Agenda: Equitable Health Care Task Force

Date: 09/23/2024

Opening and welcome, 1:00 – 1:10 p.m.

Overview of meeting agenda and objectives.

Learning and engagement: Social needs referrals, data exchange, building equity into governance structures, 1:10 – 2:10 p.m.

Innovative practices, successful strategies, challenges, and opportunities from Stratis Health.

Commissioner's welcome, 2:10 – 2:25 p.m.

Welcome from Commissioner Cunningham and an update on related One Minnesota initiatives.

Break, 2:25 – 2:35 p.m.

MDH update, 2:35 – 2:45 p.m.

MDH will provide an update on organizing and structuring the work.

Framework for solutions and recommendations, 2:45 – 3:55 p.m.

The task force will provide input on the framework and content for emerging health care equity solutions and recommendations.

Closing, action items, and preview of October meeting, 3:55 – 4:00 p.m.

We will review our accomplishments and share upcoming next steps.

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Health Policy Division
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09/16/24

A G E N D A

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

Equitable Health Care Task Force Meeting #7

September 23, 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

1:00 – 1:10 p.m. Opening and welcome

1:10 – 2:10 p.m. Learning and engagement: Social needs referrals, data exchange, building equity into governance structures

2:10 – 2:25 p.m. Commissioner Cunningham's welcome

2:25 – 2:35 p.m. Break

2:35 – 2:45 p.m. MDH update

2:45 – 3:55 p.m. Opportunity matrix for developing recommendations

3:55 – 4:00 p.m. Closing, action items, and preview of October meeting

Grounding: Task force charge

The task force will:

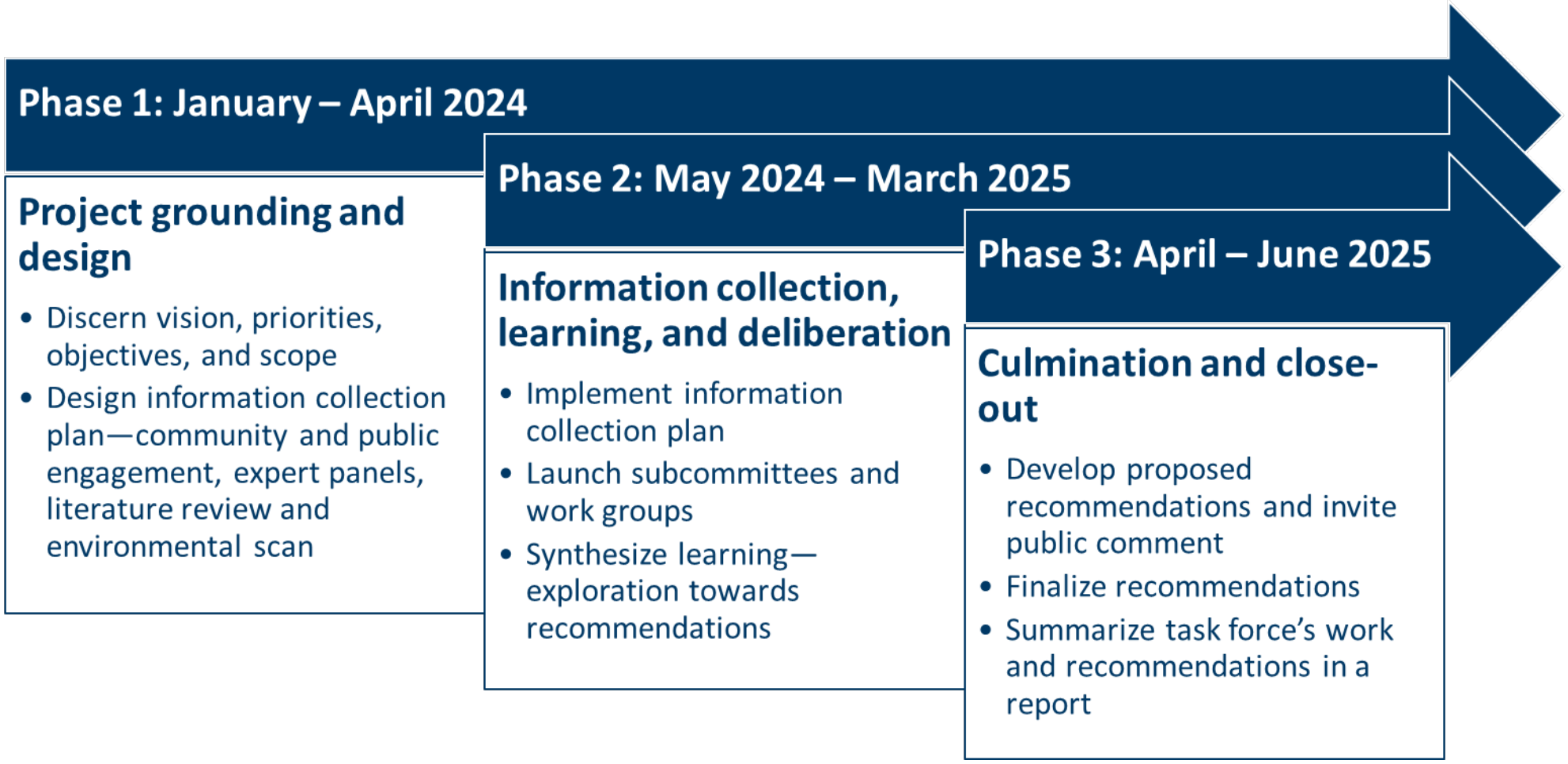
- **Identify inequities** experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age and/or disability status.
- **Conduct community engagement** across multiple systems, sectors, 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.

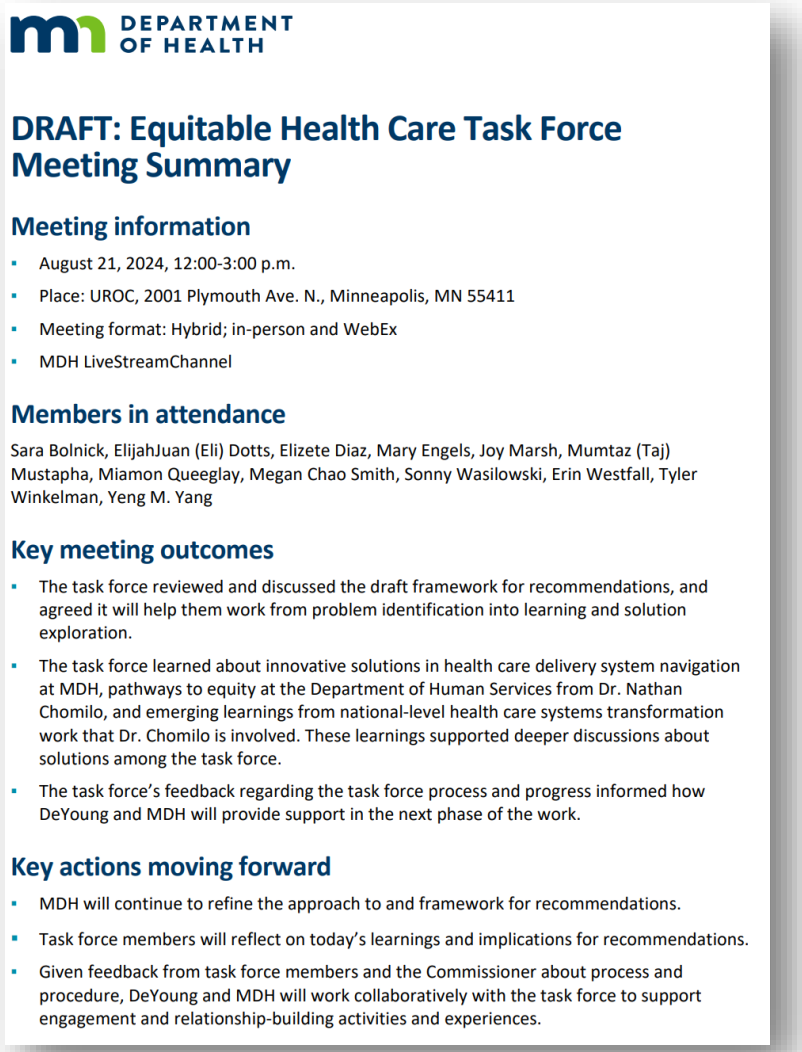
Where we are in our process



Summary of August 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?



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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.

Learning and Engagement: Stratis Health

Sarah Brinkman, Marleny Garber, Glenda Harris, Carrie Howard, Alona Jarmin, Jennifer Lundblad, De'Nika Pollard, Lindsay Roberts, Sue Severson

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Stratis Health: A Dialogue with the Minnesota Equitable Healthcare Task Force

Session Objective

- Share Stratis Health synthesis of our work to improve health equity and share solutions, innovations, lessons learned, and recommendations which will be practical and actionable for the task force in meetings its goals.

We Make Lives Better

- Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities.
- Core expertise is designing and implementing improvement initiatives across the continuum of care and with and in communities.
- Stratis Health adopted three organizational strategies earlier in 2024 (see next slide).

Strategies

Co-design 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.

With these strategies, we prioritize improvement efforts that empower those who have been historically marginalized. In implementation, we work in ways that are inclusive, systems oriented, and centered on equity. Our work is broad and inclusive, while highlighting:

- People who are age 65 and older.
- People living in rural places.
- People experiencing substance use disorders.
- People experiencing health disparities.

Team Members

Alona Jarmin

RN Program Manager

Carrie Howard

Program Manager

De'Nika Pollard

Project Specialist

Glenda Harris

Quality Improvement Advisor – Health Equity

Jennifer Lundblad

President & CEO

Lindsay Roberts

Senior Research Analyst

Marleny Garber

Program Manager

Sarah Brinkman

Senior Program Manager

Sue Severson

Vice President, Business Solutions & Innovations

Where are we coming from?

- *There is no quality without equity.*
- Stratis Health is on our own DEIB journey – we believe we have to be on an internal journey before we can credibly and authentically be working externally.
- We focus on how culture, stigma, and social factors (and intersecting identities) affect how people access to and receive care and services.

Health Equity Programs: A Sampling

- Facilitating efforts for cross-sector co-design of a shared approach to social needs resources referrals in Minnesota
- Improving health care for tribal communities served by Minnesota's two Indian Health Services (IHS) hospitals
- 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
- Closing the disparities in care and access for those with opioid use disorder
- Building capacity of clinical and non-clinical health care professionals in Minnesota to reduce health disparities and promote health equity

And more at Stratis Health - We Make Lives Better!

What have we learned in our health equity work in Minnesota?

- 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

- 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.
- Invest in community process not programs (building capacity and sustainability).

Ideas and Recommendations (cont)

- 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.

Our commitment to collaboration

- We are deeply engaged and embedded in health equity efforts in Minnesota and are ready and eager to support the task force and MDH in next steps and implementation of recommendations.

For More Information:

De’Nika Pollard

DPollard@stratishealth.org

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?

Commissioner’s Remarks

Commissioner Brooke Cunningham, MD, PhD

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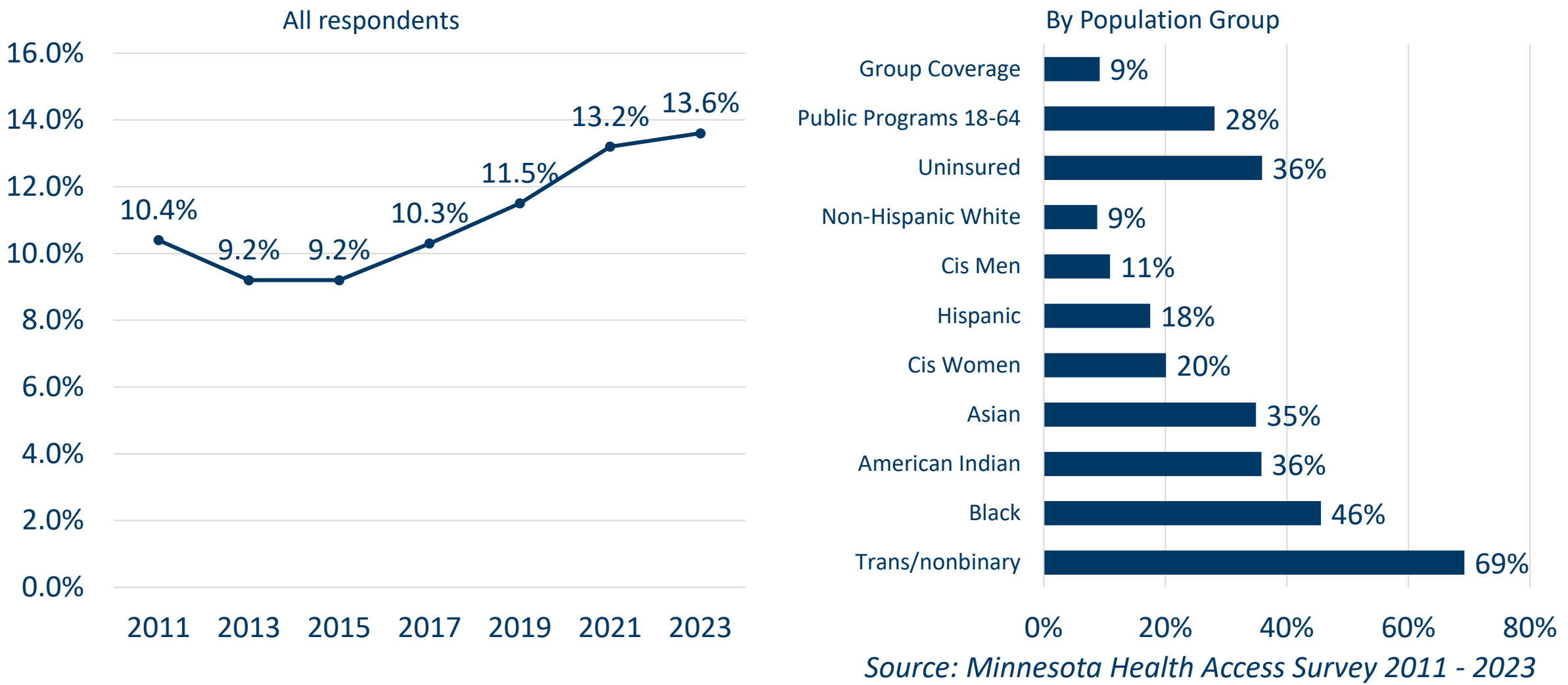
Focus Area:
Health Equity Training

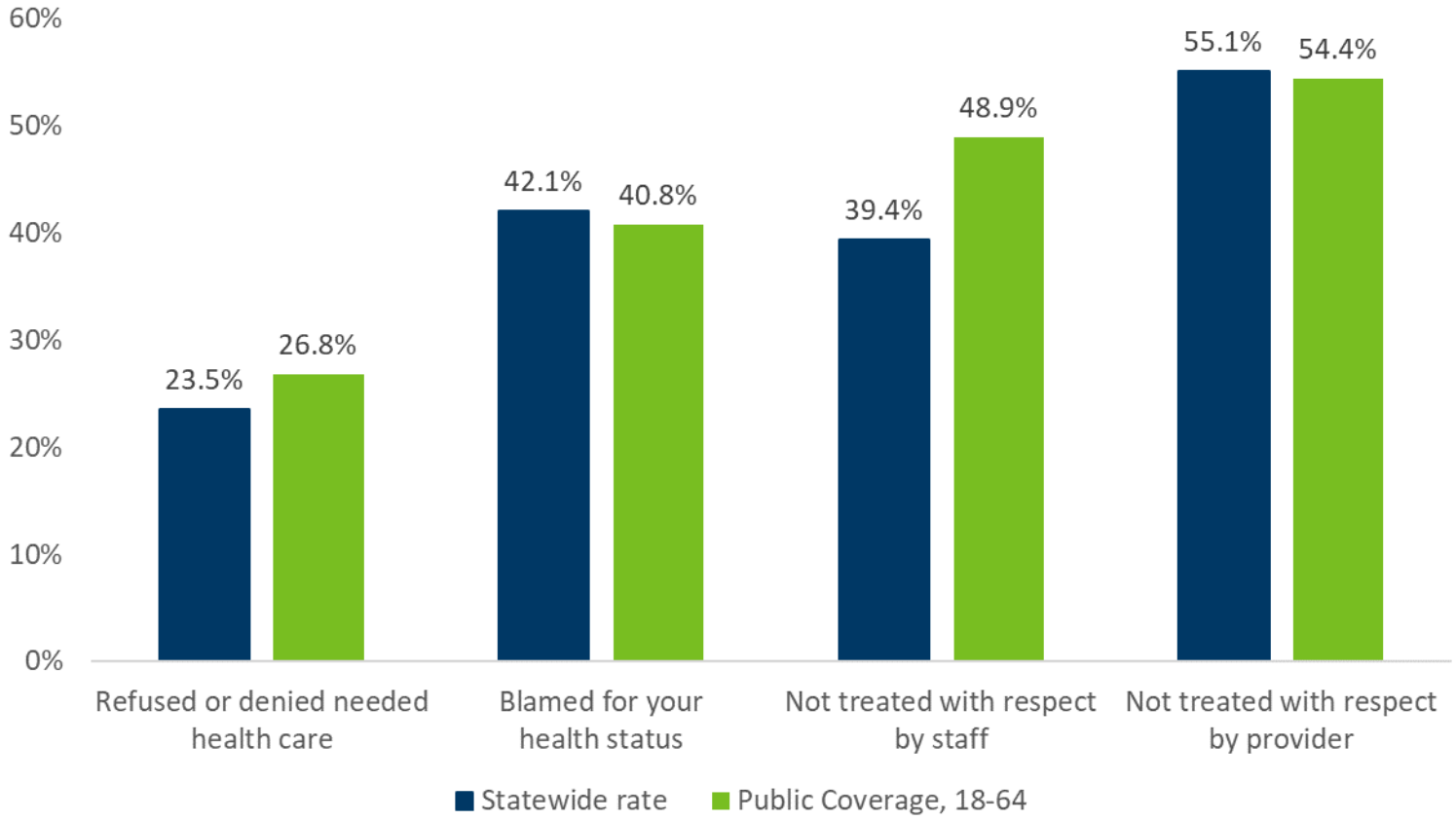
Minnesotans Reporting Any Type of Unfair Treatment



Source: Minnesota Health Access Survey 2011 - 2023

Experiences of unfair treatment, by public coverage, 2023

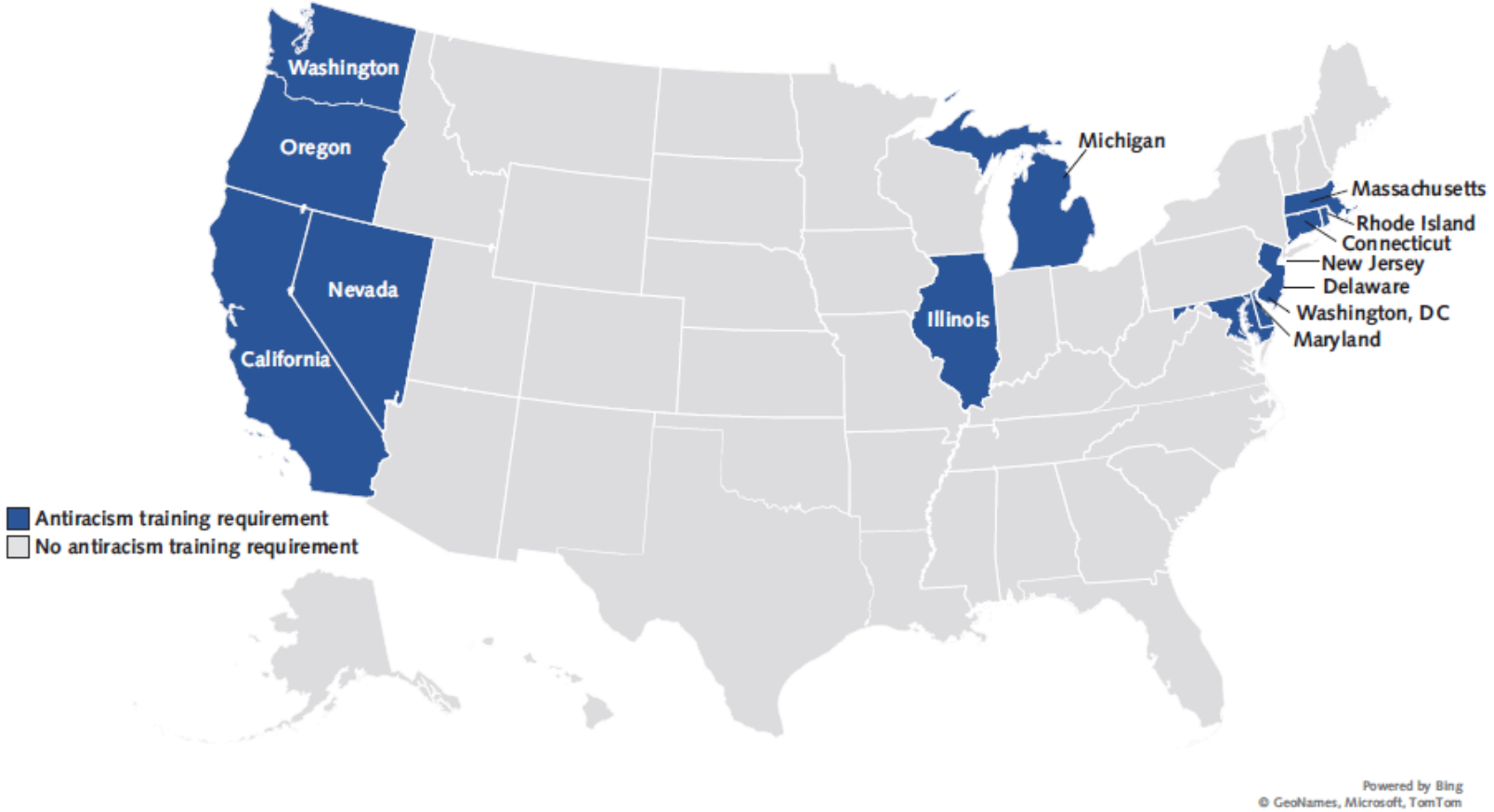
- **Among the 30.2% of publicly insured Minnesotans aged 18-64 reporting unfair treatment,** not being treated with respect by the health care provider was the most frequent experience of unfair treatment, followed by not being treated with respect by staff.
- Respondents could select multiple answers.



Source: Minnesota Health Access Survey, 2023
Rates between people with public coverage the statewide population are not statistically significant
Note: Question was asked of people who reported unfair treatment. They could selection more than one category, so totals may not equal 100%.

National Trends in Health Equity Training Requirements

Figure. Geographic distribution of state medical boards' antiracism training requirements.



- **12 states** currently have some form of health equity training requirements for health care professionals.
- **3 states** also stipulate that medical facilities ensure the availability of antiracism continuing medical education (CME).

Health Boards + Health Equity: Other State Approaches

State	Health Equity Topic	Applicable To	Year Enacted	Frequency
Delaware	implicit bias, explicit bias, reproductive justice	hospitals and freestanding birthing centers	2023	not specified
Illinois	implicit bias	health care professionals	2023	1 CME hour every 3 years
California	Implicit bias, cultural, and linguistic competency	All CME providers, physicians, physician assistants and nurses	2022	Every 2 years, number of hours unspecified
Massachusetts	implicit bias	health care professionals	2022	2 CME hours every 2 years
Rhode Island	cultural awareness	health care professionals	2022	up to 4 hours once
Oregon	cultural competency	health care professionals	2021	> 1hour per year every 4 years
Michigan	Implicit Bias Training	heath care professionals	2021	2-3 CME hours every 3 years
Washington	Health equity, bias, structural competency	health care professionals	2021	2 CME hours every 4 years
Washington, DC	implicit bias, cultural competency, culturally and linguistically appropriate services	licensed health care professionals	2021	1 of 10 topics every 5 years
Maryland	implicit bias	heath care professionals	2021	one time 2.5 hrs from approved courses
Nevada	Cultural Competency, diversity, equity and inclusion	licensed health care facilities	2021	2 CME hours every 2 years
New Jersey	Cultural Competency	health care professionals	2021	1 hour every 2 years
Connecticut	Cultural Competency	health care professionals	2015	1 CME hour every 6 years

Health Equity Training Current Proposal Pillars

WHAT:

Required Health Equity training for providers covered by health-related licensing boards. Training will include:

- Implicit bias
- Structural and systemic drivers of health and health inequities
- Culturally and Linguistically Appropriate Service (CLAS) standards
- Cultural humility
- Anti-racism in health care

The cycle of training and reporting will follow existing Board cycles and structures.

HOW:

Funding would support the creation of a workgroup that would create a library of existing continuing education options to meet this requirement and/or to develop new content.

WHO:

"Health-related licensing boards" link to statutory definition

Board of Executives for Long Term Services and Supports
Office of Unlicensed Complementary and Alternative Health Care Practice
Board of Medical Practice
Board of Nursing
Board of Chiropractic Examiners
Board of Optometry
Board of Occupational Therapy Practice
Board of Physical Therapy
Board of Psychology
Board of Social Work
Board of Marriage and Family Therapy
Board of Behavioral Health and Therapy
Board of Dietetics and Nutrition Practice
Board of Dentistry
Board of Pharmacy
Board of Podiatric Medicine
Board of Veterinary Medicine

Break

Photo by Samuele Errico Piccarini

Moving Toward Solutions

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University of Minnesota team

- **Jean Abraham**, PhD, Professor, James A. Hamilton Chair in Health Policy Management, Professor and Head, School of Public Health, Principal Investigator
- **Christina Worrall**, MPP, Senior Fellow, SHADAC
- **Megan Lahr**, Senior Research Fellow, Rural Health Research Center
- **Mary Butler**, PhD, MBA, Associate Professor, Senior Advisor
- **Elizabeth Lukanen**, Deputy Director, SHADAC, Senior Advisor
- **J'Mag Karbeah**, PhD, MPH, Assistant Professor
- **Romil Parikh**, Senior Researcher
- **Kate Beherns**, Researcher and project coordinator
- **Andrea Stewart**, Research Fellow, SHADAC
- **Amy Claussen**, MLIS, Medical Research Librarian
- **Elliot Walsh**, Research Dissemination Coordinator, SHADAC
- TBA, Graduate Research Assistants

University of Minnesota partnership

- **State Health Access Data Assistance Center** (SHADAC) and the **Division of Health Policy and Management** within the **School of Public Health**
- **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.
- Scope:
  - Health care **financing**
  - Health care **integration and coordination**
  - **Culturally appropriate** health care
  - Health **care and insurance navigation and literacy**

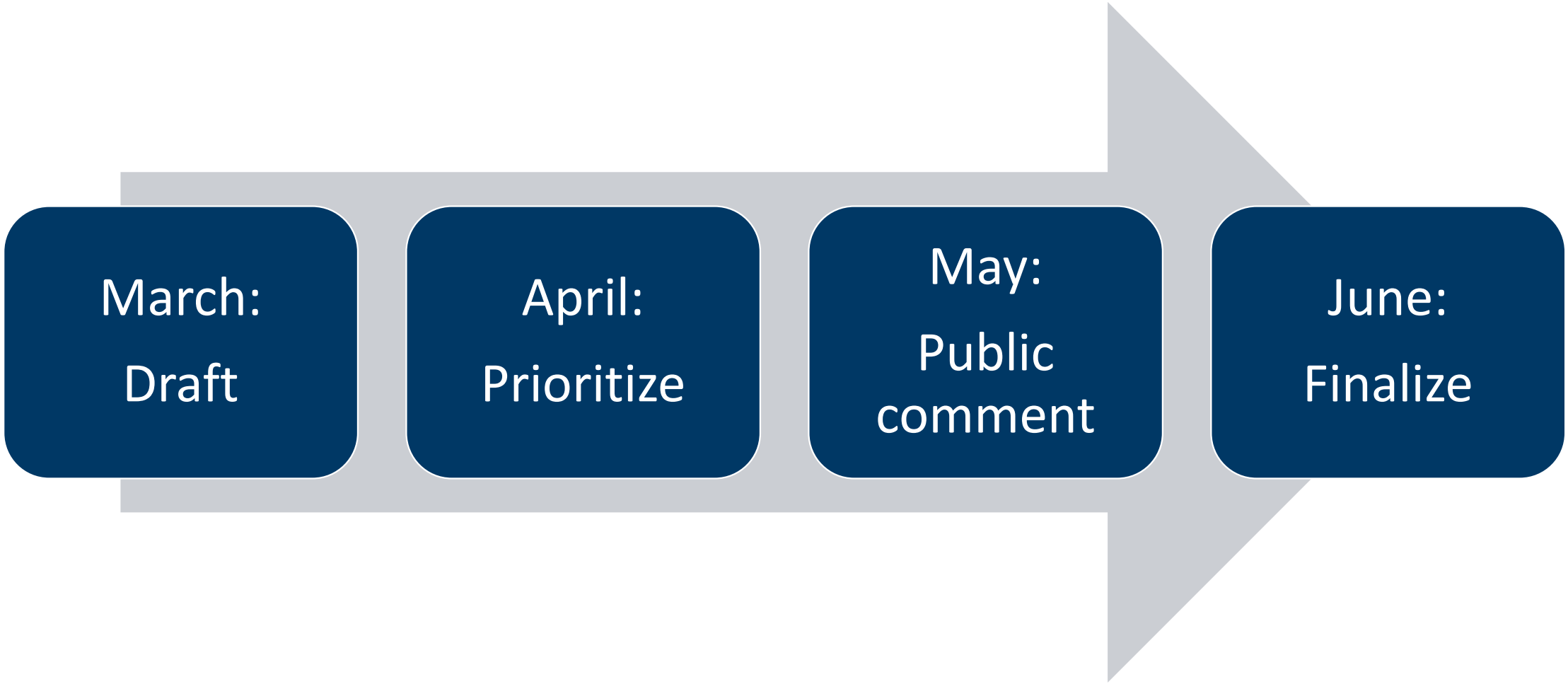
University of Minnesota activities

- 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 the **development of short-term, mid-term, and long-term recommendations** for a more equitable health care system

Phase 2 learning and solutioning

	October	November	December
Task force meeting	• Health care financing level-setting from the University • *Other items to be announced*	No meeting	• Presentation and discussion of preliminary findings on innovations, evidence, and policy and practice levers from the University • *Other items to be announced*
Learning session	Network adequacy (tentative)	Oral health (tentative)	To be determined
Workforce workgroup	No meeting	Meeting objectives to be determined	No meeting

Phase 3 recommendations



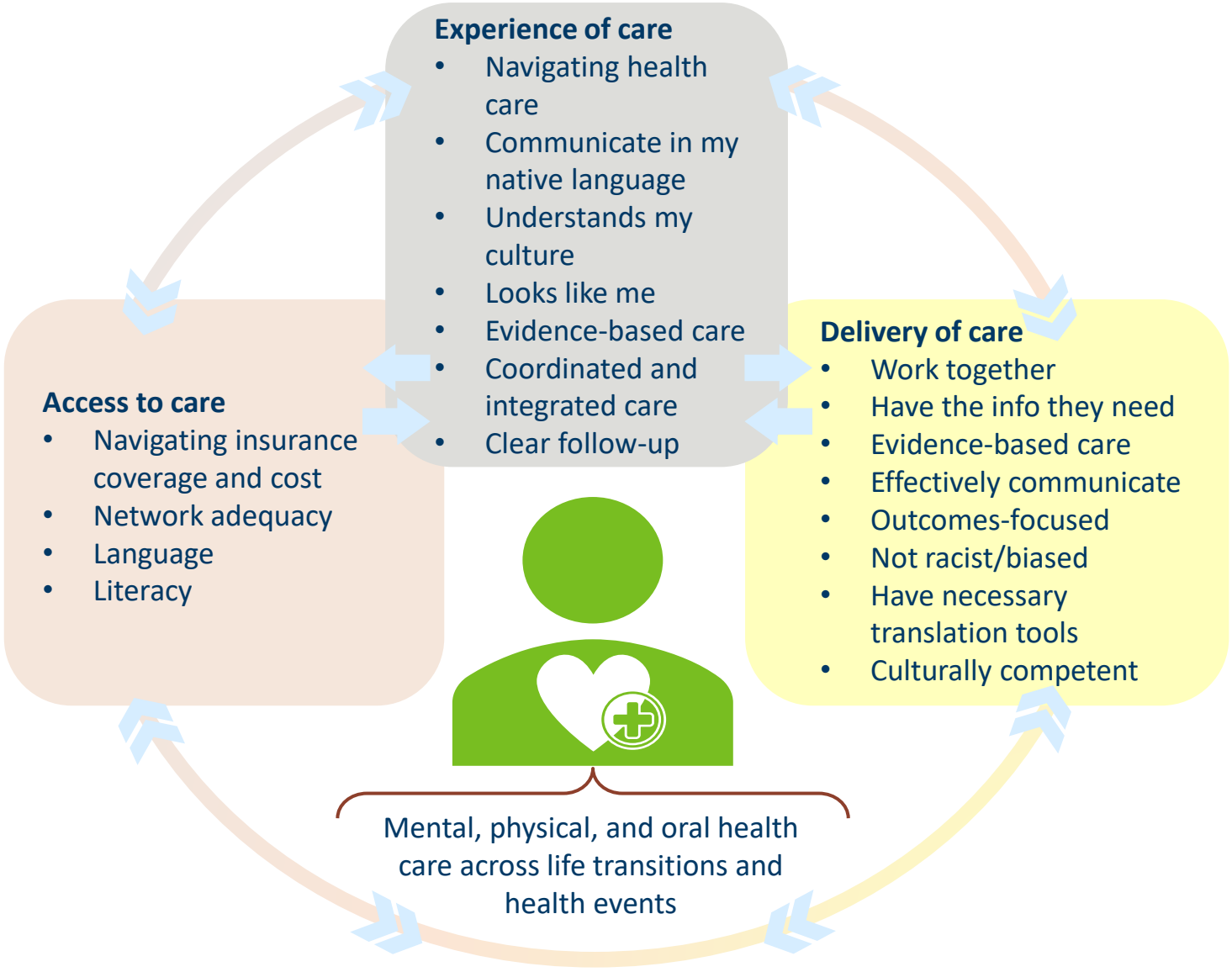
Feedback

Moving the work forward

- Task force members and MDH staff have synthesized many ideas and problems into objectives.
- MDH has compiled these into a working table to validate objectives and brainstorm opportunities to address the objectives. These opportunities…
  - Will shape future information gathering needs and recommendations.
  - May overlap multiple objectives.
  - Should help address scope and prioritization.
  - It’s all in one place to see the whole picture.
- We need your expertise to help understand how this can work in practice.

How this fits into the process

What are the opportunities to address health equity?



UNDERLYING FACTORS

Organizational accountability

- Community benefit
- Quality measures

Population health

- Evidence-based research
- Collaboration with local/community-based organizations

Translating problems into objectives & opportunities

Matrix working document

- Each row has an objective that needs to be validated by task force members. Add comments and edits as you see fit.
- 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 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 should address the “tools” available to solve the problem. Examples tools include:
    - Financing and reimbursement
    - Policies, oversight, and regulation
    - Evidence-based practice, training
    - Technology, health information exchange, and data

Matrix screenshot

	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.	

Working time

1. Orient yourself to the objectives. They fall into these topics:
   - Patient experience
   - Care integration
   - Workforce
   - Population health
2. Validate objectives by editing and/or commenting
3. Contribute to opportunities and notes (comment, edit, add)
4. Add your name to the right-most column if you are interested in working on an objective
5. You can work on this at any time

Daniel Tanase

Meeting Close

Social Get Together

- If you are interested and available to attend an in-person social get-together in the Twin Cities on Oct. 24 or Dec. 9 after task force meeting, please enter “YES” and the date(s) you can join into the chat!

Closing and action items

- Task force members will:
  - Contribute to the Opportunity Matrix for Developing Recommendations (saved in Teams)
- Project team will:
  - Summarize today's meeting
  - Provide meeting slides to the task force
  - Schedule virtual learning sessions
- Virtual learning session: October 11, 10:00 – 11:00 a.m.
  - Topic to be announced
- Next meeting is October 24, 1:00 – 4:00 p.m.
  - Health care finance level-setting
  - Continue to move our discussions toward potential solutions

Thank You!

See you October 24, 2024!