DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

- January 22, 2025, 1:00-4:00 p.m.
- MDH LiveStreamChannel
- Meeting Format: WebEx

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engels, Marc Gorelick, Joy Marsh, Maria Medina, Vayong Moua, Laurelle Myhra, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall

Key meeting outcomes

- A summary of individual "pulse check" conversations was shared to reflect the insight from task force members regarding concerns and ideas for moving forward in our process.
- Commissioner Cunningham gave remarks about task force concerns, recognizing and encouraging progress in the face of challenges.
- Task force members engaged in a recommendation development exercise and provided feedback for moving forward with the recommendation development process.
- Task force members learned from the MDH Tribal Liaison about Tribes and Tribal health care systems.

Key actions moving forward

- Task force members are asked to complete a post-meeting survey.
- MDH will consider the feedback received about the task force's development of recommendations for transformational and incremental changes.
- Task force members are encouraged to continue to add opportunities to the Opportunity Matrix, to inform the ongoing development of recommendations.

Summary of Meeting Content and Discussion Highlights

Meeting objectives

The following objectives were shared:

- Test and reflect on a collaborative recommendation development process.
- Plan next steps for engaging external perspectives such as community members into recommendations.
- Learn about Tribes and Tribal health care systems.

Welcome and grounding

Task force members were welcomed, and the agenda was reviewed. The meeting summary from December was shared. No public comments were received since the last task force meeting.

Summary of pulse check conversations

Facilitators shared a summary of the individual conversations held with 12 task force members after the December meeting. These conversations, offered to all members, were suggested by the task force to further explore some concerns expressed during the December meeting about the process overall. Themes that emerged from the conversations were shared and summarized with examples. The high-level themes were:

- Concerns expressed resonate to some extent
- Importance and perceived lack of community voice in the process overall
- Lack of clarity of the end goal and the steps to get there
- Process feeling too corporate
- Recommending transformational change is critical, alongside incremental change
- Feeling disconnected from other task force members and from content of discussions
- Co-chair model is somewhat appealing but not to everyone
- Many ideas for moving forward

There was a comment from a task force member about the meaning of “transformational change,” emphasizing that it about magnitude and significance of change and not necessarily the destruction of something or the dismantling of something that is positive. The HEAL Council and MDH Health Equity Bureau were mentioned as community engagement resources for the task force, not as a proxy for community, but tapping into things that are already in place.

MDH presented their ideas for responding to these concerns with action, including:

- Fostering connections among task force members
- Reinforcing open communication pathways
- Discussing transformational change
- Moving forward with community engagement
- Considering task force co-chair idea or co-leading other activities

Commissioner's remarks

Commissioner Cunningham shared remarks about where the task force is in the process and her thoughts about progress. At a high level, the Commissioner's remarks covered the following:

- The ground for equity is shifting, but the work continues. Perseverance is needed despite obstacles, and it is important to focus on dismantling racism and serving people.
- Encouragement and solidarity are crucial, even with diverse perspectives. The work is messy. This process is a starting point, not an end. While imperfect, it is valuable.
- The collective commitment to this work for the well-being of all people living in Minnesota is appreciated.
- The task force's recommendations are important and she looks forward to the next steps of recommendations becoming the catalyst that's needed.
- Appreciation for the task force's commitment to the work and process of making recommendations to forge an equitable health care system in Minnesota.

Recommendation development

MDH shared the framework for recommendations that was first presented in December, including high level "buckets" and an acknowledgement of task force feedback.

An example of a rough draft of recommendations was shared, specifically about community health workers (CHWs). The task force broke into small groups to review and discuss the example. The discussion was meant to be a starting point for the task force to take a first pass at developing recommendations.

Small group 1 discussion touched on:

- Concern about resources being monopolized by the Twin Cities, including for an e-bike program, and the need for different pathways for people outside the Twin Cities.
- Example recommendations vary in level of detail and we need to decide on the right level.
- Question about the process to prioritize recommendations, potentially based on impact. Suggestion to rank recommendations by type (governance, services, etc.).
- Community vetting and validation is important.
- Recognize overlap with workforce and health equity impacts.
- Need to clarify target audience (legislature, payor, provider)—include actors in the framework.
- Use plain language, avoid jargon, to ensure accessibility to those outside of health care.
- Clarify MDH's role in putting together recommendations.

Small group 2 discussion touched on:

- Example recommendation provides a place to begin on addressing access and equity issues in providing culturally responsive care with CHWs, but it does not address the needs for transformational level change.
- Recommendation needs to address barriers to workforce diversity among CHWs.
- Embedding community accountability measures into each recommendation could enhance the recommendations and inspire transformational change.

After the small group breakouts, the full task force discussed their feedback on the example and their experience processing it. At a high level, their comments included:

- Transformational and incremental recommendations
  - Our recommendations should address bias in health care, not basic things.
  - Recommendations are needed to facilitate collaboration between community organizations and health care institutions to leverage community expertise and avoid big institutions imposing services without community knowledge.
  - The example recommendations lack a community perspective. Recommendations should include community voices and be community-centered.
  - Accountability should be written into recommendations.
  - Recommend that we come up with a bold way of having community have real power in terms of determining how accountable health care is through our recommendations.
  - Bold, transformative ideas are needed to ensure health care accountability and address root causes. There is fear about losing ground due to federal threats. There is a call to push for both bold and pragmatic changes. “Pragmatic dreaming” was emphasized.
  - The task force role is more about acting upon existing recommendations rather than generating recommendations that already exist and we’ve known about for decades. The task force should provide policy and political cover and connect with community efforts.
  - We have the opportunity to act on long-standing recommendations, not rediscover them.
  - National conversations about transformation should be considered. There's a need for both straightforward recommendations and transformational ideas to address systemic issues and hold systems accountable.
- Draft CHW recommendations and exercise
  - This exercise was helpful in informing the Workforce Workgroup’s approach to recommendation development.
  - Systems are not working well with CHWs, Native communities, and other communities, and there’s a need to address bias to avoid perpetuating harm.

MDH affirmed the task force’s interests in making recommendations for bold transformation and incremental change, and holding that tension moving forward.

Engagement Approach

In response to the task force's priority of obtaining input from communities and others on emerging recommendations, high-level options for engagement methods were offered for moving forward. Options included:

- Focus groups and interviews
- Public input
- Other methods suggested by the task force, e.g., community panel, member-organized listening sessions, community input from other efforts, outreach by task force members to community members and peers

A link to a poll was provided for task force members to provide input on community engagement, including their preferences for multiple engagement methods.

MDH asked the task force for their initial thoughts about the possibility of extending the timeline for the work overall, given the significant amount of work remaining. No comments were received.

Tribal Health Care Systems

Ravyn Gibbs, MDH Tribal Liaison, provided a high-level overview of the 11 Tribes that share geography with Minnesota, Federal Indian Policies and the impact on the health status of American Indian people, and Tribal health care systems in Minnesota. Her presentation touched on:

- Overview and location of Tribes in Minnesota
- Policy affecting health outcomes and disparities
- Tribal sovereignty
- Tribal health care systems at the local, state, and federal level

The task force was invited to ask questions or give comments. Their comments touched on:

- Tribes often provide health care that is not funded by Indian Health Services. Despite a perception that tribes are well funded, there are problems with bias within these federal programs, and misunderstandings of Tribal needs and services. The federal government uses an archaic and inaccurate way of establishing funding.
- There were questions about the statute requiring state agencies to engage with Tribes and whether Tribes have created or supported any health care policies that the task force can consider and potentially advance.
    - Ms. Gibbs serves in the Tribal Liaison role at MDH. Resource provided by Ms. Gibbs: https://www.revisor.mn.gov/statutes/cite/10.65
    - Resource provided by Dr. Chomilo: Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota

Closing and action items

MDH asked the task force for their preferences for the scheduled learning session on January 24. Given no comments, MDH will communicate next steps. A meeting summary is to follow.

The task force was reminded about the next meetings:

- February 12, 1:00 – 4:00 p.m.
- Full day retreat: March 14, 9:00 a.m. – 4:00 p.m.

Contact to follow-up

With questions or comments about the Equitable Healthcare Task Force, please reach out to the Health Policy Division at health.equitablehealthcare@state.mn.us.

Meeting summary note

All task force members' comments are represented, identities are intersectional, and discussions reflect barriers and solutions that affect many communities at once.

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Public comment

Between November 2024 and January 2025, MDH was invited to provide updates about the Equitable Health Care Task Force to several groups. MDH invited comment on where audiences saw opportunities to advance health equity in the state's health care system.

MDH Health Equity Advisory and Leadership (HEAL) Council

January 8, 2025

- Health care must be accessible and affordable.
- Include vision health and services along with primary care, oral health, and mental/behavioral health in care integration.
- Health care reparations, acknowledge and atone for harms.
    - Resource: Healthcare Reparations Cooperative
- Value different forms of knowledge in health care.
- Expand access to interpreter services. Ensuring language accessibility is essential to treating the whole person and fostering equitable outcomes for diverse populations.

Minnesota Medical Association Health Equity Community of Practice

December 3, 2024

- Universal health care.
    - Health Care for All Minnesota
    - Health Care for All by Senator John Marty
    - Physicians for a National Health Program
- Solutions for health issues experienced by specific communities accompanied by metrics to assess outcomes.

Minnesota Primary Care Stakeholders Group

November 21, 2024

Bold vision

- Change how we fund health care.
    - Especially because the federal landscape is changing, we need to think about the state health system instead of a piecemeal market. We know the whole team is needed to move health outcomes—whole-person care, therapists, social workers, dentists, etc. Single-payer health is an option. Veterans Affairs is the only whole health system in the United States; it has its downsides, but it's an interesting model.
- Re-structure primary care.
    - Primary care clinicians leave the profession. They see people back-to-back, do not have brain space to think about solutions, and do not have a team. Primary care is not supported like hospitalists are. In contrast, hospitalists get paid better and have a different workload and work-life balance. They have time to solve problems and help people.

    - We know from the evidence that a team approach to providing primary care has the best outcomes for health care, yet this approach is lacking in primary care. It seems there is much more support for team-based provision of health care outside of primary care. Teams may be emphasized during school, but then students don't see this in the field. Making sustainable teams takes resources. A team-based approach to holistic care includes pharmacists, social workers, nurses, etc.
    - The primary care profession and teams must look like the communities they're serving; diverse applicants and students are needed, and they must be able to access education and training. Health care needs to show-up in diverse communities to recruit people to the profession. For example, I've met adults that were unaware of what therapy can offer; this was an indication that people in their community are not therapists. Quality education of health care professionals is also needed.
    - Team-based care education is at the foundation of the professional PA model. We are better when we work together to meet the needs of the patient rather than meeting administrative needs.
    - Integration of teams and services to provide services to patients.

Near-term opportunities

- The intersection of health equity and primary care, and social determinants of health. This can be built-into electronic health records systems and can be integrated into decision-making and plan of care.
    - To what extent is primary care equipped to address social determinants of health? Is there a need to enhance capacity? This information can be collected in electronic health record systems, we can talk about these things with patients and fill out forms for the county that indicates supports needed to get resources to attain better health. The evidence shows that what is needed for health is outside of the primary care office.

Resource challenges

- Primary care faces resource challenges and has to go above and beyond. In contrast, specialists have teams that can tackle challenges of care coordination, prior authorization, etc.
- Grants can lift-up holistic, comprehensive primary and mental health care, and remove barriers; but when grants go away, then mental health and holistic cares go away.
- Primary care gets 5-7% of the health care spending in the United States versus 14% in other countries where there's more preventive care and alignment with public health. Changing the health care system requires all of us to focus on health promotion and chronic disease prevention. The State needs to be on top of this pro-actively. Health care providers need to get on the same page about what is important in health care and be more vocal regarding that.
- Change the payment structure of primary care to incentivize and create advanced primary care systems. From the payment perspective, incent care that patients need. Try to incentivize outcomes, especially for equity. Look at the Massachusetts example.
- There is a need to look at the administrative burden that is placed on primary care to justify the care we need to provide. State and federal reporting requirements are a drag on resources and come at the expense of patients.
- Examine and redistribute where there is waste. All the systems funded to support prior authorization processes come to mind.

- Money is not finite, and patients are the ultimate payers. If there is more money for primary care, there will be less for something else. Yet, if additional funds were shifted to preventive care, then maybe not as much would be required on the tertiary end (over time).

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DEPARTMENT OF HEALTH

Vision statements

EQUITABLE HEALTH CARE TASK FORCE

Task force vision and health care equity definition

Our **vision** is that structural and institutional wrongs will be addressed, cultural practices will be newly honored, and new modes of health care delivery will be created. The Equitable Health Care Task Force will engage with entities to act on a set of actionable recommendations.

Health care equity means the health care system is accountable for every person achieving and sustaining self-defined optimal health outcomes throughout their lives.

Workgroup visions

Access, Delivery, and Quality

Every person in Minnesota has seamless access to high-quality, integrated, and culturally responsive health care. Health care and services are comprehensive across all dimensions of health, including mental health and oral health needs. The health care system is proactive and addresses the needs of all communities, eliminates disparities, and ensures holistic well-being for every individual.

Financing

To create recommendations on how to achieve a health care finance system that:

1. Eliminates arbitrary healthcare costs and pricing including price discrimination and is truly equitable and easily accessible to all parties including patients regardless of their health or social background or status, providers, and payers.
2. Reflects, accounts for, and caters to the social, cultural, and other needs of each member of the population being served to achieve optimal health.
3. Eliminates waste by streamlining processes and communication to remove unwanted redundancy in administrative and clinical work (such as when patients get repeat care from different providers, repeat paperwork processing, the seemingly endless back-and-forth between payers and providers on prior authorizations, and other excess administrative overhead costs).
4. Fosters collaboration among patients, providers, and payers where each is appropriately incentivized for preventive care, wellness, and chronic disease management, not acute or sick care while continuing to fund the provision of quality acute care to sustain overall patient and population well-being and prevent the reoccurrence or exacerbation of illnesses.

5. Is structured by policies and processes at the state level and becomes a model for other states interested in advancing healthcare equity.

Workforce

Our vision is to provide strategic guidance to Minnesota health care organizations in building, nurturing, and maturing an equitable workforce. Through these efforts, we aspire to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients and communities.

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