DEPARTMENT OF HEALTH

DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

- August 21, 2024, 12:00-3:00 p.m.
- Place: UROC, 2001 Plymouth Ave. N., Minneapolis, MN 55411
- Meeting format: Hybrid; in-person and WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, ElijahJuan (Eli) Dotts, Elizete Diaz, Mary Engels, Joy Marsh, Mumtaz (Taj) Mustapha, Miamon Queeglay, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- The task force reviewed and discussed the draft framework for recommendations, and agreed it will help them work from problem identification into learning and solution exploration.
- The task force learned about innovative solutions in health care delivery system navigation at MDH, pathways to equity at the Department of Human Services from Dr. Nathan Chomilo, and emerging learnings from national-level health care systems transformation work that Dr. Chomilo is involved. These learnings supported deeper discussions about solutions among the task force.
- The task force's feedback regarding the task force process and progress informed how DeYoung and MDH will provide support in the next phase of the work.

Key actions moving forward

- MDH will continue to refine the approach to and framework for recommendations.
- Task force members will reflect on today's learnings and implications for recommendations.
- Given feedback from task force members and the Commissioner about process and procedure, DeYoung and MDH will work collaboratively with the task force to support engagement and relationship-building activities and experiences.

Summary of meeting content and discussion highlights

Meeting objectives

The following objectives were shared:

- Receive an update from MDH about how the task force is moving from problem identification into learning and solution exploration
- Learn about solutions, challenges, and opportunities in health care delivery system navigation from two programs at MDH
- Invite feedback from the task force regarding process and progress to inform how DeYoung and MDH supports the task force and this work into the next phase
- Learn about pathways to equity at the Department of Human Services from Dr. Nathan Chomilo, including insights from his involvement in national-level health care systems transformation work

Welcome and grounding

Task force members were welcomed, and the agenda and meeting summary from June were reviewed.

Public comments

MDH received a comment regarding the rebranding and regulation of acupuncture and Chinese medicine, highlighting concerns about the distinction between acupuncture and dry needling practices. Task force members discussed the importance of licensing and integrating non-traditional and cultural practices like acupuncture into Minnesota's health care system, including coverage by insurance and inclusion in primary care settings. The task force observed that it is not within their scope to regulate acupuncture and Chinese medicine.

Road to recommendations

The MDH project team has been reviewing the task force's work on health care equity problems, focusing on emerging solutions while considering the Commissioner's interests, priorities, and opportunities. MDH provided an update on a synthesis of health equity topics and problem statements, and the emerging framework for recommendations. MDH described the approach as iterative, with ongoing learning, building, and adjustment throughout the learning and solutioning phase. The strategy is to define problems, establish a vision, identify solutions that would close the gap between the problems and vision, and outline near-, mid-, and long-term recommendations. Task force meetings will feature learning opportunities and engagements with others addressing equity issues, with dedicated time for interactions within and across workgroups. Workgroups will follow their workplans to learn synchronously and asynchronously, including engaging with others and exploring innovations. There may be additional short virtual learning sessions on cross-cutting topics. MDH is collaborating with the

State Health Access Data Assistance Center (SHADAC) and the University of Minnesota's Division of Health Policy and Management (HPM) to provide technical assistance, including an environmental scan and additional supports, with formal engagement expected in the fall. In September, workgroups will be visited by sections of MDH's Health Care Policy Division to explore problem areas and solutions, with a virtual task force meeting scheduled in September for workgroups to share-out what they've learned in their September meetings, discuss preferred emerging solutions, and engage in discussions.

Additionally, MDH provided an update on the framework for recommendations and highlighted levers for solutions including policies, regulation, and oversight, financing and reimbursement, practices and training, and health information technology and data exchange. MDH will revise the framework as needed based on task force member input in future meetings. Task force members stated that they appreciated the framework and found it helpful for advancing the task force's work.

Learning and engagement: Health care delivery system navigation

MDH staff members, David Kurtzon, the Director of Health Care Homes (HCH), and Kristen Godfrey Walters, the Director of the Community Health Worker Training Program at MDH, presented information about their respective programs that was responsive to health care equity problems highlighted by the task force. They discussed innovated solutions, challenges, barriers, and opportunities for the task force to consider in the recommendations in these areas.

David Kurtzon provided an overview of the Health Care Homes (HCH) model, emphasizing that this is a care delivery approach centered on primary care clinics. HCH aims to improve patient outcomes, experience, value of care, and health equity through coordinated care involving patients, families, providers, and community partners.

Key points included:

- **HCH model:** HCH is focused on patient-centered primary care, with care navigation as the central element. It fosters collaboration among care teams and aims to reduce barriers in care coordination.
- **Certification levels:** HCH certifies clinics meeting standards in care access, communication, care planning, and quality improvement. New certification levels emphasize community partnerships and addressing social determinants of health.
- **Challenges:** Financial sustainability remains an issue, as reimbursement rates, particularly from Medicaid, have not kept pace, creating a challenging environment for implementing and sustaining HCH models.

Kristen Godfrey Walters discussed the role of Community Health Workers (CHWs) in advancing health equity and improving health care delivery in Minnesota. CHWs are frontline health professionals who bridge the gap between health care services and communities, addressing clinical and nonclinical needs at various levels.

Key points included:

- **Role and impact of CHWs:** CHWs serve as navigators, educators, and advocates, using their community connections and lived experiences to address social determinants of health and improve patient outcomes. They play a vital role in achieving health equity by tailoring interventions and enhancing communication.
- **Models and training:** Minnesota supports various CHW models, including Behavioral Health Homes, patient-centered medical homes, and transition clinics. Minnesota was the first state to implement an academic certificate program and is developing apprenticeship and training programs to enhance CHW skills.
- **Infrastructure and funding:** There is a robust infrastructure for CHWs, including professional organizations, state funding, and legislative support for Medicaid billing. However, challenges remain, such as reimbursement barriers, sustainability of CHW roles, and alignment of service scopes with funding.
- **Opportunities and challenges:** Opportunities include addressing billing barriers, expanding Medicaid coverage through state waivers, and aligning Medicare and Medicaid policies. Persistent challenges include inadequate funding, limited CHW job opportunities at living wages, and low uptake of apprenticeship programs.
- **Future directions:** There is potential to enhance CHW integration into health care settings, improve funding models, and expand CHW programs to better meet the needs of underserved communities in Minnesota.

The discussion following the presentations centered on the challenges and opportunities associated with integrating CHWs into health care settings, addressing funding barriers, and enhancing care coordination efforts.

Task force members raised questions about the financial sustainability of CHW programs, particularly regarding how health care organizations in Minnesota have navigated these challenges. Representatives noted that while grants provide some support, such as scholarships for CHW training and registered apprenticeship programs, these funds do not cover the full costs for employers, especially regarding on-the-job training and sustained employment. There was a suggestion for MDH to consider employing CHWs directly, allowing health care organizations to refer patients to them, rather than each organization managing its own CHW workforce—a model seen in other states.

The discussion also highlighted concerns about CHW roles being overstretched, which limits their capacity to carry larger patient caseloads. Task force members suggested exploring reimbursement models that extend beyond CHWs to include other roles, such as health equity coordinators or individuals familiar with local resources, who can also support patients with nonclinical needs like food or housing. This approach could help offload some of the work from CHWs and expand their capacity to engage more effectively with patients.

Financing challenges were a recurring theme. It was noted that care coordination roles in primary care are difficult to fund under current models, particularly fee-for-service structures that do not adequately support the holistic nature of care coordination. There was consensus that primary care, especially in Minnesota, is underfunded and that new payment models are

needed to ensure that funding for these roles is directly tied to demonstrable improvements in patient care and outcomes.

The conversation also touched on the regulatory hurdles in hiring CHWs, including rigid background check requirements, which were noted as being more restrictive in Minnesota compared to other states. These barriers impact the ability of organizations to hire and sustain a diverse CHW workforce.

Overall, the discussion underscored the need for payment reform and innovative funding approaches, including the exploration of alternative payment models and expanded billing opportunities. There was agreement on the importance of integrating CHWs and other care coordination roles into health care delivery systems to increase access to care for underserved communities and address health disparities more effectively.

Commissioner welcome

Commissioner Cunningham encouraged task force members to continue their work, urging them to reflect on their experiences and think boldly about systemic change. She highlighted the need for innovative strategies, such as integrating CHWs beyond clinic settings, like neighborhood hubs funded by multiple health systems. She emphasized overcoming structural barriers and reimagining how Community Benefit can include activities like small business development, youth mentoring, and housing rehabilitation. She stressed the importance of the task force membership building relationships and networking with each other, including in-person, to be community organizers, the “people power,” and sustain the work beyond the end term of the task force.

Task force experience

Task force members were asked to discuss their experience in the task force thus far and what they would like to experience in the next phase. Members provided verbal and written feedback.

- Task force members discussed feeling hesitant at times about being bold in doing this work, but also feeling reassured by the Commissioner’s statements and other task force members in the direction of the work.
- Members talked about gathering more information about solutions and about planning group social activities to build a sense of community among task force members (e.g., picnic).
- Members talked about how the work of the task force can feel overwhelming at times. Approaching the work by keeping quick wins and shorter term goals in mind may help to manage the work.

Learning and engagement: Dr. Nathan Chomilo, Medicaid Medical Director, Department of Human Services (DHS)

Dr. Chomilo discussed the Minnesota Department of Human Service's (DHS) efforts to build pathways to equity through Medicaid and his work with the National Academies to drive transformation toward a more equitable health care system. His presentation focused on Medicaid reforms and health care system transformation, emphasizing the need for integrated, community-centered approaches. Key themes included repurposing existing funding sources and exploring new financing models, such as taxes and community benefits, to support equitable care. He highlighted the importance of team-based, cross-sector care models that integrate physical, mental, dental, and non-physician care in settings that reach underserved populations, such as schools, mobile clinics, and community health centers.

The discussion underscored the need for co-creation and governance with disadvantaged communities, emphasizing policies that require community input and collaboration in health care delivery. Dr. Chomilo outlined potential state and health care system levers such as Medicaid innovations, equitable payment models, and expanding community health centers. He stressed the importance of aligning financial incentives to support care for marginalized groups and making equitable decisions easier.

Task force members engaged actively, raising questions about adopting successful models like Oregon's Coordinated Care Organizations (CCO) in Minnesota, particularly for populations such as those experiencing incarceration. Members also highlighted the fragmentation between medical and dental care and the challenges of low reimbursement rates that limit access for Medicaid patients. They inquired about how to incentivize providers to improve access and expand roles like dental therapists. Dr. Chomilo responded by emphasizing a multi-dimensional approach to payment reform and the need for innovative care models that integrate services rather than simply mandating integration.

The conversation also touched on health equity reporting, with California's Advancing and Innovating Medi-Cal (CAL AIM) initiative cited as a leading example. Dr. Chomilo shared reflections from his work on national committees, highlighting the importance of collective, yet flexible, efforts towards health equity, akin to birds flocking together but maintaining individual space. Overall, the presentation and discussion underscored the complexities of health care transformation, the need for iterative learning, and the importance of legislative and community collaboration to drive systemic change towards health equity.

Closing and action items

The task force was thanked and reminded of the next meeting on September 23, 1:00 – 4:00 p.m., virtual. A post-meeting survey and meeting summary are to follow.

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.

Minnesota Department of Health
Health Policy Division
625 Robert St. N.
PO Box 64975
St. Paul, MN 55164-0975
651-201-4520
health.equitablehealthcare@state.mn.us
www.health.state.mn.us/communities/equitablehc/index.html

09/18/24

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

Stratis Health Handout

September 13, 2024

Stratis Health*, a local health care equity, quality, and patient safety improvement organization, provided the resources below (about 1-page each in length) to give the Equitable Health Care Task Force a sense of the range and nature of their health equity improvement efforts in Minnesota, in advance of the September 23 meeting.*

- Facilitating efforts for cross-sector co-design of a shared approach to social needs resources referrals in Minnesota:
    - Co-creating a Social Needs Common Referral Approach in Minnesota - Stratis Health
    - Social Needs Resource Referrals Minnesota Health Equity Issues Position Paper (stratishealth.org)
- Improving health care for tribal communities served by Minnesota's two Indian Health Services (IHS) hospitals, as part of Stratis Health's larger national program supporting all of the IHS-managed hospitals in the country:
    - Partnership to Advance Tribal Health - Stratis Health
- Providing tools, training, and technical assistance to Minnesota's rural health care organizations to enable them to embed health equity into their organizations and the care they deliver:
    - Stratis Health Critical Access Hospital Health Equity Learning Collaborative, for the MDH Rural Flex Program (see attached)
- Closing the disparities in care and access for those with opioid use disorder:
    - Midwest Tribal ECHO - Stratis Health in partnership with Native American Community Clinic in Minneapolis
    - MOUD Treatment in JAILS - Stratis Health now in its second cohort of county jails in Minnesota
- Building capacity of clinical and non-clinical health care professionals in Minnesota to reduce health disparities and promote health equity by recognizing and addressing biases, providing culturally responsive care, exploring and using data resources to drive action, and understanding how social determinants of health affect individuals and communities:
    - Culture Care Connection - Stratis Health focused on Minnesota's largest and fastest growing cultural communities

Learn more about Stratis Health at stratishealth.org.

StratisHealth

Stratis Health and Minnesota Flex Program for Critical Access Hospitals

The Medicare Beneficiary Quality Improvement (MBQIP) Program

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Federal Office of Rural Health Policy's (FORHP) Medicare Rural Hospital Flexibility (Flex) grant program. The Flex Program is implemented in Minnesota by the MDH ORHPC. MBQIP aims to improve the quality of care provided in critical access hospitals by increasing quality data reporting among CAHs and driving quality improvement activities based on the data.

Stratis Health has worked in partnership with the Minnesota Department of Health (MDH) Office of Rural Health and Primary Care (ORHPC) for over 15 years to support Minnesota's rural critical access hospitals (CAHs) to ensure access to high-quality health care that is aligned with community needs by providing training and technical assistance to build capacity and promote sustainable improvement in the rural health care system. Activities include:

- Providing technical assistance for inpatient, outpatient, and emergency services through root cause analysis, coaching, and networking.
- Improving quality data reporting through medical record abstraction training and feedback.
- Offering opportunities for CAHs to learn and share about best practices for MBQIP core measures data reporting and measure score improvement.
- Facilitating Social Drivers of Health (SDOH) Learning Action Network for a cohort of CAHs to develop and implement a strategy to address SDOH and prepare to report the new MBQIP SDOH-1 an SDOH-2 measures.
- Expanding population health capacity through assessment, analysis, and structured improvement initiatives.

For more information about the activities, reporting and improvement tools and resources, visit the Stratis Health Minnesota CAH Flex webpage.

MBQIP Core Measures Results to Date

- Improving reporting for core MBQIP measures: The goal is a 100% data reporting rate. As of the last quarterly MBQIP report:
    - 92% (71 out of 77 CAHs) have reported data on ED throughput measure: Median Time from ED Arrival to ED Departure for Discharged ED Patients.
    - All 77 CAHs report Emergency Department Transfer Communication (EDTC) measure.
- Focused effort to improving EDTC Transfer Communication (EDTC) composite measure scores: The goal is to help MN CAHs under 80% raise their EDTC composite measure score to >=80%. As of Q1 2024, the overall MN EDTC composite score has significantly increased from 83% in Q4 2021 when QI activities started to 87% in Q1 2024.
- For lessons learned and best practices, visit the Stratis Health Minnesota CAH Flex webpage.

Population Health and Health Equity Collaborative

The Understanding and Improving Health Equity in Minnesota's Rural Communities collaborative was a 15-month series that began in November 2022 through January 2024. A cohort of 15 CAHs worked on advancing their organizational capacity to address health equity focused on leadership and strategy, staff engagement, data, and quality and safety systems and processes. At the end of collaborative, those still participating completed an assessment to measure improvement in their organizational capacity to address health equity. Overall, there was a

33% increase across all activities: 35% (Leadership and strategy), 30% (Staff engagement), 25% (Data) and 39% (Quality and Safety improvement). Overall, the remaining participants showed improvement in confidence to define and identify health equity and disparities in their community, health equity and disparities being addressed in their facility, collect and use health equity data, resources, and tools, and understand of how to implement new regulations and requirements related to health equity.

Questions: please contact your Stratis Health Flex QI Team

- Senka Hadzic, Program Manager, shadzic@stratishealth.org
- Karla Weng, Senior Lead, kweng@stratishealth.org
- Jodi Winters, Executive Assistant, jwinters@stratishealth.org

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DEPARTMENT OF HEALTH

Equitable Health Care Task Force Opportunity Matrix for Developing Recommendations

Working document, Fall 2024

Overview

This matrix is designed to help the task force refine objectives and identify opportunities that will shape the recommendations. This matrix will help task force members see overlaps and intertwined opportunities, and to help understand what level of system change may be needed to implement the resulting recommendations. This is a working document that task force members and MDH staff can use to engage subject matter experts, gather information, and further synthesize our work into recommendations.

Note that this iterative and some recommendations will form more quickly than others. We may not be able to form recommendations to address all objectives. Some things are out of our control, and some things may be out of scope for addressing our work. To help think through these opportunities, it may be helpful to consider opportunities for local action local versus national initiatives, as well as near-, mid-, and long-term recommendations.

Matrix table

The working table (matrix) below is intended to help task force members state and validate objectives that address the previously-identified problem statements (as synthesized by MDH staff and task force members). Task force members are invited to edit and comment to help validate and refine things. Some notes:

- Each row has an objective that needs to be validated by task force members. Add comments and edits as you see fit.
    - Note that the Workforce objectives and opportunities are taken directly from that workgroup's plan.
- Topics are intended to help group objectives. These topics can also be modified (and will likely morph over time).
- For each objective, describe potential opportunities that to achieve that objective.
    - Opportunities should be active statements and specific.
    - Opportunities may be relevant for more than one objective – go ahead and repeat them.
- Rows are numbered as a reference tool and do not reflect priority or importance.

Each opportunity (and resulting recommendations) should address the "tools" available to solve the problem. Examples include:

- Financing and reimbursement
- Policies, oversight, and regulation
- Evidence-based practice, training
- Technology, health information exchange, and data

	Topics	Objectives	Opportunities	*Notes/comments*	*Interested task force members*
1	Patient experience	Patients understand how to access insurance and care, and understand billing.	Reimburse patient navigators to help patients understand coverage, billing, out of pocket costs, etc. Navigators and customer service reps are trained (or have lived experience) to be culturally competent; available in needed language(s). Establish statewide health literacy and digital literacy education.		
2	Patient experience	Address financial barriers to health care access, including the cost of insurance, medications, and preventive services.	Policies to reduce/eliminate out-of-pocket expenses for premiums, care, medications, transportation. Medical debt relief for individuals/families.	For medications, are any of these activities promising/worth exploring: New MN Initiatives About Rx Affordability, Summer 2023 (state.mn.us)	
3	Patient experience	Patients are able to schedule appointments nearby and in a timely manner.	Hold health systems and health plans accountable for network adequacy, ensuring public-facing information is up to date and correct.		
4	Patient experience	Patients are able to get to and from appointments.	Reimburse transportation and coordination of transportation services.	How does this shake out in rural vs urban areas? 8/21 suggestions from Dr. Nathan Chomilo: • Meet disadvantaged communities where they are at (e.g., school-based health services)	
5	Patient experience	Patients have culturally-inclusive care experience. Patients do not experience language barriers.	Translation services need standardization (e.g., licensing) to ensure communication is accurate. Require cultural competency training by providers. Hire more BIPOC providers Make cultural competency info available to patients (e.g., provider profile info) Establish statewide policy for hospitals to buy into a system of independent contractors for access to interpreter services. Build on communication service for the Deaf, Inc. (CSD) of Minnesota Consortium: https://accesspress.org/consortium-of-minnesota-hospitals-enters-agreement/	What happens when a family member translates during the encounter?	
6	Patient experience	Patients understand after-care instructions and any necessary follow-up.	Ensure that after-visit summaries are plain language, translated as needed, and include what the patient should do next. Reimburse follow-up care coordination.		

	Topics	Objectives	Opportunities	*Notes/comments*	*Interested task force members*
7	Care integration	Patients experience continuity of care across dimensions of prevention, sick care, chronic disease management, long-term care, complex conditions, and life (life course?) transitions.	Improve reimbursement for preventive and primary health care (align with specialty care RVUs). Implement hybrid payment models that support primary care. Reimbursement that incentivizes wellness. Use emerging professions, CHWs, Doulas, other care managers and coordinators. Develop and fund wrap-around services at the clinic. Improve communication and collaboration between specialists and primary care. Support Health Care Home's (HCH) program to improve communication between patient's care managers and coordinators. Support care (e.g., obstetrics) where that care is considered a cost center vs revenue center to reduce incentive to drop nonprofitable care. Modernize the MN Health Records Act to provide clarity and alignment with electronic workflows. Integrate traditional and non-traditional/complementary care. Develop best practices around the use of z-codes to document and act on non-disease factors impacting patient health and outcomes. Incentivize health providers and the state to participate with TEFCA (national health information exchange).		
8	Care integration	People of all backgrounds have access to culturally-sensitive mental health, behavioral health, and or SUD treatment.	Increase number of BIPOC MH/BH/SU providers through education support and incentives Improve capacity for inpatient mental health care by… Implement cultural competency training in health systems. Continue funding the MDH program that supports BIPOC mental health supervisors	This is partly care integration and partly workforce 8/21 suggestion from Dr. Nathan Chomilo: • Better integration in Medicaid—whole person health	
9	Care integration	Reduce inequities in maternal, infant, & child health outcomes	Support the recommendations developed by the Maternal and Child Health Task Force. Task Force members should review the recommendations and consider which of those will address equity the most.	Maternal/CH TF rpt Recommendations start on page 10.	
10	Care integration	Reduce inequities in oral health access and outcomes, and integrate oral care with physical care.	Improve Medicaid reimbursement to encourage more dentists to participate and increase access. Require more appointment availability among dental service providers. Address workforce shortages; rural access (e.g., dental therapists) Provide training and education that cultivates better attitudes towards patients with Medicaid	MN State Oral Health Plan, 2020-2030 Plan has 5 focus areas and strategy actions for each. Will meet with MDH team in fall 2024 8/21 suggestion from Dr. Nathan Chomilo:	

	Topics	Objectives	Opportunities	*Notes/comments*	*Interested task force members*
				• Support expansion of community health centers for integrated care and community governance	
11	Care integration	Health care and public health/social services are coordinated and integrated	Promote local collaboration between primary care and public health. Enable electronic closed-loop referrals between primary care and local supports and services. Support strategies underway with Stratis Health: - Design, implementation, and maintenance of shared directory of social needs resources - Develop standards and tools for health care, community organization, and payer engagement which include operational and financial agreements and options for payment - Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care and community organizations - Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care and payers - Secure financing for comprehensive care/needs (i.e., providing housing, etc.) - Support ability for social services/community orgs to collect and add data to patient's records; establish a single aggregated patient record via one portal.	Support Stratis Health's Co-creating a Social Needs Common Referral Approach in Minnesota Social Needs Resource Referrals: Minnesota Health Equity Issues. Policy Position Paper. Stratis Health.	
12	Workforce	Foster workplace inclusion and belonging	Recommend best practices to enhance the sense of safety, trust and belonging among employees, such as employee resource groups, regular assessments or surveys to measure the employee experience with corresponding action based on this feedback, and a culture of accountability for improved outcomes. Recommend leveraging employees and employee resource group members from underrepresented groups in the cocreation of workforce equity strategies designed to meet their needs. Recommend strategies to drive leadership accountability for workforce equity outcomes. Re-up funding for Office of Rural Health and Primary Care (ORHPC) workplace wellbeing program.		Workforce WG: Sara, Mary, Joy, Maria, Vayong
13	Workforce	Enhance workforce skills and cultural responsiveness	Recommend best practices focused on suggested requirements for comprehensive training programs for employees and providers to develop essential soft skills, including cultural responsiveness, mitigation of unconscious bias, effective communication, empathy, and teamwork.		Workforce WG: Sara, Mary, Joy, Maria, Vayong

	Topics	Objectives	Opportunities	*Notes/comments*	*Interested task force members*
			Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally congruent care. Recommend mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care. Outline solutions to address the narrowness of specialization, such as cross-training opportunities, mentorship programs, and professional development resources. Recommend workforce equity core competencies for employees and leaders. Recommend workforce equity strategies that are informed by the communities being locally served. Expand/replicate programs similar to rural training opportunities/residency programs		
14	Workforce	Address role inequities	Recommend possible solutions to address role inequities, including a pay structure analysis and evaluation of the value, impact and advocacy of care coordinator/community health workers and other similar roles. Outline a framework, model or resource to help organizations begin to collaborate with key stakeholders to examine and address any systemic biases or barriers that contribute to role inequities.	8/21 suggestion from Dr. Nathan Chomilo: • Decentralize physicians where evidence supports it	Workforce WG: Sara, Mary, Joy, Maria, Vayong
15	Workforce	Overcome workforce pipeline barriers	Recommend strategies to incorporate into hiring processes to support the hiring of underrepresented candidates and to attract and recruit a workforce that reflects the communities we serve, including strategies to support international candidates. Recommend best practices for collaborating with educational institutions and community organizations to remove barriers to entering the healthcare workforce. Recommend strategies to partner with educational and credentialing institutions to reduce representation gaps that hinder culturally concordant care for historically underrepresented groups in health care positions. Programs in K-12 that tie STEM classes to future health profession careers/introduce health professions careers. Create culture of precepting at systems like Essentia, M Health Fairview. Clarify career trajectory for professionals holding multiple credentials and/or create "universal credential". Degree programs use loan forgiveness as a recruitment tool.	Integrate MDH program info (Office of Rural Health and Primary Care) UMN rural Physician Associate Program IMG dedicated residency Conrad-30/J-1 visa waiver program Medical Education and Research Costs (MERC) Grants for BIPOC mental health provider in becoming supervisors Health care loan forgiveness repayment	Workforce WG: Sara, Mary, Joy, Maria, Vayong

	Topics	Objectives	Opportunities	*Notes/comments*	*Interested task force members*
			Educate health systems on the value of hiring IMGs (culture change).		
16	Workforce	Promote diversity at all levels, including senior leadership and boards of directors	Recommend requirements for reviewing and updating board membership to ensure adequate representation from underrepresented groups on organizational boards and committees. Identify and remove barriers for students and employees to obtaining scholarships and resources experienced by underrepresented individuals who aspire to pursue careers and leadership positions in healthcare. Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups. Recommend educational opportunities to require board members to actively engage in ongoing professional development to acquire the necessary skills to model inclusive leadership and equitable governance.		Workforce WG: Sara, Mary, Joy, Maria, Vayong
17	Population health	Primary care adopts public health principles and partners with local public health to improve population health, engage the community in defining and addressing population needs, and share and collaboratively use data and analysis	Revisit how community benefit can be applied in ways that meaningfully address equity and outcomes. Promote local collaboration between primary care, public health, and other community partners. Educate health care providers on principles of public health (e.g., disease surveillance, vaccine distribution) Enable electronic closed-loop referrals between primary care and local supports and services.	8/21 suggestions from Dr. Nathan Chomilo: • Health care provider governance structures require co-creation and co-design with disadvantaged communities (community health center and FQHC models) • Increase payment to health care providers that demonstrate community co-governance • Meet disadvantaged communities where they are at (e.g., school-based health services)	
18	Population health	Hold health care systems, including plans and payers, accountable for outcomes	Revisit how community benefit can be applied in ways that meaningfully address accountability for outcomes. Implement training for cultural competency, DEIB. Promote models for value-based purchasing, shared-savings, and cost-sharing contracts. NCQA Health Equity Accreditation for Health plans and/or providers. Intentionally leverage the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) to advance health equity Align with HEDIS/federal measures Establish standards for whole-person care, equity,	8/21 suggestion from Dr. Nathan Chomilo: • Repurpose or add equity and transformation focused financing levers (Community Benefit accountability) • Prioritize and invest in equity-focused, community-centered population health for Medicaid	

	Topics	Objectives	Opportunities	*Notes/comments*	*Interested task force members*
			Support the Minnesota Framework for Health and Equity Measurement and Improvement Expand on current evaluation of managed care organizations and their plans Come to consensus on how to pay to bridge gaps in care and reimbursement for valued care to achieve health equity. Mitigate range of reimbursement (see Medicaid reimbursement opportunity) by type of coverage and health insurance carrier	• Continue to innovate in Medicaid payments—make the equitable decision the easy decision	
19	Population health	Advance evidence-based practice	Fund practice-based research that addresses equity. Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research and maintain public health surveillance dashboards.		