DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

- April 25, 2024, 1:00-4:00 p.m.
- Meeting format: WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engles, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Vayong Moua, Laurelle Myhra, Cybill Oragwu, Miamon Queeglay, Nneka Sederstrom, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Each workgroup received feedback from the task force about their workplans
- Task force members learned about related work being done by Department of Human Services.

Key actions moving forward

- Workgroups will meet and work toward finalizing their vision and priorities, and discerning information and engagement needs.
- MDH will invite author Mary Butler to engage with the task force.
- MDH will collaborate with DeYoung Consulting Services to develop proposals for the environmental scan and engagement methods, for task force review in June.
- MDH will collaborate with DeYoung Consulting Services to update the project charter.
- A small group of task force members will meet on May 28, 2024 to discuss the draft vision statement and definition of health care equity.

Summary of meeting content and discussion highlights

Meeting objectives

The following objectives were shared:

- Task force hears workgroups' plans and provides feedback for moving forward
- Learn about some aspects of the Department of Human Service's (DHS) health care equity work

Welcome and grounding

Task force members were welcomed and the agenda was reviewed.

Commissioner welcome

Commissioner Cunningham presented information to continue encouraging the task force and guiding its work. Her comments are summarized below.

- What can med tech do in community health? Med tech can focus on access and telehealth. Even when people have access in the system, there are patterns that show not everybody gets access to the same quality of care once they come into the system. Minnesota is the "Silicon Valley of health tech or med tech." Can med tech be health tech? Where are the public private partnerships? How do we encourage that sector? How can med tech be in partnership with us? Public health, population health and health equity are a team sport.
- I invite you all to think together about oral health because we need solutions to our oral health disparities.
- Community health assessments: Are we really getting what we need out of these processes, and where is the coordination? And, are we getting the return from our nonprofit provider organizations in terms of community benefit? Much of the literature says that community benefit ends up being equated to uncompensated care.
- Accreditation for providers, for health plans—what does accreditation need to include?
- We need to hold space for being bold while also identifying specifics and being pragmatic. There's tension in this, but I know out of tension comes creative solutions.
- Today you'll talk to Assistant Commissioner John Connolly from DHS, the Assistant Medicaid Director. Later, Dr. Nathan Chomilo will do a deep dive with the task force around innovation in Medicaid. Dr. Chomilo researches Minnesota Medicaid and participates in a lot of national conversations.

There was one question for the Commission from the task force:

- **TF member**: A lot of the data and things that Dr. Chomilo is looking at do not cover and address a lot of the issues in the Native community. He's looking at a lot of non-tribal

programs. A lot of his data is skewed and is actually not getting at tribal issues and problems with funding and disparities. He's aware of that, and we're working on ways to correct that.

- **Commissioner**: I do know he is aware of that. The first report he looked at focused a lot on the data around African Americans. I believe he's coming out with a second report that specifically focuses on the experiences of care of American Indians. We hear about small numbers, but it's 2024, we can get past small numbers. Thank you for lifting that up. We are mindful at MDH of data limitations and will take any suggestions to learn more about what is underneath what you're talking about. I would love to have another conversation about that and particularly invite you to reach out to our Office of American Indian Health Director, Kris Rhodes, to move those changes in the public health space.

Emerging workgroup priorities and discussion

The task force was reminded about their prior conversation about revising a definition of health care equity, as well as revising a vision statement. Three task force members have volunteered to meet on May 28 to discuss changes needed. The full task force was invited to join this meeting and no additional members offered to participate. The updated draft definition and vision will be shared in the June meeting.

A draft charter was included in the task force's meeting materials. The group did not review it as it continues to undergo development and there was not sufficient time on the agenda given other priority items.

The task force then broke into breakout rooms to meet briefly with their workgroup, to prepare to share about their work so far to the large group. The objectives of the share-outs were to obtain feedback from task force for workgroups to add detail to their workplans to provide direction to the project team to develop an overall approach to an environmental scan of best and leading practices and policies in other states, and engagement with subject matter experts, communities, the public, and others workgroups may identify.

The task force was given the following prompts to guide their feedback after each workgroup presented:

- Is there anything you'd like clarified?
- Hearing about the vision and emerging priorities, what is important to include that you don't see represented already?
- What areas of overlap do you see or anticipate with other focus areas?
- What other reactions or input do you have with respect to these emerging priorities, and information and engagement needs?

The following are high-level summaries of each small group discussion. Detailed summaries of each discussion are included at the end of this meeting summary.

Health Care Delivery

Participants in this group are Marc Gorelick, Miamon Queeglay, Sonny Wasilowski, Erin Westfall, and Tyler Winkelman.

- It was suggested that perspectives are gathered from patients, consumers, and providers around gaps, access to care, and care coordination. There also may be reports of previous data gathering efforts to review.
- It was suggested that this workgroup discuss accountability systems. There is crossover here with the Access and Quality workgroup. Accountability for provider behavior is difficult.

Health Care Finance

Participants in this group are Bukata Hayes, Taj Mustapha, and Cybill Oragwu.

- It was suggested that this workgroup add to their workplan how an understanding of the current processes and state of financial systems will impact patients in the community.
- It was suggested that this workgroup add more to their workplan about price transparency and accountability from health care systems, including potentially creating an incentive structure for physicians to be intentional of their care outcomes.
- It was noted that there is overlap with the delivery workgroup around interpretation services.

Health Care Access and Quality

Participants in this group are Elizete Diaz, ElijahJuan (Eli) Dotts, Nneka Sederstrom, Megan Chao Smith, Patrick Simon S. Soria, and Yeng M. Yang.

- It was noted that providers' ability to provide culturally responsive care is a connection between this focus area and the Workforce workgroup. Providers are needed who can provide cultural concordance with patients. Crossover exists between access, quality, and the health care workforce, but developing patient education materials is also important.
- Task force members felt that workgroups should not solve these crossover issues independently. It was suggested that the workforce group start this particular discussion but there should be a way for the task force to capture these crossover topics.

Health Care Workforce

Participants in this group are Mary Engels, Joy Marsh, Maria Medina, and Vayong Moua

- The current assaults on diversity, equity, inclusion, and belonging (DEIB) work was noted as important context. An example was given of anti-racism training required by executive order in Michigan. More discussion is desired about the implications for how this task force gives recommendations. DEIB pushback is seen as potential overlap with other workgroups.
- It was noted that diverse Asian communities should not be lumped into one broad demographic group.

- It was suggested that this workgroup consider the responsibility to make sure public educational institutions are held accountable for training that shapes the workforce pipeline.
- Minnesota Doctors for Health Equity was offered as a resource.

MDH supports

The task force was asked what support from MDH they would find helpful going forward to achieve success. The following summarizes their discussion:

- Clarity is needed on the depth of scope. Are recommendations to be general and high-level or meant to potentially implement strategy to create programming, initiatives, legislative efforts, etc.? Workgroups understand they will develop a list of priorities, but clarity is needed around the level of their authority—this will impact how they move forward.
- There is a desire for MDH to provide resources, background material, source material, data, reports, regardless of its level of detail, for additional context for the task force, ensuring they don't "recreate the wheel."
- There is a desire for a recommendation of parties to engage as the task force moves toward seeking outside voices.
- There is a desire to sort the work being done across the four workgroups into buckets of levers that can influence government regulation, guidelines, etc. Buckets might be payers, providers, universities, community. This map of levers can overlay the four domains of the workgroups and guide the focus of their work. MDH can guide the task force to stay in those buckets of levers to what this group can influence.

DHS presentation

John Connolly, Assistant Commissioner for the Health Care Administration within DHS, provided an introduction to the health care equity work being undertaken at DHS. Highlights of his presentation included:

- Minnesota health care programs total enrollment
- How Minnesotans get health care, disaggregated by race/ethnicity
- Social drivers of health measures: deep poverty
- Minnesota health care quality metric payer disparities trends
- Childhood immunization screening
- Medicaid's role in eliminating health inequities
- Medicaid managed care requests for proposals (RFP) and contracting
- Quality measures, contracting and structural racism
- Contract requirements

- Addressing structural racism: bringing a racial equity lens to policy and budget proposals
- Equity-focused COVID-19 vaccine outreach
- Unwinding outreach
- Making it easier for eligible enrollees to keep coverage
- Unwinding disenrollment rates by race and ethnicity, including for children
- Investments in health equity work
- Addressing disparities in birth outcomes
- Looking ahead — re-entry waiver

Some task force members had questions for the Assistant Commissioner. They are represented below (close to verbatim but edited for redundancy and flow).

- **TF member**: I want to point you to an in-house resource: the Cultural and Ethnic Communities Leadership Council (CECLC). They're unique in this state because not many other state agencies have them. I would encourage you to meet with them to offer discernment and a review of your body of work here if you haven't already. I appreciate your overlay between race, ethnicity, income, geography, but when you disaggregate data, especially in the Asian community, you will see a stark and tragic difference between those who are refugees and recent immigrants and those who have been here fourth, fifth generations, as long as the Swedes and Norwegians. I want to see you continue to disaggregate that data. There is a good template for DHS and MDH to study the methodology that was used. It was done by the Hmong people administration, as well as coalition of leaders. (Resource provided: https://caalmn.org/wp-content/uploads/2021/04/CAAL-HPHA-Covid-Report-Fin-041921.pdf)
    - **AC Connelly**: I did have the opportunity and the fortune to meet with both of the co-chairs of the CECLC, so we'll continue to work with them and seek their counsel and feedback about all of this work. I also appreciate your feedback about working more deeply with the Asian American community and different groups. I think that's an important point, so will do.
- **TF Member**: Currently, several dental providers say they take Medicaid but the actual access to care is limited by their appointment availability for Medicaid patients. This creates long lines for access, even for routine preventive dental care. What can we do about ensuring that our high-quality dental care providers create more access to patients who are covered by Medicaid?
    - **AC Connelly**: Rates should be higher; we would like to pay more. Of course that has a budgetary implication. We need to do continuous outreach and work with plans as they are organizing the networks at least now to make sure that we can get as many providers engaged in the Medicaid program, of course as many providers that are situated within different communities, racial and ethnic communities, so that they can serve their communities, also making sure that we have geographic access as well as

other types of access. It's a challenge and something that we need to continue to focus on and try to seek improvement for.

- **TF member**: Beyond increasing our reimbursement rates for those providers, is there anything legislatively that we can do to hold providers accountable to these equity goals? You can encourage them all you want, and because of the budgetary constraints, you're probably never going to be comparable to commercial payers. Certain providers say they're very much into equity but they artificially limit access, and I think what that does, it limits people who are from communities who have a lot more barriers to care.
  - **AC Connelly**: There are some unique rules in place. Rare rules, like rule 101 that requires providers under certain circumstances to accept medical assistance. There are ways we might be able to look at that. Accountability is important, and we're looking for ways to do that, but open to conversation of ideas to further that.
- **TF member**: Often when we talk about equity work, we talk about care coordination, team-based care, primary care redesign, new models of care. Those things can be very challenging in a fee for-service-model, and they can be challenging if you don't have enough private pay folks to supplement a lot of these care coordination services that otherwise are hard to sustain with Medicaid rates alone. Could you say a little bit about recommendations for these calls for primary care redesign, calls for more care coordination in the space of improving inequities when the financing models make that very challenging?
  - **AC Connelly**: I would always advocate for a multifaceted strategy, one that recognizes how folks are paid, how providers are paid, in addition to the supports that we provide for developing new providers from different communities and different types of providers that we may not have historically paid for, and looking at more flexible models that are intentional about addressing certain inequities that we want to eliminate. If we find that different models of primary care that integrate behavioral health, for example, reentry from incarceration, housing, different things that in Minnesota we have integrated into the medical assistance benefit or set of services, and try to be again open minded about how those different services can align, work together and how we pay for them and how they can better support or make more feasible those different models of care.
- **TF member**: I hear an openness, an interest research-based models, and thinking beyond sort of current models of care. Sometimes we know what the right thing to do is, and it takes 10 years to pass a bill to do what we know will work. What recommendations would you make to encourage us to think about in our recommendations to speed up that process, and to be more nimble in reacting to research and innovations so that we don't have to wait 10, 15 years every time there's a change that we want to make?
  - **AC Connelly**: The Medicaid and new option services opportunity is one that health plans can certainly use to do something that's different and not necessarily explicitly in our state plan, in service of getting better outcomes, but that's without additional funding. We're basically just saying this health plan is choosing to do something that's new and innovative with the aspiration that they will eliminate inequities, reduce costs, achieve

better outcomes, and the Centers for Medicare & Medicaid Services (CMS) at the federal level has said states can do those types of things. It's always more difficult when we're talking about state policy change getting legislation passed from a budgetary impact, but there are flexibilities that we have in the Medicaid program that the federal government encourages and allows, and we do use the mechanism, so we're open to ideas about that.

Public comments

No public comments were received in this period.

Engagement with report author

During the March meeting, the task force generally agreed that reviewing the report, Strategies to Address Racial and Ethnic Disparities in Health and Healthcare: An Evidence Map, would be helpful, although there was a sense that a presentation on the report may not be needed. The task force was asked if a follow-up with one of the local authors, Mary Butler, to engage her in some other way could help inform their work. Six members responded "yes," and no members expressed concerns.

Closing and action items

A brief feedback poll was provided to the task force. The first question was, "What is one word that describes how you are feeling about this project so far?" The 15 responses included: overwhelmed, excited, curious, hopeful, cautious, encouraged, energized, inspired, challenged, unclear.

The second question was, "While we will be focusing on all of the following, what especially needs attention to ensure we move forward successfully in the coming months?" Five task force members responded, three of whom felt, "Comprehensive scan of relevant outside sources" needs particular attention, and two of whom felt, "Engagement of outside voices (guest speakers, community, etc.)" needs particular attention."

Each workgroup was charged with moving forward to further develop their vision statements and workplan.

The task force was thanked and reminded of the next meeting on June 26, 2024. It was shared that the June meeting will focus on the following:

- Finalize the vision and definition of health care equity
- Workgroups will provide another report out on priorities and workplans
- The project team will present their proposal for the environmental scan and engagement with interested parties and the public
- Dr. Chomilo will provide a deeper dive on health care equity at DHS

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.

Addendum

Questions, comments, follow-up are from task force members; responses and introduction are from workgroup members.

Health Care Access and Quality Workgroup Share-out and Discussion Notes

Question: Thinking about workforce group and some of the elements we have yet to share around building a workforce that is able to provide culturally concordant care, and some of the pieces that are in the access and quality workgroup that are talk become things like culturally responsive and inclusive care. Just wondering if there's a connecting point there that has something to do with supporting providers' ability to provide culturally responsive care with respect to training or resources or things like that. Is there a potential connection point there?

Response: Definitely. When we had the group discussion, we talked about that as well. I think this is a very broad category and there's the workforce piece. We need more people who can provide that cultural concordance in terms of language, cultural and ethnicity, identity and background. Then there's also the other piece in terms of just the actual delivery itself. Because we don't have a lot of materials, for example, now that are standardized across the different systems that patients can go to get care. Let's say they go to Health Partners versus Allina and other organizations. We each may have our own materials, whether that's well developed or not, and what I've seen in the past is that, for example, patient education materials that are just translated from one language, like from English to another language, without contextual modifications. That creates a problem in terms of comprehension, and then that can lead to poor outcomes for patients. There is a lot of cross over between the workforce development, but there is a lot of other work in terms of just developing content that are more culturally informed and culturally appropriate.

Comment: My hope is work groups outside of the workgroup group aren't solving independently for workgroup related matters.

Response: I don't know we've really discussed how to address that. That's a much bigger situation and not just growing our youth, but even just recruitment, retention, culture, the State of Minnesota being welcoming, all those things.

Response: We were hoping the workforce group would tackle that. We know it's a problem, and we welcome solutions. In order to provide that culturally responsive care, we need your group to help us to find those solutions for organizations and the state.

Response: I feel like the workforce group can start it, but it feels like it's a bigger, full Task Force discussion, because it hits all of our areas, as well. If there's some way of capturing these across group topics that needs to be like a day dedicated to it. I would put that on the list as something we should all discuss.

Comment: Understood and agreed. The goal is really to not have separate work groups solving for it. If there are aspects of workforce being addressed in other work groups, then let's clarify what those are.

Health Care Delivery Workgroup Share-out and Discussion Notes

Question: Can you all expand a bit more on how/if you plan to include patients/consumers in your investigation of delivery recommendations, and wondering if there is a feasible method to gather some patient designed workflows?

Response: That would be the goal. When trying to do surveys or interviews, it was both with people on the provider side and with recipients of care. But that's absolutely what we would be asking for, how can we get that perspective on where the gaps are, access provision of care and care coordination, and what are some of the suggestions for best practices.

Follow-up: There surely is some kind of recent qualitative reports and data of groups that have gathered some of this information, too, that I'm happy to look up, but I'm sure other people know as well.

Response: One of the things we had hoped for is some facilitation for review of the literature that's out there. There's no sense in reinventing the wheel. If somebody's done this, we want to learn from them.

Question: With the potential for overlap with the Access and Quality group, will your group also discuss or include accountability systems throughout the process of healthcare delivery? You had discussed how there's multiple levels to healthcare delivery. You could have a great delivery process up until the point of meeting with a provider, for example. And I know you also talked about how you would like to bring in, attorneys or people who could talk a little more about patient rights. So I'd be curious to see if your workgroup would be able to talk about that or if this would be an access and quality issue about accountability systems throughout, whether it's insurance, companies or providers double billing or refusing to clarify on a claim after a visit, or if it's a provider issue. I'm just speaking from a brief experience where I talked to somebody who was essentially belittled by a provider in an office setting, that multiple employees heard, and also heard back from that provider's coworkers about how that provider is well known for having anger issues, and how it's not the first time that that's happened. So I'd be curious to see if this would fall within the delivery area or if that's an access in quality thing that we can work on as well.

Response: My brain usually goes to preventing that type of behavior and sort of developing systems where people receive individualized compassionate care. We didn't talk about holding people accountable in the group, but where that falls is an open question. For me, the key point is, the system matters a lot, and the relationship and the interactions that you have matter a lot as well. But in terms of where these accountabilities lie and who's responsible, I don't know exactly how to answer it. I would say that quality is often measured at the provider clinic system level and in terms of accountability, it is interesting to broaden that to the whole, to each of the levels that are ultimately responsible for care delivery. Using the accountability tools to bring in additional players who often aren't responsible at the end of the day for the quality of care that's delivered. If you're thinking about a health care delivery system, I'd be curious to know if that where we want to focus our attention. Is that a separate issue? It seems a little outside what we had initially talked about.

Response: It's a really good question. As you can tell, I don't have a clear answer! Another question might be how much do we use accountability measures vs other tools to reduce stigma, discrimination, and/or bad behavior. Certainly an important tool in certain circumstances and very much welcome input on how much we should focus on accountability measures as a tool for improving care delivery.

Comment: That's a great point. It's tricky. It's hard for any regulatory body to say, this is how we're going to hold you accountable, this is how you deliver care, and then particularly around patient experiences with clinicians and/or the system itself, it's hard because it's a matter of culture. For example, our system has tried to put code of conducts for employees, for clinicians, and then we also have a code of conduct for patients, in terms of trying to provide some guardrails for both delivery system as well as for patients, and how do we interact in a civil and respectful manner. But you can't necessarily always control how people behave. It's a matter of culture, but it's hard to mandate culture. So I think it's a really tricky thing to have accountability that is consistent.

Health Care Finance Workgroup Share-out and Discussion Notes

Question: In your vision statement, one of your main vision statement goal was to have equitable care, equitable coverage for patients. I'm not seeing where, because it seems like in the work plan, it seems like it's a lot about understanding the processes and the current state for healthcare systems. So where are we understanding how that is impacting the patients in the community? How, for that coverage piece, and particularly for people who are lacking coverage or undercovered?

Response: I think we discussed it. We just didn't point it out in the work plan because I think there's already work being done right now by the state as far as the different health plans, and we didn't want duplicative work, but that's definitely something we can add to this work plan.

Question: We know the price transparency issue is a big issue. So is that part of your plan, to try to make that more robust, in terms of accountability from health care systems? Because that is something from a consumer standpoint, it's very difficult to get consistent price transparency for comparing services, for example, and every institution sort of has a slightly different interpretation of what that means, and that impacts how people get care and where do they go get care, in terms of the affordability aspect of that.

Response: I don't think is in our work plan either. But we also discussed it, as far as different hospitals billing differently for different services, and depending on what kind of insurance you have, you get billed different.

Question: I did have a question about understanding fee for service in RVUs. Was there a conversation amongst you about potentially creating an incentive structure for physicians to operate and be more intentional of their care outcomes to hit health equity goals and markers, and maybe incentivize in reimbursement scales through that as a financing structure?

Response: The reason why we wanted consultants to come talk to our group about that is because it's complex in the sense that right now there are different health systems that have

different health equity goals. But depending on what community you are practicing in, what patient populations you have, sometimes you might be billed as an incentive, and other times it's almost punitive because the goals are unattainable or there are other factors that are affecting those outcomes. So trying to find ways that we can adjust health equity goals equitably. Just trying to make it equitable in the right context, and I think it's a lot more nuanced than just setting like universal goal across the board.

Comment: I was just hoping that was part of the discussion, being creative in those kinds of ways.

Response: You mentioned interpreting services and reimbursement for that, and I just want to call out the fact that that's on our work plan as well - addressing equity of access and patient choice of interpreting services on the healthcare delivery work plan. There is probably some overlap there that we can maybe work together on.

Health Care Workforce Workgroup Share-out and Discussion Notes

Introduction: I wanted to recognize how political workforce support and DEIB work is, and I think this group is probably tracking the assaults on DEIB, just look at Anoka school district threatening to be defunded because of DEI work. I just want to acknowledge that. Doing core fundamental DEI work within the four walls of any single institution is absolutely necessary, but I don't think it's going to suffice. We do need to go further upstream into the School of Medicine, into the School of Public Health and begin impacting and trying to help shape curriculum training, the preparedness of the future workforce as well. And I don't know if this is within scope, but just recognizing that we were a legislative group and we're reporting ultimately to Governor Walz, the cabinet and the legislature. Promising factors in my view. I know that Governor Whitmer in Michigan has signed an executive order to require anti-racism training for medical license and to have these type of enhancements built into ongoing technical assistance, development and training, and not just into recruitment, hiring, career advancement. I just want to acknowledge the ongoing need to just get the core DEI stuff down, because we're not even close to getting that done, but also acknowledge that that's not enough. Because of the organized opposition towards that, as well as making sure that we're looking at not just the pipeline within an organization but interlocking systems. My apologies to my group if this is out of scope, but this is just kind of instinctual response here. The last point I want to make, some cross cutting priorities for us to really consider the accountability mechanism. My response is that it is very much in scope. It's within scope for the workforce group and for every group here. So we need to think about how can we make sure that we're not off the hook. This is just something that I sense within my own community. The need to have consistently disaggregated data so that Southeast Asia refugees are not lumped into a broad group, and racial inequity is really truly cross-cultural, and it's more just having REL and SOGI data. It's not just a data challenge. It really is about being cross-cultural in the way we frame, practice areas, embed it across issue areas. And it shows up blatantly in the lack of equitable data. I want to propose cross explicit and strong cross-cultural work as an overarching frame as well as making sure accountability mechanisms are woven into each of our workgroups.

Comment: Thank you for mentioning this! Osseo Area schools is also being threatened with book bans right now and I could see them dealing with what Anoka is soon.

Comment: Many good points, but one of them that we should discuss at some point is these different assaults on DEI curriculum. How do we process that, and what implications, if any, does it have for how we give our recommendations, and are there different strategies to get the work done and not end up in an argument about DEI for the next two years, and actually move some of the substance forward and not kind of derail it with buzz words that are going to set off certain groups. I don't know what the right answer is, but I would very much appreciate a discussion on what do we do, if anything, with the current state of litigation around the DEI framework and what does it mean for how we give recommendations.

Response: I'm happy to see a lot of overlap with our workforce group and other groups. I second the comments on aligning strategically on what we really want to focus on within the scope of workforce.

Response: The considerations related to the DEI pushback will certainly be within scope for the workgroup and as much as it is relevant for other workgroups, I'm hoping others consider it, as well.

Comment: When we think about pipeline development and investment, back to the question of accountability, our universities who train medical students, residents, and nurses really have a significant contribution to this area in terms of how they manage the curriculum. And right now, for example, I sit on the board of alumni at the University of Minnesota, and I've been hearing a lot about the change in curriculum for the University of Minnesota medical students, but some of that curriculum is very siloed, and it is left now up to some of the medical students who I advise on dealing with training themselves and their colleagues in this area. So being that they are a public institution that relies on funding from the Minnesota state legislature, I do wonder if this group has responsibilities to make sure that our public institutions who do some of that training, we create some kind of accountability for them in this particular topic, because that is the ultimate pipeline for us.

Response: MN Docs for Health Equity may have some ideas too.

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06/14/24

To obtain this information in a different format, call: 651-201-4520.

[REVISED DRAFT]: Foundational Definition and Vision

Health Care Equity

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

Vision

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

Equitable Health Care Problem Statements

Supplementary material for problem identification and categorization agenda items during the June 26th task force meeting.

Context

This document consolidates the content generated from task force meetings, workgroup meetings, and draft workplans. The MDH project team has reviewed, synthesized, and summarized this content into problem statements. The purpose of these problem statements is to understand the broader barriers to achieving a more equitable health care system. The task force will use these statements to validate, clarify, and potentially add to the understanding of these barriers. These problem statements will serve as a foundational tool to identify the information needed to develop effective solutions. They will guide efforts in engaging subject matter experts and conducting an environmental scan to identify promising practices and policies that advance health care equity. By identifying the specific issues and barriers, the task force and MDH can strategically seek out the expertise and information necessary to formulate targeted and impactful solutions.

Problem statements

- Patients experience interruptions in care at important life stages
- The system does not integrate all aspects of health
- Health care and public health are not integrated
- Care is uncoordinated
- Patients struggle to access to high quality and comprehensive health care
- Some of our community members are uninsured and under-insured, and these are impediments to care
- The system is hard for patients to navigate
- There is bias and discrimination in our health care system
- Systemic racism in our health care system
- White supremacy in our health care system
- The historical and ongoing impacts of colonization on tribal health outcomes
- There are not enough inpatient mental health beds
- Patients don’t experience culturally inclusive and responsive care
- Patients experience language barriers
- Health care information technology (IT) is not leveraged effectively
- We don’t have standardized data stratification to address inequities
- Health care organizations don't share data
- Health care systems and providers are not held accountable to equitable health outcomes
- Patients and communities in rural MN struggle to maintain access to services
- Specialists don't communicate with each other or with primary care
- Health care workforce demographics aren't representative of Minnesota communities
- Health care workforce lacks understanding of health care inequities
- Workforce pipeline barriers

- There aren't professional standards for language service providers in health care
- Employees from underrepresented groups don't feel sense of belonging in workplace
- Health insurance is hard to navigate
- Health insurance is not affordable including out of pocket expenses
- Medicaid enrollees are discriminated against based on coverage type
- Small health systems struggle to be sustainable
- Payment models don't support whole-person care
- Legal support for community health workers
- Providers don't know about reimbursement for culturally responsive care
- Providers aren't reimbursed for connecting patients to social supports and services
- Address funding gaps that manufacture scarcity and paternalism within the system
- Reporting burdens and lack of alignment between different metrics
- Performance metrics don't adequately address equity and outcomes
- Reimbursement doesn't support interventions that address social determinants of health