



February 26, 2026

To: Thomas Keane, MD, MBA Assistant Secretary for Technology Policy /Office of the National Coordinator for Health Information Technology (ASTP/ONC), Department of Health and Human Services (HHS).

Submitted electronically at: <https://www.federalregister.gov/documents/2025/12/29/2025-23896/health-data-technology-and-interoperability-astponc-deregulatory-actions-to-unleash-prosperity#open-comment>

Re: Minnesota e-Health Initiative Comments on Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule

Dear Dr. Keane,

Thank you for the opportunity to provide comments on the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule. The Minnesota e-Health Initiative (Initiative) is pleased to submit comments as a public-private collaborative focused on advancing the adoption and use of electronic health records and other health information technology, including health information exchange. A legislatively authorized 26-member advisory committee guides the Initiative. Review Appendix A for a list of advisory committee members. The Minnesota Department of Health, Center for Health Information Policy and Transformation, coordinates activities of the Initiative.

We applaud ASTP/ONC's efforts to continue to improve interoperability and support the wellbeing of patients by reducing administrative burdens for health IT developers, updating information blocking regulations, and creating a foundation for FHIR-based and AI-enabled interoperability solutions.

While we strongly support interoperability that improves patient care and patient health outcomes, we are concerned that HTI-5's proposed deregulatory changes could put patient privacy at risk and create a landscape where there is no, or little, accountability when harm occurs. The removal of transparency, privacy, and security guardrails risks shifting responsibility from health IT developers to providers who often lack the technical capacity, time, and resources to evaluate AI-enabled health IT or interoperability functionality. This potential burden shift would not translate into improved care delivery. To ensure progress does not widen disparities, federal policy changes must be paired with adequate funding and implementation support, particularly for under-resourced care settings and public health partners.

Reviewing the HTI-5 Proposed Rule, we've identified considerations and challenges related to the

- Removal of AI transparency and risk management guardrails
- Removal of privacy, security, and audit-related certification criteria
- Proposed adoption of USCDI v3.1 and removal of key demographic data elements

- Revisions to information blocking definitions and exceptions
- Removal of public health-related certification criteria such as transmission to cancer registries
- Removal of C-CDA, Direct, and related certification criteria without widespread FHIR readiness
- Opportunity to align progress toward FHIR-based APIs with TEFCA/QHINs

We have also included comments related to the withdrawal of HTI-2 proposals that were not finalized.

Please consider the following comments related to the HTI-5 Proposed Rule developed with input from partners across Minnesota's health care continuum, and from ongoing and previous work of the Initiative. Contact Bilqis Amatus-Salaam, e-Health Program Lead, Center for Health Information Policy and Transformation, Minnesota Department of Health at bilqis.amatussalaam@state.mn.us with any questions.

Sincerely,

The Minnesota e-Health Advisory Committee Co-Chairs



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Methods

The following response is based on a coordinated effort to seek feedback from Minnesota e-Health Advisory Committee members and our broader network of partners engaged in the Initiative which includes experts in health IT, providers, a variety of care settings, and public health. The response reflects the Initiative's experience supporting health information exchange/interoperability, and more recent, artificial intelligence work groups. The response was also informed by the Minnesota Department of Health's participation in activities related to FHIR, HL7, TEFC, USCDI, and prior HTI rulemaking efforts.

Responses

We recognize that ASTP/ONC seeks to drive progress towards greater adoption and use of FHIR and AI as both hold much promise throughout the health care ecosystem, but we identified several considerations and challenges. We have categorized these as:

- Artificial Intelligence and Transparency
- Privacy and Security
- Patient Demographics
- Information Blocking and Data Integrity
- Public Health
- FHIR Transition and Readiness
- FHIR Transition Relative to TEFC/QHIN Framework

Additionally, we have included comments on the withdrawal of HTI-2 proposals that were not finalized.

Artificial Intelligence and Transparency

We acknowledge ASTP/ONC's goal to reduce burden on health IT developers and to promote innovation in the development and use of AI—indeed, patients and caregivers want AI to make care safer, faster, and better coordinated especially during handoffs and transitions. However, though Executive Orders 14091 and 14110 were revoked, there are still concerns related to AI transparency, bias, and appropriateness for patient populations. There remains a need for assurance that AI-enabled tools are evidence-based, safe and trustworthy, especially when incorporated into clinical decision-making and care planning.

In particular, we are concerned about the proposed revision of the decision support intervention criteria to remove the AI “model card” requirements and the removal of transparency and risk management requirements that were established in the HTI-1 Final Rule. The model card criterion that would be removed serve as a transparency mechanism, or a “nutrition label” that helps providers better understand and vet AI-enabled health IT products. Without access to information such as training data demographics or other source attributes, providers may lack the ability to meaningfully evaluate an AI model's efficacy, safety, and potential bias in their local context. This information is especially important for assessing whether tools perform equitably across diverse populations and care settings. While developers may experience HTI-1's transparency and risk management requirements as burdensome,

providers and patients continue to view transparency and risk management assurances as important and expect such safeguards to be reflected in the AI-enabled health IT products they adopt.

Related to the decision support intervention criteria is the clinical decision support criteria that ASTP/ONC also proposed removing. While we recognize that the CDS certification criteria had an expiration date of January 1, 2025, partners expressed concern for its removal. If transparency measures are removed, clinicians might unknowingly rely on tools with biased or less validated logic, worsening disparities in treatment. Clinics serving underserved communities may have less access to alternative decision support tools outside certified systems, making them more reliant on default or less capable systems. Without mandated CDS standards, variability in care guidance may grow, disproportionately affecting providers with limited resources to build or buy robust decision tools. Regulatory guardrails should clearly distinguish assistive AI tools from autonomous clinical decision making and ensure that clinicians remain in the loop for decisions that affect diagnosis, treatment, or care planning.

Similarly, there are concerns about the proposed revisions to the Real World Testing Maintenance of Certification requirements. Before deployment, AI tools should be tested on populations that reflect real patients, not just ideal datasets. This includes understanding how performance varies by factors such as race, geography, health literacy, language, disability, or care setting. There is also a risk that the AI models and interoperability tools developed under the deregulatory environment put forth by the ASTP/ONC will be trained mostly on data from better-resourced, urban systems. We strongly urge the ASTP/ONC to maintain transparency guardrails that have been previously established and caution against prioritizing innovation over maintaining criteria that help users better understand if the health IT they adopt in their respective settings are accurate and safe for the patients they serve. Our partners are also concerned that high risk longitudinal data like family history, problem lists, and social data not having appropriate standards for dates and clinical context may cause inaccurate AI interpretations and clinical errors due to poor quality data and potential issues with patient care.

Overall, the proposed deregulatory changes risk shifting responsibility for AI safety, clinical decision support reliability, cybersecurity, and legal accountability from regulated health IT developers to provider organizations that lack the resources and influence to require EHR vendor changes to effectively mitigate these risks.

Additionally, ASTP/ONC's conclusion that transparency and risk management requirements have demonstrated low value and that cost benefits have not been realized is based on a relatively short time period. HTI-1 was finalized in January 2024. Not enough time may have passed to observe whether providers are using transparency features or if there have been cost savings. Rather than indicating a lack of value, lack of use of these transparency features may suggest an opportunity for additional education and guidance to support providers in understanding how to evaluate AI-enabled health IT products.

Privacy and Security

We urge ASTP/ONC to maintain the privacy and security certification criteria and the associated Privacy and Security Certification Framework as they provide an important baseline for privacy and security capabilities. While we recognize that certified health IT alone cannot ensure full

compliance with the HIPAA Privacy and Security Rules, these certification requirements provide assurance to providers and patients that basic privacy and security functionality has been incorporated. The absence of a baseline can lead to variability in how patient data protections are implemented and could widen digital trust gaps, particularly for communities that may already be wary of data use. Given ongoing cybersecurity threats and recent attacks targeting the health care sector, maintaining these criteria is still very much needed. Furthermore, providers rely on vendors to ensure privacy and security capabilities in their products. Removing privacy and security requirements may shift the burden of ensuring privacy and security mechanisms onto providers and these capabilities are not readily available to consumers outside of the health IT product.

If ASTP/ONC determines that removal of some criteria is necessary, we support the alternative proposal to retain certification requirements related to “auditable events and tamper resistance,” “audit reports,” and “auditing actions on health information.” Removal of audit-related criteria all together raises concerns that certified health IT could be marketed without the technical capability to generate and maintain audit logs, potentially leaving providers legally responsible for HIPAA audit requirements without the necessary functionality from their health IT vendor. Although HIPAA requires providers to maintain audit logs, it does not require vendors to include audit logging capabilities in their products. Retaining these criteria helps ensure providers have access to critical functionality necessary to support compliance, investigate inappropriate access, and detect potential fraud and abuse.

We also would like to acknowledge ASTP/ONC’s observation that the privacy and security criteria may be misunderstood as evaluating health IT security capabilities more comprehensively than intended. This gap highlights an opportunity to provide additional guidance and education to both developers and purchasers/users of health IT tools regarding privacy and security expectations and implementation responsibilities. If one of the goals of HTI-5 is to support developers in meeting provider needs, clearer guidance on demonstrating meaningful privacy and security safeguards beyond minimum certification requirements would help address this mismatch in expectations.

Lastly, certification must continue to require encryption of authentication credentials, multi factor authentication, and auditable access events, as weakening these controls introduces unacceptable risk to patient safety, data integrity, and health system operations. We also support strengthening requirements for encrypting authentication credentials and multi-factor authentication, as they currently only rely on attestation.

Patient Demographics

We do not support the proposed adoption of USCDI v3.1 and we do not support the removal of data elements related to name to use, pronouns, sex parameters for clinical use, sexual orientation, and gender identity. We request that ASTP/ONC retain these data elements. Removing these data elements is harmful to the people we serve and does not align with developing health IT that supports clinical decision-making, care coordination, and improved health outcomes. EHRs capturing this information, and other social determinants of health and patient demographic information allows providers, patients, and public health to better understand factors affecting health, provide better person-centered care, and implement evidence-based health policy and interventions. This removal will limit everyone’s response to

current and emerging health concerns, thus making people less healthy and care more expensive.

The removal of these important data elements also invalidates the development and implementation work done across the country. In Minnesota, the Minnesota e-Health Standards and Interoperability Workgroup met in November of 2014 to assess e-health and social determinants of health that are captured in EHRs. This was at the request of the Minnesota Commissioner of Health to fulfill part of a legislative study. This work has continued as providers, the community, and other partners recognize and benefit from the collection, use, and sharing of these data elements; they meet information and care needs.

Information Blocking and Data Integrity

The updated definitions help clarify expectations for automated access and use of health information. We are concerned that ASTP/ONC's proposal to revise the definitions of "access" and "use," and potentially "exchange," to explicitly include automated means such as autonomous AI may have unintended consequences. While we recognize that AI-enabled technologies require access to EHI to support innovation, care coordination, and clinical decision support, we encourage ASTP/ONC to consider providing additional clarity regarding guardrails and accountability mechanisms to ensure that once access is granted, EHI is used only for appropriate and authorized purposes. Stakeholders continue to raise questions regarding data stewardship, secondary use of data, privacy protections, and responsibility if automated access results in errors, data integrity issues, or privacy breaches. Additional guidance on these topics would help support safe and trustworthy implementation of AI-enabled tools. Our partners also expressed that changes to "access" and "use" could lead to different interpretations by vendors and create limitations for patients. ASTP/ONC may consider providing plain language examples of how the new definitions should work in practice and communicate that patient access should remain simple and consistent across systems.

We also have concerns regarding the proposed removal of the "third party seeking modification use" condition from the Infeasibility Exception. ASTP/ONC notes that actors may continue to rely on the "infeasible under the circumstances" condition, but stakeholders may require additional education and practical implementation guidance to understand how and when to use this condition. Without clear guidance, providers may interpret the revised requirements as them needing to allow any and all requests for access, use, and exchange, even when there are legitimate concerns.

Information blocking requirements remain complex and can be challenging for stakeholders to interpret and operationalize. If these revisions as proposed are finalized, we encourage ASTP/ONC to prioritize development of educational resources and implementation guidance that clearly outline appropriate use of exceptions, responsibilities related to automated data access, and when it is appropriate to limit third-party or AI-enabled access, use, and exchange of EHI.

Public Health

We support and applaud the focus on FHIR-based interoperability. However, for functional areas where a FHIR standard is not fully mature or widely adopted yet (e.g., Transmission to Cancer Registries), we feel that continuing to reference existing non-FHIR standards in

certification criteria provides an important baseline signal to health IT developers and public health agencies alike. Revising criteria to remove mention of any standards or removing criteria altogether due to a lack of mature FHIR standards, has the potential to destabilize current public health integration programs. We suggest that ASTP/ONC retain some certification criteria and return references to non-FHIR standards while work continues to advance FHIR maturity and adoption for those functional areas. Specifically, we recommend retaining each of the “transmission to public health agencies” criterion and “transmission to cancer registries.”

Reporting cancer to public health agencies is a critical part of public health surveillance and public health’s ability to address one of the leading causes of death in the U.S. The Central Cancer Registry Reporting FHIR Implementation Guide is still being developed and is not yet ready for widespread implementation by the cancer registry community. The HL7 CDA-based implementation guide for ambulatory provider reporting is used for current reporting workflows. We agree with concerns raised by the North American Association of Central Cancer Registries and others that it will be important not to transition too quickly to a FHIR-based approach. Doing so risks disruption to data completeness, disincentivizing developers to maintain public health reporting interoperability, increasing manual reporting burden on providers and registries, and decreasing the timeliness and reliability of cancer surveillance activities.

Alternatively, ASTP/ONC could leverage other avenues (e.g., ISA) for formally naming standards for functional areas if not in health IT certification criteria. We also encourage ASTP to help define and enable a path forward (including reasonable time frames considering budgetary and other constraints) toward advancing FHIR standards and adoption for those areas.

FHIR Transition and Readiness

We acknowledge the potential for FHIR to improve interoperability and welcome progress toward greater adoption of FHIR-based APIs. We agree with ASTP/ONC’s assessment that many of the certification criteria proposed for removal have been widely adopted and implemented across portions of the health care system; however, adoption and implementation are not uniform across all care settings. In Minnesota, while large health systems may be positioned to transition toward FHIR-based solutions, other critical sectors (including long-term care, post-acute care, behavioral health, and small, rural, and safety net providers) continue to rely on existing standards and workflows. These sectors often face resource and vendor limitations that affect readiness to fully transition to FHIR. Removing certification criteria that support currently used exchange standards without sufficient transition time risks increasing interoperability gaps across the care continuum. The proposed scale of changes could reduce transparency into whether certified health IT tools perform reliably for all settings. The patient impact is potentially worsening disparities in care coordination and in patient health outcomes.

Given these considerations, we encourage ASTP/ONC to retain all of the C-CDA-based certification criteria and the “transport methods and other protocols—Direct Project, Edge Protocol, and XDR/XDM” certification criterion proposed for removal or revision, or, alternatively extend the proposed implementation timelines. C-CDA documents remain widely used and continue to serve as a reliable and familiar method for exchanging and reviewing patient summary information across care settings. Similarly, Direct Project and Edge Protocol functionality provide foundational support for many use cases, including admission, discharge,

and transfer (ADT) notifications, secure clinical messaging, and public health data exchange. Maintaining support for these capabilities during a transition period would help preserve continuity of care and much needed data exchange.

The proposed removal of Direct-related certification criteria risks introducing significant ambiguity into the national interoperability landscape. Direct remains one of the few transport standards with widespread, real-world adoption across EHR vendors, health systems, payers, and public health agencies. Eliminating certification requirements while retaining the underlying standard creates a regulatory gray zone in which implementers no longer share a uniform expectation for transport behavior, security controls, or identity validation. This shift would predictably erode compliance over time, as vendors deprioritize maintenance of Direct capabilities and HCOs/payers face inconsistent support for sending and receiving clinical information. The result is a measurable increase in friction for transitions of care, care coordination, and payer provider data exchange—precisely the domains where Direct currently provides reliable, low burden interoperability.

Maintaining privacy, security, and identity management requirements associated with Direct is essential to preserving a safe and trustworthy exchange ecosystem. Direct uniquely embeds certificate-based identity validation, mutual trust anchors, and end-to-end encryption both in transit and at rest, providing a hardened security posture for PHI that many alternative transport mechanisms do not replicate. Removing these requirements without establishing an equivalent or stronger baseline risks weakening identity assurance, increasing susceptibility to misrouting or spoofing, and reducing the overall security of PHI exchange. Retaining Direct's associated privacy, security, and identity management provisions within certification ensures continuity of protections that stakeholders rely on today and prevents a regression in national interoperability performance during the transition to newer API based exchange methods.

While we appreciate ASTP/ONC's intent to collaborate with industry and federal partners to advance FHIR, we encourage development of a migration and readiness timeline for FHIR. Providing stakeholders with a clear timeline, implementation guidance (especially equity-focused implementation support for under-resourced providers), and readiness expectations would help ensure a smoother transition across the care continuum. A phased approach would help maintain current interoperability capabilities while supporting the broader goal of FHIR becoming the new, widely used and widely implemented standard.

FHIR Transition Relative to TEFCA/QHIN Framework

We acknowledge ASTP/ONC's focus on reducing administrative burden, strengthening interoperability, and modernizing the regulatory foundation to support FHIR-based APIs and AI-enabled data exchange. Improving coordination across HIEs and QHIN ecosystems to achieve better treatment-oriented data transfer between health systems will improve the burden on providers and patients. We request that ASTP/ONC designate resources to help organizations become part of a QHIN, provide appropriate QHIN oversight, require QHIN's to share data effectively in a standardized way, and require EHR vendors to take that data and show it to physicians and care givers in a way that is consistent with their workflow. This will greatly enhance the ability for patients to navigate health systems to get optimal care with efficiency for providers. ASTP/ONC should also structure the TEFCA network in a way that QHIN's can help with federal and state public reporting for regulatory purposes and share standardized quality

data as the next goals for interoperability through TEFCA. Aligning FHIR certification requirements with TEFCA and QHIN goals of improving patient care through data exchange will help.

We request ASTP/ONC to develop a clear, staged roadmap with consistent versioning and migration timelines, and clear testing windows for providers and vendors allowing coordination that would ensure national interoperability frameworks reinforce one another rather than create duplicative or conflicting obligations. We request that they incentivize better structured data for common workflows like nursing documentation, lab results with reference ranges, and quality metrics that would allow better FHIR-based API's and interoperability to promote safe AI-ready data exchange that allows better summarization of all health data and a more complete patient focused healthcare story. ASTP/ONC should also be planning for how to update FHIR requirements to have QHIN's prepare to share standardized quality/reporting data to national and state organizations in a way to offload that burden from individual health systems and standardize the public health and reporting areas.

Conclusion

We support ASTP/ONC's efforts to continue to push health care towards greater interoperability and embracing innovation, though it is clear from our partners that this forward momentum must be balanced with recognizing the variability in FHIR readiness across the health care continuum. Certain provider types and care settings (including public health) still rely on existing functionality supported by certification criteria that could be removed. If these capabilities are no longer supported and a provider or organization lack the resources or technical capacity to transition to FHIR-based approaches, there is risk that critical data exchange activities may be reduced or discontinued. Market-driven strategies are unlikely to resolve a potential widening of the interoperability gap; therefore, under-resourced settings will need additional support.

We encourage ASTP/ONC to consider the broader collection of policies, rules, education and implementation guidance necessary to fully support the transition to a FHIR-enabled ecosystem and AI-enabled health IT. This includes continued federal investment in TEFCA and QHINs, as strengthening nationwide interoperability infrastructure will help accelerate the progress ASTP/ONC seeks, improve data exchange across all sectors within health care, reduce administrative burden, and support emerging technologies such as AI. A crosswalk document that illustrates how these criteria will be reestablished through updated standards may also be helpful. Any crosswalk or mapping of removed certification criteria should explicitly identify which prior requirements supported patient safety, clinical quality, auditability, provenance, and liability protections, and how those safeguards will be preserved under revised standards. We also encourage ASTP/ONC to develop strategies to anticipate and mitigate unintended consequences associated with these proposed changes. Indeed, there is danger that implementation, oversight, and compliance burdens would shift from health IT developers to providers who have limited technical and financial resources to bear it.

Lastly, we would also urge ASTP/ONC to be mindful of the desire from providers and patients alike for a baseline for privacy and security in health IT, and for increased adoption of AI in health care to be accompanied by strong transparency, accountability, and governance frameworks.

Withdrawal of Unfinalized HTI-2 Proposals and Public Health Considerations

Despite the removal of the public health certification, PHAs still do not have sufficient, sustainable funding for public health interoperability. Public health funding is often periodic, program-specific, and/or siloed grants – almost all is from the federal government. Significant funding is needed to purchase and maintain public health IT systems, update policies and processes, and train public health professionals while maintaining normal day-to-day operations. To do this work in a coordinated approach, agencywide funds are needed as well as program-specific resources. The Data Modernization Initiative (DMI) funds need to continue.

The funding needs for local public health (LPH) differ from the state public health needs to achieve interoperability, send and receive FHIR and implement AI. The same expertise and staff are needed by state programs, and therefore, funds are needed for local, regional (state staff who support LPH within a region), and state staffing.

As laid out by HIMSS¹, state, territorial, local, and tribal public health “require significant investment to maintain the software, hardware, workforce, licensing sustainability, and technical support to transmit vital public health data.” We agree with the report’s findings that a significant investment is needed and if there are certification criteria in the final rule, the dollar amounts should be adjusted to include the costs related to certification and other components of the rule.

Minnesota is working to better leverage syndromic surveillance reporting. Some PHAs need new and ongoing funding to operationalize syndromic surveillance, incorporating the lessons learned from COVID. We support any effort to advance hospital and CAH participation in CDC’s NSSP. We recognize that there is not a one size fits all approach to achieve *all* hospitals participating and without all hospitals participating the benefit of certified public health IT systems will be limited. Therefore, we encourage a three-prong approach for participation that includes:

- require participation of all hospitals – including specialty hospitals such as behavioral health and children’s - and CAHs in CDC’s NSSP using CMS policy and funding levers;
- coordinate with federal partners to assure that all federal hospitals (e.g., VA and IHS) are participating in the CDC’s NSSP; and
- build relationships with tribal hospitals and identify strategies to encourage participation.

Public health remains a critical component in achieving improved interoperability and must not be inadvertently deprioritized. To improve health outcomes nationwide, we ask that ASTP/ONC ensures that public health agencies remain engaged and fully integrated into ongoing interoperability and innovation efforts. Meaningful progress can be made with support from our federal partners.

¹ HIMSS. Public Health Information and Technology Infrastructure Modernization Funding Reporting: Core Investment Strategies to Modernize and Interoperate Federal, State, Local, Tribal Public Health Systems. 2002. https://www.himss.org/sites/hde/files/media/file/2022/04/29/pubpolicydatamodernization_final.pdf

Appendix A

2025-2026 Minnesota e-Health Advisory Committee Member List

Co-Chairs

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

Lindsey Sand, LHSE, NHA
Representing: Health Care Administrators, Co-chair

Members

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

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

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

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

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: 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

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

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

Tarek Tomes, Commissioner
Representing: MNIT

Laura Topor, President, Granada Health
Representing: Pharmacy

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

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

Designated Alternates

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

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

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

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