DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

- December 9, 2024, 12:00-3:00 p.m.
- MDH LiveStreamChannel
- Meeting Format: WebEx

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engels, Marc Gorelick, Joy Marsh, Maria Medina, Laurelle Myhra, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang.

Key meeting outcomes

- Task force members gave important feedback about the recommendation development process and their experience on the task force in general.
- Preliminary findings from the University of Minnesota (UMN) Research Team's rapid evidence scan were shared, and the task force provided important feedback regarding new lenses and new areas for inquiry.

Key actions moving forward

- MDH will consider the feedback received about the task force's experience so far and respond to the task force with their thoughts about moving forward.
- Task force members are encouraged to follow up on the discussion with the UMN Research Team by either contacting health.equitablehealthcare@state.mn.us or posting in Teams.
- Task force members are encouraged to continue to add opportunities to the Opportunity Matrix, to inform the ongoing development of recommendations.

Summary of Meeting Content and Discussion Highlights

Meeting objectives

The following objectives were shared:

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

Welcome and grounding

Task force members were welcomed, and the agenda was reviewed. The meeting summary from October was reviewed. No public comments were received since the last task force meeting.

Welcome from MDH – Assistant Commissioner Carol Backstrom

Assistant Commissioner Carol Backstrom made welcoming remarks to highlight the critical importance of addressing health disparities and achieving health equity for all Minnesotans. She stressed that the task force's work must center on eliminating systemic barriers and should be informed by the experiences and voices of communities most impacted by inequities. The Assistant Commissioner emphasized the need for cross-sector collaboration and encouraged innovative, community-driven solutions to create meaningful and lasting change. She called for transparency, accountability, and a commitment to outcomes that reflect the shared goal of equitable health care access, quality, and outcomes for all. While some ideas may be quickly adopted, she acknowledged others will take time and focusing on enduring good ideas and a strong vision is crucial. Her remarks concluded with a call to action, encouraging members to focus their efforts on creating impactful, lasting change.

Recommendation and report development

Grounding and recap

The project team provided an overview of the task force's progress and outlined the next steps in the recommendation development process. The team began by summarizing key milestones, including the task force's development of a guiding vision for equitable health care, their creation of a health care equity definition, and task force workgroups' establishment of work plans. Subject matter experts were engaged to provide insights, which have informed the opportunities and solutions identified thus far. The project team has documented the task force's discussions, ideas, and learnings in the Opportunity Matrix, a living document that organizes content by topic and opportunity. The matrix, shared in Teams, continues to be a resource for consolidating and refining ideas, with ongoing task force contributions welcomed.

Recommendation development

MDH noted the task force is fully entering into the recommendation development phase. Future meetings and working sessions will prioritize this effort, while also incorporating additional learning opportunities. Updates and draft recommendations will be shared by the UMN Research Team. Additionally, input from tribal health leaders is anticipated during a January meeting to provide further insights into the tribal health system. The team emphasized the importance of engaging with interested parties and the public to inform the task force's recommendations.

MDH introduced a proposed framework for developing and organizing the task force's recommendations. The framework synthesizes input from task force discussions and subject

matter experts. It begins by categorizing recommendations into two areas: those that align within the existing health care system and those that propose bold transformation outside the current system. The existing system recommendations are organized into overarching themes or "buckets," including:

- Bolster primary and whole-person care
- Strengthen and diversify workforce
- Ensure system accountability
- Other

Each bucket will incorporate financing and reimbursement, as well as infrastructure. The framework also acknowledges interconnectedness between bold transformation and current system recommendations. MDH will hold space for discussions about bold transformations that may not necessarily be a set of recommendations like the other ones, this may be more about setting a direction for how things can go in the future. The MDH team emphasized that this structure is preliminary and expected to evolve with ongoing input from task force members and subject matter experts. The discussion paused for task force members to provide initial reactions or feedback to the proposed framework. Task force members had varied reactions to the framework and content.

Several members emphasized the importance of clearly articulating equitable access to primary care, noting that robust primary care is foundational for addressing broader health care challenges and achieving health equity. Members commented on the need to define primary care as comprehensive, team-based care that integrates behavioral health, mental health, and substance use services.

Members also highlighted the critical role of technology in health care, particularly regarding equitable access to telehealth and other digital tools. They discussed how barriers such as internet connectivity, device access, language, and health literacy exacerbate inequities, suggesting that access to technology might warrant its own category or should be explicitly addressed across recommendations.

The conversation expanded to include health literacy as a broader issue impacting care access and navigation across the entire health system. Members stressed that health literacy, care coordination, and navigation are essential for enabling individuals to effectively access and utilize services, whether in primary, specialty, or behavioral health care. Concerns were also raised about the lack of integration between physical and behavioral health care, with a call to prioritize stronger connections across these services. Additional feedback included ensuring that dental health is incorporated into the framework, recognizing its impact on overall health.

There was a suggestion that meaningful access (beyond insurance coverage) could be an organizing bucket that encompasses access across the system. There could be hard recommendations to improve access to everything in health care, including primary and specialty care. Meaningful access includes things like patient navigation and care coordination supports, access and ability to use health technology, and health literacy acumen.

The task force was invited to ask questions and provide feedback on what MDH presented. They expressed a need for the recommendations to address the following:

- Emphasis on primary care as foundational
- Access to technology
- Health literacy, including access to information
- Connectivity between primary care, specialty care, and mental health
- Dental health
- Focus on where improved access is needed most

Next, MDH presented high-level examples of draft recommendations within the proposed buckets, while noting that the recommendations are preliminary and expected to evolve with further input. The MDH team encouraged task force members to reflect on the examples, asking if the recommendations resonated with their input and identified any gaps. MDH noted that in their development of recommendations and adding specificity, the task force can consider details such as who needs to act, how, and within what timeframe, as well as identifying tools like policies, financing, and training needed for implementation. Members agreed that the examples provided were a good starting point but emphasized the need for greater specificity to ensure the recommendations are actionable.

Additionally, task force members raised the importance of having a clear decision-making process for refining, adding, or removing recommendations. There was a request for a shared space where members could provide input while preserving ideas for the entire group to weigh in on. Members noted that some recommendations might evolve into multiple, interconnected actions, and it is important to balance high-level direction with concrete, detailed proposals.

The discussion then moved to “bold transformation,” with the MDH project team proposing a small group to focus on reimagining Minnesota’s health care system. This group would develop a transformative vision that could set a future direction beyond the current system. Members were invited to participate in these working sessions, with results to be shared for broader feedback and refinement by the full task force. The project team affirmed that this vision would accompany the main recommendations in the final report.

Task force members were invited to participate in a small group that would discuss bold transformations. Megan Chao Smith volunteered.

MDH staff presented a multi-pronged approach to engagement of external parties with the intention of discussing options for incorporating external input on solutions and recommendations to address health care equity problems. Engagement methods could include focus groups and interviews with community members, health care providers, payers, and others.

Discussion

The task force was invited to give their feedback on the recommendation development approach. Task force members provided critical feedback about the project overall. The following is a high-level summary of their feedback.

- Some task force members expressed feeling disconnected from each other and from the process in general. They felt that to write good recommendations, the task force needs to connect more outside of work sessions, to sit down together and share ideas, potentially in a day long, retreat-style meeting.
    - Megan Chao Smith expressed interest in engaging with task force members outside of meetings to discuss health care equity topics.
- For some task force members, this process has felt frustrating, exclusionary, corporate, and very white.
- It is felt that documentation of the meetings hasn't reflected everyone's thoughts during meetings.
- A new process is needed to make sure everyone's voices will be heard, not just in small groups or those of outside experts.
    - MDH responded that the term "small group" may be misleading and they can call them "groups of interested task force members" to emphasize that all are welcome to join.
- Some task force members said the process has felt systems-heavy or provider-centered, and it should shift to be more client-centered and rooted in communities. One idea offered was to have a community panel during a task force meeting. Several task force members supported this or some other method of inviting the community to inform the recommendations.
- One idea offered to address these concerns overall was to hold an in-person all day retreat. One difficulty with monthly meetings is a stop-and-start feel that loses momentum. There was general support for a retreat, although several task force members said they'd need at least 2 months advance notice to schedule an in-person retreat.
- There was a concern about the process for prioritizing recommendations, particularly given that the recommendations span a broad scope and task force members have different understandings of systems. There is a need to mitigate the potential for people feeling excluded.
- Task force members acknowledged that the group and work are at an inflection point and it is a great time to pause and reflect as the task force moves into recommendation development.

Throughout the discussion, the MDH project team responded to some of the task force's questions and comments. MDH acknowledged the concerns about inclusivity and process transparency and committed to making adjustments. They expressed openness to holding a full-day, in-person retreat to allow deeper discussions and confirmed that all draft recommendations would return to the full task force for input and refinement. MDH

emphasized the importance of robust community engagement and welcomed further feedback to ensure the process is equitable and reflects all voices accurately.

UMN Research Team preliminary findings

The UMN Research Team shared preliminary findings from their rapid review of select evidence. This team was asked to help fill in knowledge gaps where having deeper insights would be helpful for the task force in making recommendations. The research team invited the task force to choose two areas in which they were most interested. After brief discussion about incremental change versus bold transformation, the research team presented about the "Integration of Health Care and Public Health" and "Whole Person Health."

During the presentation, the task force was invited to add their insight. The following is a high-level summary of their comments.

- To avoid having multiple providers reinvent the wheel, there should be support to build the infrastructure at the state level, emphasizing community partners as foundational to these efforts.
- Reducing bias in health care systems and addressing systemic racism remains covered and that is a need.
    - The research team responded that bias was not the primary focus of their initial evidence review but committed to applying this lens in their deeper dive moving forward, including broader gray literature.
- Dental therapist workforce innovation is an area to explore. A member requested additional information and resources on this model.
- It is important to provide health care navigation at the patient level. Care coordination must involve navigators who follow up in the community to ensure continuity of care. This is especially critical for immigrants, limited English-speaking populations, patients with limited health literacy, and patients with disabilities. The University of St. Thomas' Integrated Behavioral Health Care training for social workers was cited as a model to explore. Developing this type of integrated role in health care will require collaboration with educational institutions.
- There was a concern about quantifying impact as "low" or "moderate", as this may overlook the significant, life-changing impact these efforts can have for individuals and communities.
- There is a need to move beyond incremental changes and address systemic racism and inequities within the health care system. Recommendations should reflect deeper, transformative solutions rather than surface-level interventions.

Closing and action items

The task force was thanked and reminded of the next meeting on January 22, 1:00 – 4:00 p.m., and working session on January 24, 10:00 – 11:00 a.m. A meeting summary is to follow.

Contact to follow-up

With questions or comments about the 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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DEPARTMENT OF HEALTH

Equitable Health Care Task Force Recommendation Development Exercise

Description: During the January 22 meeting, the Equitable Health Care Task Force will engage in a recommendation development exercise. The MDH Project Team is providing this document to the task force in advance of the meeting. Following the exercise, task force members will reflect on this approach and provide feedback on preferences for developing recommendations going forward. ***Please read this handout in advance of the meeting.***

Recommendation drafting bucket: Bolster primary and whole-person care

Subtopic: Community health workers (CHW)

Expand, finance, and sustain the Community Health Worker (CHW) workforce in Minnesota to increase statewide access to appropriate and effective CHW services to improve cultural, language and community responsive health care access, patient experience, quality and cost of care, and equitable care and health outcomes.

Rationale/Background/Evidence: According to the American Public Health Association, Community Health Workers (CHWs) are trained frontline public health professionals that often come from the communities that they serve and act as a liaison and link between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Evidence shows CHWs improve access to care and health outcomes, and reduce disparities through cultural, language, and community specific navigation, education, advocacy, and linkage to services. CHWs play a crucial role in addressing health related social needs (HRSNs), which are key drivers of health disparities and health care costs. Access to CHWs lower health care costs and improve quality and satisfaction, including through fewer ER visits and hospitalizations. A recent study found a $2.47 return on investment for every Medicaid dollar spent on CHW interventions.

Draft recommendations, first pass[1]:

1) Working with schools and health care providers to increase a pipeline of diverse health care workers by sponsoring CHW training. *OM*

2) CHWs provide follow-up wraparound services to ensure patients are getting to the next appointment and referrals are scheduled in a timely manner. *OM*

[1]OM = Opportunity Matrix, SME = Subject Matter Experts

3) CHWs provide transportation needs. *OM*
4) Establishing a state office to implement CHW policies and coordinate stakeholders. *(SME)*
5) Incorporating CHWs and CHW stakeholders in state advisory boards/work groups. *(SME)*
6) Partnering with State Medicaid on payment policies and rates, CHW services claims tracking and reports. *(SME)*
7) Incorporating funding for CHWs into state initiatives to address social determinants of health/health related social needs, community care hub infrastructure. *(SME)*
8) Financial aid and funding for CHW training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce. *(SME)*
9) Education, training, and support for CHW Supervisors and employer organizational readiness and sustainability. *(SME)*
10) The legislature should support the Minnesota Department of Health and Department of Human Services to develop opportunities to advance and sustain the CHW workforce in Minnesota. *(SME)*