizations.

Committee members appreciated this information, and Bryan suggested that MDH utilize the committee as the initiatives are implemented to help provide valuable expertise.

Draft Workgroup Charges

Based on last year's committee meetings, CHIPT staff and the co-chairs recommend establishing two workgroups for the coming year: Artificial Intelligence (AI) and Bridging

Information and Care. CHIPT staff drafted charges for the committee to review and comment. These were presented to the committee for discussion, with an ask to:

- Provide feedback on charges
- Identify self or other individuals or groups to engage in the work group
- Consider servings as a co-chair on one of the work groups
- Share resources (reports, tools, examples)

The draft charges are attached to the end of this meeting summary, and a summary of the discussions is below:

Artificial Intelligence

- Kari Guida is the lead staff member who will coordinate this workgroup. Questions and comments can be directed to her at kari.guida@state.mn.us.
- Member discussion:
  - Should we also look at legislative or regulatory activity around AI and what is permissible? Others agreed that this is in scope, as long as it is focused on the sphere of the advisory committee's influence.
  - There is a lot of chatter about AI, but in practical terms have not seen great examples from an integrated health perspective where it impacts the person. It will be important to connect with our networks and bring forward the ideas and actions that really make a difference. Bryan commented that ambient listening AI technology has been well-received among providers at his organizations, saving administrative time and allowing them to focus on the patient.
  - Patient privacy and security needs to be considered in scope.
  - Safe, ethical, and trustworthy use of AI should be in scope.
  - Use of AI in clinical research should be in scope.
- Bryan asked for a motion to move forward with the charge, subject to edits from today's discussion and workgroup refinement. George Klauser moved, Adam Stone seconded, the motion was approved.

Bridging Information and Care

- Anne Schloegel is the lead staff member who will coordinate this workgroup. Questions and comments can be directed to her at anne.schloegel@state.mn.us.
- Member discussion:
  - Bryan – perfect timing for both subcommittees (TEFCA, connecting Epic death records to state, national activities happening), many examples for this committee to look at.

- We need to address sustainability – funding and incentives to establish and maintain services.
- There are many references to HIE in the charge. We need to be clear that we are talking about interoperability in terms of services (the verb) and not HIE organizations.
- One component of sustainability is the value of reusing data, which is about applying data standards and creating interoperable systems to support reuse of data. We need to understand what systems are currently in place and build upon those. While the national networks are important, there is stronger value to establishing local networks to apply use cases that are valuable locally. We will need to differentiate between national, state, and regional/local interoperability and access to complete information.
- We should consider focusing on the high priority use cases as that affects the needed solutions and area(s) of focus. We also need to be cognizant of the federal initiatives around interoperability and the upcoming implications. For example, refer to current national CMS - Make Health Tech Great Again - White House, Tech Leaders Commit to Create Patient-Centric Healthcare Ecosystem | CMS.
- We also need to think about QHINs. Now that QHINs are taking shape, we may need to establish or identify guidance for smaller providers on how to connect.
- The concept of network-of-networks is critical. The QHINs are a pathway, but they aren't necessarily a comprehensive answer. We need to think about what our infrastructure for a statewide solution should be, or needs to include, because at this point, we have a lot of EHRs acting as HIEs - doing the verb (moving data or sharing through provider portals) but the reuse of the data across populations is inhibited because we don't have a common state MPI, provider directory, routing mechanism, consent management, provider and consumer portals. The HIOs have pieces, but they have low utilization at this point. So, getting a common infrastructure or network of networks is key. We are really a network of networks relying on portals, going back and re-thinking infrastructure is important for this group. Minnesota and New Hampshire are two states that standout as not having the broad definition of statewide. (Lisa has example about husband if interested.)
- This can't be just Epic as that leaves out so many, especially LTC communities. We need to create a way for everyone to communicate and be sure we are including their EHR vendors/capabilities.
- It’s also important to remember the FHIR infrastructure that each health plan in the state will be standing up by January 2027.
- The education component is important. We are all well versed in this language, but small and rural providers/administrators are on their own and need education on what we are talking about. We can’t be technically arrogant – others won’t know what we’re talking about as they try to address their real-world situations.

- Bryan asked for a motion to move forward with the charge, subject to edits from today's discussion and workgroup refinement. Lisa Moon moved, Laura Topor seconded, the motion was approved.

Next steps and closing remarks

Bilqis Amatus-Salaam provided a reminder about the MN HIMSS & Minnesota e-Health Initiative Conference series beginning on October 23rd and summarize the next steps staff would take to promote work groups and prepare for work groups to begin. The importance of advisory committee members to share the opportunity to participate in a work group was reiterated.

Comments submitted by survey form

There were no comments submitted for the meeting.

Attendance

Members present

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

Lindsey Sand, LHSE, NHA, Vice President of Population Health, Vivie
Co-chair, Representing: Health Care Administrators

Najma Abdullahi, Executive Board of Directors-Member, UMN Community-University Health Care Center, Representing: Consumer Members

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

Brittney Dahlin, MS, RHIA, CPHQ, Chief Operating Officer, Director of Quality Improvement, Minnesota Association of Community Health Centers, Representing: Community Clinics/Fed Qual. Health Centers

Greg Hanley, MBA, FACHE, CPHQ, Vice President, Health Services Quality and Operations, UCare, Representing: Health Plans

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 and Education

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

Sarah Manney, DO, FAAP, Chief Medical Information Officer, Essentia Health, Representing: Physicians

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

Lisa Moon, PhD, RN, LHIT, LNC, CEO, Principal Consultant, Advocate Consulting, LLC, Representing: Experts in Health IT

Nathan Moracco, Technology Director, Representing: State of Minnesota, Direct Care and 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

Peter Schuna, Chief Executive Officer, Pathway Health Services, Representing: Long Term and Post-Acute Care

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

Laura Topor, President, Granada Health, Representing: Rotating Professionals - Pharmacy

Mary Winter, Senior EDI Analyst, PrimeWest Health, Representing: Health Care Purchasers and Employers

Members absent

Kim Heckmann, MSN, FNP-C, SCRN, PHN, Primary Care NP Residency Program Director and APRN Educator, VA Medical Center, Representing: Nurses

Lisa Klotzbach, MA, BA, PHN, Public Health Supervisor – Informatics, Dakota County Public Health, Representing: Local Public Health

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

Tarek Tomes, Commissioner, Representing: MNIT

Laura Unverzagt, MBA, Vice Chair-Information Technology, Mayo Clinic, Representing: Health System CIOs

Alternates present

Alexandra De Kesel Lofthus, Associate Director, State Strategy, Unite Us, Representing: Consumer Members

Alicia Jackson, MS, CPPM, Healthcare Analyst Principal, Blue Cross Blue Shield of Minnesota, Representing: Health Plans

Kari Majors, Vice President and Executive Director, CyncHealth Representing: Health IT Vendors

Emilie Maxie, DNP, CCRN, ICU Enterprise Staffing Pool RN, Mayo Clinic, Representing: Nurses

Adam Stone, Vice President Services Delivery, Chief Privacy Officer, Secure Digital Solutions, Inc., Representing: Experts in Health IT

Tamara Winden, PhD, MBA, FHIMSS, FAMIA, Founder Principal Consultant, Winden Consulting, LLC, Representing: Academics and Clinical Research

Alternates absent

Roxanee Pierre, MD, MHA, Medical Director/ Administrator, Eden Pathways Homecare Agency, Representing: Physicians

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11/17/25

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