Equitable Health Care Task Force Meeting Summary

Meeting information

- June 26, 2024, 1:00-4:00 p.m.
- Meeting Format: WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, ElijahJuan (Eli) Dotts, Mary Engels, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Laurelle Myhra, Cybill Oragwu, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Erin Westfall, Yeng M. Yang

Key meeting outcomes

- Workgroups began to organize these problem statements in terms of feasibility and impact of potential solutions to those problems, while ensuring alignment with the vision statements of each workgroup.
- Barriers to achieving an equitable health care system were fleshed out as numerous

Key actions moving forward

- Workgroups will meet to complete the problem identification and categorization (with technical and facilitation support from DeYoung Consulting and MDH).
- MDH will review the outcomes of each workgroup discussion to draft a proposal for engagement of outside subject matter experts and the public. Additionally, MDH will outline the approach for conducting an environmental scan of promising practices and policies with a research team at the University of Minnesota.

Summary of meeting content and discussion highlights

Meeting objectives

The following objective was shared:

- Identify and clarify the problems the task force wants to solve for that align with their vision of an equitable health care system in Minnesota.

Welcome and grounding

Task force members were welcomed and the agenda was reviewed.

MDH Update

MDH provided an update on where the task force is in the overall process: workgroups have developed visions and workplans, while MDH and DeYoung Consulting have analyzed the content of those workplans and discussions so far to get a sense of cross-cutting issues, information and engagement needs, and gaps, and to identify areas in need of clarification. The planning team, in its analysis, felt more clarity was needed on the health care equity problems that the task force wanted to solve. Thus, MDH created an initial set of problem statements based on all insight gathered so far. These problem statements serve as a foundational tool to identify the information needed to develop effective solutions.

MDH plans to use the results of the discussions during this meeting to firm up our plans for engagement with subject matter experts and the public, and the approach to the environmental scan of promising practices and policies in other states with a research team at the University of Minnesota.

Additionally, in response to requests for more support, MDH staff will begin to participate more in workgroup discussions. Their roles will encompass providing support, engaging with workgroup members, and facilitating discussions with subject matter experts. They will share valuable information and perspective to ensure that each workgroup has the necessary resources and guidance to achieve their goals effectively.

Vision and Definition of Health Care Equity

A separate meeting with two task force members was held previously to revise the vision and definition of health care equity based on the task force's feedback on the initially drafted statements. The revised statements were presented to the task force members, who rated their support. The revised statements were supported by all or nearly all task force members present. The term "self defined optimal health" was particularly called out as strong, although there was a question about how to measure self-defined health goals. There was also a question about what is meant by "health care system," and it was shared that this term should refer to every aspect of the health care system and every touch point that a patient might have so it encompasses delivery, payers, etc. There was a desire to clearly communicate this. The task force was invited to email or call with any pending major concerns.

Problem Identification

MDH shared a compilation of problem statements that were lifted from task force workplans and discussion notes thus far. The problem statements were organized by the four health care focus areas: workforce, financing, access and quality, and delivery. Because discussions about access and quality have overlapped with discussions about delivery, those problem statements

were combined. Task force members were asked to review during the meeting and elaborate by adding more statements to their own workgroup's area.

Problem Categorization

The task force split into their workgroups in breakout rooms to discuss the four priority areas. They were charged with organizing the many problem statements into four quadrants based on two axes: feasibility and impact. The axes represent high and low feasibility, and high and low impact, allowing the workgroups to prioritize the issues.

Below are the problem statements that each workgroup perceived as potentially presenting the most feasible and most impactful solutions.

Health Care Finance

Members of this group are Bukata Hayes, Taj Mustapha, and Cybill Oragwu.

- Miscommunication in healthcare financing, who charges or pays who, and for what. Patients assuming providers determine cost, overinflated pricing by7 facilities, payers paying less than agreed rates, etc. Cost of care is a mystery for patients. Don't know what our of pocket costs will be.
- Reimbursement is different based on type of coverage and health insurance carrier
- Low reimbursement rates for mental health care
- Low reimbursement rate for preventative and primary health care when compared to sick care, procedures and surgeries
- lack of recognition of pay for preventative care vs sick care in reimbursement and clinician pay.
- Payment models don't support whole-person care
- Reimbursement doesn't support interventions that address social determinants of health
- Payors don't work fast enough to update benefits, reimbursement etc. It takes multiple years 2-3 to make coverage changes.
- insurances can change coverage mid-year
- Instability in healthcare coverage tied to employment, poor continuity of care
- Payors aren't incentivized to provide adequate and appropriate coverage to reimburse and sustain what needs to be done to address patient health
- No consensus on where the source of funds needed to bridge gaps in care to achieve health equity
- Paying for service instead of paying for outcomes
- Not uniformed coverage for community health workers
- private equity ownership impacting cost and delivery of care

- CMS coverage and reimbursement isn't enough, it needs to be updated
- Small health systems struggle to be sustainable
- Financing rewards treatment vs prevention

Health Care Workforce

Members of this group are Mary Engels, Joy Marsh, Maria Medina, and Vayong Moua.

- Barriers to the cocreation of workforce equity strategies include the lack of Employee Resource Groups (ERGs) and ERG input
- Lack of standardized Diversity, Equity, Inclusion, and Belonging (DEIB) training and access to training resources and training requirements.
- Barriers to mentoring and leadership development exposure for emerging leaders from underrepresented groups.
- Employees from underrepresented groups don't feel sense of belonging in workplace
- Health care workforce lacks understanding of health care inequities
- Healthcare pipeline efforts often times just focus on recruitment, not retention and inclusion
- Small and public funded clinics (FQHCs) can't offer competitive wages
- Health Professional accreditation, licensing policies a barrier for students who are low-income
- Lack of accountability to drive workforce equity outcomes
- We aren't creative in assessing/defining who is a member of the equity team (ie taxi drivers, landlords, etc.)
- Primary care is losing out to specialty care and hospital medicine due to incongruent compensation structure.
- No requirements for Board and Sr. Level positions to reflect community demographics.
- Lack of new types of positions that would address equity (e.g., cultural navigators, advocates, etc.)
- There aren't professional standards for language service providers in health care
- Challenges in systems/staff turnover, to recruit and retain staff which increases work loads and demands
- Cost and time a barrier to education for diverse and low income students
- minoritized communities need financial assistance to pursue careers in healthcare; big barrier to entry
- Clear connection and support from Pre-k to Graduate school

Health Care Delivery and Access & Quality

Members of this group are Marc Gorelick, Laurelle Myhra, Miamon Queeglay, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Elizete Diaz, ElijahJuan Dotts, Nneka Sederstrom, Megan Chao Smith, Patrick Simon S. Soria, and Yeng M. Yang

Note that the following list is partial; the group did not have time to organize all problem statements that were identified.

- Public health and clinical data are not integrated
- Patients experience language barriers
- Transportation barriers to accessing services
- Lack of data to identify and address health inequities
- Performance metrics don't adequately address equity and outcomes
- Lots of interactions among these issues - implementing one solution isn't going to have the same impact as doing many of them together
- Evidence shows that by itself DEIB Training has modest impact, needs to come with other systemic changes/ cultural transformation , too
- Patients don’t experience culturally inclusive and responsive care
- Barriers to providing culturally congruent care include the lack of required DEIB foundational training for all
- Inadequate capacity for mental health care
- Lack of broadband internet in rural communities with which to receive care
- Lack of technology access and broadband internet generally (not focused on rural areas)

Public comments

No public comments were received in this period.

Closing and action items

No public comments had been received to present in this meeting.

A brief feedback poll was provided to the task force. Seven individuals responded. Their responses are summarized here:

- Respondents mostly strongly agreed that the meeting was effective. Average rating was 3.7 (on a scale of 1-4, with 4 being “strongly agree” that the meeting was effective).
- Respondents mostly agreed that the task force is fairly on track toward developing thoughtful recommendations by June 2025. Average rating was 3.4 (on a scale of 1-4 with 4 being “strongly agree” that the task force is on track).

The task force was thanked and reminded of the next meeting on August 21, 2024, which will be an in-person meeting with the option to join virtually. Workgroups are charged with meeting before the full task force meeting in August, to complete the problem identification and categorization, and information and engagement activities in Mural with facilitation support from DeYoung and MDH.

- Workforce: July 8
- Access and Quality / Delivery: July 12
- Financing: July 15

Contact to follow up

With questions or comments about 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.