Agenda: Equitable Health Care Task Force

Date: 12/09/2024

Opening, 12:00 – 12:10 p.m.

Overview of meeting agenda and objectives, and October meeting summary review.

Welcome from MDH, 12:10 – 12:20 p.m.

Welcome from the Minnesota Department of Health (MDH).

Recommendation and report development, 12:20 – 1:40 p.m.

The Task Force and MDH will walk through and refine the recommendation development process for January through June 2025, including engagement with interested parties and the public.

Break, 1:40 – 1:50 p.m.

Preliminary findings from the UMN Research Team, 1:50 – 2:55 p.m.

The University of Minnesota (UMN) Research Team will share preliminary findings on their scan of promising health care equity practices and policies.

Closing and action items, 2:55 – 3:00 p.m.

We will review our accomplishments and share upcoming next steps.

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11/26/24

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

Equitable Health Care Task Force Meeting #9

December 9, 2024

Opening

Acknowledgement of thanks

Thank you for your continued efforts!

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

Today's objectives

- Further develop and refine the recommendation development process
- Learn about what the UMN Research Team is finding

Today's agenda

12:00 – 12:10 p.m. Opening

12:10 – 12:15 p.m. Welcome from MDH

12:15 – 1:40 p.m. Recommendation and report development

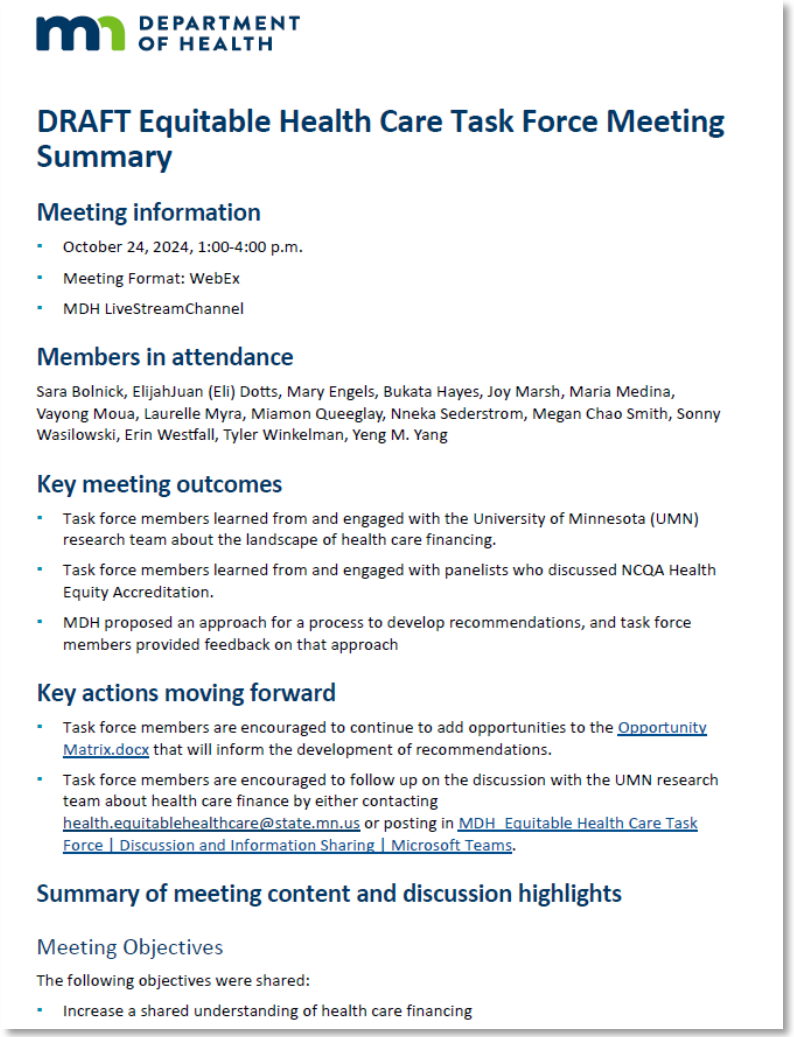
1:40 – 1:50 p.m. Break

1:50 – 2:55 p.m. Preliminary findings from the UMN Research Team

2:55 – 3:00 p.m. Closing and action items

Summary of October meeting

- 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

- October 24, 2024, 1:00-4:00 p.m.
- Meeting Format: WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, ElijahJuan (Eli) Dotts, Mary Engels, Bukata Hayes, Joy Marsh, Maria Medina, Vayong Moua, Laurelle Myra, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Task force members learned from and engaged with the University of Minnesota (UMN) research team about the landscape of health care financing.
- Task force members learned from and engaged with panelists who discussed NCQA Health Equity Accreditation.
- MDH proposed an approach for a process to develop recommendations, and task force members provided feedback on that approach

Key actions moving forward

- Task force members are encouraged to continue to add opportunities to the Opportunity Matrix.docx that will inform the development of recommendations.
- Task force members are encouraged to follow up on the discussion with the UMN research team about health care finance by either contacting health.equitablehealthcare@state.mn.us or posting in MDH_Equitable Health Care Task Force | Discussion and Information Sharing | Microsoft Teams.

Summary of meeting content and discussion highlights

Meeting Objectives

The following objectives were shared:

- Increase a shared understanding of health care financing

Welcome from MDH

Carol Backstrom| Assistant Commissioner of the Health Systems Bureau

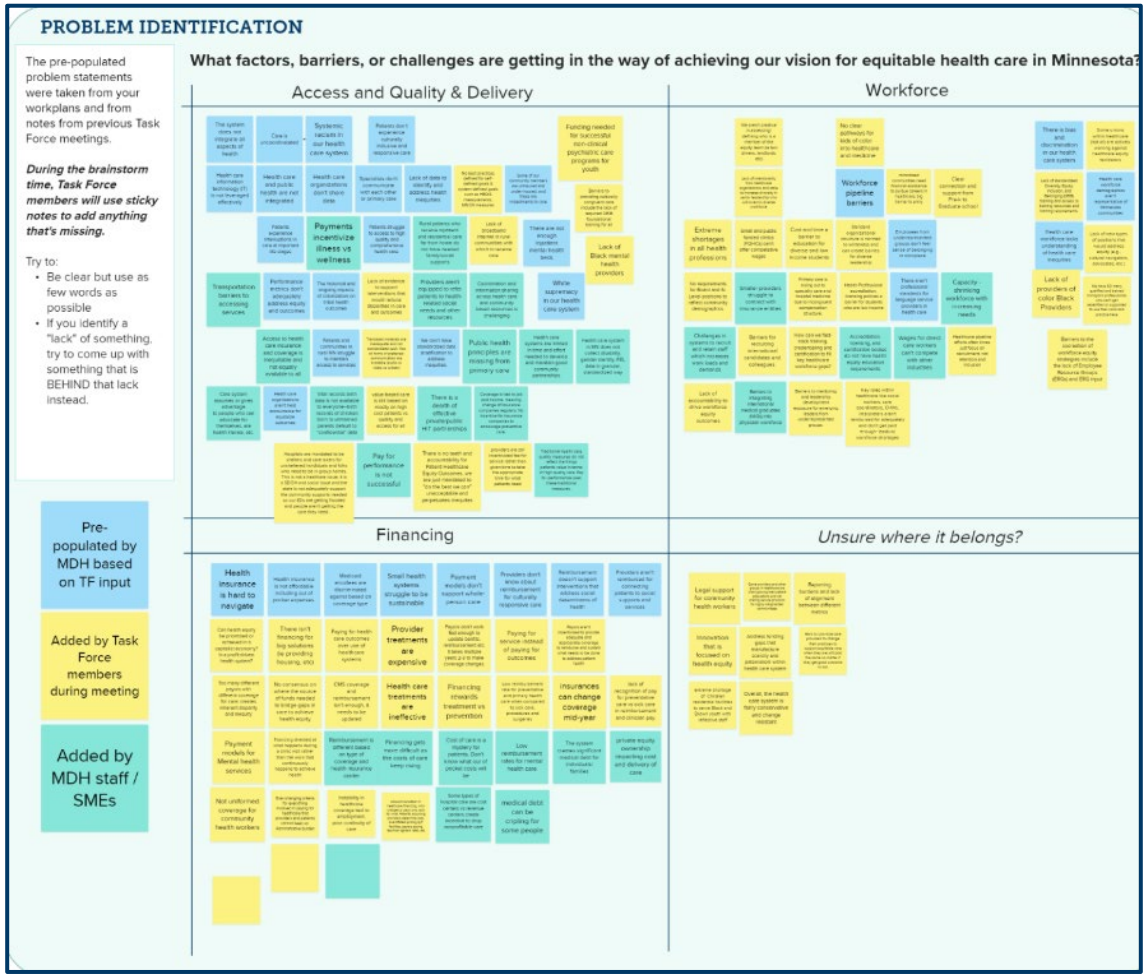
Grounding and Recap

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.

Start-up and problem identification



Learning about solutions

Task force meetings	Workgroup meetings	Learning and solutioning sessions
• Bolstering community voice in health care • Community health workers • Health care equity initiatives at the Department of Human Services • Health care financing • Health Care Homes and primary care • Health equity continuing education requirements, licensing requirements, and changing culture and practices within health care • NCQA health equity accreditation	• Health care workforce pipeline • Health information exchange and technology	• Mental health parity • Network adequacy, complaints and appeals • Oral health care

Synthesizing

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:

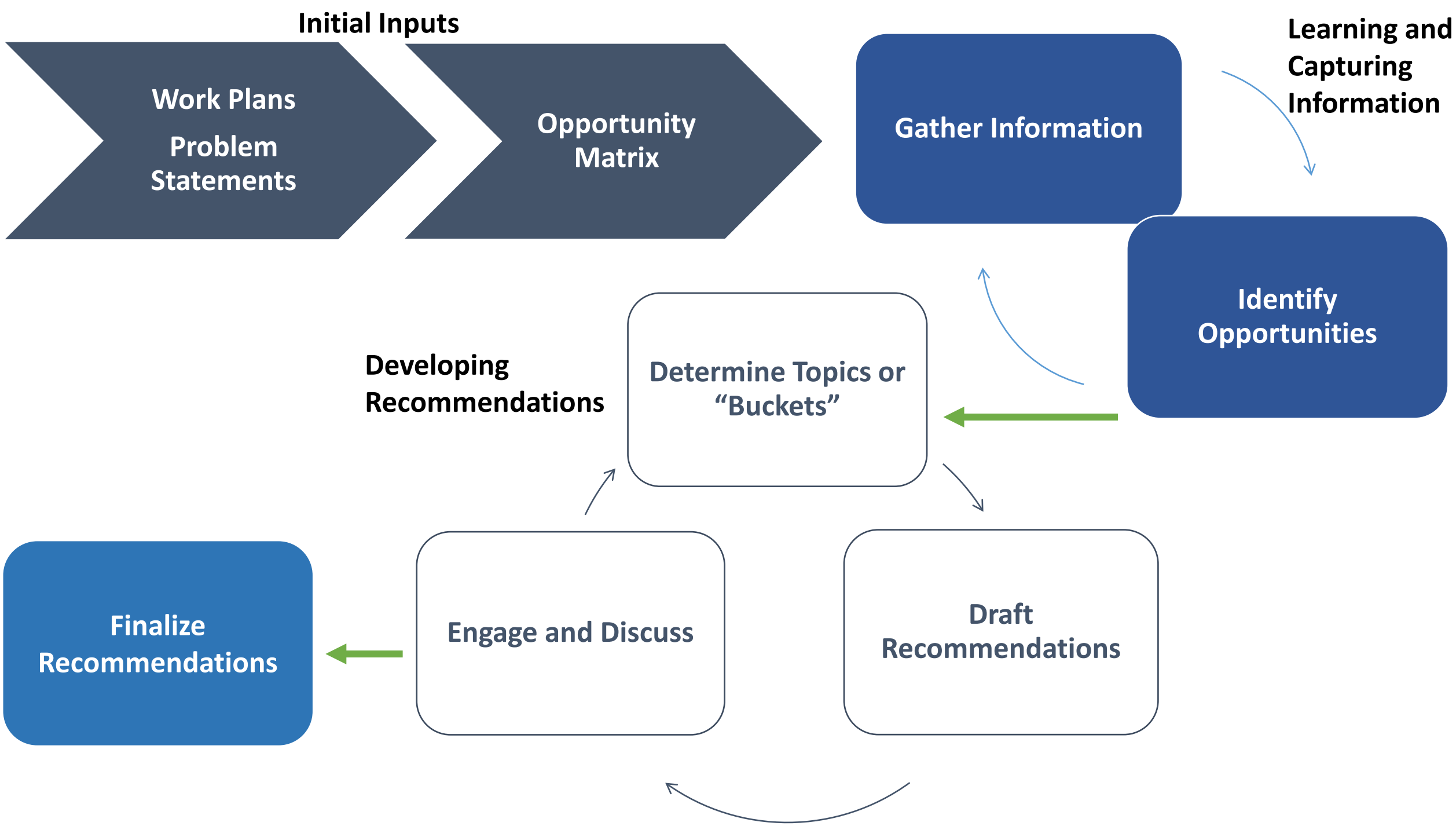
- Each row has an objective that needs to be validated by task force members. Add comments and edits as you see fit.
    - Note that the Workforce objectives and opportunities are taken directly from that workgroup's plan.
- Topics are intended to help group objectives. These topics can also be modified (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:

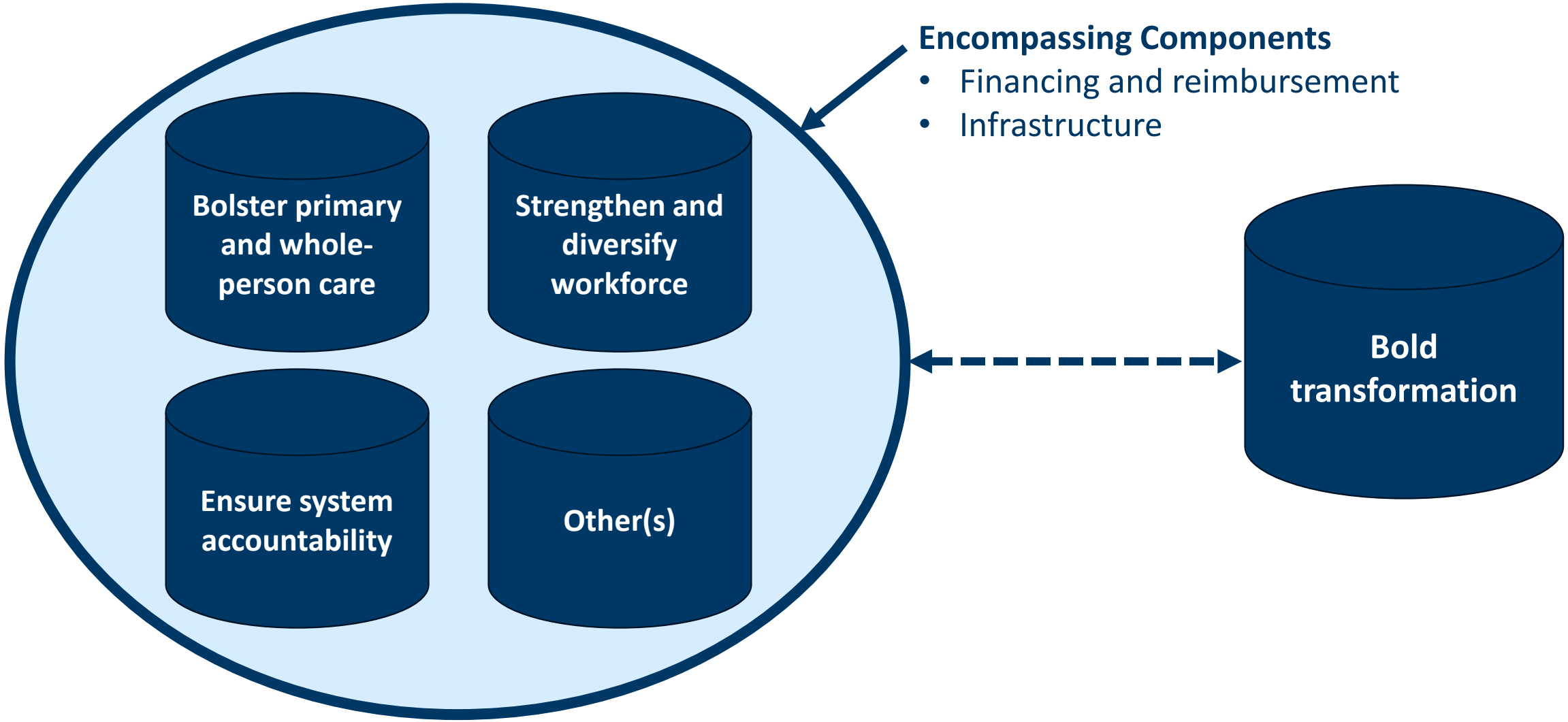
- Financing and reimbursement
- Policies, oversight, and regulation
- Evidence-based practice, training
- Technology, health information exchange, and data

	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).	Will UMN engage/look into payer side of this equation? What can we ask payers to do, what incentives are needed? Do we need a payer focused learning opportunity?	

Recommendation Development


Initial Inputs
Work Plans
Problem Statements
Opportunity Matrix
Gather Information
Learning and Capturing Information
Identify Opportunities
Developing Recommendations
Determine Topics or "Buckets"
Draft Recommendations
Engage and Discuss
Finalize Recommendations

Potential recommendation framework



Bolster primary and whole-person care

Examples:

- Increase the adoption of value-based payment models to reimburse community health workers/ similar care navigators.
- Expand coverage and reimbursement of Community Health Worker (CHW) services for care integration, navigation, and linkage to supportive services.
- Integrate oral health, mental health, and behavioral health into primary care.
- Decrease financial burden of health care by eliminating out-of-pocket expenses.
- Support coverage of complementary care.

Strengthen and diversify workforce

Examples:

- Foster workplace inclusion and belonging by developing and sharing best practices to enhance sense of safety, trust and belonging among employees.
- Include culturally-appropriate care training in academic programs and continuing education.
- Overcome workforce pipeline barriers through financial support and pre-professional internship opportunities.

Ensure system accountability

Examples:

- Require health care organizations that contract with the State of Minnesota, and/or are regulated by the State of Minnesota, to seek NCQA Health Equity Accreditation.
- Support the One Minnesota proposal to require CME equity training for health-related boards.
- Modify guidance on hospital community benefit to incorporate accountability for equitable health care outcomes.

Example recommendation development

Opportunity:

- Expand coverage and reimbursement of Community Health Worker (CHW) services for care integration, navigation, and linkage to supportive services.

For the recommendation…

- Who needs to act, how and when (short-term, mid-term, long-term)?
- What policies, training, technology, or financing are needed?

Next steps in developing recommendations

- MDH will draft recommendations for the Task Force to start from, review, edit, delete, and enhance.
- We will utilize Task Force meetings and working sessions to review and modify recommendations. Members may participate asynchronously as well.
- The Workforce Workgroup is developing recommendations that will be shared with the Task Force for review.
- Engagement with others will further inform recommendations.
- Task Force will do some prioritizing that considers the sequencing of recommendations, opportunity for impact, importance, and their level of support for each of the final recommendations.

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Bold Transformation

Reimagining health care

- What: Envision a completely reimagined future for an equitable health care system in Minnesota
- How and when: Small group
  - Two meetings between January and February with work in-between
  - Bring proposal to the Task Force in March for further refinement

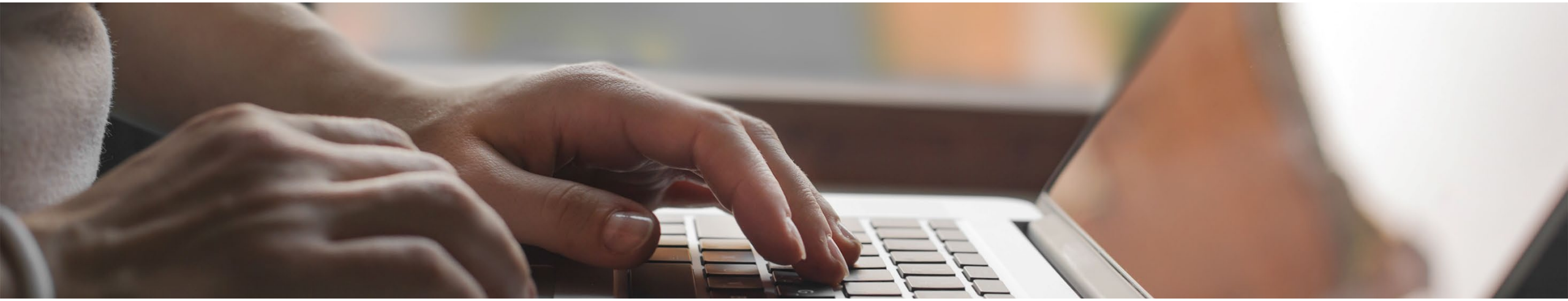
➢ Drop your name in the chat or contact the MDH project team

Engagement

Objectives and methods

- **Objectives:** Obtain input on emerging solutions to health equity problems, and probe for whether these solutions are headed in the right direction, what is missing, and what would be most impactful and make the biggest difference
- **Methods**

Focus groups and interviews	Public input	Other
• Organizations and bodies representing, serving, and advocating for communities impacted by health care disparities • Health care providers and payers and the organizations that represent them • Facilitated by MDH vendor	• Listening sessions • Open to observation by task force members • Written comment	?



Report

Report outline

- Letter from the Task Force to the Commissioner of Health
- Commissioner of Health's acknowledgement
- Overview
- Recommendations
- Conclusion
- Appendices
  - Legislation
  - Task force membership
  - Resource guide

2025: Focus on Recommendations

Timeline and activities

	January	February	March	April	May	June
Task force meeting	22nd: Recommendation review, editing, refinement	12th: Recommendation review, editing, refinement	17th: Workforce and bold transformation recommendation review, editing, refinement	10th: UMN presents draft recommendations	20th: Finalize recommendations and report, Part 1	17th: Finalize recommendations and report, Part 2
Work session	24th: Recommendation review, editing, refinement	21st: Recommendation review, editing, refinement	21st: Refinement of open items in all or priority topics	18th: Refinement of UMN recommendations	16th: Draft cover letter from task force	6th: Finalize cover letter from task force
Workforce workgroup	9th: Recommendation development		10th: Recommendation development			
Bold transformation?	TBA: Development	TBA: Development				
Engagement and input	Preparation	Ongoing	Ongoing	Ongoing	Ongoing	

Meetings in 2025

As the task force moves into more intentional and intense recommendation development, some may have a preference to do this work in-person.

Recognizing that MDH will maintain online options for people who can’t meet in-person, at what point in the recommendation development process should we encourage in-person work?

Break

Preliminary Findings from Rapid Review of Select Evidence

Jean Abraham, PhD, Professor, James A. Hamilton Chair in Health Policy Management, Professor and Head, School of Public Health, University of Minnesota
Christina Worrall, MPP, Senior Fellow, SHADAC, member of the project steering team

DEPARTMENT OF HEALTH

University of Minnesota Research Team

Division of Health Policy and Management (HPM) within the **School of Public Health**

- Jean Abraham, PhD, Professor, HPM Division Head
- Christina Worrall, MPP, Senior Fellow, State Health Access Data Assistance Center (SHADAC)
- Megan Lahr, MPH, Senior Research Fellow, Rural Health Research Center (RHRC)
- Mary Butler, PhD, MBA, Associate Professor, Co-Director Minnesota Evidence-based Practice Center (EPC)
- Elizabeth Lukanen, MPH, Deputy Director, SHADAC
- Katie Behrens, MPH, Researcher, EPC
- J'Mag Karbeah, PhD, MPH, Assistant Professor, HPM
- Romil Parikh, MBBS, PhD, MPH, Senior Researcher, EPC
- Andrea Stewart, MA, Research Fellow, SHADAC
- Amy Claussen, MLIS, Medical Research Librarian, EPC

Scope and activities

Research and analyze promising health care practices and public policy supports to address disparities in access, quality, and outcomes among priority population segments.

- Priority population segments include individuals based upon racial-ethnic identity (e.g., individuals who identify as Black, Indigenous, or Persons of Color), those who identify as LGBTQ+, those who have a disability, and persons residing in rural geographic locations.

Provide information synthesis and expertise to help Task Force members produce recommendations based on the problems identified and solutions considered

Scope:

- Health care **financing**
- Health care **integration and coordination**
- **Culturally appropriate** health care
- Health **care and insurance navigation and literacy**

✓ Provision of **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

➢ Assistance with **drafting short-term, mid-term, and long-term recommendations** for a more equitable health care system

Priority Topic Rapid Evidence Review and Discussion

Jean Marie Abraham, PhD

Presentation to the Minnesota Equitable Health Care Task Force

December 9, 2024

SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF MINNESOTA

UMN Scope of Work (10/2024-6/2025)

- To research and analyze promising health care practices and public policy supports to promote equity in access, quality, and outcomes among priority population segments, as characterized by racial and ethnic identity, rurality, sexual orientation and gender identity, and disability.

  Deliverable: Resource Guide (2/28/25)

- University will offer information synthesis and other technical expertise to support the development of draft policy recommendations by Task Force members.

Sequence of Activities

Priority Topic Area Evidence Review and Discussion

- Integration of Health Care and Public Health
  - Screening and referral for health-related social needs
  - Health insurance literacy
- Value-based Payment Models
- Whole Person Health
  - Integrated care delivery (oral and behavioral health)
  - Patient navigation
  - Complementary health approaches
- Culturally Appropriate Care
  - Doulas
  - Culturally sensitive SUD treatment
  - Language interpreter services

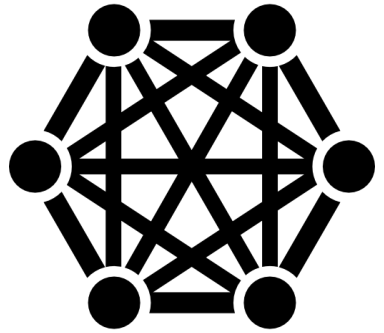


Image Source flaticon.com

Approach: Rapid Evidence Review

1. Initial background searches of topic in public domain from peer-reviewed and gray literature (research, government, industry sources)
2. Team leads worked with UMN librarian to conduct rapid review of *scholarly literature*
    - Existing published literature reviews and other pre-synthesized materials
        - Quality and strength of evidence
        - Outcomes examined
    - 2014-present to summarize state of evidence
    - Additional focus on disparities reduction and/or equity promotion among priority populations
3. Teams summarized up to 5 systematic reviews, and developed summaries and early recommendations on topics to pursue a 'deeper dive' of individual studies, gray literature, and state policy examples

Integration of Health Care and Public Health

Problem Background

- Health care delivery system is limited in its ability to address health-related social needs (food, housing, transportation, safety, education) and there is need for greater coordination across medical and community-based resources
  - Providers and facilities are typically only paid for health care services provided to patients
  - Many providers are not equipped to screen and/or refer patients to community-based resources
  - Availability of community-based resources

- Health insurance literacy
  - Individuals face challenges in understanding health insurance, both in terms of enrollment and effective ‘use’ of coverage for accessing care

What does evidence tell us about the effectiveness of **health-related screening and referral** programs overall?

- 5 systematic reviews identified that reviewed screening for a variety of social needs
- Overall effects of screening and referral programs can improve patient outcomes
  - Uptake and enrollment in resources
  - Utilization: lower ED visits, hospitalizations, readmissions, and more primary care/preventive visits
  - Minor to modest health improvements (e.g., blood pressure, A1C, medication adherence, cholesterol, etc.)
  - Referral type (indirect vs. direct) affected outcome success
- Equity-specific effects
  - References to rural populations or Medicaid, but outcomes not reported by group

Health Insurance Literacy (HIL)

- **Definition**: Degree to which individuals have knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their family and health circumstances, and use the plan once enrolled (Quincy, 2011)
- **Who is at greater risk?**
  - Racial and ethnic minority populations, young adults, and those with limited English proficiency
- **What outcomes exhibit an association with HIL?**
  - Low HIL and increased risk of delayed or forgone care
  - Higher HIL and greater use of preventive and primary care (Yagi et al. 2021)
- **Small number of 'community-based' HIL programs**
  - Access Health Connecticut (Villagra et al. 2019)
  - Insuring Good Health (Patel et al. 2019)*
  - Smart Choice Health Insurance (7 university extension services)
  - Savewithcare.org (Peirce et al. 2024)
- **No systematic reviews & limited empirical evidence**
  - Outcomes focused on change in knowledge, self-efficacy

Value-based Payment (VBP) Models

Problem Background

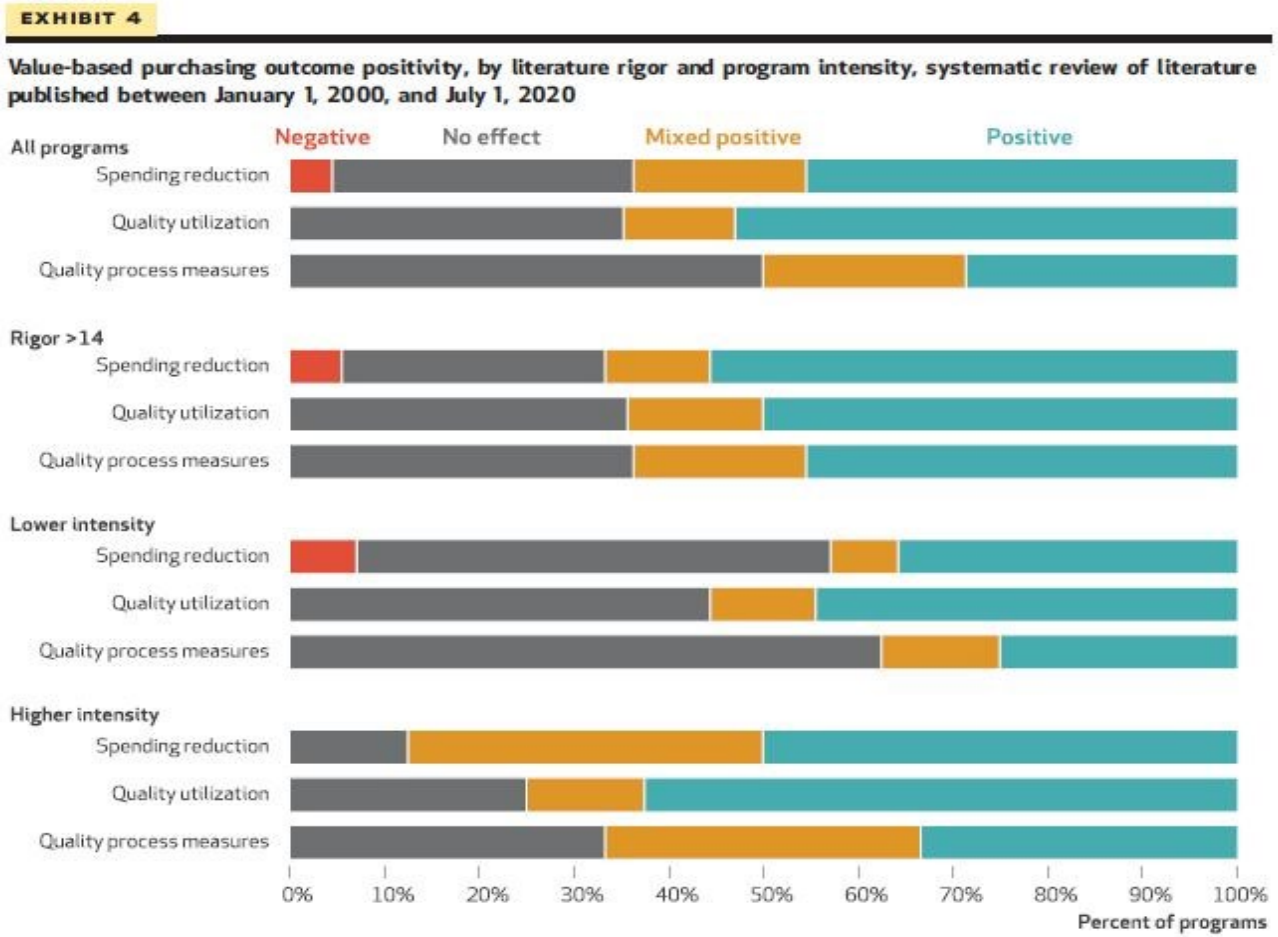
- Financial incentives in the health care system are misaligned.
- Health care costs are too high and are rising.
- Performance and quality metrics fail to measure the right things and lack accountability.
- Poor data and data exchange prevents information sharing and monitoring.

Innovation

- Link provider payment to performance outcomes, including clinical quality of care, patient experience, utilization, and spending.
  - Pay-for-performance
  - Bundled payments
  - Population-based models

What does evidence tell us about the overall impact of **value-based purchasing models**?

- 11 systematic reviews selected for rapid review
  - 3 directly discussed strategies or outcomes related to health equity or disparities reduction



Pandey, A., et al. (2023). "Value-Based Purchasing Design and Effect: A Systematic Review and Analysis" *Health Affairs*. 42(6): 813-821.

What does evidence tell us about **value-based payment models for equity promotion**?

- 3 systematic reviews with health equity focus
  - Designing pay-for-performance models for disparities reduction (Conway)
  - Designing models and assessing the impact of social risk adjustment for outcomes by racial and ethnic populations and dual eligible status (Rogstad)
  - Assessment of eight models stratified by race and ethnicity to understand ability to achieve or impact equitable outcomes or reduce disparities (Tao)

Deeper Dive Recommendation: Integration of Health Care and Public Health

Dimensions	
Literature	Individual studies with particular focus on **addressing transportation-related needs**
Minnesota landscape	Legislative-commissioned DHS report on meeting unmet **HRSNs**
Other federal and state policy innovations	Medicaid 1115 waivers, Medicaid managed care, Accountable Health Communities model, Health Care Homes

Deeper Dive Recommendation: Value-based Payment Models

Dimensions	
Literature	Individual evaluations with focus on **population-based payment models** and **embedding equity performance into model design**; emphasis on **standardized data stratification** and **measure alignment**
Minnesota Landscape	MN IHP program; Insurers' efforts outside of IHP
Other State / Federal Policy Examples	Oregon's CCOs; CMMI ACO REACH; State of Massachusetts

Discussion #1:

- Integration of Health Care & Public Health
- Value Based Payment Models

- What from your personal or professional experience relates to this work?
  - If you are already engaged in similar work, what needs to be refined or scaled?
  - If you are not already engaged in similar work, what are you interested in learning more about?

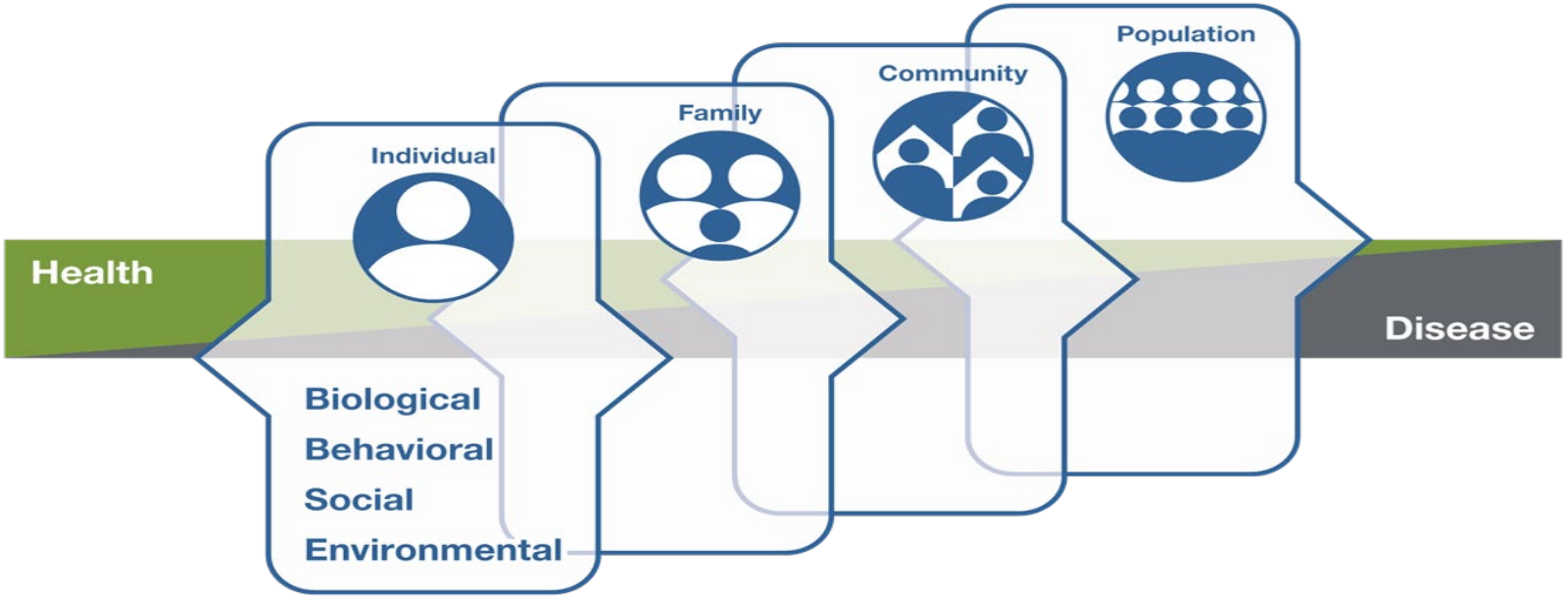
- When you think about the needs of specific populations, which areas of focus stand out and why?

Whole Person Health

Problem Background

- System is not designed to deliver or pay for whole person care.
  - Not enough focus on preventive care relative to acute and chronic disease management
  - Complementary services that may promote health that are not encouraged for use given existing insurance designs and payment models
- Accessing the right care at the right time and place is challenging.
  - Greater integration of care may improve accessibility and outcomes

Whole person health: approach that considers multiple interconnected factors that promote either health or disease, including biological, behavioral, social, and environmental factors



Innovation

- Patient navigation
- Integrated primary care and oral health
- Integrated primary care and behavioral health
- Complementary health

Source: The National Center for Complementary and Integrative Health

Whole Person Health: Patient Navigation

- **Definition**: community-based service delivery intervention designed to promote access to timely diagnosis and treatment of cancer and other chronic diseases by eliminating barriers to care (Freeman & Rodriguez, 2011)
- **Attributes**: education, outreach, coordination of medical appointments, home visits, coordinating health-related social supports, coordinating end-of-life care
- **Who is the target population?**
  - Cancer patients, Transitional care, Vulnerable and socially disadvantaged
- **Who provides patient navigation?**
  - Care professionals (e.g., nurses, social workers)
  - Lay persons (e.g., community health workers, volunteers)

What does evidence tell us about the impact of **patient navigation** (PN)?

- 5 systematic and scoping reviews identified
  - Overview of systematic reviews (Budde et al. 2021)
  - 2 cancer-related; 1 HIV; 1 immigrant and ethnic minority populations
- Other resources
  - WHO Policy Brief & ASPE Report on patient navigation in Medicare
- Outcomes
  - Cancer & HIV: Treatment adherence; follow-up care receipt; improved screening rates
  - Transitional care: improved self-management; lower readmissions in older patients
  - Programs supporting immigrant and ethnic minority populations, focused on diabetes management, hypertension, and CVD risk reduction (e.g., intermediate clinical outcomes)
- Did not find studies explicitly measuring disparities reduction

Whole Person Health: Integration of Primary Care and Oral Health

Definition: collaborative model of care that incorporates oral health (e.g., education, dental service provision) into primary care delivery

- Care delivery location (e.g., co-located services)
  - Patient-centered medical home ‘extensions’
- Workforce (e.g., interprofessional teams, scope of practice)
- Referral support (e.g., dental care referral coordinators)
- Information sharing (e.g., shared electronic health records)
- Financing (e.g., population-based payment models; benefit design)

What does evidence tell us about the impact of **integrated primary care and oral health** on outcomes?

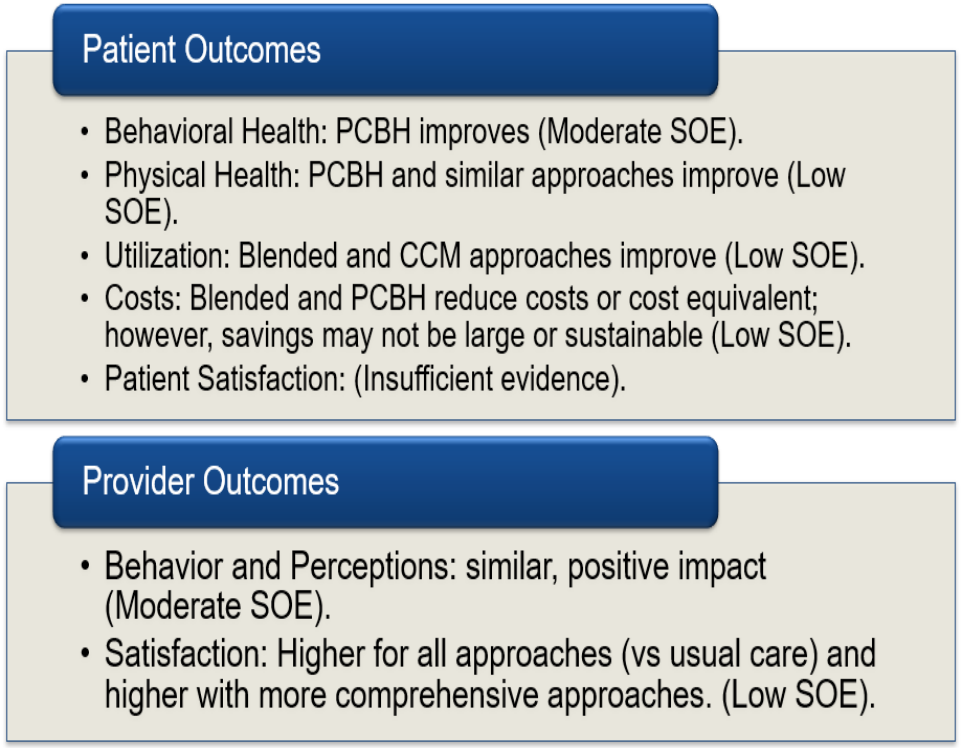
- 3 systematic reviews identified
- Overall effects
  - Patient-focused: Improved access to care; oral health outcome improvement (e.g., fluoride, oral health assessment, plaque, pocket depth), access to care, perceptual outcomes
  - Organization-focused: barriers and facilitators of integration
- Equity-specific effects
  - Discussion of care innovation in FQHCs; coverage and delivery innovations for children and pregnant persons with Medicaid coverage
  - Qualitative review of dental therapist workforce innovation impacts

Whole Person Health: Integration of Primary Care and Behavioral Health

- **Definition:** a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population (AHRQ)
- Continuum of integration
  - Consultation
  - Co-location
  - Team-based, collaborative care models

What does evidence tell us about the impact of **integrated primary care and behavioral health** on outcomes?

- Behavioral Health - 12 systematic reviews
  - Collaborative Care Model (CCM): psych provider + care manager
  - Primary Care Behavioral Health (PCBH): screening and counseling
  - Blended/comprehensive: CCM + PCBH



Complementary Health Approaches

- **Nonpharmacological treatments**
  - Exercise and mind-body practices (e.g., yoga)
  - Physical modalities (e.g., ultrasound, low-level laser therapy, traction)
  - Mindfulness-Based Stress Reduction (MBSR)
  - Manual therapies (e.g., spinal manipulation, massage therapy)
  - Psychological therapies (e.g., cognitive behavioral therapy)
  - Acupuncture
- **Condition Contexts**
  - Chronic pain (low back pain, headache, fibromyalgia)
  - Mental health (depression, anxiety)

What does evidence tell us about the effects of **complementary health approaches**?

- 4 systematic reviews (approach-specific and condition-specific)
- Overall Effects
  - Strength of evidence: low or moderate with few exceptions
  - 'Slight' to 'moderate' magnitudes of effects with variation over time horizon.
  - Limited understanding of heterogenous effects or approaches as substitutes for pharmacological treatment
    - Age, gender, and social determinants of health
  - Promising contexts and approaches at present
    - Chronic pain (fibromyalgia, low back pain, headache): acupuncture, massage therapy, spinal manipulation, mindfulness-based stress reduction, exercise
    - Depression and anxiety during perinatal period: Cognitive behavioral therapy and interpersonal therapy
    - Tobacco use disorder: acupuncture
- Equity-specific Effects
  - Individual studies to consider complementary modalities (e.g., migraine treatment)

Culturally Appropriate Care

Problem Background

- Care is often not available or delivered in a culturally and/or linguistically appropriate way.

- **Definition:** based on the belief that individuals have different ideas about what constitutes proper medical care and are best served when they can draw upon their own cultural traditions while receiving treatment.

Innovation

- 3 focus areas
  - Expansion of **doula care** with focus on payment models
  - Culturally-sensitive **mental health** and **substance use interventions**
  - Cost-effectiveness and reimbursement for **language interpretation services**

Culturally Appropriate Care: Doula Care

Definition: Doulas are nonclinical trained professionals who provide emotional, physical, and informational support during pregnancy, delivery, and after childbirth

- Hospital or community-based

What does evidence tell us?

- Small percentage of births involve doula services
  - Coverage varies by state and insurance type
- Clinical outcomes
  - Lower C-section rates and risk of pre-term births
  - Improved APGAR scores for infants
  - Less robust evidence on maternal mental health
- Improved patient experience
  - Concordance between patient and doula
- Equity effects
  - Focus on Medicaid populations
- Key policy issues
  - Workforce
  - Payment/financing models

Culturally Appropriate Care: Language Interpretation Services

Definition: Availability of language services for individuals with limited English proficiency (LEP)

- Ad hoc vs. trained medical interpreters

What does evidence tell us?

- Clinical outcomes
  - Pain control
  - Length of stay
  - Readmission
- Patient satisfaction

- Equity effects
  - Focus is on populations with LEP

Culturally Appropriate Care: Mental Health and Substance Use Treatment Interventions

Definition: Interventions that incorporate ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population into design and delivery of the treatment program (Resnicow et al. 2000)

What does evidence tell us?

- Populations and interventions studied vary widely
- Racial and ethnic minority adolescents: small (1/3 standard deviation), but heterogeneous improvements based on validated instrument responses (Steinka-Fry et al. 2017)

Deeper Dive Recommendation: Whole Person Health

Dimensions	
Literature	**Populations for whom patient navigation is most effective;** lay vs. clinical patient navigation; **collaborative care models within FQHCs; linkages between oral and behavioral health.**
Minnesota Landscape	Need to understand existing state of patient navigation use and financing by MN providers and payers (Medicaid and MA); MNCARES study results.
Other State / Federal Policy Examples	New Medicare payment for patient navigation (monitor); recent Medicaid dental coverage expansions for specific service types or populations.

Deeper Dive Recommendation: Culturally Appropriate Care

Dimensions	
Literature	Individual evaluations with focus on **doula care payment models; interpreter services/language translation; culturally sensitive care for mental health and substance use disorder**
Minnesota Landscape	Investigate doula utilization; better understand challenges related to interpreter service provision in inpatient and outpatient settings
Other State / Federal Policy Examples	Institute for Medicaid Innovation's National Doula Learning and Action Collaborative; other innovations to support delivery organizations' efforts related to doula care provision; interpreter service provision

Discussion #2

-Whole Person Health

-Culturally Appropriate Care

- What from your personal or professional experience relates to this work?
  - If you are already engaged in similar work, what needs to be refined or scaled?
  - If you are not already engaged in similar work, what are you interested in learning more about?

- When you think about the needs of specific populations, which areas of focus stand out and why?

Final Discussion

- Is there anything you were expecting to see so far that you didn't?

- What else are you observing here in MN or in other states that you want us to make sure we research?
  - Incremental (e.g., fine tuning existing policies)
  - Broad-based (e.g., sweeping changes)

- How do you want to receive the evidence?

Questions & Discussion

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Meeting Close

Closing and action items

- Task force members will:
  - Review example task force report (will be sent by MDH)
- Project team will:
  - Summarize today's meeting
  - Provide meeting slides to the task force
  - Update recommendation development process components
- Next meeting: January 22, 1:00 – 4:00 p.m.
  - Recommendation review, editing, refinement
  - Engagement approach
  - Tentative: Tribal Health System
- Virtual work session: January 24, 10:00 – 11:00 a.m.
  - Recommendation review, editing, refinement

Thank You!

See you January 22, 2025!