Equitable Health Care Task Force Meeting Summary

Meeting information

- March 28, 2024, 1:00-4:00 p.m.
- Meeting format: WebEx
- MDH LiveStreamChannel

Members in attendance

Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engles, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Mumtaz (Taj) Mustapha, Cybill Oragwu, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- The task force came to general consensus around how to review/discuss a recent publication about strategies to address racial and ethnic disparities in health and health care.
- The task force determined that a small group (four volunteers) will finalize the vision statement and definition of health care equity.
- Four small groups, each assigned to four key health care issues, began to identify "Starting places" for their ongoing workgroup.
- The small groups identified which outside voices are needed in the process toward developing recommendations within each key health care issue.

Key actions moving forward

- Four task force members will meet separately to discuss changes needed to finalize the task force vision statement and definition of health care equity.
- Each of the four workgroups will meet or otherwise collaborate to develop a vision for the group, as well as identify objectives and a draft engagement plan.
- MDH will collaborate with DeYoung Consulting Services to update the draft charter to include a project purpose statement, objectives, scope, methodology, timeline, and milestones; parameters for external engagement and an environmental scan/literature review will be further informed by the workgroups.

Summary of meeting content and discussion highlights

Meeting objectives

The following objectives were shared:

- Learn about some aspects of MDH's health care equity work and gaps
- Share what you would like to learn about DHS's health care equity work in preparation for the April meeting
- Discuss grounding statements: vision and definition
- Launch workgroups based on primary key health care equity content

Welcome and grounding

Task force members were welcomed and the agenda was reviewed. The current process for developing meeting summaries was also shared to the task force to ask any questions or express concerns. The process is to thematically analyze all notes taken during discussions, which are then discussed and summarized collaboratively by the planning team to deliver a high-level summary. Upon receiving important feedback about the February meeting summary, additional detail was added to that meeting summary. An idea offered to the task force was to add a footnote to future meeting summaries that explains all task force members' comments are represented, that identities are intersectional, and that the discussion reflects barriers and solutions that affect many communities at once. There were no questions or concerns from the task force about this process. Several expressed support.

Other relevant work

Because the task force has asked to learn what other work has been or is being done in health care equity, Commissioner Cunningham and the MDH team provided an overview of other work.

Relevant work at MDH: The Commissioner stressed that this task force's work and recommendations will not likely be duplicative of MDH's work. There is a lot of opportunity in the health care space for the task force to develop new recommendations. She briefly presented where MDH is making relevant efforts, including:

- Grantmaking to clinics and community-based organizations, local public health, and others
- Inclusion of race and ethnicity in payors' claims if the data is available
- Research into barriers to access
- Conducting network adequacy evaluations (to create more equitable provider networks)
- Discussions about NCQA health equity accreditation for health plans
- Grantmaking for people to become community health workers

- Loan forgiveness for rural providers
- Developing Maternal Mortality Data Report and continuing education in that area
- Support for primary care and community clinics through grants to federally qualified health centers (FQHCs)
- Vaccination program for uninsured and underinsured
- Grantmaking to address disparities through Division for Health Equity
- The HEAL Council advises the Commissioner and Division for Health Equity about strategies that advance health equity
- Inclusion of Office of American Indian Health and Office of African American Health into budget
- Established a new Office of African American Health
- Hiring of health equity strategists in every division of MDH

There was one question for the Commission from the task force:

- **TF member**: What sorts of things can MDH make happen based on recommendations so that we can make the recommendations that fit what you are able to do in the state?
- **Commissioner**: Don't even focus on MDH. Focus on whatever strategy that you all feel will be impactful, because what we can do as a convening agency is get people around the table to push on the whom, the who in terms of making the strategy happen. It can be on policymakers to do a policy lever or it can be on employers if it's about employer based insurance. We can work with the table with the Council of Health Plans. I want people to go bold and to not really be limited in any way. I anticipate the group considering what are things that we can do today, what is the next step for the next legislative session, and I would encourage you all to be bold enough to say 'this probably realistically may not happen next legislative session or the next year, but we have this longterm vision' … We will convene partners. We will move something through the health and human services budget, if we can, but we will also draw on whatever levers, in partnership I hope with you all on the task force, to say here are the next steps… These may not be MDH, maybe they'll be DHS, maybe they'll be Commerce. Maybe they won't be the state. Maybe at the Department of Health's planning tables with sort of grassroots organizing to say this is what we think needs to happen for Minnesota… I want us to be free to really imagine how we can get to that state where we are not seeing the healthcare disparities that we have been struggling with for decades, centuries even.

Relevant work at DHS: MDH briefly shared that they are in conversation with the Department of Human Services (DHS). A DHS representative plans to attend the April task force meeting to give an introduction to their health care equity work. DHS administers the state's Medicaid program, so they can talk about how Medicaid serves as a policy lever to greater reforms in health care, including building equity into that work specifically.

Additional relevant resource: At the suggestion of a task force member, prior to the meeting, MDH shared an article, Strategies to Address Racial and Ethnic Disparities in Health and Healthcare: An Evidence Map, with the task force. Authors concluded that, "most studies aimed to improve care for a target group, and very few directly addressed the question of whether disparities between groups were reduced or eliminated to improve health outcomes. This leaves the important issue of improving health equity largely unaddressed."

Task force members generally agreed that reviewing this article will be helpful. They discussed whether to invite the author to a task force meeting. Several expressed interest in learning from the author, but there wasn't general consensus around the appropriate format (presentation, brief Q&A, discussions outside of a meeting, etc.).

Foundational groundwork

The definition of "health care equity," revised with task force input via the pre-meeting survey, was shared. The group was asked to indicate their support for this revised version, and while there was general support overall, there were some remaining concerns to address. A draft vision statement was shared as well. The task force gave feedback, including to emphasize disability and to change language referring to sexual orientation. and to balance brevity with language inclusive of many identities. There was also a specific request to have an intentional dialogue about balancing the importance of brevity with the importance of referencing specific communities being represented, within a context of implied "prioritization" of communities. Three task force members volunteered to meet and incorporate feedback into a revised definition and vision statement.

Overview of roadmap and topics

MDH reviewed the phases of the project overall, as well as a high-level look at the flow of meetings and milestones. Workgroups will be launched during this meeting and confirmed at the April meeting. Workgroups are to meet in between full task force meetings and report out highlights from their discussions to the full task force. Workgroups are responsible for exploring and identifying key gaps, barriers, opportunities, and recommendations within the purview of their workgroup topic.

The four topics, which have emerged from task force discussions as priorities, are health care access and quality, delivery, financing, and workforce.

Task force members indicated their preference for one to two workgroups and were split into breakout rooms to discuss.

Small group discussions of four key health care equity issues

The objectives of this discussion were to:

- Begin prioritizing key topics within each focus area

- Begin identifying information and engagement needs to move toward developing recommendations for this focus area

The insight gleaned from each group will inform MDH's parameters of an environmental scan of leading and best practices, and effective models of improving health care equity. This environmental scan proposal will be shared with the task force in April to finalize the objectives and scope.

Because of time limitations, there was no large group share-out from small groups. A summary of each group discussion, as well as raw notes, will be shared in the new shared Teams workspace for task force members to review as they wish.

Workgroups were asked to identify two co-leads who will be responsible for keeping the workgroup on track and moving forward, serving as a point of contact for MDH and DeYoung Consulting Services, and preparing workgroup updates for future task force meetings.

The following are high-level summaries of each small group discussion.

Health care access and quality

Participants were Elizete Diaz, Nneka Sederstrom, Megan Chao Smith, and Yeng M. Yang.

- Priority areas to further discuss were identified as:
  - Mental health (particularly models of combined primary care/mental health)
  - Continuity of care (chronic, preventive, sick care, etc.)
  - Health care literacy
  - Culturally responsive/inclusive care (how providers meet with people and culturally concordant clinicians)
  - Equitable insurance coverage (including under- and uninsured populations)
  - Maternal/prenatal/postnatal health
  - Accountability systems
- "Starting places" for moving their discussions forward were identified as:
  - Explore existing accountability systems
  - Explore examples of systems using best practices to be culturally responsible
  - Research community-based clinics (e.g., queer, homeless youth)
  - Build our understanding of legislation
  - Identify key stakeholders
  - Explore successful primary care models that meet definition of continuity of care
  - Research data on uninsured people
- Areas of further discussion include homecare/telemedicine/remote monitoring, disability populations, language access, and housing

- Promising practices identified were Northpoint Health, Southside clinic, FQHC, and the Institute for Healthcare Improvement
- Voices needed in this process include:
  - Community members (e.g., parents, young people, queer community, women)
  - Leaders health care orgs and agencies (e.g., FQHCs, MDH, DHS, clinics)
  - Health care personnel (e.g., nursing, physicians, community health workers, doula)
  - Community clinics not recognized as traditional medical centers
  - Payer leaders
  - Queer Caucus in legislature
  - Insurance companies
- Workgroup co-leads identified will be Nneka Sederstrom and Yeng M. Yang. The group's goal is to meet virtually before the April task force meeting.

Health care delivery

Participants in this group were Marc Gorelick, Miamon Queeglay, Sonny Wasilowski, Erin Westfall, and Tyler Winkelman.

- "Starting places" for discussing health care delivery include:
  - Building up primary care (including ensuring access, meeting people where they're at, mental health)
  - Making sure experiences are equitable (making navigation easier, addressing stigma, addressing concerns around interpretation including for disability community)
- Areas of further discussion include:
  - Collaborative care models
  - Intersection with health care financing (resources for more interpreters, cost of overhead, etc.)
  - Concerns around mandated reports
  - Difficulty for patients to see a real person
  - Culturally congruent health care
- Voices needed in this process include:
  - Legislature
  - Payers
  - State/federal policymakers
  - People and institutions who need to address solutions

- Community needs health assessment

Workgroup co-leads include Miamon Queeglay and TBD. The group has not determined when to meet again.

Health care financing

Participants in this group were Bukata Hayes, Taj Mustapha, and Cybill Oragwu.

- "Starting places" for discussing health care financing include:
  - Identifying a framework for what is incentivized for health care
  - Identifying opportunities for more transparency around reimbursements
- Areas of further discussion include:
  - Setting intentional goals that avoid punishing some populations
  - Looking for a middle ground between public health and health care
  - Identifying differences between reimbursement models
  - Exploring how to even the playing field regarding the among paid for care
- Promising practices identified were value-based care models
- Voices needed in this process include:
  - Ontario's health system representative
  - TF member Dr. Nneka Sederstrom
  - Clinics that have value-based contracts with insurers
  - Actuary in health care
  - Private insurance person e.g., Dr. Susan Pleasants
  - Community input needed (either via interviews or review studies that have gotten broader community insight)
  - Employee(s) of insurance companies, health systems (physicians, providers, etc.)
  - Commonwealth Fund representative who does systems research

Workgroup co-leads will be Bukata Hayes and Taj Mustapha. The group will meet again on April 10, 2024.

Health care workforce

Participants were Mary Engels, Joy Marsh, and Maria Medina.

- "Starting places" for moving their discussions forward were identified as:
  - Inclusive workplace environment (sense of safety and belonging)
  - Workforce skills including cultural responsiveness, other soft skills

    - Intentional recruitment and hiring practices (e.g., *requirements to recruit from diverse sources*
- Areas of further discussion include:
    - Role inequities
    - Workforce pipeline barriers to diversify all levels including senior leadership (provider network credentialing, barriers to new American providers, cost/awareness of education, rural physicians, apprenticeships, etc.)
- Voices needed in this process include:
    - Human resources
    - Folks hiring international nurses/physicians
    - Whomever is determining credentialing requirements for providers
    - Social workers, community health workers, care coordinators
    - Labor unions representing affected groups
    - Cultural awareness trainers
    - People leading DEI work within organizations
    - Language interpreters
    - Employee Resource Groups
    - NCQA and the accreditation organizations are seeking

Workgroup co-leads identified will be Mary Engels and Joy Marsh. They are looking at several potential dates in April to meet again.

Public comments

Public comments that had been received previously were shared:

- I have been watching the event online from the YouTube channel. I learned of the event from the MDH mailing list (by email) and did not receive a Webex invitation, so I cannot comment through Webex. The following is my comment for the Group 1 question asked:
    - When I think of health care equity, I think of similar costs for various populations.
    - What concepts come to mind – for individuals with disabilities healthcare costs are based on higher need and therefore higher consumption (such as increased copays every time the doctor is visited).
    - The current healthcare system, unless if someone qualifies for Medicaid, charges more for the medically fragile or disabled populations than the healthy populations. In other words, the disabled or medically fragile are more likely to achieve their out-of-pocket maximum rather than healthy populations.

  - Innovations, such as capping co-pays, or other innovations that are possible in computer claims processing systems to make healthcare more equitable for individuals with disabilities not yet on Medicare are my thoughts.
  - I was thinking of applying co-pay caps more as an example for individuals who receive coverage through private plans, rather than through public plans.
  - Considering reducing MA-EPD premiums would also benefit the population of individuals with disabilities. MA-EPD is MA for Employed Persons with Disabilities.
- Recommendation that people take a look at this, "The Patient Revolution".
  - It's inclusive in that everyone is welcome Including Patients. It's free and there a learning group (A cohort). And once finished, can be a "Fellow".
  - There's a Minnesota connection too in that Dr Montori (Mayo Clinic) is a co-founder.
  - Please consider collaborating with this group and please let people know about this resource.
  - And please remember for your efforts to work well Patients and family members need to be fully included.
  - Will you have subcommittees that include people from the public?
  - Including Older people and People with disabilities (the biggest equity group and often left out of equity efforts).

Closing and action items

Each workgroup was charged with collaborating before the April task force meeting to develop a vision statement, overall objectives, and a draft engagement plan for their group.

The task force was thanked and reminded of the next meeting on April 25, 2024. A post-meeting survey and meeting summary are 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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04/22/24

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