Agenda: Equitable Health Care Task Force

Date: 08/21/2024

Opening, welcome, and public comment, 12:00 – 12:10 p.m.

Overview of meeting agenda, objectives, and public comment.

Road to recommendations, 12:10 – 12:25 p.m.

MDH will provide an update on workgroup workplan synthesis, and approach to learning about solutions and developing recommendations and a call to action.

Learning and engagement: Health care delivery system navigation, 12:25 – 1:25 p.m.

Navigation solutions, challenges, and opportunities from MDH Health Care Homes—David Kurtzon, Director—and the Community Health Worker Training Program—Kristen Godfrey-Walters, Director.

Break, 1:25 – 1:35 p.m.

Commissioner's welcome, 1:35 – 1:45 p.m.

Welcome from Commissioner Cunningham.

Task force experience, 1:45 – 2:00 p.m.

Sharing and reflecting on experiences during Phase 1 of the task force.

Learning and engagement: Dr. Nathan Chomilo, Medicaid Medical Director, Department of Human Services (DHS), 2:00 – 2:55 p.m.

Pathways to equity at DHS and health care system transformation.

Closing, action items, and preview of September meeting, 2:55 – 3:00 p.m.

We will review our accomplishments and share upcoming next steps.

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08/13/24

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

Welcome and housekeeping

Task force members:

- Help yourselves to refreshments and socialize
- Join the WebEx meeting
  - Mute WebEx
  - Turn off laptop microphones and speakers

Equitable Health Care Task Force Meeting #6

August 21, 2024

Hush Naidoo Jade Photography

Opening and Welcome

Acknowledgement of thanks

Thank you for your continued efforts!

- Workgroup meetings and conversations
- Reading materials and preparing for meetings
- Your commitment to advance equitable health care

Today's agenda

12:00 – 12:10 p.m. Opening, welcome, and public comment

12:10 – 12:25 p.m. Road to recommendations

12:25 – 1:25 p.m. Learning and engagement: Health care delivery system navigation

1:25 – 1:35 p.m. Break

1:35 – 1:45 p.m. Commissioner Cunningham's welcome

1:45 – 2:00 p.m. Task force experience

2:00 – 2:55 p.m. Learning and engagement: Dr. Nathan Chomilo, Medicaid Medical Director, Department of Human Services

2:55 – 3:00 p.m. Closing, action items, and preview of September meeting

Grounding: Task force charge

The task force will:

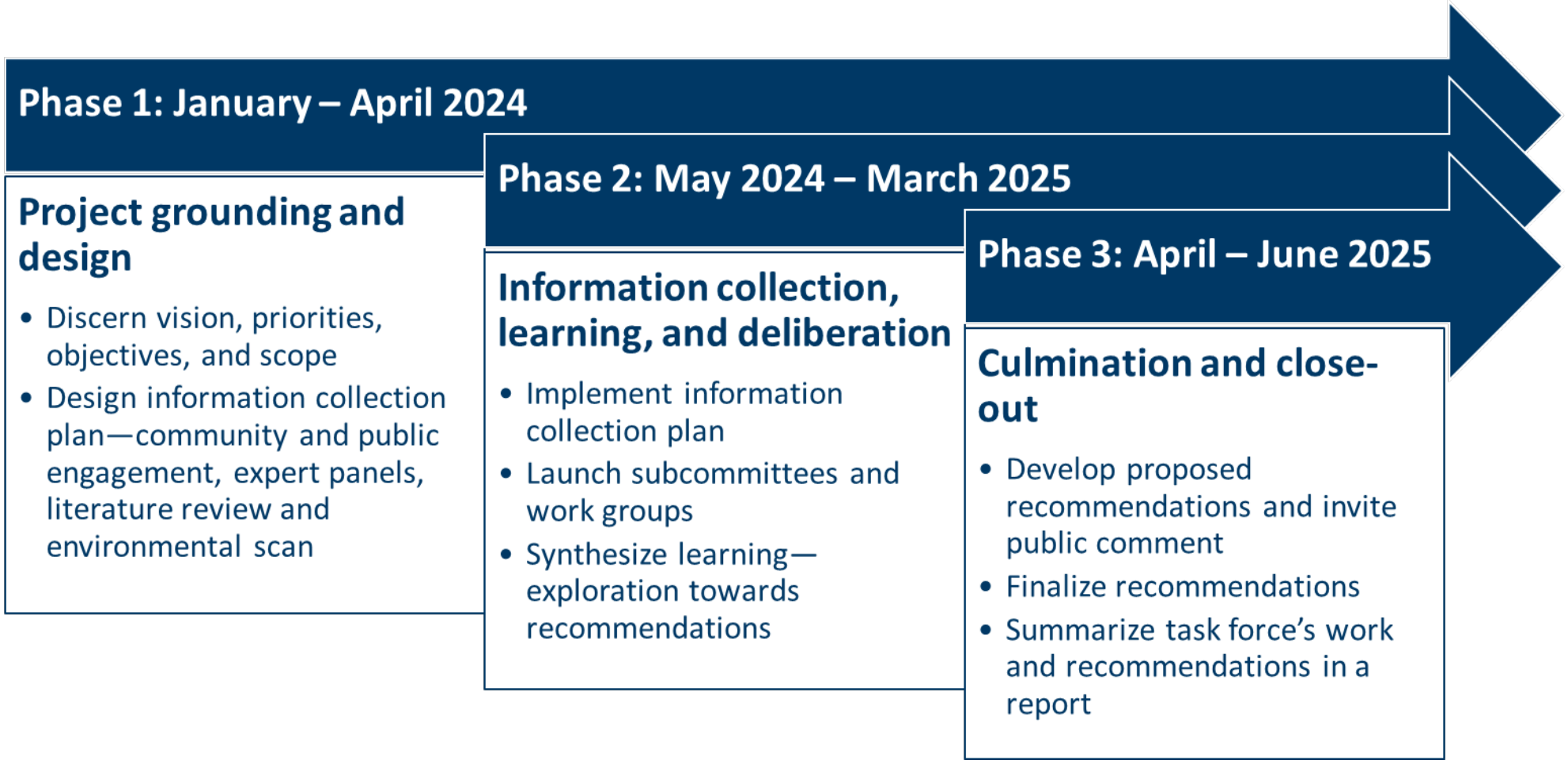
- **Identify inequities** experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age and/or disability status.
- **Conduct community engagement** across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care.
- **Identify promising practices** to improve experience of care and health outcomes for individuals in these population groups.
- **Make recommendations** for changes in health care system practices or health insurance regulations that would address identified issues.

Grounding: Vision and 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.

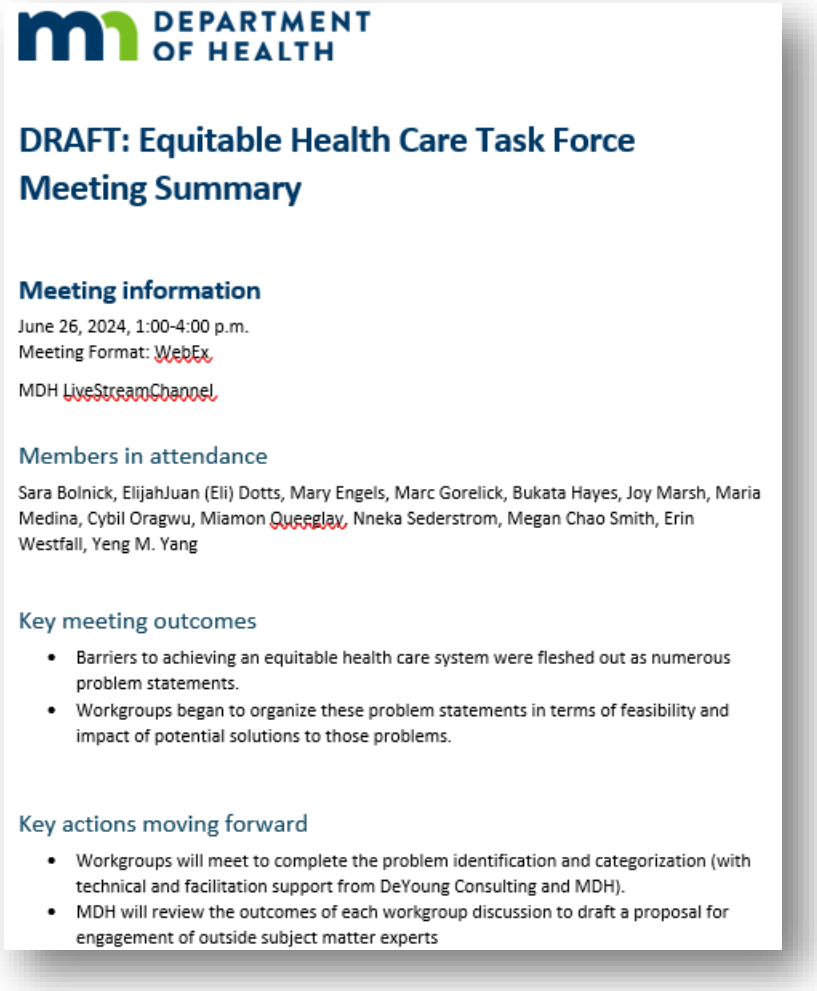
Where we are in our process



Summary of June meeting

High level summary of notes

- What clarification questions do you have about this summary, if any?
- What concerns do you have about this summary, if any?



DEPARTMENT OF HEALTH

DRAFT: 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, Cybil Oragwu, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Erin Westfall, Yeng M. Yang

Key meeting outcomes

- Barriers to achieving an equitable health care system were fleshed out as numerous problem statements.
- Workgroups began to organize these problem statements in terms of feasibility and impact of potential solutions to those problems.

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

Public comment

The full public comment is included in the meeting packet. The following are excerpted from the comment.

- There is an effort to rebrand acupuncture and Chinese medicine. I was wondering if there is an opportunity to discuss this?
- In Minnesota it took over 20 years for the practice of acupuncture to be established.
- Rebranding of acupuncture started about 10 years ago. The American Physical Therapy Association, in order to get around licensing laws, started using acupuncture needles claiming they are not doing acupuncture but dry needling.
- There are techniques in which we leave the needle in for seconds and then there are techniques where we leave them in for several minutes.
- Chinese medicine also includes some non needling techniques like cupping and gua sha.


Photo by Samuele Errico Piccarini

Road to Recommendations

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Issue summary

Care coordination and integration	Financing: Funding, payment, reimbursement	Health care delivery system navigation	Health information technology (HIT) and data	Workforce
• Integration of "all the cares" (e.g., primary care, pediatric care, maternal care, dental care, mental health, behavioral health, substance use disorder care) • Culturally concordant, congruent, and complimentary care • Whole-person health • Coordination within health care systems, and between health care and public health	• Incentivizing equity and holding systems accountable • Value-based care and purchasing, shared-savings, cost-sharing, pay for performance, quality measurement • Cost of care • System inefficiencies and inaccuracies	• Health literacy • Accessing care • Patient trust	• Data sharing • Health information exchange • Data and evidence • Leveraging HIT • Patient use of HIT	• Individual and systemic racism and bias • Pipeline • Diversity, inclusion, and belonging • Skill-building, culturally responsive • Emerging and non-traditional providers • Role inequities

Solutions: Tools and levers

- Policies, regulation, and oversight
- Financing and reimbursement
- Practices and training
- Data and technology
- Others

Example

- **Topic/issue:** Health information technology and data.
- **Subtopic:** Health care information and exchange.
- **Problem:** Patients do not fully understand consent. Some patients that opt not to allow health care providers to share their health information are then frustrated when their information does not follow them from provider to provider across the care continuum (e.g., primary care, specialty care, hospital care, mental health care). Providers then face obstacles to coordinate among each other to provide optimal care.
- **Future state:** Patients understand consent because it is explained in plain language in the patient's preferred language. The vast majority of patients allow their information to be shared.

Example, continued

Potential recommendations, solution tools and levers, and call to action

Near-term	Mid-term	Long-term
Policies, regulation, and oversight: • Minnesota Legislature establishes a Center for Health Literacy.	**Policies, regulation, and oversight:** • State launches Center for Health Literacy. **Practices and training:** • In consultation with consumer, community, and advocacy organizations representing diverse communities and patients, State develops and maintains plain language consent templates for use by health care providers. State will provide templates that are translated into the preferred languages of communities in Minnesota. • State provides training for health care providers to effectively implement patient consent education • Health care providers meaningfully engage and educate patients about consent.	**Policies, regulation, and oversight:** • Minnesota Legislature modifies consent language in Minnesota Health Records Act so that it is clear and expressed in plain language.

Learning and deliberation phase

- Task force meetings
  - Learning opportunities
  - Workgroup share-outs and engagement
- Workgroups
  - Synchronous and asynchronous learning
- New supports
  - State Health Access Data Assistance Center (SHADAC) and the Division of Health Policy and Management (HPM) at the University of Minnesota School of Public Health
  - Policies and practices that offer solutions to identified problems with health care delivery and financing

September

Workgroups

- Delivery, Access, and Quality
  - Information exchange – Center for Health Information Policy and Technology
- Financing
  - Recent policies – Managed Care Section
- Workforce
  - Pipeline – Office of Rural Health and Primary Care

Meeting

- Learning and engagement: TBA
- Workgroup share-out and engagement
- MDH updates

Learning and Engagement: Health Care Delivery System Navigation

David Kurtzon, Director, Health Care Homes, MDH

Kristen Godfrey-Walters, Director, Community Health Worker Training Program, MDH

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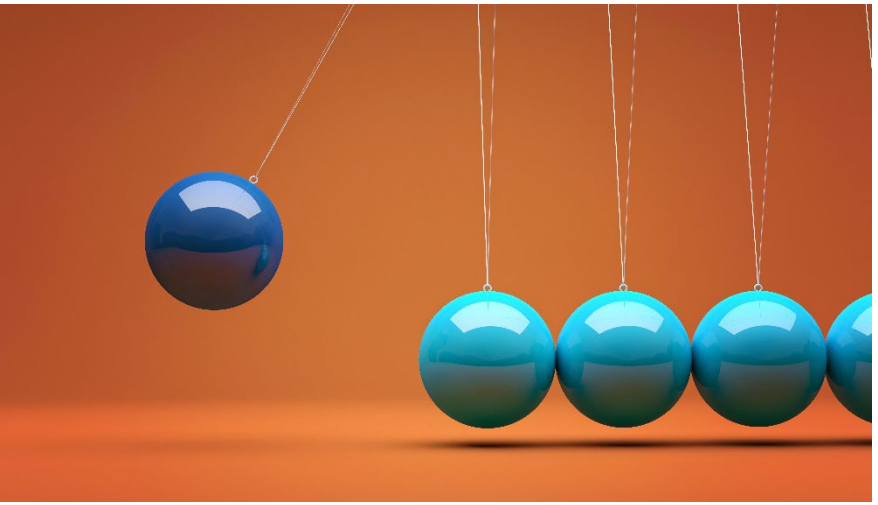
Health Care Home Model



A care delivery approach in which primary care providers, patients, families, and community partners work together to improve…

- Health Outcomes
- Patient Experience
- Value of Care

HCH certification is Minnesota's version of what is nationally known as a Primary Care Medical Home (PCMH) or advanced primary care model.

Certification Standards

- Standard 1: Access and Communication
- Standard 2: Patient Registry and Tracking
- Standard 3: Care Coordination
- Standard 4: Care Planning
- Standard 5: Performance Reporting and Quality Improvement

Care Coordination

- A key aspect of the Health Care Homes model.
- Support in navigating the health system and facilitating communication between providers.
- Requirement that patients be a part of care planning and decision making.
- Clinics must work with community providers to facilitate the availability of resources.

HCH Model Progression – Changing the Rule

Current standards

Foundational

- Focus on team-based patient-centered care

Progression level 2

Accountable Care for Populations

- Screening and addressing for social needs
- Enhanced access to care
- Integrated care teams
- Addresses health disparities and advances equity
- Strengthened community partnerships

Progression level 3

Community Integrated Health Care

- Contribute to a community health needs assessment and population health improvement planning process
- Share responsibility in implementing and monitoring the progress of community health improvement efforts

Coordinating the Care Coordinators – A Pilot

- HCH is working to launch a pilot project with a payer and healthcare providers.
- Multiple care coordinators leads to inefficiency and patient confusion.
- Purpose is to organize care coordination efforts.
- Leverage the resources of clinics, payers, and others to best serve patient interests.

Health Equity and Health Care Homes

- Foundational standards include a focus on access, point person to support navigation of the health care system
- Level 2 and 3 certification supports clinics in addressing health disparities and social determinants
- Primary care is foundational

Challenges (and Opportunities)

- Primary challenge facing Health Care Homes is billing.
- Legislatively established payment via Medicaid, but rates are static.
- Limited support from commercial insurance providers.
- Certification at Level 2 and 3 supports advancement of health equity, but funding mechanisms lacking.
- Incentives for certification: benefits beyond doing the right thing.

CHW Definitions

"A **Community Health Worker (CHW)** is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

- American Public Health Association

"CHWs are not defined by training or licensure but by who they are and what they do"
Shreya Kangovi, Penn Center for CHWs

CHWs and Health Equity

CHWs play an integral role in helping health care organizations achieve health equity. CHWs:

- Have a deep understanding of communities served which strengthens relationships and trust
- Facilitate access to services and improve the quality and cultural competency of service delivery
- Address both the clinical and nonclinical needs of patients and clients
- Gain understanding of the socioeconomic and environmental factors that impact health and quality of life
- Facilitate organizational understanding of language, health literacy, social isolation, and other factors that present barriers to care
- Identify and address barriers to care by engaging people in ways that other providers may not
- Integrate health care with social care, which can lead to better patient outcomes
- By addressing social, economic, and environmental factors, CHWs contribute to reducing health disparities. They work toward equitable health outcomes for all.

CHW Care Team Roles

Navigator

Cultural and language specific care coordination and navigation of the healthcare and human services system

Address SDOH/Community Connector

Address social determinants of health; screen and connect patients to healthcare and community resources; outreach and connection to services.

Bridge/Advocate

Serve as a bridge between the patient and care team; serve as an advocate for individual and community

Health Coach/Educator

Support patients in setting and achieving goals to improve health; identify and eliminate barriers to care; provide health education

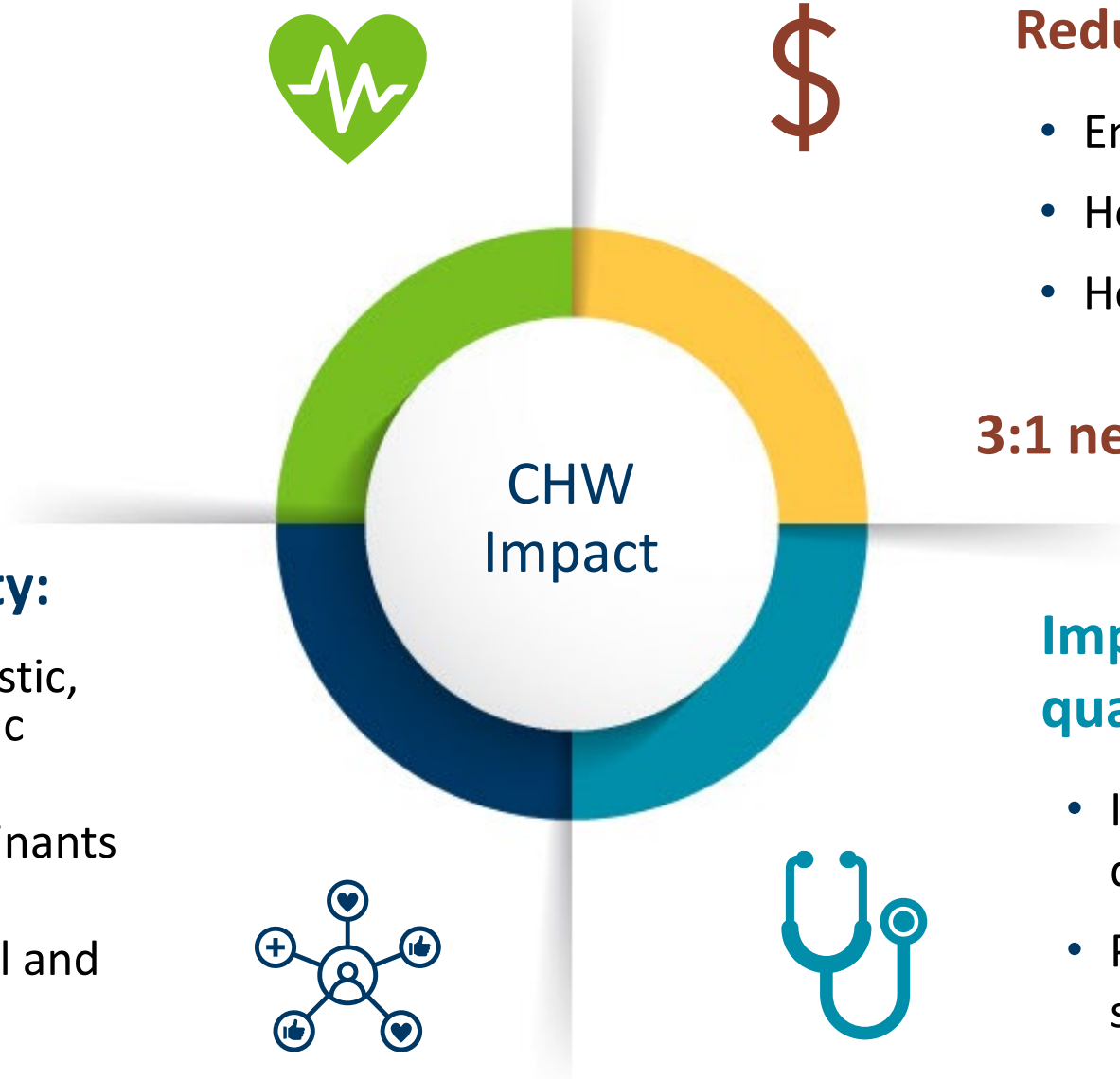
CHW Models in MN

Model	Description	Examples in MN
Behavioral Health Home (BHH)	BHH integrates primary care, mental health s, and social services for adults and children with mental illness. CHWs are integrated within health and behavioral health teams and assist individuals in coordinating care and services while supporting health and wellness goals. Robust PMPM payment model through MN DHS.	There are 42 certified BHH orgs across rural and urban areas in MN. Safety net clinic serving Latine Youth and families in medically underserved metro area.
Health Care Home (HCH)	Patient centered medical home model in MN, where CHWs are members of the health care team and provide functions of care coordination, system navigation, health education, SDOH screening and connection to community resources. PMPM payment model through MN DHS	At least 15 healthcare systems certified as HCH primary care clinics in both rural and urban areas employ CHWs in MN.
Individualized Management toward Patient-Centered Targets (IMPaCT)	CHWs support individuals in achieving personal goals leading to improved outcomes in inpatient, ED and clinic setting. Drive health system engagement; navigate clinical appointments. Outcomes supported in the literature.	Currently implemented in 3 clinics in rural clinic system in MN. Previously piloted in an urban safety-net hospital.
Pathways and Pathways Community HUB	Identify and address non-clinical needs that impact health. Navigate individuals to relevant social services. Uses a regional community care coordination approach and pay for-performance financing from public and private payors.	Several organizations utilizing CHW pathways across the state 3 community hubs coordinating services and payment in rural and urban areas
Transitions Clinic Network	Employs specially trained CHWs with a history of incarceration who help patients leaving prison make a successful transition to better health	One urban safety net health care system in collaboration with county jail health services

Sources: Advisory Board, 2019; MN DHS, 2024, MN MDH, 2016

Improve health outcomes:

- Chronic disease control
- Mental health
- Healthy behavior
- Health disparities



Reduce health care costs

- Emergency room use
- Hospitalizations
- Health care spending

3:1 net return on investment

Advance health equity:

- Provide cultural, linguistic, and community specific services
- Address social determinants of health
- Advocate for individual and community needs

Improve satisfaction and quality

- Improve patients' perceived quality of care
- Positively impact provider satisfaction

Source: Lau et al., 2021; ASTHO

CHW Infrastructure in MN

MDH CHW Initiatives

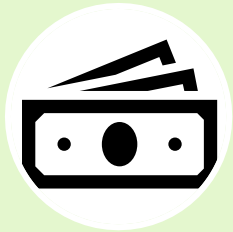
Collaboration and coordination between state and community partners

MN CHW Alliance

Professional, advocacy, capacity building organization for CHWs

Training

CHW certificate program, apprenticeship, upskilling



Financing

Medical billing

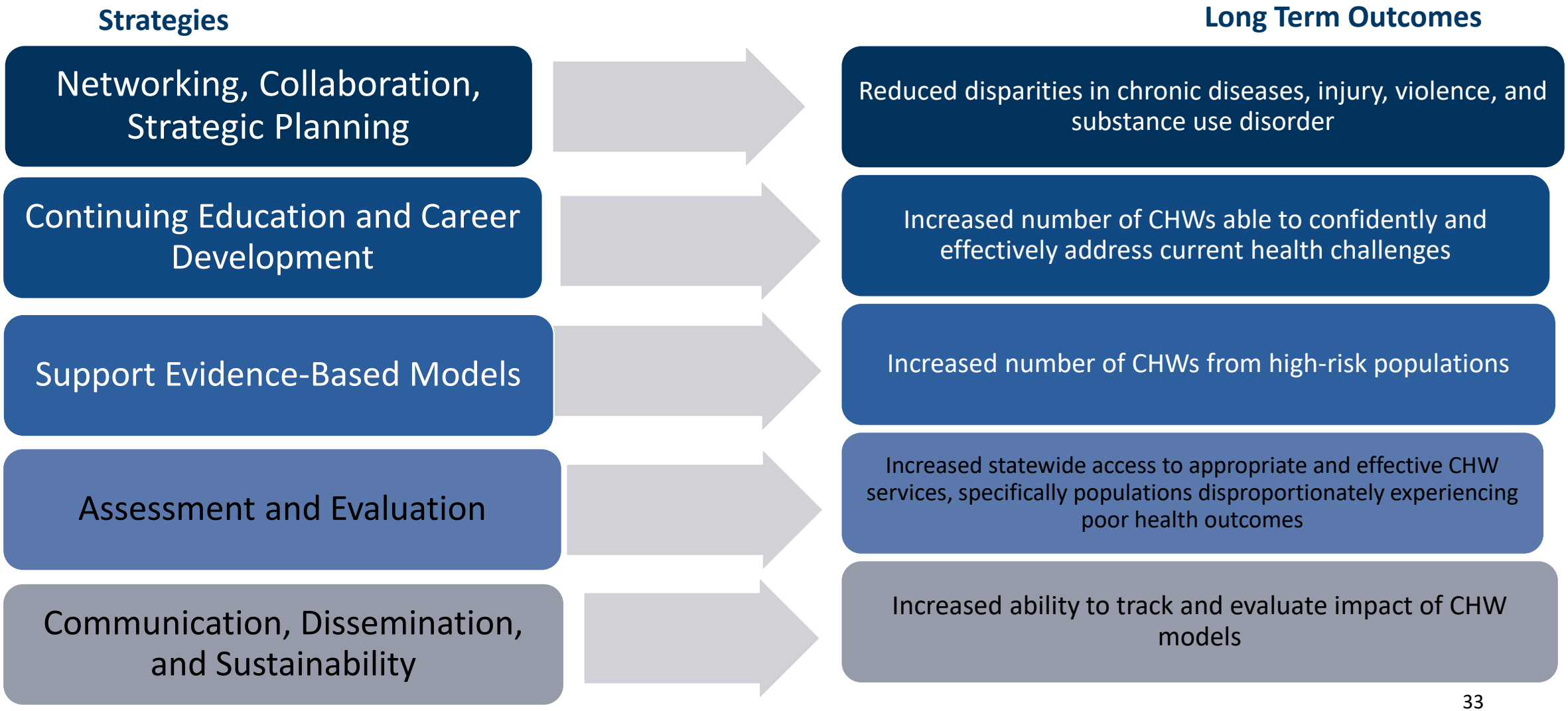
Grants

Legislative appropriations

Evaluation and Measurement

Environmental scan, measure development

MDH CHW Initiative Logic Model



What's working well?

- **Academic Credit-based CHW Certificate training program**
  - Expansion of number, geographic location, diversity of CHWs trained through HRSA grant
  - Part-time, hybrid and fully virtual/online training options have expanded access and geographic reach
- **Expanded billing/reimbursement for CHW services in 2024**
  - Expansion in scope of services covered and higher reimbursement rates
- **Evidence-based CHW models to address SDOH, health outcomes, cost, quality**
  - Pathways Community Hubs, Transition Clinic Network, IMPaCT, Health Homes
- **CHW infrastructure and workforce development initiatives in MN**
  - MN CHW Alliance grant for capacity building, technical assistance to CHWs and employers
  - MDH sustainable plan development, evaluation and measurement, upskilling, reimbursement

Source: Partnership to Align Social Care, 2024; MN DHS, 2024; MDH, 2016

Barriers/Challenges

- **Funding and sustainability of CHW services/programs**
  - CHW service reimbursement rates and scope of services covered are not in alignment; gaps for FQHCs and CBOs
  - Barriers for provider organizations in enrolling CHWs as providers, billing for services, and receiving reimbursement
  - Funding mechanisms rely heavily on grants and traditional FFS billing
- **Workforce expansion**
  - Lack of CHW positions available, sustained and paid at living wages
  - Lack of statewide access, geographic reach, and diversity of CHWs, employers/settings of CHW services
- **Infrastructure and capacity**
  - Organizational readiness and capacity for integration of CHW role – job duties, supervision, model implementation, measurement, billing, financing, etc.
  - Integration of CHWs across settings for patient navigation, addressing health related social needs, patient education, outreach and advocacy
- **CHW training**
  - Low employer uptake in CHW Registered Apprenticeship, lack of funding for CHW apprenticeship positions
  - Lack of funding for CHW Certificate Program and continuing education when HRSA grant funding goes away

Opportunities for state health agencies

Establish state strategy and coordination

- ❑ Establish state office to implement CHW policies & coordinate stakeholders
- ☑ State plan for accountability
- ☑ Support state CHW Association capacity and involvement
- ☑ Measurement & outcomes reporting

Design and implement Medicaid and Medicare Policy

- ❑ Incorporate CHWs & stakeholders in state advisory boards/work groups
- ❑ Partner with State Medicaid on payment policies and rates
- ❑ Education & support to employers
- ❑ CHW services claims tracking & reports

Support CBO and employer capacity

- ❑ Incorporate CHWs into state initiatives/funding to address SDOH
- ❑ Encourage coding alignment between Medicaid & Medicare
- ❑ Support Community Hub infrastructure
- ❑ Employer and apprenticeship program grants

Design and refine CHW Training Programs

- ☑ Align training with reimbursable services
- ❑ Offer dual training and specialization pathways
- ❑ Training reciprocity between states and tribal populations
- ❑ Financial aid and funding for CHW training programs

☑ *Denotes planned, completed, or work in progress*

Source: ASTHO and CHCS, 2024

Opportunities – Addressing current billing barriers

- **Determine alternative payment models or codes for FQHCs & CBOs for CHW services**
- **Streamline and provide education and technical assistance for CHW Provider Enrollment and billing processes**
- **Modification of existing billing guidance/MHCP language**
  - Inclusion of codes for care coordination services provided by CHWs outlined in statute
  - Expansion of referring provider types and/or consideration of need for referral requirement
  - Revise/clarify current language indicating CHW services are “not a social service”
- **Alignment of Medicare and Medicaid billing guidelines**
  - Coding to allow for both face-to-face and non-face-to-face time
  - Referral vs. initiating visit
  - Units of service alignment – remove units limitations
  - Align billable services with Medicare services for addressing HRSN
  - Align Medicaid payment rates with Medicare rates
- **Expansion of services covered to align with CHW scope of practice**

Pathways for expanded Medicaid coverage

Mechanism	Description	Example Approaches
State Plan Amendment (SPA) & ACA Health Home Option	CMS approval to cover CHW services as formal Medicaid benefits under preventive services, outpatient services benefit, or include CHWs as providers reimbursed as a part of a Health Home.	• MN DHS FFS billing for CHW education services • MN DHS inclusion of CHWs in Behavioral Health Home services reimbursement • Other states define CHW services more broadly
Section 1115 Demonstrations and new HRSN related 1115 Waivers	CMS approval allows states to test innovative policy approaches to support Medicaid members and their needs, fund state pilots for Medicaid-funded CHW programs, invest in CHW training and workforce development infrastructure	• Capitated payments for HRSNs (e.g. housing supports) • ACO incentive payments fund hiring CHWs and CHWs reimbursed through ACOs • CHW core competency and specialized trainings • MCO funding for CHW programs • Community Pathways hubs and Community Hubs • Pre-release services for justice-involved individuals
Managed Care Contracts	State requirements for managed care plans and CHW integration	• Requirements for MCOs to hire CHW directly or contracted through a clinic or CBO based on MCO member ratio • Performance measures or incentive payments for coverage of CHW services • MN MCO covers CHW services at higher rate than required by DHS
Alternative Payment Models	Alternative payment and service delivery approaches aimed to achieve value-based care including Accountable Care Organizations (ACOs), Integrated Health Partnerships, etc.	• CMMI initiative to support integrated wrap-around services for pregnant/postpartum women with OUD • Capitation/sub capitation models

Source: NASHP, 2021; ASTHO, 2024

Key takeaways

- CHWs demonstrate impact on health outcomes, health disparities, cost, & quality
- MN has a robust structure for CHW education, training, delivery models, and billing
- Barriers still exist for equitable access to CHW services, integration and financing of CHW services within organizations, and CHW training and workforce development
- Opportunities exist for state health agencies to advance sustainable CHW services through strategies, policy, funding, training, and support for CBO & employer capacity
- New Medicare and Medicaid billing codes for CHW services provide additional reimbursement opportunities for funding sustainability
- Opportunities have been identified to address barriers with current coverage and expand coverage using Medicaid coverage options adopted by other states

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Contact Us

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Community Health Worker Initiatives for Health Promotion and Chronic Disease - MN Dept. of Health (https://www.health.mn.gov/communities/commhealthworkers/index.html)

Supplemental Information

MNCHWA -CHW Scope of Practice in MN

- Role 1: Bridge gap between communities and health/social service systems
- Role 2: Help patients navigate health and human services systems
- Role 3: Advocate for individual and community needs
- Role 4: Provide direct services: health screenings, health education and self-management, support groups
- Role 5: Build individual and community capacity

Source: Roles – CHW (mnchwalliance.org)

CHW Education in MN – CHW Certificate Program

- Competency-based CHW academic certificate program
- 16 credits - includes coursework and internship
- High school diploma or GED required at some schools
- Stand alone program or as an educational pathway with public health, health and social services professions
- Offered at five accredited post-secondary schools.
- Required for Medicare and Medicaid billing in MN
- No board of licensure or certification for CHWs in MN

Source: Education – CHW (mnchwalliance.org)

CHWs and Health Disparities

CHWs play an integral role in helping health care organizations reduce health disparities. CHWs:

1. **Cultural Competence**: CHWs understand cultural norms, beliefs, and practices within their communities. This cultural competence allows them to tailor interventions and communication effectively.

2. **Access to Care**: CHWs bridge gaps by connecting underserved populations to healthcare services. They provide information about available resources, help schedule appointments, and assist with transportation.

3. **Health Education**: CHWs educate community members about preventive measures, healthy behaviors, and disease management. By promoting health literacy, they empower individuals to make informed decisions.

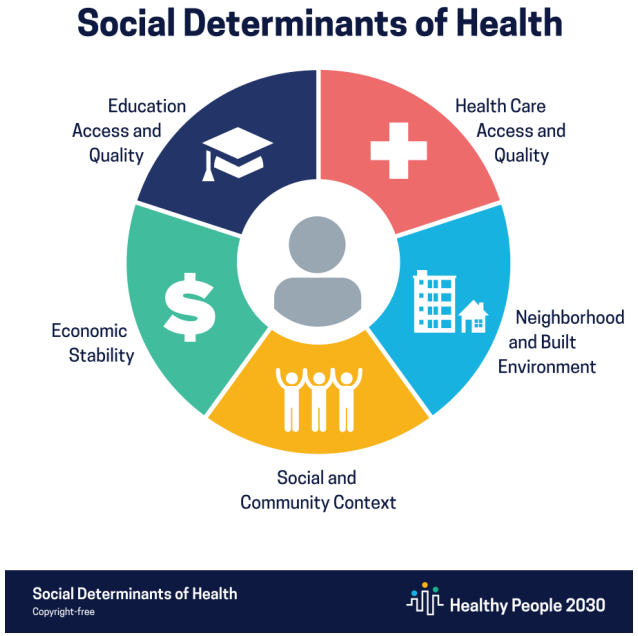
4. **Advocacy**: CHWs advocate for policy changes and community-based solutions. They raise awareness about social determinants of health, such as housing, employment, and food security.

5. **Trust and Relationship Building**: CHWs build trust with community members, which is essential for successful health interventions. Their shared experiences foster rapport and encourage participation.

6. **Reducing Disparities**: By addressing social, economic, and environmental factors, CHWs contribute to reducing health disparities. They work toward equitable health outcomes for all.

CHWs Address SDOH

- Identify and address barriers to accessing resources, services and care:
  - Screening for SDOH needs (e.g. housing, food, transportation, utilities, financial, education, etc.)
  - Providing education and resources
  - Clinical - community linkages – closing the referral loop
  - Navigation assistance to access care (e.g. appointments, interpreters, transportation, insurance, prescriptions)
  - Enrollment assistance (e.g. public programs, childcare, insurance, financial support, etc.)
- Provide services in the clinical, home, and community setting
- Individual and community advocacy
- Social and emotional support



Source: Healthy People 2030

CHW SDOH Model Frameworks

Model/Framework	Examples/Resources
Screen, referral, and assistance with non-medical needs and barriers	• Ohio CHAP CHW Pathways Model: Charting A Pathway To Better Health | Health Affairs • Advancing social care integration in health systems with community health workers: an implementation evaluation based in Bronx, New York - PMC (nih.gov)
Population and community-based models	• CHW Pathways Community HUB Manual (ahrq.gov) • Community Care Hubs: Improving Health And Well-Being Through Community Care Hubs | Health Affairs
Patient/Client Outcomes	• IMPaCT model - Inpatient and outpatient intervention with personalized action plans • Camden Coalition “Hot spotters” CHW Model • Chronic Disease Self-Management Models

Funding for CHWs in MN

CHW positions are generally supported by:

- Grants – government and foundation
- General operating dollars
- Medical Billing and Reimbursement
  - Minnesota Health Care Programs (MN Medicaid)
  - CMS Medicare
  - Third Party Payor Arrangements
- Sustainability often supported by evidence of outcomes and ROI

Reimbursement – CHW (mnchwalliance.org)

Medical Reimbursement of CHW Services in MN

Minnesota Health Care Programs (MHCP) has covered CHW Education services since 2009:

- "Diagnosis–related health education" ordered by an authorized provider and billed under general supervision of an eligible provider
- CHW must have Certificate and register with DHS for services to be billable

As of 2024, MHCP will cover new SDOH related services defined by Medicare and performed by CHWs

- Services are intended to "**address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems."**
- **Covered services include:** assessment & planning, system navigation, facilitating access to resources, care coordination, health education, self-advocacy, social & emotional support, health coaching or motivation to reach care plan goals

As a result of this expansion of coverage for Medicare defined codes, the covered CHW services in MN are more closely aligned with the MN CHW scope of practice.

Source: MN DHS, 2024; Partnership to Align Social Care, 2024; CMS, 2024

MDH CHW Initiative Activities

CHW Initiative Logic Model provides a framework for the following current activities:

- HRSA CHWTP Workforce Development Grant
  - Scholarships for CHW Certificate Program | Apprenticeships | Upskilling Trainings
- 2023 CHW Statute/Appropriations
  - Collaboration and coordination between state and community partners to develop, refine, and expand the CHW profession
  - MNCHWA Capacity Building Grant | Operationalize Logic Model | Environmental Scan| Measurement
- MDH and Cross-Agency Collaboration for CHW Initiatives
  - MDH Internal CHW Leadership Steering Team | Integration of CHW Strategies | CHW Training

MDH CHWI - Looking Ahead

CHW Training and Workforce Development

Environmental scan and development of measurement system

Refine and operationalize CHW Initiatives logic model

Collaboration with state and external stakeholders to address reimbursement and financial sustainability barriers

Collaboration and coordination between state and community partners to develop, refine, and expand the CHW profession

Community Health Worker Training Program (CHWTP) Funded by HRSA

Goal: To expand the public health workforce through training of new CHWs and extending knowledge of existing CHWs

CHW Awareness

CHW Certificate Program Scholarships

Registered Apprenticeship Program

CHW Upskilling Training

HRSA Health Resources & Services Administration

Minnesota Community Health Worker Alliance

DEPARTMENT OF LABOR AND INDUSTRY

DEPARTMENT OF HEALTH

CHW Training Program Progress

Aug 2023 - July 2024

CHW Certificate Program Trainees Enrolled

121

Registered Apprenticeship Sites

3

Upskilling Training Modules developed

4

Upskilling Trainees Enrolled

53

CHW Apprentices

1

Coming Soon!
Asthma
Dementia
Oral Health

Free CHW Training Modules – MDH Learning Center

Trainings can be accessed through the [MDH e-learning center (www.health.state.mn.us/about/tools/learningcenter.html)](www.health.state.mn.us/about/tools/learningcenter.html).

Arthritis Management for CHWs

CHWs roles in supporting patient arthritis management including understanding risk factors, management, treatment, and referral

CHW Role in Diabetes Care

Learn about diabetes and how CHWs can play a vital role in managing this serious chronic health condition

Heart Health Conditions: Education for CHWs

A short 10-minute course for CHWs that reviews the risk factors for heart health conditions and what can be done to reduce a client's risk

Stroke Care for CHWs

A short 10-minute course for CHWs that reviews the risk factors for stroke and what can be done to reduce a client's risk

Learning and engagement

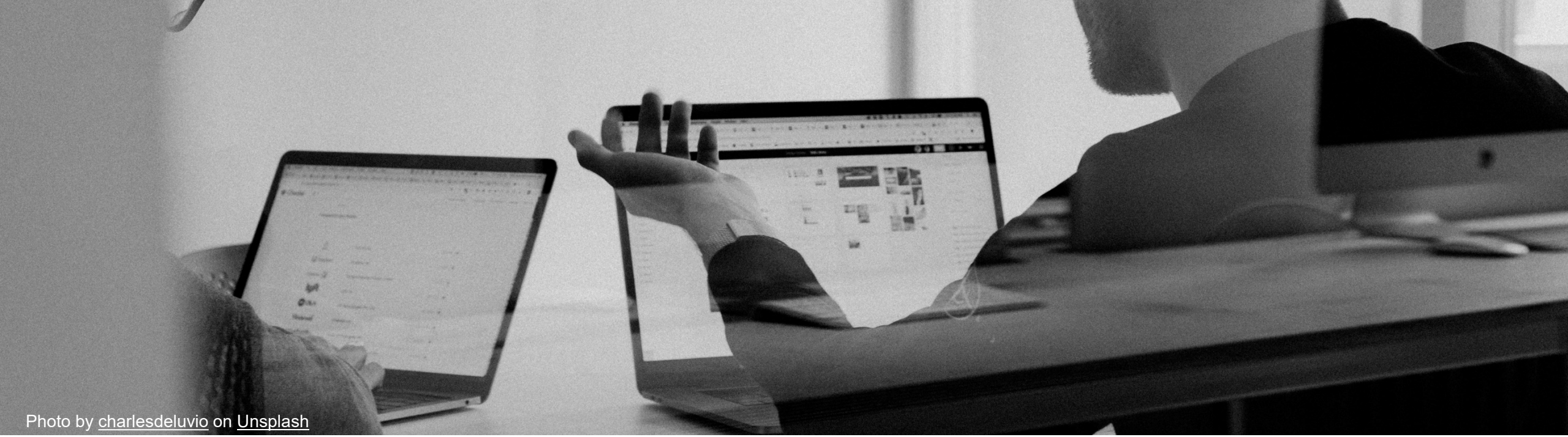
- What did you hear that is new or surprising?
- How does the information you heard intersect with the issues raised by your workgroup?
- What can you add to what you've heard that is a promising or successful practice?
- What stands in the way of generalizing these successes?
- What incentives and levers will make the health care system implement these solutions?

Break

Commissioner’s Remarks

Commissioner Brooke Cunningham, MD, PhD

DEPARTMENT OF HEALTH



Task Force Experience

DEPARTMENT OF HEALTH

Experience

- Please see handout with questions about your experience so far with the task force.

Learning and Engagement: Dept. of Human Services

Dr. Nathan Chomilo, Medicaid Medical Director, DHS

DEPARTMENT OF HEALTH

DEPARTMENT OF HUMAN SERVICES

Pathways to Equity in Health Care Systems: Presentation to the MDH Equitable Health Care Task Force

Nathan T. Chomilo, M.D. FAAP, FACP | Medicaid Medical Director

“Give the community the opportunity to start a journey of trusting larger agencies that provide resources and services.”

– 2022 Building Racial Equity into the Walls of MN Medicaid: a focus on US-born Black Minnesotans Community Conversation participant

“Like water through a canyon, as long as it takes, we need to make changes.”

– 2024 MN Medicaid Pathways to Racial Equity American Indian Duluth Community Conversation participant

Roadmap:

1. From Building Racial Equity into the Walls of MN Medicaid to Pathways to Racial Equity

2. Brief Case Studies of other states

3. National Conversation around Health Care Transformation

4. Calls to Action for MN

Recognition of past trauma and abuse

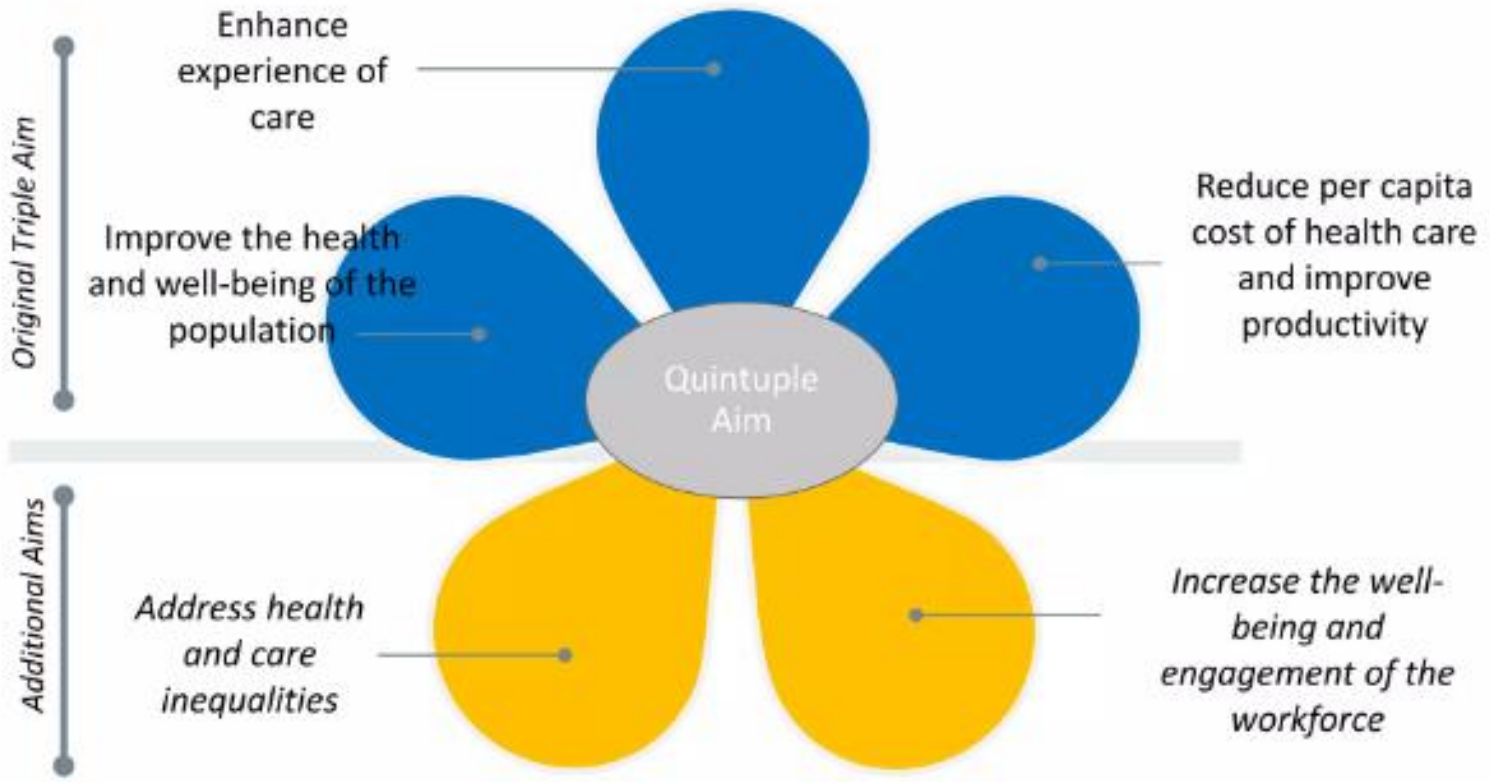
The state of Minnesota and the Department of Human Services recognize the trauma, medical abuse, and discrimination that have happened to our Black, Native/American Indian, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine and social service providers.

The work of equity and antiracism requires that we are all actively committed to rebuilding trust with communities and bringing community members' voices to the table.

MN Medicaid's role in eliminating health inequities

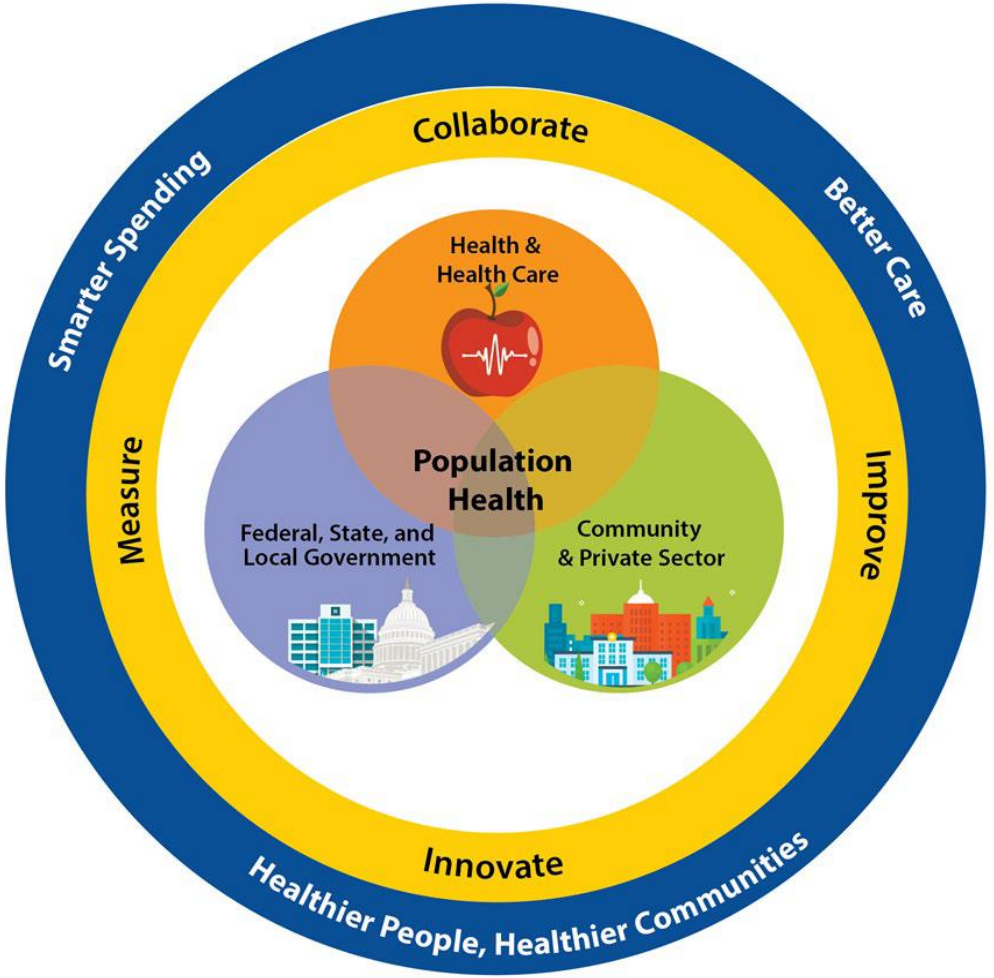
- **Minnesota Department of Human Services as a service provider.**
  - Fee for service provider & contracts with MCOs
- **Minnesota Department of Human Services as an employer**.
  - Increasing diversity in recruitment, retention and advancement. Developing employee curriculum.
- **Minnesota Department of Human Services as an engaged and accountable community partner.**
  - Scaling up models with sincere community engagement → ex. Integrated Care for High-Risk Pregnancies (ICHRP), Medicaid Equity forums, Renewal work, co-creation of Medicaid racial equity reports
- **Minnesota Department of Human Services as a leader in process transformation among state agencies and other state Medicaid agencies**
  - Racial & health equity assessments of ALL policy & budget development processes.

Moving from Triple Aim to Quintuple Aim



CMS is committed to four principles for improving population health

- **Establish health equity as a strategic priority**
- Empower and enable measured entities and other stakeholders to take a **data-driven approach to measuring and improving population health**
- Leverage state **innovation and local leadership through partnerships**
- Address **all determinants of health including clinical, social, behavioral, and environmental** factors.

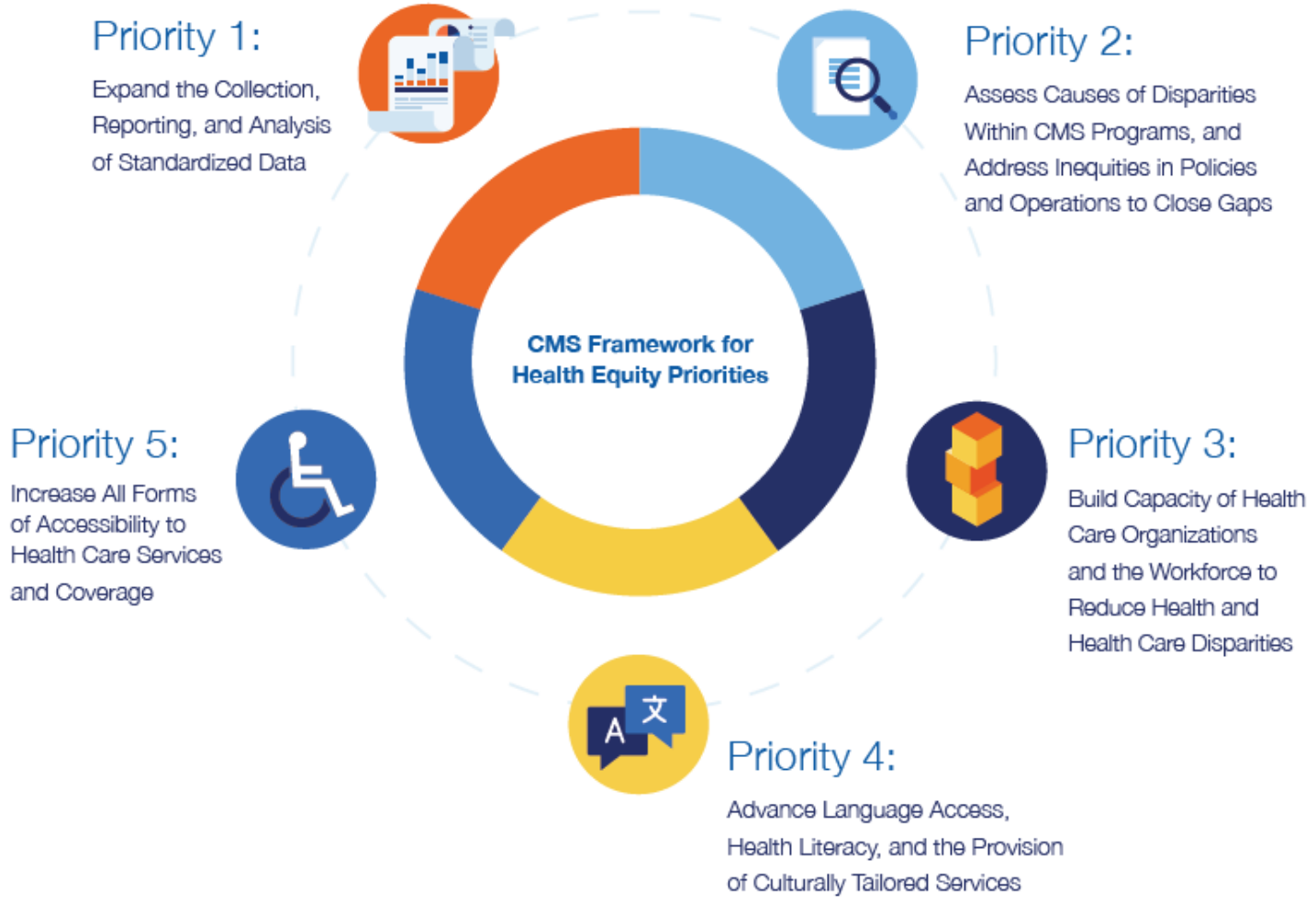


Achieving population Health Equity in Medicaid

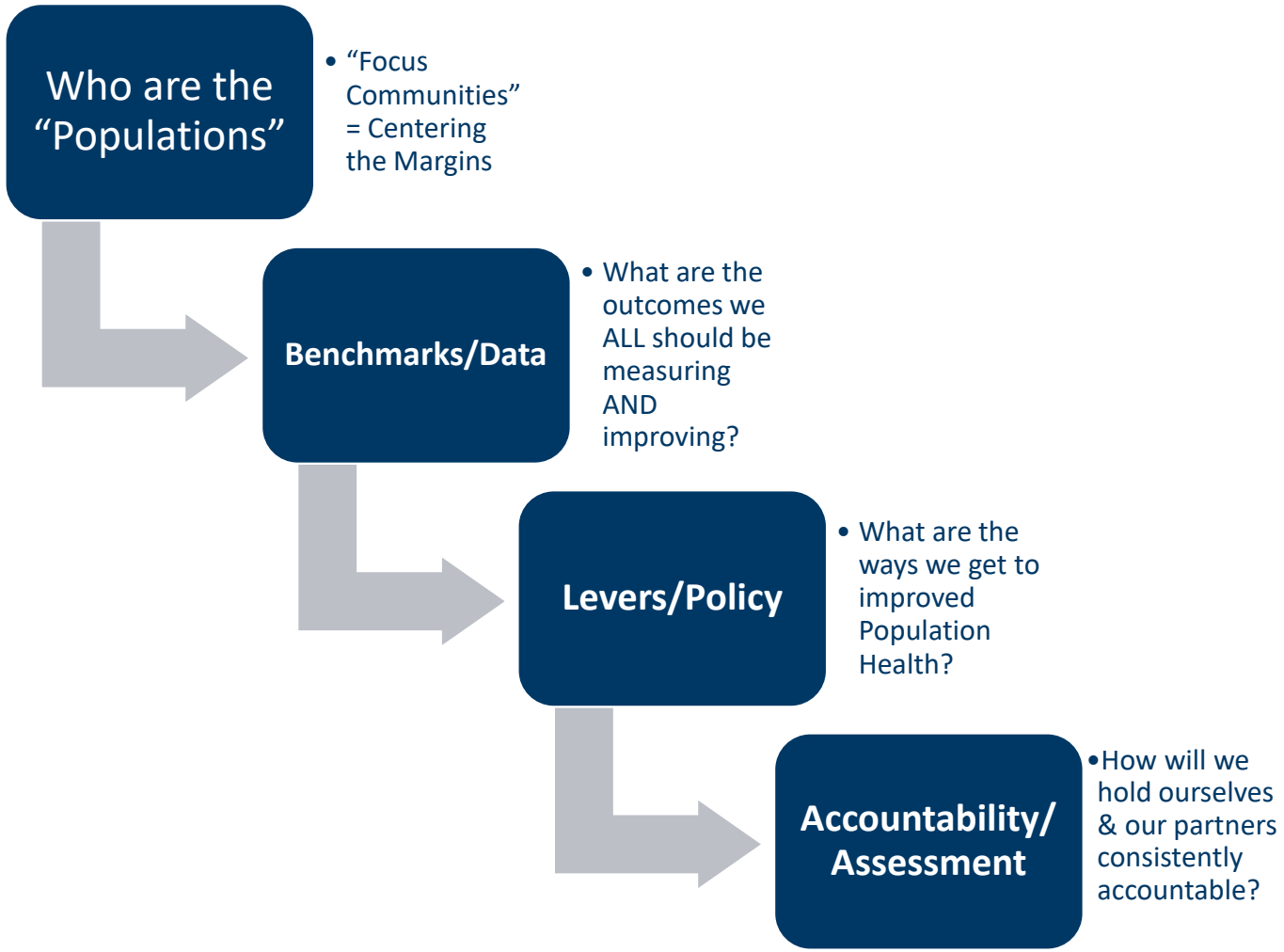
- Medicaid has experienced inconsistent health outcomes and system fragmentation.

➢ Collaboration across physical health, behavioral health, and community sectors is essential for improved outcomes.

➢ Across the lifespan Health means having access to Housing, supports for Behavioral/Mental/SUD treatment, and knowing that at one point we will all navigate disability

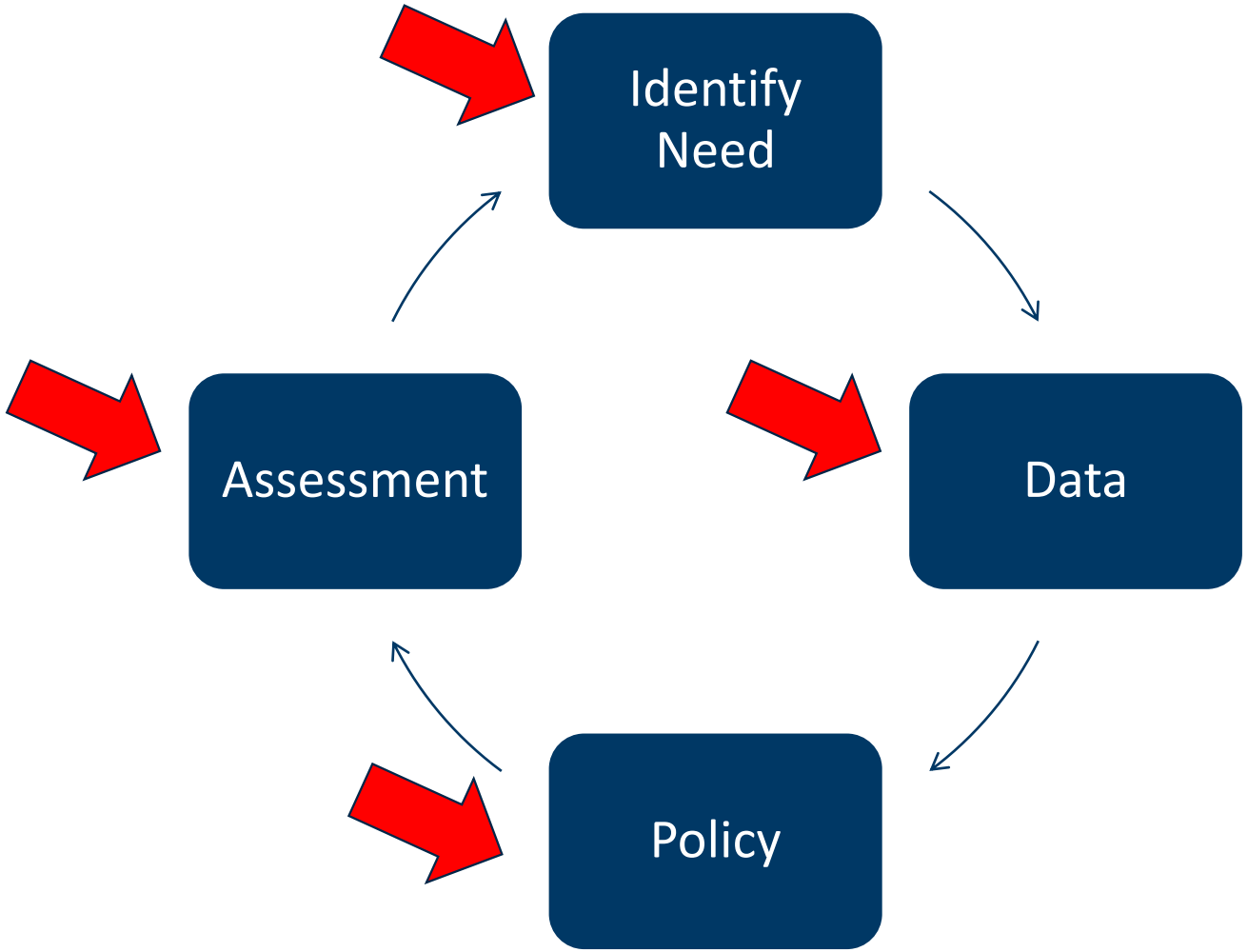


DHS Office of the Medicaid Medical Director (OMMD) Team Approach to Population Health

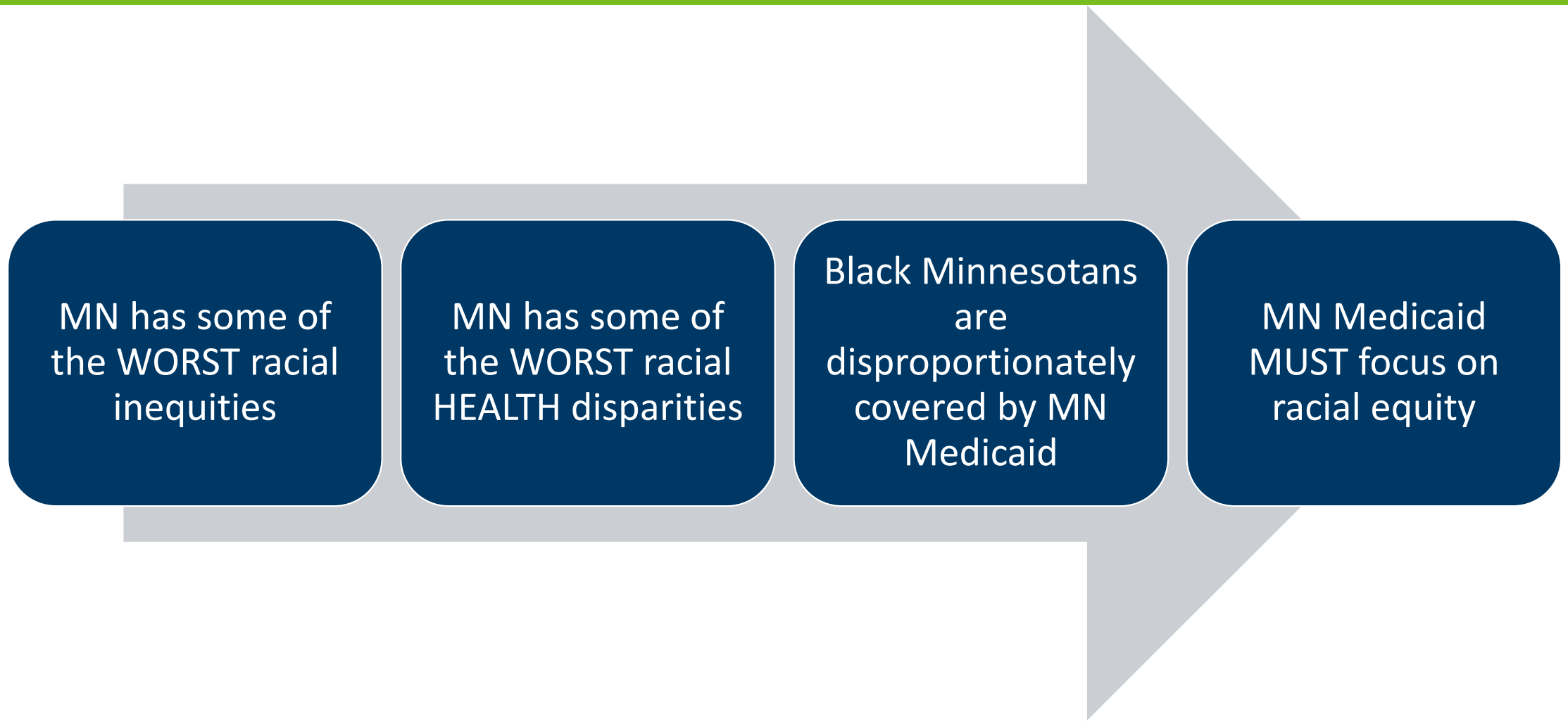


OMMD Approach to a Community-Centered Policy Cycle

Community Co-Creation



Minnesota Medicaid's Role in Addressing Structural Racism & Health Disparities



Honesty about how ready our systems are to co-create

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Focus of Report: Community Strength + Medicaid Levers

DEPARTMENT OF HUMAN SERVICES

Building Racial Equity into the Walls of Minnesota Medicaid

A focus on U.S.-born Black Minnesotans

February 2022

Community Conversation Participants

- Minnesota Health Care Program (Medicaid) enrollees
- Health Care Providers
- Community Based Organizations
- County Public Health and Human Service staff
- Managed Care Organization staff
- University of Minnesota School of Public Health and Medical School faculty
- Minnesota DHS and other State agency staff

- Co-create with community involvement, highlighting both community strengths & impact of structural racism

- Medicaid “Levers”
  - Eligibility/Enrollment
  - Access
  - Quality
  - Early Opportunities

2022 BREW Report's Calls to Action → Demonstrated Impact

2022 Building Racial Equity into the Walls (BREW) of MN Medicaid: a focus on US-born Black Minnesotans report Calls to Action

1. **Simplify and support enrollment and renewal**

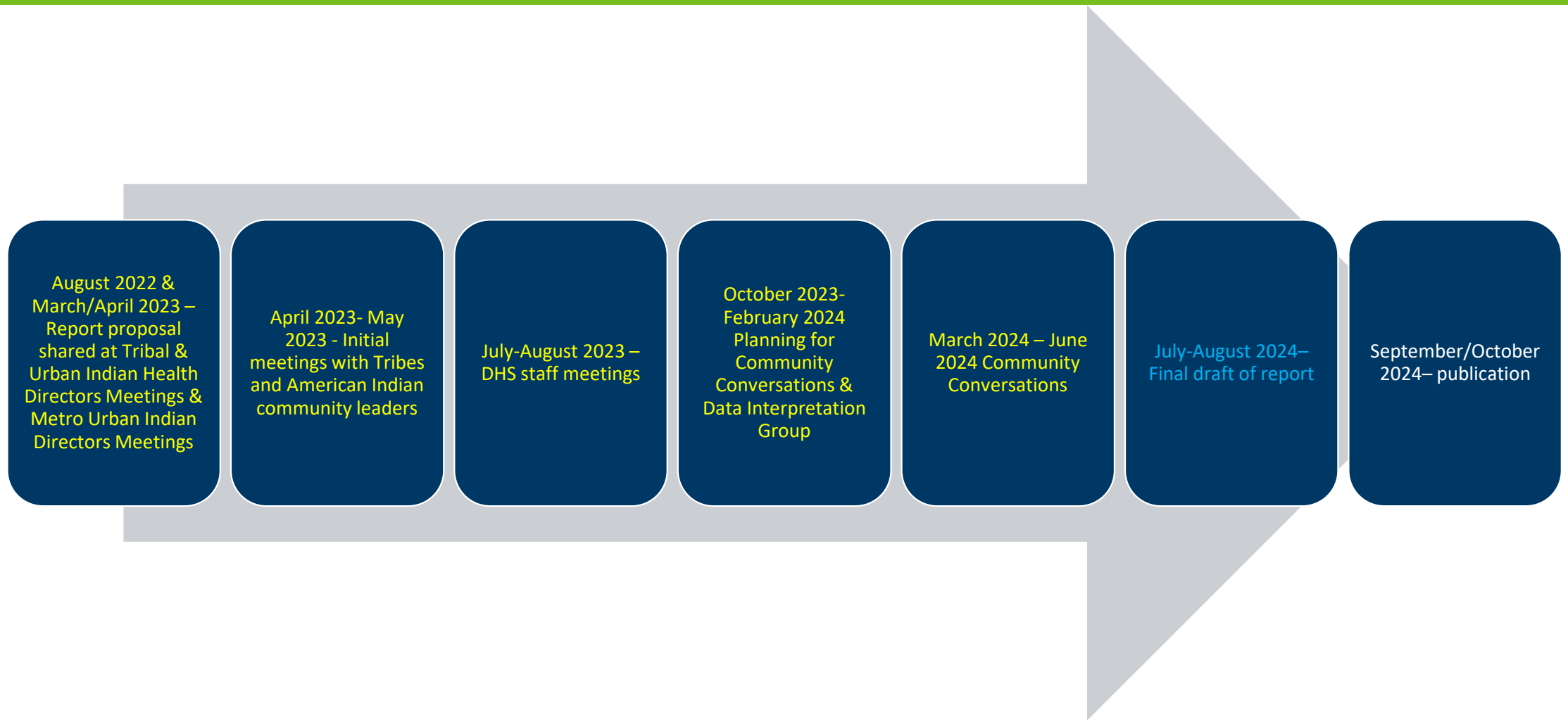
2. **Increase investment in culturally relevant care for U.S.-born Black Minnesotans on Medicaid**

3. Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Governor Tim Walz's budget for the 2023 legislative session included several proposals that aligned with the 2022 report's recommendations & were passed into law:

- **Starting in 2024 will have 12 months of continuous, stable Medicaid coverage for Minnesotans 0-19**
- **Starting in 2025 will have continuous Medicaid coverage for children 0-6 years of age**
- **Simplified enrollment and renewal processes in Medical Assistance and MinnesotaCare**
- **Increased support for community-based navigator organizations**
- **Improved payment and decreased barriers for doulas**

2024 Pathways to Racial Equity in Medicaid Report Current Timeline



Pathways to Racial Equity in Medicaid: Pushing our system towards authentic community co-creation

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- **Report Co-creators**
- **Data Guidance Panel**
- **Facilitated Community Conversations**

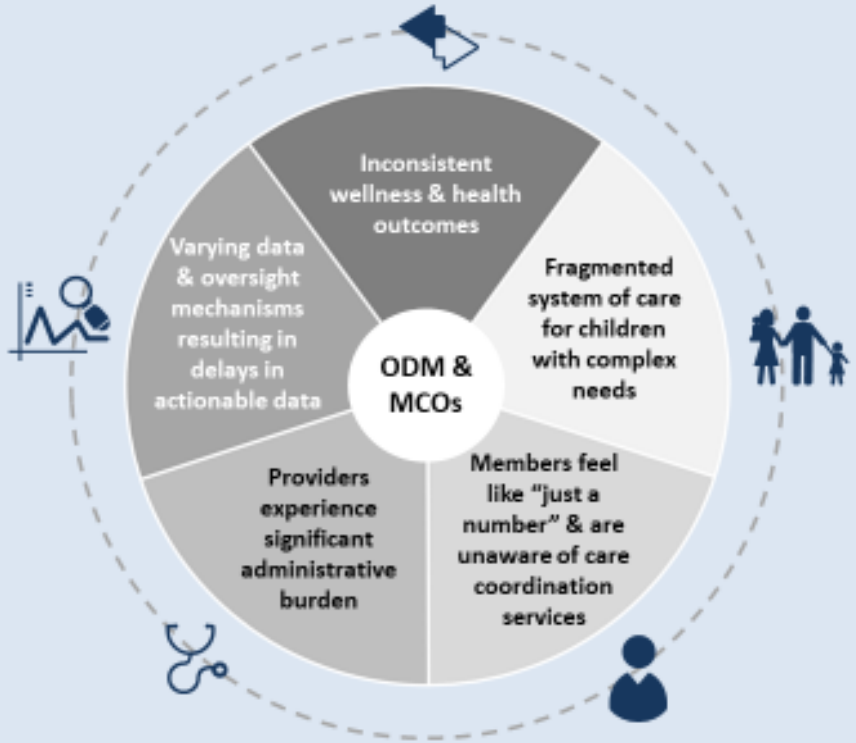
State Medicaid Transformation Case Study: Ohio

Ohio | Department of Medicaid

Ohio's Medicaid Managed Care Program

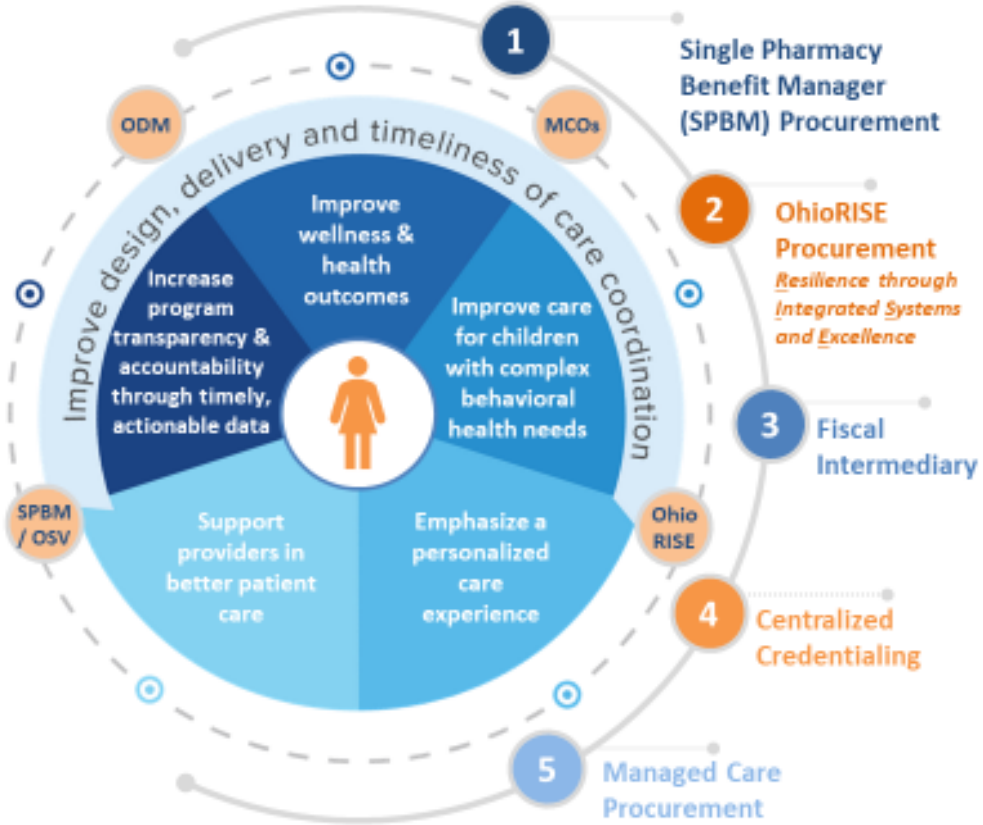
Today's Ohio Medicaid Managed Care Program

Members are impacted by business decisions that don't always take their needs or circumstances into consideration. Providers are not always treated as partners in patient care. We want to do better for the people we serve.

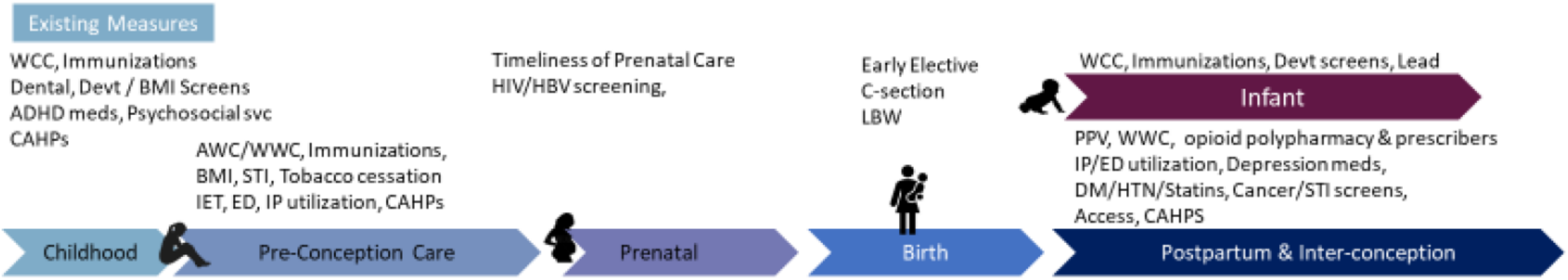


"Next Generation" of Managed Care in Ohio

The focus is on the individual with strong coordination and partnership among MCOs, vendors & ODM to support specialization in addressing critical needs.



Lifecourse view of measures and services for Mother with Opioid Use Disorder



Measures that may reflect individual experience of care and best evidenced care

Cultural competence
Provider adequacy
Stratified measures
CSHCN
ACE supports
%PCMH/CPCkids
School success

Overall health status
HRA incl Tob use
School absenteeism
Care Continuity/PCMH
Integration of BH
Including telehealth
Screen BH/stressors
Intentionality

Immediate NOP/ePRAF%
Risk stratification
Early/ holistic PNC
Care at high Q sites
IPV/OARRS screen
Continuity of care
OB/PCP integration
EBP including meds:
ANS,Prog,Naloxone,MAT,
Tobacco use

NTSV
unnecessary inductions
New Hosp indicators,
AIM, SMM measures
Safe sleep
Baby friendly status
Breastfeeding rates
CAHPSPE

Breastfeeding, %NAS; residential care
PPV: PMPI measures incl. depression screen
Contraceptive care, Interpregnancy Intervals
Routine PCP/BH care
MAT & BH retention
Community connectivity
Well, woman check, CA screens
Safe sleep supports

Services Designed for Continuum of Care

CPC kids, InCK
Support parents: HV,
Parenting, supports
Gov Initiatives
Q childcare/Early Educ
Complex Care network
SBHC; SDOH supports

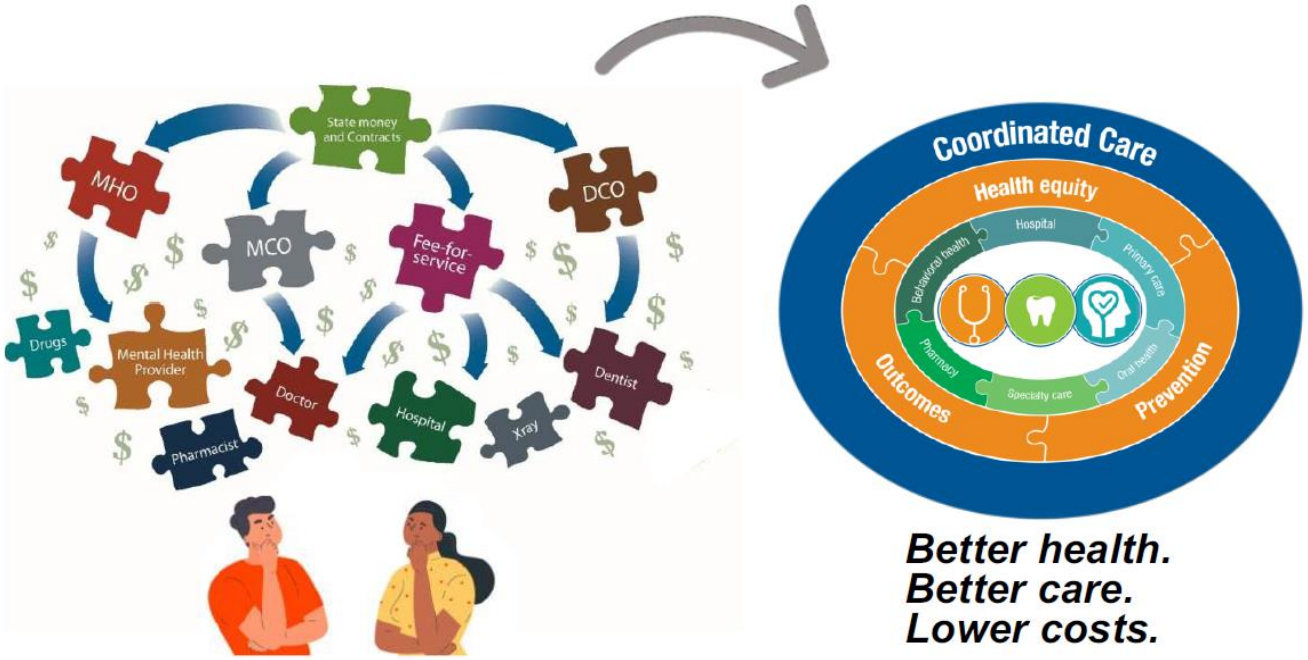
CPC; BH Integration
Women's svc at BH sites
Extracurricular school
supports

Group Care,
NFP & Home Visiting
Community & Peer supports
CMC; Dyad care; Hub & spoke
Welcome Home
Expanded workforce- lactation, doula,
midwives
Choice of sites of service

12 mo PP coverage
CPC w telemedicine
Intensive Care coordination
Peer & social supports
SDOH supports incl childcare, employment
Dyad care

State Medicaid Transformation Case Study: Oregon

Oregon's Coordinated Care Organizations



Better health.
Better care.
Lower costs.

The center builds capacity of health system partners to improve, innovate and eliminate health inequities.

We support:

- Population health
- Behavioral health integration
- Oral health integration
- Primary care
- Value-based payment
- CCO metrics
- Health-related services
- Social determinants of health and health equity

Multi-partner learning

The Transformation Center has held 389 multi-partner events across CCOs, community partners, tribes and clinics.

- Statewide CCO peer learning opportunities (such as the Innovation Café)
- Learning collaboratives
- Multi-CCO trainings, including webinars
- Community advisory council supports
- Innovation and project implementation leadership development

These events help spread CCO interventions to other CCOs and organizations.

By the numbers

(Data represents work during July 2013–May 2021)

592 supportive activities

15,400+ participants*

91% found support to be valuable**

97% said they would take action as a result of support**

**Number of participants for each episode counted separately*

***Data from evaluation respondents*

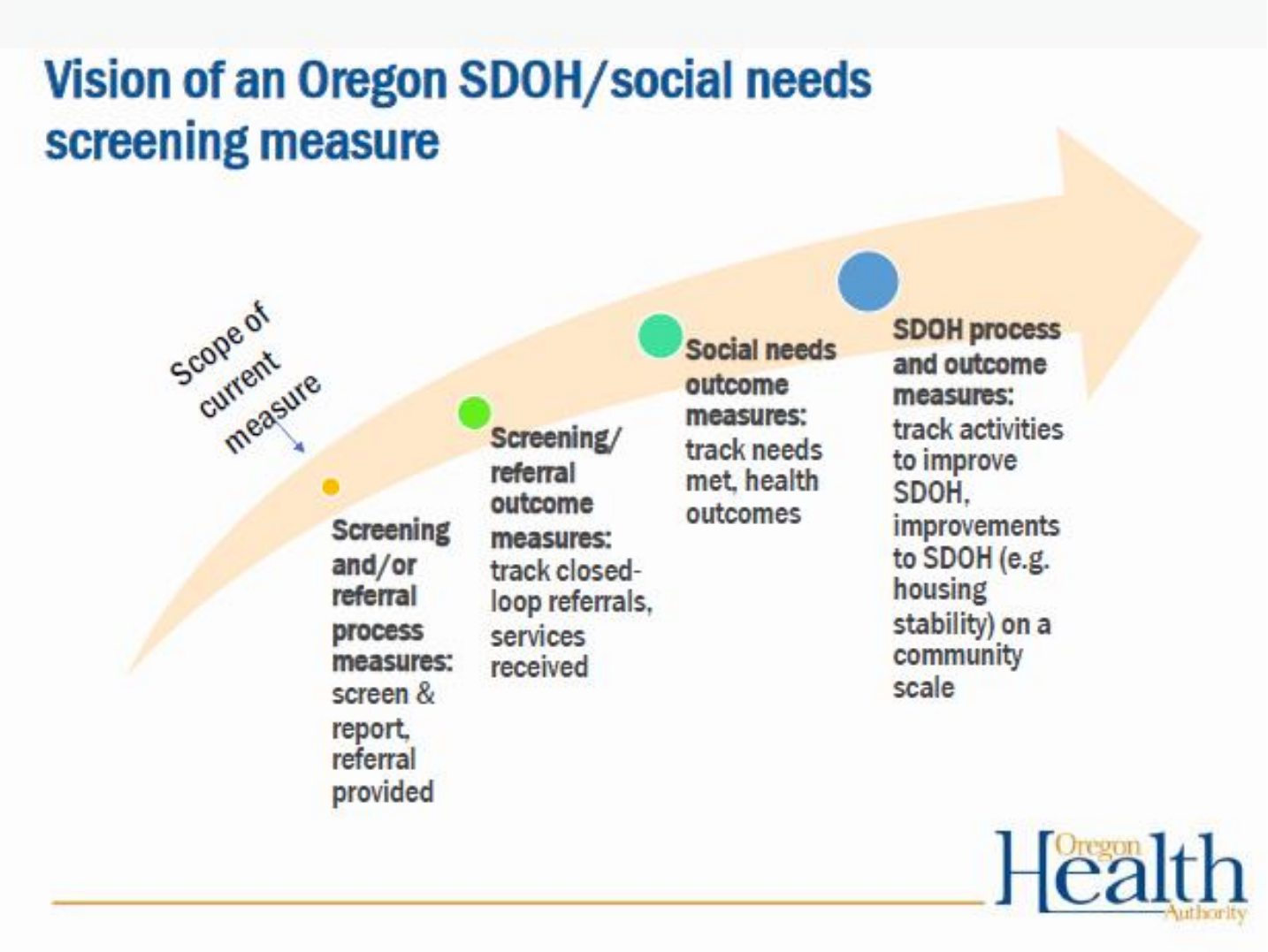
> *The Transformation Center provides a nice link for local community advisory council members to be heard at the state level... the support and encouragement are really valuable.*
>
> - CCO community health improvement coordinator

> *The inclusion and engagement of stakeholders was wonderful. The meeting duration, cadence and timeframe of several months was helpful to learn… and build momentum.*
>
> - Participant of meaningful language access learning collaborative

www.transformationcenter.org

State Medicaid Transformation Case Study: Oregon

- **Population Health Approach Successes/Lessons Learned**
- Robust technical assistance (TA) for CCOs
  - Convenings, learning collaboratives, 1:1 TA, guidance documents, webinars
- Increased alignment across SDOH-related requirements
- Innovative partnerships and projects involving the health care and social service system have expanded



Taking my DHS hat off from here on out

National Calls for Health Care System Transformation

- National Academies of Science, Engineering and Medicine (NASEM) reports
  - Ending Unequal Treatment Strategies to Achieve Equitable Health Care and Optimal Health for All (2024)
  - Emerging Stronger from COVID-19: Priorities for Health System Transformation (2023)
  - Transforming Health Care to Create Whole Health: Strategies to Assess, Scale, and Spread the Whole Person Approach to Health (2023)
  - Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care (2021)
  - Integrating Social Care into the Delivery of Health Care Moving Upstream to Improve the Nation's Health (2019)

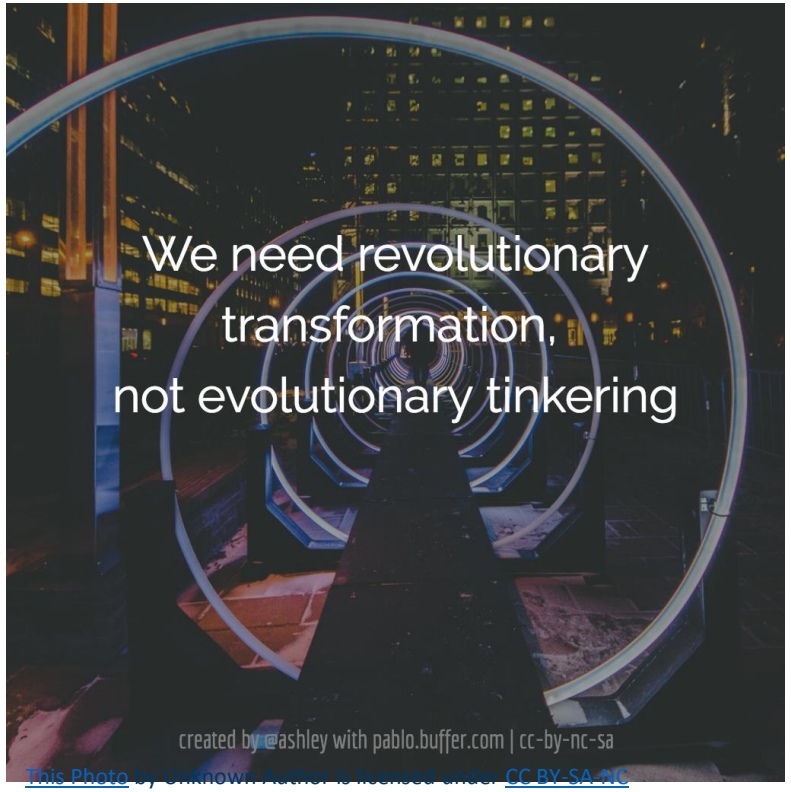
NATIONAL ACADEMIES Sciences Engineering Medicine

BOARD ON CHILDREN, YOUTH, AND FAMILIES

Committee on Improving the Health and Wellbeing of Children and Youth through Health Care System Transformation

Transformation Principles

- Employ a life course perspective
- Partner with communities
- Prioritize & drive equitable outcomes through resources & accountability
- Make it sustainable over time



NATIONAL ACADEMIES Sciences Engineering Medicine

BOARD ON CHILDREN, YOUTH, AND FAMILIES

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Dr. Chomilo's Select Strategies to Drive Transformation to a more Equitable Health Care System

- **Financing**
- **Models of Care & Quality**
- **Care Setting**
- **Governance**

Dr. Chomilo's Takeaways for Transformation to a more Equitable Health Care System

Financing

i. Repurpose existing financing sources?
   i. Tax Exclusions for Employer Sponsored Insurance
   ii. Provider & Premium Taxes & Fees
   iii. Hospital Community Benefit

ii. New funding?
   i. MCO Community Benefit → Massachusetts ex
   ii. De novo taxes or fees

2(C) Overview of Taxation for Minnesota Health Care

The chart below further explores each tax described in the preceding charts. It describes the remittance of each tax, or who is assessed, followed by the rate, total amount taxed in 2022, the destination of tax revenues, and finally the statutory authority governing the tax.

Type	Who Pays	Rate	Amount Paid in 2022[4]	Destination	Relevant Statute
Health Care Provider Tax	Hospitals and surgical centers; health care providers that furnish directly to a patient or consumer medical, surgical, optical, visual, dental, hearing, nursing services, drugs, laboratory, diagnostic or therapeutic services. Nursing homes and pharmacies are not included.	1.8% gross revenues on patient services	Providers: $266,416,000 Wholesale drug distributors: $167,500,000 Hospitals and Surgical Centers: $265,686,000	Health Care Access Fund	295.52 taxes imposed
HMO Premium Tax	Health maintenance organizations (HMOs) and nonprofit health service plan corporations.	1.0% on gross premium revenues	$122,708,000	Health Care Access Fund	297i.05 tax imposed
Insurance Premium Tax	Non-HMO Health Care Insurance Companies	2.0% on gross premium revenues	N/A*	State General Fund	297i.05 tax imposed
HMO Medicaid Surcharge	Health maintenance organizations and community integrated service networks.	0.6% of total premium revenues	$257,835,000**	State General Fund	9510.2020 medical care surcharge
MNSure Exchange Fee(withheld premiums)	Insurance companies indirectly: MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure	3.5% of total premiums	$22,240,000	Retained by MNSure	62v.05 responsibilities and powers of MNSure
Medical Assistance Hospital Surcharge	1.4 %of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.	1.56% of net patient revenues	N/A**	State General Fund	256.9657 provider surcharges

* Disaggregated collections from health insurance companies versus all insurance providers, including life, health, homeowners, and others is not available. Total 2% gross premiums taxes on all insurers were $624.050,000 in FY22.
**Similarly, disaggregated surcharge totals from HMOs, licensed nursing homes, hospitals, and intermediate care facilities are not available. The surcharge total was $257,835,000 in FY 22

[4] Source: 2022 MN Tax Handbook

Minnesota Center For Fiscal Excellence, & Miedaner, D. J. (2024). *HEALTH CARE TAXES IN MINNESOTA*. https://cdn.ymaws.com/fiscalexcellence.org/resource/resmgr/studies/2024_health_care_taxes_in_mi.pdf

Dr. Chomilo's Takeaways for Transformation to a more Equitable Health Care System

Models of Care & Quality

i. Team-based & Cross-sector Care
   i. Community Health Centers
   ii. Integrated Physical, Mental/Behavioral, Dental models
   iii. High Performing Medical Homes
   iv. Non-physician Care

ii. Alternative Payment
   i. Population Health outcomes
   ii. Prevention & Promotion
   iii. Patient Experience**
   iv. Eliminating Inequities**

	Country	Covered by national insurance?	Timing and number of covered visits	Typical provider
	Australia	Yes	Within week 1, typically one to three visits	Midwife
	Canada	Yes	Varies by province; typically contacted or visited within 24 to 72 hours and 1 week after going home	Typically a public health nurse or midwife
	Chile	Yes	Within first 10 days ideally between 48–72 hours after being released from the hospital, ongoing home visits thereafter	Midwife and nurse
	France	Yes	Starting within 24 hours after discharge, up to 12 days; after that, mothers incur 70% of the cost of postpartum services	Midwife
	Germany	Yes	Up to 36 postnatal home visits and phone calls up to 12 weeks after birth	Midwife
	Japan	Yes	Home visits within 28 days and up to 4 months	Midwife, public health nurse, nurses, authorized personnel
	Korea	Yes	Home visits up to 2 years of age for vulnerable families	Nurse
	Netherlands	Yes	Home visits soon after birth with a general recommendation of 49 hours of postpartum care over 8–10 days	Maternity nurse
	New Zealand	Yes	At least 5 visits over 4 to 6 weeks, starting within 24 hours postpartum	Midwife
	Norway	Yes	At least 3 visits starting at 24 hours to 3 days (for low-risk multiparous women) after going home	Midwife, public health nurse
	Sweden	Yes	First visit during the first 1 to 2 weeks; visits thereafter every 1 to 2 weeks until week 8	Midwife, nurse
	Switzerland	Yes	Up to 16 home visits from community midwives during the first 56 postnatal days for a first child/complex situation, and up to 10 visits for the second child and beyond	Midwife, family nurse
	United Kingdom	Yes	Visits until around 10 days postpartum	Midwife
	United States	Covered by some state Medicaid programs and certain health plans	Varies by state Medicaid program and by individual insurer	Nurse, physician, community health worker, doula, home health worker

Insights into the U.S. Maternal Mortality Crisis: An International Comparison. (2024). *www.commonwealthfund.org*. https://doi.org/10.26099/cthn-st75

Dr. Chomilo's Takeaways for Transformation to a more Equitable Health Care System

Care Setting

i. Go where disadvantaged patients, families & communities are
   i. Schools
   ii. Mobile Clinics
   iii. Local Public Health
   iv. Community Based Organizations

Dr. Chomilo's Takeaways for Transformation to a more Equitable Health Care System

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Governance

i. Require Co-creation & Co-Design with Disadvantaged Communities
   i. Existing Models = Community Health Centers/FQHCs
   ii. Levers to explore
      i. Requirement for Non-Profit status
      ii. Requirement for all providers or providers of a certain size who receive MA/MNCare payments
      iii. Increased payment for providers that demonstrate community co-governance

Potential Asks of State to Aid in Transformation to a more Equitable Health Care System in MN

- **State Medicaid Levers**
  - Better Integration → Whole Person Health
  - Prioritize & Invest in Equity-focused, Community-centered Population Health
  - Continued Innovation in Payment → *Make the Equitable decision the Easy decision*
- **Health Care System Levers**
  - Repurpose or add equity & transformation focused financing levers
    - Community Benefit accountability
  - Support expansion of Community Health Centers
    - Integrated care, community governance
  - Meet disadvantaged communities where they are at
    - Ex. School-based health services
  - Decentralize physicians where evidence supports it

Discussion

Discussion

- What did you hear that is new or surprising?
- How does the information you heard intersect with the issues raised by your workgroup?
- What can you add to what you've heard that is a promising or successful practice?
- What stands in the way of generalizing these successes?
- What incentives and levers will make the health care system implement these solutions?

Daniel Tanase

Meeting Close

Closing and action items

- Project team will:
  - Summarize today's meeting
  - Provide meeting slides to the task force
  - Continue work on the approach to and framework for recommendations
  - Prepare for workgroup and task force meetings in September
- Workgroups will:
  - Reflect on today's learnings and implications for task force recommendations
  - Prepare for September workgroup and task force meetings
- Next meeting is September 23, 1:00 – 4:00 p.m., virtual
  - Learning: To be announced
  - Workgroup share-out and engagement
  - MDH updates on supports from the University of Minnesota and recommendations framework

Thank You!

See you September 23, 2024!