Equitable Health Care Task Force Meeting Summary

Meeting information

- February 12, 2025, 1:00-4:00 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, Vayong Moua, Laurelle Myhra, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Yeng M. Yang

Key meeting outcomes

- Commissioner Cunningham gave remarks to encourage the task force to imagine an equitable health care system that is truly different from the current reality.
- Task force members engaged in discussions about their vision of an equitable health care system and brainstormed initial recommendations to achieve that vision.
- Task force members gave feedback to MDH about the plan for engaging external perspectives and for planning the March task force retreat.

Key actions moving forward

- All task force members are invited to a discussion on Fri., Feb. 21 from 10:00 – 11:00 a.m. to continue their development of transformative ideas and recommendations for an equitable health care system.
- All task force members are invited to help plan the March 14 retreat by attending at least two 2-hour planning meetings. If interested, please contact MDH at health.equitablehealthcare@state.mn.us.
- MDH and DeYoung Consulting Services will synthesize insight gathered about transformational change.
- MDH will follow up with the task force members who expressed interest in helping plan the March retreat.
- MDH will follow up with the task force about the commitment requested to collaborate with the State and the external vendor to plan the overall community engagement.

Summary of Meeting Content and Discussion Highlights

Meeting objectives

The following objectives were shared:

- Work on developing your ideas and recommendations for transformational changes in the health care system.
- Hear an update from MDH on community engagement to inform your recommendations.
- Provide input on the March retreat and the outcomes you want to achieve.

Welcome, grounding, and public comment

Task force members were welcomed, and the agenda was reviewed. The meeting summary from January was shared.

MDH shared that three groups had requested updates on the task force: the Health Equity Advisory and Leadership (HEAL) Council that MDH convenes, the Minnesota Medical Association Health Equity Community of Practice, and the Minnesota Primary Care Stakeholders Group, which is a group convened by the Minnesota Academy of Family Physicians and MDH's Health Care Homes Program. MDH invited feedback about ways to advance health equity in Minnesota and shared a summary of their input with the task force as public comments.

Task force members asked who specifically from those groups attended the meetings. MDH will request meeting attendance lists from the conveners of the three groups.

One task force member indicated their support for the ideas suggested by the HEAL Council and noted the alignment with ideas shared by some other task force members.

Commissioner welcome

Commissioner Cunningham made remarks to encourage the task force to continue imagining a health care system that looks and feels very different from the current reality. She was struck by the task force's vision and encouraged the group to liberate their thoughts and challenge their assumptions, imagining what a system would look like if the goal weren't to maximize revenue but instead was proactive and emphasized well-being and mental health. The current system feels very transactional. Much is happening that discourages working for equity, but the Commissioner stressed that it is possible and encouraged the task force members to give themselves permission to imagine it. Commissioner Cunningham encouraged members to use sensory imagination, asking them to envision what an equitable health care system would look, feel, and even smell like, emphasizing the need to break free from limiting beliefs.

Transformative recommendations

Task force members discussed their visions for transformational change first in small groups, and then shared a summary of their discussion as a large group. Task force members described

what they would see and feel if the health care system were equitable. Some task force members offered individuals who inspire them in this work. They mentioned a boss, family members, immigrants, and youth who receive inadequate or biased care.

The following is a collection or summary? of their descriptions of that vision and solutions to help achieve it:

Access and experience

- Universal care: Everyone should be able to get care. Health care is a human right. There should be a baseline comprehensive care package for all Minnesotans that offers high-quality, holistic, community-based, free and preventative care, with additional options for those with more resources.
- Inclusive access for individuals with different capabilities, including non-tech access points. Care is affordable.
- Follow existing models that are promising, including VA system and Federally Qualified Health Centers (FQHCs) that are community-focused, wrap-around services, and better reimbursement models. Increased funding for community organizations and innovative models.
- Quality interpretation services, including licensure for interpreters and access to interpretation services "at the door."
- Patient-clinician matching that matches patients with clinicians who they identify with and meet their needs and preferences.
- Care is integrated—dental, mental, behavioral, wraparound services. There is more investment in mental health, chemical health, and birth justice efforts.
- Universal patient-owned health records: A single, patient-owned health record that is accessible at any point of care, getting rid of multiple different health records.
- Culturally concordant and patient-centered care that is culturally appropriate and feels good to the patient.
- Administrative burden is reduced, less paperwork, streamlined processes.
- More choice in health care representatives, preventing monopolization.
- Chronic disease management is tailored with culturally congruent practices for long-term health.
- Communities are involved in co-designing culturally responsive care and overall models of care. Communities play a larger role in their health systems, with local resources like walkable spaces, public health services, and community organizations being prioritized.
- Public health infrastructure and systems are robust within communities. With that investment, health care is more narrowly focused.
- Focus on preventative care, providing more resources for primary care and harm reduction models. Providers take their time and address all health types, particularly in primary care.

Accountability

- Community-led health care accountability:
- Establish an accountability group for patients and providers
- Safety incident reports
- Restructure compensation and incentives so they are tied to outcomes, integrated with insurance policy. Providers are reimbursed for actual care costs, reducing medical errors.
- Success is identified by patients
- Grievance resolution process with legal services and hotline to Lt. Governor to voice grievances
- Health care oversight committee
- Smaller systems for better accountability and community-specific solutions.
- Reimbursement policies are flexible, supporting diverse health care models and culturally appropriate care. There's investment in community knowledge, funding traditional health and healing services, including doulas.
- Uphold treaties by ensuring 100% health care coverage for American Indian individuals as per federal treaty agreements (contrasting with the current Indian Health Service system).
- Funding is reoriented to address social determinants of health, tailoring care to communities' needs.
- Equity is the foundation of health and healing systems. Racism is removed from clinical decision-making.

Workforce

- Workforce is educated and represents different communities, attracting and acknowledging diverse expertise, less reliance on high-cost specialists and more integration of community expertise.
- Training includes addressing discrimination, bias, and the revision of outdated medical practices and standards, community-led training, promote accountability.

The task force was asked how they want to further develop transformational ideas between now and their March 14 retreat. Their responses are summarized as:

- Five task force members agreed that the task force should further this work during the Feb. 21 working session with technical support from MDH.
- Five task force members agreed that MDH should synthesize the insight gathered and share back with the task force.
- Three task force members agreed that there should be a small group of task force members who meet on their own (with or without technical support from MDH).

- MDH agreed to synthesize and reflect back content from today's discussions, and to focus the working session on this topic, as well.

Earlier in the discussion, one task force member expressed interest in forming an Accountability Workgroup. In closing-out the discussion and summary of next steps, facilitators followed-up with the member on this item. Them member responded that the task force's continued work on transformative change would meet their interests.

Community engagement and timeline

MDH shared that the objective of community engagement is to obtain input on emerging recommendations 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. They shared a compilation of community engagement approaches, some used by MDH in prior efforts and others suggested by task force members.

MDH is contracting with an experienced outside vendor to conduct community engagement. Task force members asked about timeline and how the vendor will be informed by task force insight. MDH clarified that the contract is written in such a way that the task force will inform the vendor as to who to engage, how, and about what kind of content.

The task force was asked about their level of support for extending the task force timeline beyond June to allow for more thorough development of recommendations and community engagement. The following discussion is summarized as:

- Five task force members indicated strong support for this idea, and it was acknowledged that some members were not present.
- There was general support for the idea that draft recommendations be completed by June 30, and inviting the task force to support the community engagement efforts beyond June, while allowing members to choose to finish their commitment in June.
- MDH clarified that task force members are always welcome to reach out into their communities on their own anytime to learn and bring back insight to the full group.
- When asked if they'd like to help plan the community engagement efforts, some task force members expressed interest but wanted more information about the commitment before deciding. MDH said there would likely be two to three planning meetings and opportunities for input into the planning outside of the meetings.

March retreat

The task force was invited to share what they hope to achieve at the March retreat.

Task force members generally agreed that today's meeting was productive. Their suggestions included:

- Put everything discussed today into draft recommendation format and conduct an exercise to visualize implementation.

- Backward planning: Work backwards from the desired end result, focusing on practical solutions from various perspectives (payment, finance, operational, public health, care delivery).
- Keep big bold wishes in mind as end goals.
- Flesh out recommendations that are both transformative and pragmatic.

Maria Medina and Yeng M. Yang volunteered to collaborate with DeYoung Consulting Services and MDH to plan the March retreat. MDH will follow up with them.

Close

A meeting summary is to follow. The task force was reminded about the next meetings:

- Working session on transformational change: February 21, 10:00 a.m. - 11:00 a.m.
- Full day retreat at UROC: March 14, 9:00 a.m. – 4:00 p.m.
- Meeting at UROC: April 10, 10:00 a.m. – 1:00 p.m.

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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