DEPARTMENT OF HEALTH

Equitable Health Care Task Force Meeting Summary

Meeting information

- September 23, 2024, 1:00-4:00 p.m.
- Meeting Format: WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engels, Joy Marsh, Maria Medina, Mumtaz (Taj) Mustapha, Miamon Queeglay, Nneka Sederstrom, Yeng M. Yang, Tyler Winkelman

Key meeting outcomes

- Task force members learned from and engaged with Stratis Health about their work to improve health equity, solutions, innovations, lessons learned, and recommendations which were framed to be practical and actionable for the task force in their consideration of health care equity recommendations.
- Task force members engaged with Commissioner Cunningham about a proposed OneMinnesota initiative pertaining to health equity training requirements for providers.
- Task force members were informed of how its remaining work will be structured.
- Task force members reviewed the Opportunities Matrix for Developing Recommendations and added initial insights.

Key actions moving forward

- Task force members will continue to add thoughts to the Opportunities Matrix for Developing Recommendations (accessible in Teams), particularly to validate the objectives and add opportunities.
- MDH will share upcoming opportunities to learn and discuss health care equity topics.

Summary of meeting content and discussion highlights

Meeting Objectives

The following objectives were shared:

- Learn and discuss social needs referrals, clinical and non-clinical data exchange, governance structures and community inclusion with Stratis Health.

- Hear from the Commissioner about some related health care equity opportunities coming out of the One Minnesota initiative.
- Get an update on how the work will be structured for learning, solutioning, and recommendation development.
- Have some focused work time to refine objectives and identify opportunities that will shape recommendations.

Welcome and grounding

Task force members were welcomed and the agenda was reviewed. The meeting summary from August was reviewed and discussed.

Learning and engagement

Representatives of Stratis Health presented about their work to improve health equity, solutions, innovations, lessons learned, and recommendations. Highlights from their presentation include:

Stratis Health follows three strategies

- Codesign system changes that connect health care and community organizations to improve health
- Advance a safe and compassionate health care environment for those receiving and those providing care
- Accelerate evidence-informed and culturally responsive care and services

Lessons learned in health care equity include:

- The tendency and status quo leans toward health care and payers, not patients or communities.
- Data needs to evolve toward community-informed measures to better understand needs and gauge progress in reducing disparities.
- Community is the “unit of action” in health improvement.
- There is significant intersectionality between identities and between communities.
- Ageism is an important and often neglected aspect of health equity.

Ideas and recommendations to advance health care equity:

- Offer more realistic mechanisms for funding to communities, with flexibility for evaluation and accompanied by assistance and support.
- Build in time and resources for authentic community input and co-design. Involve the community as partners. This ensures health programs are shaped by the people they aim to serve.

- Invest in community process not programs (building capacity and sustainability). This ensures needs are met even after specific funding ends.
- Pay attention to where and how funding lands – is it with those that need it most or where it will have the most impact? Wrong pockets examples abound!
- Move toward standardized health equity and disparities metrics for payers which are transparently reported and used to guide state funding, contracting, and other opportunities. This increases accountability.

There was some discussion after the presentation. Task force members had the following questions and comments:

- Appreciate the point about intersectionality.
- Appreciate the point about making sure that funding lands appropriately. Organizations that are more visible continue to receive funding, but they may not be the right ones. It's important to recognize smaller organizations or who haven't benefited.
- Artificial intelligence (AI) is an issue—it can be set up for bias when there is not enough diversity to help AI learn what the real world looks like. That drives algorithms that are inherently biased and thus perpetuate bias and inequity.

Task force members were interested in how Stratis Health assesses impact. Highlights from the conversation include:

- Working with county jails, we adapted an approach for implementation around opioid use. There are disproportionate impacts on Black Americans. The assessment measures progression to say whether care is getting better. Another example: we used a pulse check with participants of a learning collaborative to see how comfortable they were with the concepts. We also gathered stories and pulled together a promising practices document.
- We often get stuck on outcome data. We're looking for creative ways to assess impact of health equity. A proxy measure is staff diversity. We can't directly tie that to decreasing disparities. Example of proxy measures: assessment of internal readiness and structure around health equity, Board of Trustees, etc. There are signals to how care is delivered, how resources are prioritized. Translate federally mandated measures to how that looks in the community.
- We did a community health assessment, designed by community partners and leaders in the Cass Lake tribal community. It included more of the community's traditional values, questions around their participation in events, physical health, mental and emotional health, and spiritual health.
- A task force member expressed concern that the questions on community health assessments are not necessarily culturally informed.
- People are trying to move this work forward without using triggering words. We've moved toward using the term "evidence informed" instead of evidence based. We know evidence can be biased.

- A task force member mentioned that many of the Minnesota community health centers use a patient experience satisfaction survey developed by Midwest Clinicians' Network specifically for community health centers. A few community health centers in the Twin Cities have engaged with SoLaHmo to conduct an in-depth needs assessment. SoLaHmo works alongside community and are entirely comprised of community members—from research conception to dissemination, they are community run. Generally, community health centers include patients in their governance structures, so by design, they're at the ready to tackle these issues.

MDH asked Stratis to further explain their slide about not having standardized health equity and disparities metrics for payers, and what would be different compared to what we have now. Stratis Health commented that Minnesota has a robust quality measurement system around care delivery that is transparent at a state and federal level. However, that same transparency doesn't exist on the payer side. Medicare data is opaque and nearly impossible to access. There is a need to bring more consistency to payers to have a complete picture and accountability around disparities. Minnesota has terrific payers, but they don't exist in the same system of transparency and reporting as providers, so there is misalignment.

The task force engaged Stratis Health in a conversation about Culturally and Linguistically Appropriate Services (CLAS) standards. Highlights from that discussion include:

- CLAS standards have seen a resurgence in the last few years. It's one framework we see a lot of organizations leverage in their implementation of health equity. It might be a mechanism for the state. It's not just checking the box. It's meaningful. You can't implement CLAS meaningfully unless you've done a community assessment. And your staff reflect the community.
- Some of the language in CLAS doesn't seem feasible or even desirable, e.g., "culturally competent" and CLAS at one time seemed like it was weakened. Are we liking CLAS again?
- CLAS standards could be cross walked with others to see what's most meaningful.

Commissioner's remarks

Commissioner Cunningham presented an update on One Minnesota initiatives related to health care equity, including continuing education requirements, licensing requirements, and changing culture and practices within health care delivery systems.

The Commissioner invited the task force members to provide their insight into the proposed initiative to require equity training for health care providers. Task force members provided feedback such as:

- The need to understand the "why" and for rigorous change management tools to manage potential pushback from providers.
  - Key sponsors or a "sponsor coalition" to carry the messages.
  - Explain what's changing and why, what's in it for me and for them, and what are the first steps.

- How the initiative will incorporate what already exists.
- How changes will be implemented in systematic ways.
- How to hold providers accountable for behavior.
- Learning from other states with mandatory training:
  - How they may be answering the question about accountability for behavior change post-equity training.
  - Impact on patient experience gaps.
  - What, if anything, was done beyond training to improve patient outcomes.
- Interest in inclusion of LGBTQAI in required health equity training.
- The initiative should include providing resources with the health care equity training to develop an interactive and collaborative effort, which will make mandatory training appealing to providers.
- Health care workforce's experience of inclusion and belonging is also important along with the experience of the patients and members served.

MDH update

The MDH team gave an update about how the task force's work will be structured moving forward.

A research team from the University of Minnesota will support the task force it its development of recommendations for a more equitable health care system as related to financing, care integration and coordination, culturally appropriate care, and health navigation and literacy. The team is comprised of faculty, staff, and students from the State Health Access Data Assistance Center at the University plus the Division of Health Policy and Management within the School of Public Health.

The team will research and analyze promising health care practices and public policy supports to address disparities in access, quality, and outcomes among priority population segments. They will dive into some, but not all priority areas, focusing on gaps in collective knowledge among the task force and MDH.

The university team will provide:

- Health care financing level-setting session in October,
- Background searches and rapid review of existing evidence and preliminary findings in December, and creation of a resource guide on innovative policies and practices by February, and
- Assistance with the development of short-term, mid-term, and long-term recommendations for a more equitable health care system.

MDH and DeYoung Consulting will continue to support the task force in developing recommendations in other areas, such as workforce, health information exchange, and other topics.

MDH will make some structural changes to facilitate collective learning and recommendation development in this phase of the work. In addition to full task force meetings with opportunities for learning and engagement with others and discussions about solutions, MDH will set-up short, supplement virtual learning and solutioning sessions for cross-cutting topics. The Access and Quality and Delivery workgroups have agreed to open-up their monthly meeting times to all other task force members. Other organizations or state program staff will be invited in to engage with task force members about health care equity solutions and opportunities for recommendations. All interested task force members can attend. Sessions will be recorded for those who cannot attend but would like to be informed. These sessions may also be leveraged for focused task force discussions and recommendation development.

The Workforce workgroup has a tight scope and will continue to meet. There are not other meetings of the Financing workgroup at this time and because health care financing cuts across all topics, those discussions will be incorporated into other topics for all task force members to participate in. Some task force members suggested that one to two people take ownership of certain issues to help manage what can feel overwhelming. MDH will continue to explore this idea.

MDH summarized the meeting and learning structure for the coming months in this phase of the work. Most months between now and through February will feature a combination of task force meetings and learning sessions. Initial recommendation development will also occur in this time period. MDH will track and synthesize learnings from task force meetings and learning and solutioning sessions, inviting task force members to communicate anytime openly. By March, the task force is expected to be fully immersed in drafting recommendations.

Moving toward solutions

MDH staff gave an overview of how MDH has compiled the insight from the task force thus far. They shared a working table called Opportunity Matrix for Developing Recommendations. This matrix is designed to assist the task force with refining objectives and identifying opportunities that will shape the recommendations. It will help task force members see overlaps and intertwined opportunities, and 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 work into recommendations.

Task force members were invited to edit the live matrix document by validating the objectives and adding opportunities and other notes. The group dedicated 20 minutes to this quiet working time.

Appreciation was extended to MDH for the effort in pulling the matrix document together, as it shows information from all the workgroups and the task force in the same place and allows task force members to see parallels.

MDH reminded the task force that the matrix is a working document and the opportunities listed can be seen as the beginning of recommendation development. The task force was asked to notice any gaps, and together, we will build out the specificity of the opportunities. Some of these might lend themselves to actionable recommendations, and others will be longer-term, big solutions that take time to develop.

Public comments

No public comments were received in this period.

Closing and action items

During a break in the meeting, task force members were given a link to a poll to provide their preferences for additional meeting dates, a social get together, and opportunities for topical discussions in between task force meetings. At the end of the meeting, the responses to the online poll showed that the majority of respondents (6 out of 10 task force members) were interested and available to join an in-person social gathering on December 9. MDH will follow up with the two task force members who volunteered to organize that get-together.

The task force was thanked and reminded of the next meeting on October 24, 1:00 – 4:00 p.m., which will be virtual. A meeting summary is 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.

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