DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

June 17, 2025, 10:00 a.m. – 1:00 p.m.
MDH LiveStreamChannel
Meeting Format: WebEx

Members in attendance

Elizete Diaz, Mary Engels, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Mumtaz (Taj) Mustapha, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Task force members shared their level of support for each leading recommendation.
- The task force reviewed the draft report outline and key messages.

Key actions moving forward

- MDH will send an online survey to the task force, allowing members who did not attend today's meeting to score each leading recommendation, and allowing all members to make additional comments.
- MDH will revise the leading recommendations and sub-recommendations based on the task force's insight.
- Task force members are invited to attend the public listening session on July 15 from 5-7:30 p.m.
- Task force members may encourage colleagues and peers to submit public comments. MDH will send talking points and a worksheet for task force members to use in those conversations.
  Task force members are encouraged to continue to review draft recommendations, make comments, and contact MDH with questions and feedback at health.equitablehealthcare@state.mn.us.

Summary of Meeting Content and Discussion Highlights

Welcome

The task force was welcomed. The agenda was reviewed and the summary of the May meeting was shared. The task force had no questions or concerns.

Recommendation development

Task force members engaged in an exercise to score each leading recommendation to indicate their level of support and suggest changes needed to increase their support. Sub-recommendations and action steps were not included in this activity to preserve enough time to work through the leading recommendations and because feedback from listening sessions and the public comment period may further inform the task force's refinement of sub-recommendations. Nevertheless, task force members were encouraged to consult sub-recommendations during the scoring activity if that would aid in their decision-making.

The scoring options were as follows:

- 1 – Support or can live with it
- 2 – Would support with changes
- 3 – Do not support

The table below shows a snapshot of the 19 leading recommendations that were scored by topic, and a high-level summary of the task force insight for each. Some insight applied to all recommendations, including:

- The report should include an overarching message that the recommendations are interdependent, not an a la carte menu—they are designed to work together.
- There is a need to clarify who the recommendations are aimed toward (e.g., state agencies, providers, payers), recognizing that multiple entities are likely involved in the implementation of each recommendation.
- As part of its supporting role for the task force, MDH may combine like recommendations and sub-recommendations, re-order recommendations, and streamline content.

Summary of Task Force Insight and Scores

Topic	Leading recommendation	Insight	Score
Ensure system accountability	1.1 Ensure full and equitable health care coverage for American Indian communities and Tribal citizens in Minnesota.	May fit better under Access rather than Accountability due to reference of health care coverage.	Support= 7 Support with changes = 1

Topic	Leading recommendation	Insight	Score
Ensure system accountability	1.2 Minnesota should strengthen and harmonize its approach to health care patient protection.	Unclear what problem this addresses. Concerns raised about creating a new office vs. strengthening existing processes. Sub-recommendations need clarification to align with intent.	Support = 5 Support with changes = 1 Support with changes/Do not support = 1
Ensure system accountability	1.3 Health care in Minnesota should have community co-leadership and equity-focused oversight.	Request to clarify the entities responsible (agencies, organizations) and implementation details.	Support = 4 Support with changes = 4
Ensure system accountability	1.4 Minnesota should strengthen data infrastructure to advance health care equity.	Recommendation to explicitly include data protections and ensure a systems approach across the health care ecosystem.	Support = 5 Support with changes = 1
Meaningful access	2.1 Minnesota should implement universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota.	Strong support for universal health care. Coverage alone does not eliminate inequities, yet universal coverage is an essential component of creating an equitable health care system. Request to clarify meaning of baseline comprehensive care (e.g., does “baseline” mean “primary care”?).	Support = 6 Support with changes = 1 Support/Support with changes = 1
Meaningful access	2.2 Minnesota should support a health care delivery system that patients can access where and when they need it.	Clarification needed on sub-recommendations regarding incentivizing vs. requiring. The concept of supporting is right, and the right mix of requirements and incentives are needed to provide that support.	Support = 7 Support with changes = 1
Meaningful access	2.3 Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.	High support that this is needed with questions around the funding and infrastructure to support implementation. Concern raised about unfunded mandates and the difficultly in internal funding for clinics and systems with a high proportion of non-English speaking patients.	Support = 7 Support with changes = 1
Meaningful access	2.4 Minnesota should expand inclusive and accessible telehealth by investing in broadband infrastructure, mobile care, and phone-based services to ensure equitable access in rural and underserved communities.	High support	Support = 7
Meaningful access	2.5 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.	High support but would like to define "community transportation infrastructure" in appendix.	Support = 7 Support with changes = 1
Meaningful access	2.6 Minnesota should strengthen patient health literacy.	High support but would like to include payers in the sub-recommendations.	Support = 8

Topic	Leading recommendation	Insight	Score
Meaningful access	2.7 Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.	High support	Support = 7
Bolster primary and whole-person care	3.1 A re-envisioned primary care system should include the integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally concordant care.	High support but would like to replace "culturally concordant" with "culturally responsive."	Support = 6 Support with changes = 1
Bolster primary and whole-person care	3.2 Minnesota should invest in team-based primary care models that coordinate activities with public health.	High support	Support = 7
Bolster primary and whole-person care	3.3 Minnesota should adopt reimbursement and payment models that will support investments in primary care.	High support but want to make sure different types of providers are recognized (e.g., specialty and community clinics, FQHCs).	Support = 7 Support with changes = 1
Bolster primary and whole-person care	3.4 Minnesota should modernize data sharing among payers, health care providers, researchers, social service providers, and public health.	High support but would like to add "community organizations" and would like to see clear guidance on data sharing and patient protection.	Support = 6 Support with changes = 1
Strengthen and diversify the workforce	4.1 Foster workplace inclusion, belonging, safety, and well-being to encourage retention of current diverse workforce members. Minnesota to create a model for inclusion, belonging, safety, and well-being including implementation guidance and resources for health care organizations.	Moderate support with discussion around interpretation of "diverse" with a request to provide a definition in the appendix to guard against a narrower interpretation than intended. Add “equitable” retention and optimization of the workforce with possible reordering of the sub-recommendations	Support = 1
Strengthen and diversify the workforce	4.2 Enhance workforce skills and cultural responsiveness. Minnesota to create a mandated or incentivized training for all healthcare workers. Accrediting bodies can adapt it to their field but need to provide the same content. Include content for members of healthcare organization boards of directors.	High support with discussion about incentivizing vs. mandating. Some concern about mandating training.	Support = 7
Strengthen and diversify the workforce	4.3 Address workforce inequities. Minnesota to outline a framework and model to help healthcare organizations collaborate with stakeholders to examine and address systemic barriers that contribute to healthcare workforce inequities. Include guides and implementation resources.	Moderate support, with a suggestion to streamline the sub-recommendations, clarify stakeholders involved, and potential overlap with 4.4.	Support = 1 Support with changes = 2
Strengthen and diversify the workforce	4.4 Optimize the workforce. Health care organizations to diversify who and how care is delivered to make it more effective, accessible, comprehensive, holistic, and culturally congruent for patients and members.	High support with suggestion to change "culturally congruent" to "culturally responsive." Request to add definition to appendix. Consider beginning the workforce recommendations with this one.	Support = 4 Support with changes = 1

Note: Although 10 members attended the meeting, there are not 10 scores for every leading recommendation because some members did not score certain items and/or had other obligations during this part of the meeting.

Recommendation Prioritization

The task force was invited to share which recommendations are rising as top priorities and whether the task force would like to prioritize recommendations. They shared the following insight:

- The guiding questions shared in the scoring exercise could help the task force prioritize the recommendations.
- To prioritize, clarity is needed around the agencies and/or organizations each recommendation is directed towards and the timing (e.g., short-term or long-term).
- Suggest sequencing recommendations rather than prioritizing, with the concern being that "low priority" recommendations will never be implemented.
- Recommendations could be presented as a journey for organizations, with foundational steps coming first and transformative ones later.
- Any prioritization should have a lens of community feedback.

Report development

Consultant Katie Burns gave an update on the structure and content of the report. Highlights include:

- Katie and the MDH Project Team are drafting content for the report outside of the recommendations while the task force continues to focus on developing the recommendations.
- The task force will review a first draft of the report in July, and a final draft in August that integrates community feedback. MDH will finalize and post the report in September.
- Task force members are invited to a June 25 small group discussion to discuss key messages for the transmittal letter. Small group sessions will also take place in July and August to discuss integrating recommendations and community feedback into the report.

The structure of the report was proposed to contain the following:

- Letter from the Commissioner
- Transmittal letter from task force
- Executive summary
- Introduction
- Background
- Recommendations - with examples for action and inclusion of community feedback
- Conclusion

- Appendices

Task force members were invited to comment and ask questions about the report. They expressed support for the plan, commenting that it was straightforward and thorough. No concerns were expressed.

Close

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

- MDH will send an online survey to the task force, allowing members who did not attend today's meeting to score each leading recommendation, and allowing all members to make additional comments.
- Working session on June 25 will focus on the key messages for the transmittal letter.
- Task Force meeting on July 28, from 1:00 – 4:00 p.m. In this meeting, task force members should expect to hear and discuss findings from the community engagement and public comment, in the context of the full set of recommendations.
- MDH and Alliant will begin the public comment period and community engagement sessions. MDH will send materials to the task force to guide any conversations they have with peers and colleagues.
- Task Force members will receive communication from MDH to help prepare for the July meeting.

Contact to follow-up

With questions or comments about the Equitable Health Care 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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DRAFT: Equitable Health Care Task Force Recommendations

Contents

Meaningful Access

Recommendation 1. Minnesota must ensure all persons in Minnesota have comprehensive health care insurance, timely access to needed health care services, and a basic understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

Recommendation 1.1 Minnesota should implement universal health care to provide comprehensive care for all persons living in Minnesota.

Recommendation 1.2 Ensure full and equitable health care coverage for American Indian communities and Tribal citizens in Minnesota.

1.2.1 Tribal members and children should be automatically enrolled in a health care plan that provides full coverage.

1.2.2 Uphold federal treaty agreements with Tribes to ensure full health care coverage for Tribal communities with plans that are on par with others.

1.2.3 The State of Minnesota should support Tribal Nations in accessing care for their members and ensuring access to equitable health care.

Recommendation 1.3 Minnesota should support a health care delivery system that patients can access where and when they need it.

1.3.1 Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools and mobile care models.

1.3.2 Expand information in provider directories related to provider demographic information so patients can choose providers with whom they identify.

1.3.3 Require and/or incentivize providers to offer flexible hours for evening and weekend appointments.

1.3.4 Expand provision of school-based and community-based health services, including oral health screenings and preventive services. Expand primary prevention programs through healthy youth development programs.

1.3.5 Enhance policies for coverage and availability of in-home monitoring systems (for example, blood pressure monitoring and glucose monitoring) that integrate with health care delivery systems.

1.3.6 Expand use of common referral approaches (a shared strategy to link Minnesotans with essential and culturally appropriate health care services and health-related social needs like food, transportation, and housing) among cross-sector partnerships to ensure health-related social needs are met.

1.3.7 Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics and hospitals.

1.3.8 Expand the use of Community Health Workers or Patient Navigators to provide wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner.

Recommendation 1.4 Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.

1.4.1 Standardize translation services through licensing of translators to ensure they are knowledgeable about health-related concepts and terminology as well as meet quality standards.

1.4.2 Establish infrastructure to provide access to independent contractors offering interpreter services and make it available for hospitals and other providers to buy into.

1.4.3 Ensure consistency in reimbursement by payers for interpretation and translation services.

1.4.4 Consistent with federal civil rights regulations, provide interpretation services for patients who need this immediately upon arrival at a health care facility. Providers should have standard processes in place and train staff about how to access these resources.

1.4.5 Ensure that translated patient-facing education and materials are vetted with bilingual clinicians or professional translators to ensure cultural context is taken into account for some of the languages that are not easily translatable from English, such as Hmong, Somali, and others with different health paradigms.

1.4.6 Require after-visit summaries to be translated, written in plain language, and include after care and follow-up instructions.

1.4.7 Develop a centralized hub for providers to access vetted translated materials in commonly spoken languages across Minnesota to promote consistency and reduce provider costs.

1.4.8 Require providers to adhere to the National Association for the Deaf's "Minimum Standards for Video Remote Interpreting Services in Medical Settings."

Recommendation 1.5 Minnesota should expand inclusive and accessible telehealth by investing in broadband infrastructure, mobile care, and phone-based services to ensure equitable access in rural and underserved communities.

1.5.1 Expand telehealth and mobile health services especially for rural and underserved areas. Continue support for audio-only telehealth for people covered by Medicare and Medicaid, especially in rural areas, where reliable internet access is limited and phone-based care may be the most equitable option. The State of Minnesota should further expand broadband access in rural communities. This will provide the infrastructure to ensure telehealth is equitably accessible across the state.

Recommendation 1.6 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.

1.6.1 More transportation and transportation coordination options need to be available to all individuals to ensure patients can access health care services. Assess what transportation support is currently available and recommend strategies for scaling up existing infrastructure and filling gaps. One strategy may be to expand non-emergency medical transportation benefits under Minnesota Department of Human Services (DHS)/Medicaid.

1.6.2 Ensure that transportation services meet all patient needs (e.g., car seats, adaptive equipment).

Recommendation 1.7 Minnesota should strengthen patient health literacy related to accessing, navigating, and paying for health care.

1.7.1 Establish state-wide health literacy initiative related to health care access, navigation, coverage, billing, and out-of-pocket costs. Develop partnerships with providers, communities, and others to participate in this work.

1.7.2 Establish digital literacy education to help ensure individuals may access health care services virtually.

1.7.3 Deliver health education in community spaces, such as schools, libraries, and other trusted local venues, particularly in Greater Minnesota, to address access gaps and avoid default reliance on telehealth.

1.7.4 Reimburse for patient navigators to help patients understand coverage, billing, and out-of-pocket costs.

Recommendation 1.8 Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.

1.8.1 Increase reimbursement rates for mental and behavioral health services to ensure they are equitable with physical health care, thereby improving provider participation and patient access.

1.8.2 Redirect resources in the health care system to support health care access for populations not covered by public payers, including undocumented immigrants.

1.8.3 Align funding strategies with access goals by addressing regulatory and reimbursement barriers that limit provider participation, particularly for patients enrolled in public programs.

Bolster Primary and Whole-Person Care

Recommendation 2. Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages and events.

Recommendation 2.1 A re-envisioned primary care system should integrate and coordinate care for physical health, mental health, substance use, complementary care, and culturally responsive care. Reimbursement and payment models must support these investments in primary and preventive care.

2.1.1 Service delivery and reimbursement must integrate mental and behavior health care, and primary care clinics must treat opioid use and alcohol use with FDA approved medications.

2.1.2 Primary care clinics must provide comprehensive and culturally inclusive care that reflects and respects traditional healing and wellness practices.

Recommendation 2.2 Minnesota should invest in team-based primary care models that coordinate activities with public health and community-based organizations.

2.2.1 To ensure that health-related social needs are addressed, primary care clinics need to employ social workers, community health workers (CHWs), and licensed alcohol and drug counselors (LADCS), and the services of these workers needs to be reimbursed.

2.2.2 To optimize the impact of community-based organizations (CBO), promote the community care hub model of CBO networks that streamline referral and business processes, and engage more efficiently with health care providers and payers.

2.2.3 Incentivize the integration of dental services into primary care through improved reimbursement for dental care provided within primary care and through reimbursement for oral health education, fluoride varnish, silver diamine fluoride, and other preventive oral health services that can be provided by dental hygiene and primary care clinician teams.

2.2.4 Support population health outcomes by promoting and funding coordination between primary care and local public health.

Recommendation 2.3 Minnesota should adopt reimbursement and payment models that will support investments in primary care.

2.3.1 To address current and historic underfunding of primary care services and to sustain ongoing investments in primary care, require commercial and public payers to increase primary care spending as a percent of total medical expense (e.g., Primary Care Investment Ratio).

2.3.2 Incentivize primary care clinic certification as health care homes by updating and simplifying Medicaid reimbursement rates to reflect the true costs of service while reducing administrative burden.

2.3.3 Incentivize oral health preventive care by increasing the Medicaid reimbursement rate.

2.3.4 Expanding alternative dental care team models (e.g., dental therapy, dental hygiene collaborative practices) to support more efficient care delivery and increase access to oral care in community settings.

Recommendation 2.4 Minnesota should modernize data sharing among payers, health care providers, community organizations, researchers, social service providers, and public health.

2.4.1 Ensure interoperability, data governance, quality standards, and policies to enable seamless data exchange and communication across different electronic health records (EHRs) adhering with data protection and patient consent policies and protocols.

2.4.2 Incentivize health providers and the state to participate with the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing.

2.4.3 Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care, and community-based organizations.

2.4.4 Envision the goal of establishing a single, aggregated patient record via one portal that supports the ability for social services/community organizations to collect and add data to patient records.

2.4.5 Update the Minnesota Health Records Act to provide clarity and alignment with electronic workflows.

2.4.6 Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research, maintain public health surveillance and dashboards, and add additional partners across Minnesota.

Strengthen and Diversify the Workforce

Recommendation 3. Our vision is to provide strategic guidance to Minnesota health care organizations in building, nurturing, and maturing an equitable workforce. Through these efforts, we aspire to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients and communities.

Recommendation 3.1 Foster workplace inclusion, belonging, safety, and well-being to encourage equitable retention of current diverse workforce members. Promote diversity at all levels of health care organizations, including senior leadership and Boards of Directors.

3.1.1 Minnesota should create a model for inclusion, belonging, safety, and well-being in health care. We recommend that this framework includes best practices, regular assessment, and strategies for leadership accountability, and leverages insights from underrepresented employees and employee resource groups.

3.1.2 Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups.

3.1.3 Maintain and/or increase funding for programs that support health care professionals. There is high demand for programs to support individual health care providers manage the stress of their professions.

Recommendation 3.2 Enhance workforce skills for cultural responsiveness.

3.2.1 Minnesota agencies and relevant entities to collaborate to create a common framework and set of core competencies for training that ensures consistency in content and learning outcomes across healthcare professionals, including healthcare organizations boards of directors and those in leadership roles. This training framework should reflect learnings on training providers on similar content/competencies. This training framework can be mandated and/or incentivized and adapted to fit specific fields and roles. Partnerships with local organizations and universities can be leveraged to develop culturally appropriate training. To develop essential soft skills and competencies that advance equitable

health care, training should address: cultural humility, cultural responsiveness, cross-cultural understanding, trauma-informed care, elimination of implicit and unconscious bias including attitudes and beliefs regarding patient health insurance status, disability inclusion, empathy, effective communication, teamwork, patient-centered care, and inclusive leadership/governance.

3.2.2 Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally congruent care. Continuing education requirements may include courses on diversity, practice-based cultural concordance models.

3.2.3 Recommend incentive–based mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.

3.2.4 Recommend workforce equity strategies that are informed by the communities being locally served.

Recommendation 3.3 Increase diversity of the current health care workforce through shorter term strategies.

3.3.1 Recommend strategies to incorporate into hiring processes to support the hiring of underrepresented candidates and to attract and recruit a workforce that reflects the communities we serve, including strategies to support international candidates.

3.3.2 Increase the use of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.

Recommendation 3.4 Introduce long-term changes to health professional training programs and the broader education system to increase the diversity of the future health care workforce.

3.4.1 Increase funding and remove barriers for underrepresented students and employees to obtain grants, scholarships, and loan forgiveness who aspire to pursue careers and leadership positions in health care.

3.4.2 Ensure that some NorthStar Promise funding, which provides scholarships for students from income-eligible families for many Minnesota public colleges and universities, is dedicated to students seeking health care degrees.

3.4.3 Recommend best practices for collaborating with educational institutions, credentialing entities, and community organizations to remove barriers to entering the health care workforce.

3.4.4 Support and expand programs focused on increasing culturally specific health care professional training programs.

3.4.5 Leverage remote learning modalities to grow health-related career and technical education to reach non-traditional learners such as adults considering second careers or residents of greater Minnesota communities who may need different modes of access to higher education.

3.4.6 Expand dual-training pipeline programs.

3.4.7 Encourage health professional education programs to take a holistic approach when screening for potential candidates vs. over reliance on standardized scores such as MCATs.

3.4.8 Increase awareness among K-12 students of the array of medical professional pathways.

3.4.9 Expand the development and use of partnerships between K-12 schools and health care providers to sponsor Community Health Worker (CHW) training and increase the pipeline of diverse health care workers.

3.4.10 Professional schools should broaden the membership of admissions committees for medical/dental/pharmacy/nursing schools and other health professional education programs to include staff with expertise in state workforce needs.

Recommendation 3.5 Optimize the health care workforce by making strategic investments to address workforce shortages; to ensure care is more available in underserved areas of Minnesota; and to appropriately maximize scope of practice for health care professionals to meet basic health care needs.

3.5.1 Health care organizations should identify and implement strategies to restructure how care is delivered to make it more effective, accessible, comprehensive, holistic, and culturally congruent for patients and members. Decentralize the role of physicians where evidence supports it and when care can be provided within other health care professionals' established scope of practice.

3.5.2 Address workforce shortages, especially focused on addressing rural access issues (e.g. dental therapists).

3.5.3 Establish an independent (meaning outside of a state agency) Minnesota Health Care Workforce Advisory Group to provide objective health care workforce research and data analysis; identify workforce gaps and barriers; collaborate and coordinate with other entities on health care workforce policies; recommend appropriate public and private sector policies, programs, and other efforts to address identified health care workforce needs.

3.5.4 Identify strategies to expand the dental workforce, particularly dental therapists, hygienists, and assistants.

3.5.5 Increase reimbursement for lower paid health professions to attract more individuals to train for and work in these health care roles.

3.5.6 Augment the range of MDH-administered loan forgiveness programs to include health care professions for which such relief doesn't currently exist as a recruitment incentive to sites that are in health professional shortage areas.

3.5.7 Increase the utilization of Health Navigators from underrepresented communities.

3.5.8 Shore up the Community Health Worker profession in Minnesota through the following strategies:

3.5.8.1 More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.

3.5.8.2 Provide legislative authorization to the Minnesota Department of Health (MDH) and Department of Human Services (DHS) to develop opportunities to advance and sustain the Community Health Worker (CHW) workforce and establish a state office to implement CHW policies and coordinate stakeholders.

3.5.8.3 Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.

3.5.8.4 The Minnesota Department of Human Services (DHS) should recognize Community Health Representatives without requiring duplicative training. Enable Community Health Representatives to bill for services as Community Health Workers, especially given the historical and community-specific role they serve.

3.5.9 Identify strategies for increasing the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.

3.5.10 Establish additional residency and fellowship programs for health professionals to work in underserved, rural, and tribal communities to ensure that they are exposed to the specific needs of these populations.

3.5.11 Track the retention of health care professionals in underserved areas to identify gaps and opportunities to improve retention.

3.5.12 Require managed care organizations to fund community-based partnership staffing to increase managed care organizations' capacity for coordinating health-related social needs services.

3.5.13 The health care system must shift from solely expanding traditional staffing to integrating innovative, accessible service delivery models. This includes automated driverless transportation, drone-enabled delivery of medications or supplies, and public self-service kiosks – ideally equipped with video/voice interfaces and

available in libraries and other community hubs across Minnesota. Additionally, optimization must prioritize direct services such as direct video calling with providers, multimodal health literacy (written, spoken, and American Sign Language), and hiring individuals with federally defined targeted disabilities. The current system disproportionately benefits large urban health systems. Investment in smaller community-based health organizations in greater Minnesota may yield more equitable and culturally responsive care.

Recommendation 3.6 Address workforce inequities within the current health care workforce.

3.6.1 Minnesota to outline a framework and implementation resources to help health care organizations collaborate with stakeholders to examine and address systemic barriers that contribute to health care workforce inequities.

3.6.2 Examine inequities between similar roles, including a pay structure analysis and evaluation of the value, impact and advocacy of care coordinator/community health workers and other similar roles. Recommend solutions to resolving these inequities.

3.6.3 Establish a mandate to hire, retain, and advance individuals with disabilities as defined under the federal government's list of targeted disabilities.

3.6.3.1 To ensure meaningful change, Minnesota should also require health care organizations to centralize their budgets for accommodations for persons with disabilities. This approach ensures costs are shared across the organization and helps normalize disability inclusion as part of standard workforce infrastructure.

Ensure System Accountability

Recommendation 4.1 Minnesota should strengthen and harmonize its approach to health care patient protection to address health care discrimination and unfair treatment.

4.1.1 Minnesota's system for accepting consumer complaints should be restructured to ensure a "no wrong door" approach. In addition, to the extent a consumer complaint crosses jurisdiction of multiple agencies, an agency or office needs to be designated as the lead agency for investigating and following up with consumers about their complaints.

4.1.2 Minnesota should establish a consumer-based organization that assist patients with access to and quality of health care services or health care discrimination, and provides free legal services.

Recommendation 4.2 Health care in Minnesota should have community co-leadership and equity-focused oversight.

4.2.1 Strengthen the State's regulatory role in population health expectations, impact, and accountability of health plan and provider systems.

4.2.2 Health care provider organizations should establish patient and community advisory boards to provide ongoing feedback on health care policies and ensure cultural relevance. This should include co-designing health care evaluation and delivery, non-clinical treatments that reflect community needs and values.

4.2.3 Create policies that support communities in playing a larger role in the systems that serve them, including representation in local health care systems, community organizations, and local partners.

4.2.4 Provide funding that gives local communities the resources to create healthy environment such as walkable spaces, access to nutritious foods, and other public health services.

Recommendation 4.3 Minnesota should strengthen data infrastructure to advance health care equity.

4.3.1 Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ameliorate disparities in health outcomes.

4.3.2 The Minnesota Department of Health (MDH) should implement recommendations from the Health Equity Advisory and Leadership (HEAL) Council to standardize and disaggregate data.

Recommendation 4.4 Require All Health Care Organizations to Meet CLAS Standards.

Recommendation 4.5 Require health equity accreditation for providers and applicable health care systems under NCQA or The Joint Commission.

Recommendation 4.6 Require health equity accreditation for health plans under NCQA.

Recommendation 4.7 The State should establish an Accountability Group of patients and health care workers to oversee health care equity accountability, transparency, measurement, and reporting in the state.

4.7.1 Regularly assess how health care equity accountability is defined, who is responsible for it, and how it's enforced.

4.7.2 Develop a platform to allow real-time data access on health care system equity performance, outcomes, and accountability.

4.7.3 Hold health systems and health plans accountable for network adequacy and for ensuring public-facing information is up to date and correct.

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EHCTF Community Engagement Event Feedback Summary

Community Health Clinic Patient Boards Listening Session

Number of Participants: 3

Organizations represented

- Mayo.edu
- MN Care
- Open Cities Health Center

Input Summary: [NONE]

General Feedback [none]

Ensure System Accountability [none]

Meaningful Access [none]

Bolster Primary and Whole-Person Care [none]

Strengthen and Diversify the Workforce [none]

Health Navigators and Care Coordinators Listening Session

Number of Participants: 1

Organizations represented

- Minnesota Community Health Care Worker Alliance

Input Summary

General Feedback [none]

Ensure System Accountability [none]

Meaningful Access

Which recommendations do you think are the highest priority and why?

2.6.5 Reimburse for patient navigators to help patients understand coverage, billing, and out-of-pocket costs.

- This is a critical need, reimbursement rates are low and is critical for CHWA and dental reimbursement; the reimbursement process is not easy

Bolster Primary and Whole-Person Care [none]

Strengthen and Diversify the Workforce

What will be important to consider when implementing these recommendations?

4.4.12 Provide legislative authorization to the Minnesota Department of Health (MDH) and Department of Human Services (DHS) to develop opportunities to advance and sustain the Community Health Worker (CHW) workforce, and establish a state office to implement CHW policies and coordinate stakeholders.

- Consider how a CHW office would function in partnership with organizations doing the work (e.g. the way the state operates vs how the alliance operates to support the organizations).

4.4.13 The Minnesota Department of Human Services (DHS) should recognize Community Health Representatives without requiring duplicative training. Enable Community Health Representatives (CHRs) to bill for services as Community Health Workers, especially given the historical and community-specific role they serve.

- How would this impact the professionalization of CHW? It’s currently very strong but changes could affect the unification of the same knowledge and training, yet we must support CHR’s in the community.
- CHRs who often work with tribal nations may already have their own cultural training. There's ongoing conversation about whether requiring them to also complete Community Health Worker certification could be duplicative. The Alliance is exploring how CHRs can continue hiring and recruitment while navigating certification requirements. However, skipping state training isn’t straightforward, more discussion and stakeholder involvement are needed.
- CHRs care for indigenous patients who don’t live on the reservation but are being supported by the CHR; if they change locations would that be validated if they were not in a facility that did not predominantly support indigenous patients?
- There is a desire to do cross training or development of a CHR model of training but nothing is approved.

Health Care Providers Serving Impacted Communities Listening Session

Number of Participants: 32

Organizations represented

- American Academy of Physician Associates
- Blue Cross and Blue Shield of Minnesota
- Essentia Health
- Health Partners
- Hennepin County
- Medica
- Minnesota Academy of Family Physicians
- Minnesota Council of Health Plans
- Minnesota Department of Health
- Minnesota Department of Human Services
- MN Care
- Open Door Health Center
- OutFront Minnesota
- University of Minnesota School of Nursing

Input Summary

General Feedback

- Some of the recommendations are massive and will require large infrastructure, regulatory changes and other things dictated by federal changes. Recommend a phased approach, identify low hanging fruit then build infrastructure for larger initiatives.
- Consider the federal bill going through, there are some concerning things on infrastructure build due to funding or defunding so would be interested in seeing these changes based on federal level changes
- Consider prioritizing the recommendations; the list is overwhelming and seems like a collection of ideas instead of strategic and actionable; suggest pairing down to a small number of high impact activities
- System components are missing, we have great ideas and ways to provide services, what are we doing with data, who has access, what are the metrics, what are the performance

- There is no explicit mention of 2SLGBTQIA+ communities and their specific health needs beyond data collection.
- It's unclear who the recommendations are directed towards. Recommend information be added about who would lead or implement each recommendation. Prioritization is also missing.
- At a high level, federal budget changes are going to make health care less affordable, accessible, and stable for the foreseeable future - prioritizing our resources and efforts as a state will be essential for navigating this climate.
- A major thing to think about is how will each piece be funded? Is it advocating insurance reimbursements or provider covering? Across the hospital system how do we get these pieces paid for?
- Some of the recommendations are already required federally. Are we looking to have these on the state level in case of federal changes?
- When implementing, ensure alignments and simplifications where possible and being thoughtful about not putting additional burdens on already over-burdened clinicians.

Ensure System Accountability [none]

Meaningful Access

Which recommendations do you think are the highest priority and why?

Recommendation 2. Minnesota must ensure all Persons in Minnesota have comprehensive health care insurance, timely access to the health care services needed, and a baseline understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

- Meaningful access should be a priority once the bill is implemented.
- We lack communications and infrastructure within systems both in the state level that can talk to each other and report back; some of the meaningful access pieces will be vital as we go through next few years of federal changes.

2.1 Minnesota should implement universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota.

- Comprehensive insurance is more of a sub-point of meaningful access. Insurance is one way of organizing health care access and is both an essential pathway and a barrier to meaningful access.

What is missing from the recommendations?

2.3.5 Ensure that patient-facing education and materials are vetted with bilingual clinicians to ensure cultural context is taken into account for some of the languages that are not easily translatable from English, such as Hmong, Somali, and others with different health paradigms (or an additional bullet).

- Take into account low literacy, which is not exclusive to non-English speakers.

What will be important to consider when implementing these recommendations?

2.3.4 Provide interpretation services for patients who need this immediately upon arrival at a health care facility.

- This is already a federal requirement; or are we trying to get more independent contractors in place and to enhance or is this different based on who will be funding these services?

Bolster Primary and Whole-Person Care

Which recommendations do you think are the highest priority and why?

- Bolster Primary and Whole Person Care is significant, when it comes to strengthening equity in general Primary care is the gateway to healthcare and offers meaningful connection between provider and patient. It has enormous potential and overlaps with other care such as access, offering greater points to health care system as a whole, and other areas in the recommendations.
- Primary and whole-person care is priority and its impact on improving access and improving health.

What is missing from the recommendations?

- Emphasis on care coordination within bolstering primary care. This helps address the concerns raised around implementing "next steps" based on what patients are learning from their primary care providers. Robust care coordination supports patients connecting with specialists and other providers and gaining access to services that are outside the traditional domain of primary care.

What will be important to consider when implementing these recommendations?

- Investment in primary and whole person care is deeply related to meaningful access and equitable outcomes, for those with and without comprehensive insurance.
- The interoperability piece in **3.4.6** is an important piece that our family physician members continually highlight as a frustration for patients and clinicians
- Access to primary care is important, but the bigger issue is what happens after—like imaging, medications, or therapy. The problem isn't just seeing a doctor but being

able to follow through on their recommendations. That's where many gaps exist. Things like high drug costs and limited access to treatments aren't technically part of primary care, but they're essential to completing a care plan—and those parts of the system also need attention.

Strengthen and Diversify the Workforce

What will be important to consider when implementing these recommendations?

- Has there been conversations with educators? Are young people getting access to healthcare exploration in elementary school for instance. Use work pathways in the school system.
- There are new barriers affecting retention and workforce pipelines, especially due to recent changes in federal policies and immigrant communities.

Community and Advocacy Groups Listening Session

Number of Participants: 2

Organizations represented

- Minnesota Association of Community Mental Health Programs
- National Alliance of Mental Illness

Input Summary

General Feedback

- Whole-person care includes loneliness, which includes lack of sharing info to family members when someone is in crisis, asking if they have a connection to someone in the community; this typically hasn't been included.
- A lot of work has been done in the mental health community, are we looking at previous recommendations to build on those?
- An issue in mental health is that people can't be transported to emergency rooms when they're in crisis, the infrastructure for access and crisis mental health services is becoming a bigger issue.

Ensure System Accountability

What will be important to consider when implementing these recommendations

1.3.2 Establish patient and community advisory boards to provide ongoing feedback on health care policies and ensure cultural relevance. This should include co-designing health care evaluation and delivery, non-clinical treatments that reflect community needs and values.

- Advisory Boards can be a challenging and limited way to gather input—they often reflect a "middle-class white" approach and pose barriers like transportation and meeting times. They shouldn't be the primary method for community engagement.

Meaningful Access

Which recommendations do you think are the highest priority and why?

2.2.3 Require and incentivize providers to offer flexible hours for evening and weekend appointments.

- Offering times outside of work shifts/schedules greatly improves access to care.

What is missing from the recommendations?

2.2.4 Expand school-based health services, including oral health screenings and preventive services.

- This recommendation refers to “school based” mental health services, do we have “school linked” services in the recommendations?

2.3 Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.

- In the mental health community, some interpreters interpreting mental health issues are being retraumatized as they interpret, there should be mental health supports available for interpreters.

What will be important to consider when implementing these recommendations?

2.5.2 Expand non-emergency medical transportation benefits under Minnesota Department of Human Services (DHS)/Medicaid.

- In rural MN volunteers are largely used, but it’s becoming less of an option due to the IRS volunteer mileage which is less than the standard mileage reimbursement rate and they don’t get the return trip paid for.

Bolster Primary and Whole-Person Care

Which recommendations do you think are the highest priority and why?

3.1 A re-envisioned primary care system should include the integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally concordant care.

- Appreciates that mental health is being brought in to integrate with primary care, it would be nice to see it vice versa where mental health is integrated to primary care

What is missing from the recommendations?

3.1 A re-envisioned primary care system should include the integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally concordant care.

- We need to think of what the framework looks like, a health care exchange of information, care coordination, fragments of care, how do we preserve that?

3.4 Minnesota should modernize data sharing among payers, health care providers, researchers, social service providers, and public health.

- Need greater awareness around the Family Involvement Act
- A strategy to implement social drivers of health.

Strengthen and Diversify the Workforce

What is missing from the recommendations?

4.3.8 Encourage health professional education programs to take a holistic approach when screening for potential candidates vs. over reliance on standardized scores such as MCATs.

- Are there recommendations for alternatives to National Exams? They are typically not culturally responsive; social work passed last year to create an alternative to the test but we' like to see others as well.

4.4 Optimize the workforce.

- Expand the use of peers in mental health and SUD system

What will be important to consider when implementing these recommendations?

4.2 Enhance workforce skills and cultural responsiveness.

- FYI to task force members: all mental health licensees are required to obtain 4 credits continuing education in the area of becoming more culturally responsive

4.3.20 Provide financial aid and funding for CHW training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.

- We like to see the ability for CHWs to get a certificate in mental health so they can practice literacy and mental health through the community.

General Public Listening Session

Number of Participants: 7

Organizations represented

- Council for Minnesotans of African Heritage
- Hennepin Health
- Minnesota Department of Health

Input Summary

General Feedback

- Middlemen, like insurance companies, play a vital role in the US health care system; people should be able to buy insurance directly from the providers. Right now, middlemen negotiate prices and profit the most, making healthcare unaffordable, especially for minority communities. This issue should be reviewed by independent groups like the government or watchdog organizations.

Ensure System Accountability

What is missing from the recommendations?

- Provider accountability. They have an accountability to support this work since they are working directly with patients. Also health insurance plans, as they are a significant part of health care.
- Understand the health care system is a group of stakeholders, how can they assure the medical providers are equitably distributed across MN and are held accountable?

Meaningful Access

What will be important to consider when implementing these recommendations?

Recommendation 2. Minnesota must ensure all Persons in Minnesota have comprehensive health care insurance, timely access to needed health care services, and a baseline understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

- People need to understand private funded and public funded first; some minority communities in MN don't understand how this works in the USA; we have private and government; how do you address meaningful access if you don't know where you belong?

- Health care provider types and locations are limited in greater MN; people need to travel far for care such as dental and specialty care and transportation is an issue.

Bolster Primary and Whole-Person Care

What is missing from the recommendations?

- A lot of patients are newly migrated patients with different types of diseases native to their home countries and they have complex needs. Can counties with large populations of immigrants have more funds to deal with care for those that live with diseases? Some might be contagious and spread it in the community.

Strengthen and Diversify the Workforce

What is missing from the recommendations?

4.4.11 More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.

- Mental health specialists and people of color to represent the people they service (address people of color provided services to other people of color).

4.4.14 Increase the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.

- Make it easier to get through the rigorous process.

Local Public Health Association (LPHA) of Minnesota Listening Session

Number of Participants: 20

Organizations represented

- American Indian Development Corporation
- Carver County Public Health
- City of Minneapolis
- Health Partners
- Hennepin County Public Health
- Horizon Public Health
- Local Public Health Association
- Mower County Public Health
- Pennington & Red Lake County Public Health & Home Care
- Polk County Public Health
- Quin County Community Health Services
- Renville County Public Health
- Washington County Public Health
- Wright County Public Health

Input Summary:

Ensure System Accountability

Which recommendations do you think are the highest priority and why?

1.2.1 Minnesota should establish an office to coordinate the work of entities that field patient complaints so there is one consumer-friendly entry point for all patients. Entities include the Minnesota Department of Health Office of Health Facility Complaints, Minnesota health licensing boards, Minnesota Department of Health (MDH) HMO Enrollee External Review and Complaint Process, Minnesota Department of Commerce Consumer Response Team, Minnesota Department of Human Services Office of Inspector General, the Minnesota Department of Human Services Program Integrity Oversight Hotline, and the Minnesota Attorney General's Office.

1.2.2 Minnesota should establish an office that assists consumers and patients with access to and quality of health care services and provides free legal services.

- Commenter put 1.2.1 and 1.2.2 as a high priority.

1.3 Health care in Minnesota should have community co-leadership and equity-focused oversight.

- This would be the highest priority because it would help ensure the others are addressed appropriately.

1.4 Minnesota should strengthen data infrastructure to advance health care equity.

- The available data on healthcare coverage and services is outdated—often around five years old. In her county, major recent changes have significantly affected access to care, creating urgent needs that are immediately visible through things like child and teen checkups or community health assessments. However, data systems aren't able to respond quickly to these shifts. While we have strong data on diagnoses through HTAC, we lack accurate, up-to-date information on local providers—like knowing how many doctors are actually nearby, not 50 miles away.

What is missing from the recommendations?

- 1.3 could also integrate additional aspects like adults with developmental an/or intellectual disabilities.

What will be important to consider when implementing these recommendations

Which recommendations do you think are the highest priority and why?

2.2 Minnesota should support a health care delivery system that patients can access where and when they need it

- Not sure how we design a future system but pleased to see this for rural access in light of closures and challenges for care such as maternal care and delivery.

2.3 Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.

- We have a lot of trouble accessing in-person interpreters especially for post-partum visits in Carver county (however, not so much in Chaska and Chanhassen). We have high need for in-person Spanish speaking interpreters.
- We'd like to see more interpreters. We have over 50 languages spoken in our student body; people who are new to the country that don't read or write, and many only use spoken language. It takes a lot of time to get translators (especially for certain languages) and written translation is not easy. Having an in-person interpreter puts people at ease and makes them feel more confident so providers can get answers

that make sense. A large percent of her community is Spanish speaking, and they only have one community health worker that speaks Spanish.

2.4 Minnesota should expand inclusive and accessible telehealth by investing in broadband infrastructure, mobile care, and phone-based services to ensure equitable access in rural and underserved communities.

- The mobile care piece is very important, they are about to launch a mobile medical unit in Minneapolis focused on serving underserved and on substance use disorder (SUD) and related complications like mental health, infectious diseases and in-patient families in the communities. People need easier access to SUD treatment that reduces stigma, making people feel welcomed, not feeling like they failed morally but rather struggling with chronic diseases.

2.5 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.

- 2.4 and 2.5 from a rural perspective: the commenter works with one of the smallest populated counties in MN. Things like broadband, mobile care, and increasing telehealth and transportation access are tremendous barriers on rural communities.

What is missing from the recommendations?

- **2.1** Minnesota should implement universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota.
    - If we're saying 'health care for all' are we saying people with legal status; will federal funding changes be taken into consideration? If we're really saying for all that would be a high priority.
- **2.2.1** Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools and mobile care models.
- **2.4.1** Expand telehealth and mobile health services especially for rural and underserved areas, implementing technology to provide health care access where there are fewer providers can be a low-cost, immediate solution.
- **2.6.1** Establish state-wide health literacy and digital literacy education.
    - 2.2.1 and 2.4.1 and 2.6.1 - there are huge gaps in digital access and literacy in her county, they really rely on mobile medicine over telemedicine, the aging population struggles to access telemedicine and so they focus on mobile medicine.
- **2.2** Minnesota should support a health care delivery system that patients can access where and when they need it.

- **2.6** Minnesota should strengthen patient health literacy.
    - 2.2 , 2.6 could also integrate additional aspects like adults with developmental an/or intellectual disabilities.

What will be important to consider when implementing these recommendations?

2. Minnesota must ensure all persons in Minnesota have comprehensive health care insurance, timely access to needed health care services, and a baseline understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

- How is comprehensive insurance defined? What is the recommendation around this? The main category language is pulled through other recommendations but doesn't know how with health insurance companies pulling out of the market because of cost for health care, to be able to access translators, medical rides, etc, but the ability to have health insurance, whether documented or not, the definition of under insured is getting bigger and bigger,

2.2.1 Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools and mobile care models.

2.2.2 Create a system for patients that enables patient/provider matching so patients can choose providers they may identify with and/or provide the services they need.

2.2.3 Require and incentivize providers to offer flexible hours for evening and weekend appointments.

- 2.1, 2.2, and 2.3 need to work together to provide equitable access to an appropriate level of quality health care.

Bolster Primary and Whole-Person Care

Which recommendations do you think are the highest priority and why?

3.2 Minnesota should invest in team-based primary care models that coordinate activities with public health.

- This is important in public health as we work through disease work, there is a disconnect to primary care, we don't cross over or work collaboratively; if we could work together, we could both be strengthened in how we deliver care to the community; public health and primary care resources have decreased.
- Would improve efficiencies with cost of primary care due to focus on prevention; collaboration would allow us to do that with the focus on upstream efforts.
- Could expand impact and efficiency.

3.3 Minnesota should adopt reimbursement and payment models that will support investments in primary care.

- The most critical since this is a limiting factor for not covering insurance but would be nice to see a holistic integration with 3.1, but without funding it won't go anywhere.

What is missing from the recommendations?

What will be important to consider when implementing these recommendations?

Strengthen and Diversify the Workforce

Which recommendations do you think are the highest priority and why?

What is missing from the recommendations?

4.4 Optimize the workforce.

- Not seeing standardized public health education in what is offered in general public health for students, need baseline knowledge for students in public health is needed and would be a great project.
- Recruitment only has 3 references in the recommendations and is pretty generic and should have more emphasis; recruitment and onboarding of other public health workers needs to be front and center.

What will be important to consider when implementing these recommendations?

Urban American Indian Community Listening Session

Number of Participants: 0

Input Summary: none

Written Public Comment and MDH Hosted Events

Organizations, entities, and individual commenters represented: 26 (as of 7/25/25)

- Advocates for Better Health
- American Telemedicine Association – ATA Action
- Community Health Worker Concepts
- Council for Minnesotans of African Heritage
- Department of Human Services Cultural and Ethnic Communities Leadership Council (CECLC)
- eHealth Advisory Committee
- Great Lakes Inter-Tribal Epidemiology Center
- HealthPartners
- Hennepin County Public Health
- Hennepin Healthcare System
- Minnesota Association of Community Health Centers
- Minnesota Community Measurement
- Minnesota Council of Health Plans
- Minnesota Council on Disability
- Minnesota Department of Health (MDH)
    - Staff of Child and Family Health Division representing Adolescent School Health and School-Based Health Centers
    - Staff of Health Equity Strategy and Innovation Division – 2
    - Staff to Rural Health Advisory Committee
- MDH Health Equity Advisory and Leadership (HEAL) Council
- Minnesota Hospital Association
- Minnesota Medical Association
- Minnesota School-Based Health
- Minnesota's Health Care Future
- Tribal Health Directors
- Anonymous (including private citizens) – 2

Input Summary:

General/Other Comments Not Attributed to a Recommendation

- The recommendations did not touch about how Insurance companies operate and indiscriminating oppress the minorities.
- Elimination of middleman (the insurance companies), granting contracts to local owned companies and Standardizing Background checking's to allow more POC enroll in health courses- An example of the Hennepin County Attorney General's clinic of expunging petty criminal cases of POC to allow the join programs such medical school, nursing school and other public health programs. These graduates will come to serve their communities.
- When presenting recommendations, the task force should specify root causes and the problems the recommendations are trying to solve. Tie the thread to the root cause or issue to show what they're trying to fix and how they're trying to be helpful. Without this explanation, there is risk of others negatively targeting the recommendations.
- Actions of the federal government/CDC may undermine public trust in immunization efforts and the broader health care infrastructure.
- With the increased presence of ICE in hospitals and clinics, it could be beneficial to include broader consideration of the relationship between care systems and law enforcement.
- There was a lack of voice for rural, healthy aging, and disability communities. It is important to incorporate these.
- All of these recommendations are important and will be difficult to accomplish without funding for the initiatives, but can be good recommendations to consider, especially as work continues from federal directives.
- The unequitable and spiking costs of healthcare delivery services model in MN is neither due to insurance costs nor coverage issues but a cascade of overpriced care by hospitals throughout the State, which disproportionately affects low-income populations, who have been historically marginalized.
- Strongly supports the overarching goal of advancing health equity. This commitment is reflected in our strategic map, our organizational values, and in existing policies and initiatives. While we are aligned with the broad intent of many of the recommendations, their lack of specificity precludes us from offering explicit support at this time. We hope you can appreciate that there are many specific policy approaches that the State might take to execute any one of these recommendations, and those alternatives have meaningful pros and cons for

physicians, patients, and Minnesotans writ large. Therefore, we believe the draft recommendations would benefit from greater specificity regarding policy approach, including implementation, funding, and accountability. We also encourage the Task Force to consider how each recommendation may uniquely impact different historically marginalized communities, not only across racial and ethnic lines, but also across other dimensions of inequity, such as geographic location (rural vs. urban), income, LGBTQ+ identity, age, and disability. We appreciate the opportunity to review and reflect on this draft and commend the Task Force on its progress to date.

- Coordinate more closely with the Great Lakes Inter-Tribal Epidemiology Center (GLITEC) and the Tribal Health leaders. Include Tribal representatives on the MN Health Care Workforce Advisory group. Institute and increase the utilization of patient navigators, especially for Tribal elders entering the non-tribal healthcare systems. Include all 11 of Minnesota's distinct, independent, autonomous, self-governing Tribal nations.
- Focus on what MDH and the state can do most effectively and push there. In an era of constrained resources and political headwinds, perfect will be the enemy of good, and attempts to get there on areas where there is no leverage may potentially harm efforts that can be effective elsewhere.
- Minnesota needs to be mindful of offering options for people in between--not able to qualify for MA due to income but not able to pay for adequate coverage due to lower wages.
- Many of these recommendations are incredibly broad and aspirational and would be extremely difficult to implement and measure, or sometimes even something that cannot be done on a state level. At the July 8th listening session, several questions were asked on how these recommendations were collected and evaluated, but no details were provided by the moderator. The workgroup should refine their recommendations to an actionable list of top priorities that they believe would have the greatest impact in moving our state towards a more equitable health care ecosystem. List the who, how, and framework for achieving these refined goals. Some of the larger recommendations require further study and likely an economic or actuarial analyst, which does not appear to have been done by the workgroup. The Council urges further deliberation and discussion and many of these recommendations and welcomes the opportunity to participate in these discussions.
- I provided specific recommendations for the whole report on the first page of this document since it was very tough to break it out in sections and quite honestly, I didn't have time to do so. However, I and several colleagues did put together

recommendations after reading the report and I entered them all in the first section as some of them were by section and some of them were general so it was hard to break them down. If it's easier to just put the whole thing in a separate document, you can email me and I can do so. Thank you!

- The draft reflects a commendable attempt to operationalize equity across Minnesota's healthcare systems. However, given the shifting national discourse around reproductive justice, trans healthcare access, and Medicaid expansion, the recommendations would benefit from stronger political positioning and explicit policy commitments.
- While the document references "historical harms," it avoids direct acknowledgement of structural racism as a root cause of disparities. Explicitly naming the legacy of racism on institutional and statewide practices and policies could align more firmly with current advocacy efforts statewide.
- The draft does not explicitly name bills, regulatory efforts, or funding streams that could operationalize its goals. Strategic alignment with current legislation—such as Minnesota's ongoing push for Medicaid equity—would increase momentum and accountability.
- Current sociopolitical tensions around gender-affirming care and reproductive rights call for direct integration of these concerns into proposed recommendations. Silence in this area may be perceived as avoidance rather than neutrality.
- To ensure these recommendations remain responsive and impactful, we urge the Minnesota Department of Health to update the draft to reflect the current sociopolitical climate—including heightened legislative threats to reproductive justice, trans health care, and immigrant access to services. These shifts demand explicit policy alignment and stronger language that names structural racism and systemic inequities as ongoing barriers to health equity. We also recommend that the document more clearly elevate the role of community partnerships with leaders and local organizations who remain steadfast in their commitment to equity. These partnerships must be recognized not only as implementation vehicles but as co-creators of policy and practice. The recommendations should reflect the lived experiences and leadership of marginalized populations, including Black, Indigenous, immigrant, LGBTQ+, and disability communities, whose insights are essential to building accountable and culturally grounded health systems. To meaningfully diversify Minnesota's healthcare workforce, the Minnesota Department of Health (MDH) should prioritize partnerships with institutions that center minoritized, first-generation, and immigrant students—rather than defaulting to legacy collaborations with the University of Minnesota, which continues to prioritize traditional student populations and academic pathways.

- MDH can strengthen its equity impact by:
  Partnering with community colleges, tribal colleges, and HBCU/MSI-aligned programs that offer culturally responsive training and support for students from historically excluded backgrounds.
  Investing in pathway programs at institutions like Metropolitan State University, Augsburg University, and Saint Paul College, which have demonstrated success in serving first-generation and immigrant learners.
  Funding mentorship and career development initiatives led by community-based organizations that reflect the lived experiences of BIPOC and immigrant communities.
  Requiring equity benchmarks in institutional partnerships, including demographic representation, retention rates, and culturally grounded curriculum development.
  Accountability will require enterprise-wide collaboration with the Minnesota Department of Human Services to ensure rigorous monitoring, transparent data tracking, and coordinated evaluation across all health care systems and partner agencies. A unified approach is essential to uphold equity commitments and drive measurable outcomes statewide.
  Please see the attached document (from CECLC), which outlines the specific recommendations we have highlighted to underscore the importance and urgency of our feedback. These priorities reflect the voices and needs of impacted communities and are grounded in a commitment to equity, accountability, and systems-level transformation.
- By shifting focus toward institutions and programs that actively dismantle barriers to entry and advancement in healthcare careers, MDH can better align its workforce equity goals with the realities of Minnesota's changing demographics and community needs. These priorities reflect CECLC's long-standing commitment to cultural responsiveness, participatory governance, and systemic change. We urge the Department to advance these recommendations with transparency, urgency, and direct collaboration with impacted communities. We remain committed to supporting this process through continued dialogue and advocacy.

Ensure System Accountability

Which recommendations do you think are the highest priority and why?

- **1.1.1** - Tribal members and children should be consulted regarding whether or not they "should" or "may" be automatically enrolled in a health care plan (e.g., through Medicaid or MinnesotaCare). There should be an opt-out option, and autonomy of each individual of Minnesota's 11 Tribal nations needs to be honored and respected.

- **1.2.1** - establish office to coordinate patient complaints to prevent people from slipping through the cracks when issues arise, increases accountability for medical abuse.
- **1.3** - if you don't include community members then all proposed solutions risk unintended consequences on those we are trying to serve.
- **1.3.4** - provider cultural competency info available to patients; gives patients the information they need to select providers based on shared lived experience.
- **1.4.2** - improvement of the states data management is vital for the care of Minnesotans.
- Recommendation **1.2** is the most important. Care system mandates are important but will be impossible to achieve if gaps in coverage are not addressed. Health plan (insurance) mandates need to be supported at the state level. This will help all patients, both those covered by such plans, and those without coverage or with Medicaid, as covering patient members more thoroughly will ensure better reimbursement for organizations, allowing them more leeway to cover gaps for Medicaid patients and the uninsured, both in urban and in rural areas.
- Recommendations **1.3 and 1.4** - Community Inclusion and Data Equity. Invest in Robust Community Inclusion and Data Equity to Ensure System Accountability. Effective accountability depends on the extent to which a system's processes and standards align with the realities of the people the system serves. In other words, a system needs good data to ensure effective accountability. Good data, in turn, requires organic community connections and knowledge resources. Minnesota must invest in community co-leadership, equity-focused oversight, inclusive data standards-setting, and other strategies that empower marginalized groups in health care governance.
- We believe strengthening patient health privacy and protections is critical to maintaining the sense of trust and safety that our Minnesota Health Centers have cultivated with their patients, providers, and partners over the past sixty years. We continue to earn the trust of our patients and communities through the co-leadership governance model, where a majority of Health Center board members are patients of the Health Center, which is effective in providing preventative care.
- Recommendation **1.3 and 1.4**. Listening to the community and individuals who receive health care about their experiences is critical to understanding the dynamic between qualitative barriers and real outcomes. Only tailoring (stet).
- Section 1 - Recommendation **1.2** Minnesota should strengthen and harmonize its approach to health care patient protection. **1.2.1** Minnesota should establish an office to coordinate the work of entities that field patient complaints so there is one

consumer-friendly entry point for all patients. Entities include the Minnesota Department of Health Office of Health Facility Complaints, Minnesota health licensing boards, Minnesota Department of Health (MDH) HMO Enrollee External Review and Complaint Process, Minnesota Department of Commerce Consumer Response Team, Minnesota Department of Human Services Office of Inspector General, the Minnesota Department of Human Services Program Integrity Oversight Hotline, and the Minnesota Attorney General's Office.

Section 2 - Giving all Minnesotans access to universal healthcare. There is too much overlap and confusion about where to report issues. I have had to call many of these and most of them are not responsive at all and nothing gets done about the complaint even when I reported my mom's death which was suspicious and there were numerous other deaths at the same facility. Also, this is costly and confusing to the public.

- Our lens is children and youth. We are concerned this document does not accurate scale the influence of school nurse visits, other health support service providers in schools, or partnership-based health care access models such as school-based health centers and school-linked behavioral health services. For our population and particularly those from the most historically marginalized, schools are the most significant provider of healthcare services. They also represent an opportunity to ensure safe, affordable access to care for all children and youth.
- Recommendations **2 and 3**
- Recommendation **1.1** ensuring equitable health care coverage for American Indian communities is the highest priority. This step is essential to addressing long-standing health disparities and ensuring access to care without unnecessary barriers. Automatic enrollment, when done in true partnership with Tribal governments and supported by trusted community health workers, community health representatives has the power to make a real and lasting impact. This would be foundational move toward building a more equitable and accountable health system for American Indian communities. I believe Recommendation 1.1 is the highest priority because it directly addresses access to care for American Indian communities. Implementation of automatic enrollment can remove major barriers and improve health outcomes. If done in partnership with Tribal leaders to respect sovereignty and ensure success. This would be a key step toward a more equitable and accountable health system.
- **1.1 and 1.3. 1.1**: because American Indians experience some of the worst health disparities and they are owed a comprehensive healthcare through the government trust responsibility; 1.3: because having community co-leadership and equity-focused oversight will drive broader system change in a fundamental way.

- **1.1**. Ensure full and equitable health care coverage for American Indian communities and Tribal citizens in Minnesota.

What is missing from the recommendations?

- An emphasis on Tribal health that centers, elevates, and prioritized the health of all Tribal families in the state is missing.
- **1.3.3** - who is doing the supporting (health care entities, the State, etc.)?
- **1.3.3** - I don't understand what is meant by 1.3.3. I'm not following how the resources listed relate to community shaping their health systems.
- **1.4.2**: consider addressing how to ensure all people are represented in the data (not everyone wants to provide this data, American Indians do not have to give data to government, not all people are represented in the health care system.
- A component about transparency and reporting should be included to improve accountability.
- Also, adding resources to support patients who don't typically serve on these committees (childcare at meetings, virtual meetings, interpreters at meetings).
- Health care providers must be held accountable to provide high quality care to all patients no matter their identity and circumstances so patients have the confidence to go into a health care facility and know their life is going to matter enough to get the right health care and address the issue they're coming in for. Everyone who comes in should be treated as an individual and assessed in every way needed to get correct care.
- Explicit discussion that accountability for health insurers providing coverage in Minnesota is more primary than health care system issues.
- How will cultural differences be accommodated/affirmed in accountability processes and standards (e.g., in the lens/rules used to measure care quality, health equity, etc.)? What makes community engagement authentic? The answers to these questions require greater investment in community participation---more funding for best practices that affirm and empower community voices in organizational leadership decisions and processes.
- Across all sections, the report insufficiently centers Minnesotans with disabilities and the aging population. These underrepresented communities face persistent, system-wide barriers to equitable care, including physical, attitudinal, communication, transportation, and financial barriers. Their intersectional experiences, especially where disability overlaps with race, ethnicity, age, geography, language, gender, and socio-economic status, must be explicitly named and addressed throughout the Task Force's recommendations. The final report

should fully integrate principles of disability inclusion, aging equity, accessibility, and universal design into all components of Minnesota's health care transformation strategy.

Section 1 – System Accountability - Add:

- Disability and aging data inclusion: Require the routine collection and disaggregation of health outcome and access data by disability status, age, functional limitation, cognitive ability, and other identity factors (race, ethnicity, income, geography, language). Cross-tabulate data to reveal intersectional disparities and target interventions accordingly.
- Create a Disability and Aging Health Equity Advisory Group, modeled after the HEAL Council, to inform all health equity-related policy and implementation decisions.
- Require health plans and managed care organizations to annually report compliance with the ADA, Olmstead Plan, and age-friendly health system standards, with consequences for noncompliance.
- School-based health centers
- It's importance to recognize the extensive volume of services provided to school-aged children are delivered within schools when looking at k12 health. School nurses and districts with SBHCs play an integral role in the health of school aged children.
- What's missing from the Accountability recommendations is a clear plan for how progress will be measured and enforced. Without defined metrics, timelines, and accountability mechanisms, it will be hard to ensure lasting change. There was also no mention about guaranteed funding and community-led oversight to support implementation and sustainability.
- Accountability by healthcare system for its historical and ongoing contributions to health inequities for people who are poor and for people who are not white.

What will be important to consider when implementing these recommendations?

- Timeline of when action should be taken if health systems are not meeting the requirements (i.e. at what point are they held accountable).
- **1.1.1** - how will the federal cuts to Medicaid impact this recommendation?
- Thoughts on Recommendation **1.4** Minnesota should strengthen data infrastructure to advance health care equity.
- MDH should consider how to develop their own data submission process instead of contracting it out to avoid costs for the government and health systems, they should

make the data from this available to systems and payers as a way to generate revenue and promote quality data that would be most useful.

- **1.4.2** - MDH should implement recommendations from the Health Equity Advisory and Leadership (HEAL) Council to standardize and disaggregate data. MDH should create a plan and action steps for implementing standards on data collection, data analysis and data dissemination. Within this plan, data disaggregation standards are needed, specifically regarding race, ethnicity, and language, sexual orientation and gender identity, disability status, and social determinants of health.
- Input from Tribal health leaders across all of the 11 autonomous Tribes within the state of Minnesota.
- Given massive federal cuts to Medicaid, and tax cuts that will trigger massive cuts to Medicare, it will be difficult for healthcare systems to have enough margin to cover "walkable spaces, public health services, and community organizations."
- Strengthening and maintaining patient privacy and protection will require multiple partners working together to develop solutions that center on the needs of healthcare users.
- When collecting data, it will be important to have employees that act as community liaisons front these.
- Recommendation **1.2.1** – As is mentioned, several state agencies serve roles in being a point of contact for patients seeking assistance in the health care system. This could be a worthwhile effort if this streamlines this point of contact. If the state embarks on this path, it should be a consolidation of layers, not a new separate one.
- Recommendation **1.3.1** - Strengthening the state's regulatory role. There have been significant new state regulations of plans and providers passed in the last couple of years at the Legislature. Before layering on more regulations, it is important to see the impact of these new regulations. It is important to keep in mind that additional regulations have the potential to add administrative costs at a time when health care affordability is a key consumer concern. Advocates should carefully weigh the potential benefits of any mandates against the potential cost increases and affordability challenges.
- How to do the most amount of good with the least amount of money.
- The different between school-based services, school-based health centers, mobile health services, telehealth services and school-linked behavioral health services. These all have distinct definitions. They co-exist and complement each other in many school districts. Each model optimizes care for youth and children dependent on community factors. For Recommendation 1.3.1, continued investment in the Statewide Quality Reporting and Measurement System (SQRMS) is essential to

advancing statewide quality measurement, support ongoing quality improvement efforts, and ensuring accountability of health plan and provider systems.

- For Recommendations 1.3.5 and 1.4, it will be important for MDH to build upon and align with existing efforts that address social needs and services. For example, beginning in 2024, MNCM has initiated the collection of data on 11 social risk factors from ambulatory care providers. These factors include food insecurity, housing instability, transportation challenges, utility assistance needs, interpersonal violence, education, financial strain, social isolation, substance use, and alcohol use during pregnancy.
- The social risk factor (SRF) data is intended to provide insight into how these variables influence health care quality outcomes, to identify opportunities for improvement, to inform potential risk adjustment of quality measures, and to support the development of value-based payment strategies aimed at closing equity gaps.
- Recommend that MDH consider national initiatives focused on modernizing demographic data standards to advance health equity. One such initiative is the collaborative effort among Civitas Networks for Health, Health Level Seven® International (HL7®), and AHIP, which seeks to enhance the quality and consistency of demographic data across health systems.
- Support the recommendation to disaggregate data to uncover disparities, enabling MDH and its partners to implement targeted, equity-driven interventions.
- It will be important to consider community voice, especially from those most impacted, and ensure partnership with Tribal nations throughout implementation. Clear accountability structures, culturally responsive approaches, and sustainable funding will also be essential for long-term success.
- state funding, buy in from all sectors

Other comments regarding Ensure System Accountability

- **1.2.1, 1.4.2, 2.5.1**- Editing note: stay consistent with utilization of acronyms - either use them or don't - recommend not using them for plain language.
- Recommend moving **1.1** (and 1.1.1) under 2 and make it 2.1. This seems to align better with section 2. It makes sense to ensure ALL Minnesotans have universal free healthcare.
- **1.3.5 -** Require managed care organizations to fund community-based partnership efforts to increase managed care organizations' capacity for coordinating health-related social needs services. (ensures funding is not limited to staffing time alone).

- **1.4.1** - (plain language edit): 1.4.1 Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ~~ameliorate~~ *improve* disparities in health outcomes.
- **1.4.2** - MDH has expanded disaggregation data standards already. They haven't been implemented across the agency.
- Tribal members and children often have access to health insurance already (not all of that community is without insurance). I wonder if automatically enrolled is the right answer, I wouldn't want to force a Tribal Member to pay for their regular health insurance (through their job for example) and also MinnesotaCare if they make more than the income threshold for Medicaid. Tribal members also receive free health care from IHS. I get concerned that this will be a tough push for those folks that don't see a need if they already go to an IHS.
- **1.4.2**, most of MDH does not collect their own data. I am unsure how this recommendation could be possible without enforcing our data standards on health systems, other agencies, etc.
- "Cultural competency" information is somewhat nebulous. Race, gender, and language should be made available, but many providers may be "culturally competent" in caring for a range of patients, and no validated metrics exist for that.
- There wasn't much specificity about people with disabilities or people who are aging and the intersectionality with other populations, i.e. GLBTQ+ and people of color and indigenous people.
- School based health services refer to services delivered by school district employees. School-based health centers, and school-linked mental health refer to care delivered by community partners under contract with school district.
- **1.4.2** doesn't address Tribal and Indigenous data sovereignty concerns. It should include a requirement that MDH work with Tribes and Native-serving health organizations on develop a plan and action steps regarding data.
- The recommendations referencing community engagement to engage impacted communities, particularly through advisory councils and compensated participation, align with current best practices in equity research. (**1.3**)
- **1.4.2**. Recommendations to improve data disaggregation and usage are timely, especially as states face increased pressure to demonstrate measurable progress on equity metrics.

Meaningful Access

Which recommendations do you think are the highest priority and why?

- Access to health care insurance and services; universal health care.
- **Recommendation 2.7** Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services. Most healthcare systems know what their patients need to improve access; they just don't have the funding/person-power/resources to do it.
- **2.1** - universal health care for all Minnesotans. Everyone deserves affordable health care.
- **2.2.1** - increase health care facilities in Greater Minnesota. Greater Minnesota has so few health care facilities to meet needs. This is a dire need.
- **2.2.3** - expand health care facility hours to evenings and weekends. Many cannot get time off of work to go to medical appointments for themselves and those in their care. It is important to ensure all have available clinic hours that don't require you to take time off or miss work hours if you don't have PTO.
- **2.3.4** - ensure timely interpreter services at health care facilities. Everyone deserves high quality health care regardless of their language needs. If an English-speaking patient can understand staff and health materials immediately upon arriving at a health care facility, this same access should be available to patients who have limited or no English proficiency.
- **2.2** - Minnesota should support a health care delivery system that patients can access where and when they need it. This will mean healthcare services are at the doorstep and not struggling to find a clinic or a provider.
  2.2.1 - address closures of rural health care facilities, particularly those serving Tribal members living on the 11 federally recognized reservations within the state of Minnesota. Primary prevention services is the most economically sensible and humane way to prevent illness, disability and human suffering.
- The recommendations that are a part of **2.4** and recommendation **2.2.6**. While all of the recommendations under **2.4** are important for expanding patient access to care, the one most top of mind in Minnesota is continued access to audio-only care.
- ATA Action was pleased to see Minnesota extend the inclusion of audio-only care in the definition of telehealth through legislation earlier this year. This will be especially beneficial for citizens without reliable internet access, due to broadband or personal technological limitations. However, this extension only pushed the sunset for the inclusion of audio-only to 2027. Ensuring that audio-only care remains an option in perpetuity is essential to supporting recommendation **2.4.2**. With the continued existence of the audio-only sunset providers lack the necessary certainty

and patients may fear that they will suddenly lose access to the audio-only care they use or have grown accustomed to.

- Support the adoption of technology-neutral telemedicine policies that enable practitioners to utilize synchronous (real-time) audio-visual or audio-only, and asynchronous (non-real-time) technologies in the delivery of care. Policy makers should not restrict the modalities which practitioners may use when providing care to patients, permitting licensed health care professionals to determine which technologies are sufficient to meet the standard of care for the condition presented by the patient.
- Supportive of enhancing policies for coverage of in-home monitoring systems that integrate with health care delivery systems as a crucial element of supporting aging in place.
- The first (**2.0**), access to coverage and care, is the most important. This will be the greatest challenge in the next few years given cuts to Medicaid and likely also to Medicare. It will require pressure placed on health insurers providing coverage in Minnesota.
- Recommendation **2.1 and 2.2** are top priorities. We view recommendations related to timeliness, telehealth, transportation, etc. as necessary parts of a universal health care framework. Invest in Universal Health Care (Health Care for All) Goals and Practices to Ensure Meaningful Access. High costs and inconsistent care and coverage are inefficiencies of the health care marketplace. Information gaps in the consumer marketplace limit patient options and reduce access to quality care. A universal health care or health care for all policy framework would provide a baseline for comprehensive care for all persons living in Minnesota. Such a baseline would be preferrable to the current realities of disparate treatment and unequal health outcomes. Minnesota's baseline must center affordability, health literacy, and patient needs (across age, place, race, and income).
- Support the lead recommendations outlined in the draft to enhance access to, and invest in, primary health care and wrap-around services, strengthen telehealth and broadband services, support a community transportation infrastructure, improve patient literacy, and create more standardization for interpretation and translation services. Minnesota Health Centers models all of these recommendations, and have for over sixty years. Minnesota's Health Centers are located throughout the state. At over 82 sites, Minnesota Health Centers offer co-located and often integrated primary medical, dental, and behavioral health services, as well as translation, transportation, pharmacy, legal support, care coordination, and more. Minnesota Health Centers provide services to all who reside in their service area and do not turn anyone away if they are unable to pay for services.

- Recommendation **2.1, 2.2** (particularly 2.2.2, 2.2.3 2.2.8, 2.2.9), & 2.6. With the changes in Medicaid, it will be very important to catch people that fall through the cracks because of loss of federal funding. Additionally, if we want to continue supporting positive health outcomes, we have to be mindful that certain communities may not seek care due to cultural preferences and norms, such as Somali women needing female practitioners, being mindful that new immigrants may not understand the current system so having an advocate for them on what resources are available will be very important. Likewise, many people cannot access daytime hours if they have inflexible employment that requires them to miss a few hours of pay or use sick/vacation if they even have access to it. Taking children out from school to miss lessons can severely hurt their education.
- The highest priority is Recommendation 2.1: implementing universal health care to ensure all Minnesotans have comprehensive coverage. Without access to insurance, many people cannot benefit from other critical services like telehealth, interpretation, or transportation. Universal coverage is the foundation for achieving truly equitable and meaningful access to care. I selected prioritizing universal healthcare because universal coverage removes the biggest barrier to care lack of insurance and ensures everyone can access needed health services. It creates a foundation that supports other access improvements like flexible scheduling, transportation, and language services. Without healthcare coverage, even the best access programs cannot reach those most in need.
- **2.1**. Because this would ensure that everyone has access to health care. But it also needs to be comprehensive, easily accessible, timely, and culturally inclusive and appropriate care.
- **2.2.4** Expand school-based health services, including oral health screenings and preventive services.
- **2.2.7** Expand use of common referral approaches among cross-sector partnerships.
- **2.2.8** Expand the use of Community Health Workers or Patient Navigators to provide wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner.
- **2.2.9** Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics and hospitals.
- Recommendation **2.3** Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.

- Recommendation **2.4** Minnesota should expand inclusive and accessible telehealth by investing in broadband infrastructure, mobile care, and phone-based services to ensure equitable access in rural and underserved communities.
- **2.4.1** Expand telehealth and mobile health services especially for rural and underserved areas, implementing technology to provide health care access where there are fewer providers can be a low-cost, immediate solution.
- **2.4.2** Continue support for audio-only telehealth for people using Medicare and Medicaid, especially in rural areas, where reliable internet access is limited and phone-based care may be the most equitable option.
- **2.4.3** Develop infrastructure and funding strategies to expand broadband access in rural communities, ensuring telehealth is equitably accessible across the state.
- **2.6.2** Establish a system of patient-owned electronic health records to facilitate care coordination and shared understanding of patient needs.
- **2.7.1** Increase reimbursement rates for mental and behavioral health services to ensure they are equitable with physical health care, thereby improving provider participation and patient access.
- **2.7.2** Explore and invest in alternative or supplemental funding streams—such as state surplus funds, community reinvestment strategies, community benefit—to support health care access for populations not covered by public payers, including undocumented immigrants.

What is missing from the recommendations?

- Translation services are important and patients need additional advocacy supports so they may understand the kinds of questions they may ask medical professionals to obtain medical professional advice.
- Make sure children are not interpreting for parents in the health care setting.
- Video/audio remote interpreting without training hospital staff of how to use the equipment.
- Improving access to dental care, nutrition/dietetics, nursing in schools.
- More information about how all people in MN will have baseline understanding of care delivery and insurance (recommendation 2) - does this entail a public education campaign? Other strategies?
- **2.2.3** - would change from provider incentives to health care facility incentives - providers don't always have the power to change clinic hours.
- Recommendation on increasing interpreter workforce.

- Add after **2.2.2: 2.2.3**: Decrease the barriers for individuals to get a degree and become licensed or certified in health care fields to ensure there are providers that match patient's needs and identity.
- Add **2.2.11** Expand healthy aging supports, including age in place, assisted living, long term care options, especially in rural communities to address physical and mental wellbeing of elder Minnesotans.
- Add **2.2.12** Create regional or local health care delivery designed to provide mental health care to individuals in crisis – addressing mental health crisis and stabilization to decrease emergency department boarding using evidence-based models like Mobile Crisis Response and Emergency Psychiatric Assessment, Treatment & Healing units.
- Add **2.4.4**: Support telehealth access in community settings like libraries, pharmacies, and clinics to aid individuals who don't have technology available to them or need support while using the technology.
- Add **2.5.4**: Expand reimbursement for EMS transportation, especially for both legs of a trip while doing patient transfers between facilities.
- Add **2.6.6**: Invest in education for health care providers on how to discuss patient's health with them in terms the patient understands (ie in a culturally competent and plain language way).
- Add after **2.7.1**: Increase reimbursement rates for dental health services to ensure they are equitable with physical health care, thereby improving provider participation and patient access.
- Culturally competent trained providers within these communities.
- What seems to be missing is a statement about striving for closer coordination with Tribal serving entities, programs, services, hospitals, clinics, and other wrap-around and follow-up services in all areas of MN where Tribal community residents live and work.
- **2.7.2** is an important recommendation to focus on, as alternative state support will be necessary, especially if universal coverage is envisioned.
- We are concerned about rollbacks of federal and state commitments to health care access, including cuts to Medicaid and efforts to exclude immigrants in eligibility requirements for public programs and services.
- Adding some wrap-around services FROM BIRTH such as doulas and especially the availability of night doulas to support getting more sleep for families that may be stretched thin, even if they do qualify for Family Paid Leave come 2026. Having expanded funding for some home-visiting for new mothers could help determine

high risk situations and lead to better postpartum outcomes for mom and baby, as well as offering support for mom to heal from birth.

- Section 2 – Meaningful Access - Build on existing recommendations by adding:
  Communication Access
  - Require both in-person and telehealth access to ASL interpreters, CART services, and AAC-compatible platforms.
  - Train providers in neurodivergent-friendly communication and require all materials to be provided in plain language (MNIT resources), with options for audio and visual learners.
  - Ensure after-visit summaries are provided in plain language and alternative formats (e.g., Braille, large print, AAC-compatible digital files).

  Physical Access
  - Mandate statewide ADA compliance audits for all health care facilities; tie accessibility improvements to facility licensing and funding.
  - Establish minimum accessibility standards that include: adjustable-height exam and changing tables, automatic doors at accessible heights, sensory-friendly waiting areas, and accessible restrooms and parking.

  Transportation (**Expand 2.5**)
  - Ensure that non-emergency medical transportation (NEMT), including rideshare options—includes vehicles equipped with lifts, tie-downs, and trained drivers who can assist people with disabilities and aging adults.
  - Fund and support community-based mobility programs that offer same-day scheduling and real-time dispatch for those with functional impairments and rural or tribal transportation gaps.

  Health Literacy (**Expand 2.6**)
  - Develop disability-centered health literacy initiatives, with clear visuals, plain language, and culturally relevant content, particularly for individuals with developmental, intellectual, or cognitive disabilities.
  - Train providers to effectively communicate health information to people with neurodivergent communication styles, memory loss, brain injuries, or limited verbal communication—using trauma-informed approaches.
- Please consider the following considerations in the recommendations:
  - **2.2.1**: Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools, school-based health centers, and mobile care models.
  - **2.2.4**: Expand school-based health services, including oral health screenings and preventive services. Expand SBHC where appropriate including primary care, dental and behavioral health care access.

    - **2.2.9**: Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics, hospitals, and schools.
    - **2.4.1**: Expand telehealth and mobile health services that are connected with accessible local healthcare services (vendors serving Minnesotans should be local and Minnesota based), especially for rural and underserved areas, implementing technology to provide health care access where there are fewer providers can be a low-cost, immediate solution.
- I think the Access recommendations could do more to address the shortage of health care workers, especially in rural and underserved communities where access is already tough. It would also help to have clearer plans for tracking progress and making sure these changes really happen and last. Including more focus on mental health care as part of regular health services would make the recommendations even stronger.
- Missing throughout--every time the recommendations mention Community Health Workers, they should also include Community Health Representatives.

What will be important to consider when implementing these recommendations?

- The most important thing is to address methodologies of access to insurance coverages and payment models in place. The " Chargemaster" which is known to carry enormously inflated prices of products and services. These are directly unaffordable by the minorities due to their LSES.
- For many deaf and hard of hearing patients, English is a second language, and they need appropriate and qualified interpretation services.
- Health care should use an intersectional lens.
- Health care must be safe. The federal and local environment impedes care for undocumented adults and this may impact how adults seek care for children, even if the children have health insurance. The only health care option for undocumented adults is the emergency room.
- Adult Native Americans, Black Americans, and undocumented people lack access to MinnesotaCare. Migrant workers lack access to health insurance in Minnesota.
- Implementing community voice to prioritize the funding allocation to improve access appropriately.
- **2.3.5** - may be challenging for clinicians to have the time to vet materials in other languages - will need to adjust appointment hours to accommodate and also

increase compensation for clinicians providing this service above and beyond their colleagues who are not vetting materials.

- Hollist approach to provide patient centered care. Medical, spiritual, and cultural paradigm healing models must all be intertwined when treating patients of diverse backgrounds.
  Re-building trust relationships with Tribal health leaders which have unfortunately been broken and breached over and over again.
- Encourage the Task Force to consider how telehealth could be a resource in implementing other Access recommendations. One example is translation and interpretation services for patients as discussed in recommendation **2.3**. The use of telehealth can allow easier access to providers who speak different languages, either at home or within healthcare facilities, which in some cases may remove the need for a translator all together.
- Encourage the Task Force to consider how telehealth could be a resource in implementing other Access recommendations. One example is translation and interpretation services for patients as discussed in recommendation **2.3**. The use of telehealth can allow easier access to providers who speak different languages, either at home or within healthcare facilities, which in some cases may remove the need for a translator all together.
- The language, transportation, and telehealth recommendations are great and can help offload systems while also standardizing requirements and content.
- Minnesota must act with urgency and consistency to address systemic disadvantages in health care and mitigate the impacts of federal cuts to the national safety net.
- Minnesota Health Centers operate mobile clinics, school-based clinics, migrant health clinics, public housing clinics, and clinics in shelters for those currently unhoused. They also provide community and home-based case management services, remote monitoring care, and pop-up clinics at community-based organizations, parks, events, grocery stores, and more. Minnesota Health Centers are the roadmap for creating meaningful access to health care services for all Minnesotans and should be a priority for the State's solution.
- Being culturally and socioeconomically sensitive when thinking about resolving barriers will be critical to foresee what changes will make the most impact coming up in the 2026 year when Medicaid will be severely underfunded.
- Recommendation **2.1** - Implement universal health care/ health care for all. States that have made an effort to implement universal health care, particularly California and Vermont, have not been successful. Providers, many of which are already

struggling financially, have significant concerns about low government reimbursement rates impacting their ability to hire and retain a sustainable workforce. There are many potential negative consequences that need to be evaluated.

- Recommendation **2.2** - Improve access for patients – Minnesota's nonprofit health plans have worked to form robust provider networks to help patients receive care when and where they need it. Interested entities should be concerned with the CARMA legislation passed in 2025 that would allow counties to limit choices for those on managed care. Currently, enrollees in Medical Assistance and MinnesotaCare throughout the state can choose from at least two managed care plans (and their differing networks) and selects which plan provides the best access for them. The CARMA legislation would allow counties to limit enrollee's choice to only the County Based Plans, removing an enrollee's ability to choose a network that worked better for them and their particular access needs. Minnesota should roll back this model or study its impact on equitable access to care.
- Recommendation **2.3** – Interpretation and translation standards. This past session, the legislature appropriated funds to establish the Spoken-Language Translator Workgroup and this workgroup will focus on this recommendation. We would encourage members of the Equitable Health Care Task Force to engage with the workgroup and bring back implementable language to the legislature.
- For Recommendation **2.2.2**, MNCM collects provider data from participating medical groups to support the provider registration requirements of the SQRMS mandate. Submission of provider data that falls outside of the mandate is also allowed and completed at the discretion of the participating medical groups. All data is collected via our proprietary PIPE application, which serves as a unified system to manage these submissions.
- For Recommendation **2.6.2**, the implementation should consider the requirements outlined in the CMS-9115-F and CMS-0057-F interoperability rules. Under these regulations, health plans must implement a Patient Access API that enables members to access their claims, encounter, clinical, and prior authorization data through third-party applications. These applications, authorized by the patients, will query and retrieve data via a FHIR-based API. The rules mandate that payers make this information available within one business day, thereby ensuring near real-time access to health data. MNCM recommends that MDH leverage existing infrastructure wherever possible to avoid duplication of effort and to promote efficient implementation.
- When implementing the Access recommendations, it will be important to prioritize meaningful community engagement to ensure solutions really meet the needs of

those most impacted. Building strong partnerships with local providers and trusted community health workers and other trusted messagers will be key to successful outreach and care coordination. Ensuring adequate funding and clear accountability measures will help sustain these efforts and make sure improvements are equitable and lasting.

Other comments for meaningful access

- Patient navigators who are familiar with each Tribe's traditional medicine and healing need to be provided to all Native American Indian/Alaska Native patient in MN, particularly to Tribal elders. There could be consideration given to options for evacuation of patients from reservation clinics and health centers to appropriate higher-level facilities whenever needed (potentially look into helicopter medical air ambulance services).
- Train more and more community-based patient navigators.
- **2.2.1**: Additional language: Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools, mobile care models, *and collaborative care models (physical, mental, dental, eye all in one location)*.
- **2.2.2**: Additional language: Create *an easily accessible* system for patients that enables patient/provider matching so patients can choose providers they may identify with and/or provide the services they need*, regardless of the provider being in or out of network on health insurance plans, at no additional cost to the patient*.
- **2.2.4**: Additional language: Expand *community and* school-based health services, including oral health screenings, *mental/emotional health and* preventive services that everyone in the community can access.
- Recommendation **2.6** Minnesota should strengthen patient health literacy, *with support from providers*.
- **2.6.1**: Additional language: Establish state-wide health literacy and digital literacy education *which is available via in person or online education and provided in multiple languages with accessibility for all*.
  Health equity and access through the lens of geographic disparities - particularly by zip code. This is especially critical as hospitals begin to face federal budget cuts, which are already resulting in the discontinuation of certain programs and, in some cases, the potential closure of medical facilities.
- Strongly supportive of Recommendation **2.4** and is happy to serve as a resource to the task force in crafting specific policy initiatives to support these recommendations.

- Telehealth may allow for care improvements and extensions in the face of funding cuts. Lean in to this.
- W have concerns regarding the Access recommendation calling for a universal health care system. Every Minnesotan deserves access to affordable, high-quality health coverage and care. However, evidence shows that replacing the state's health care system, including the employer-sponsored plans many residents prefer, with a government-controlled single-payer system would not only be unaffordable for Minnesota families, but also deeply unpopular with patients and taxpayers. Many states, such as Colorado, have explored similar single-payer proposals, but there has yet to be a single successful single-payer system in the country for a reason: a government-controlled single-payer system would require massive tax hikes for hardworking families. In fact, 80 percent of Colorado voters rejected the unaffordable costs and consequences of a proposed single-payer system at the ballot box (Vox, 2017). Taxpayers should not be forced to accept and foot the bill for an expensive policy they don't want. As voters in Colorado have made clear, the cost of implementing a one-size-fits-all state government-controlled health insurance system is far too high to justify. Additionally, there is concern that a single-payer system could threaten patients' access to care in Minnesota. In 2023, FTI Consulting conducted an analysis of a public option – a more modest proposal compared to single-payer – on behalf of Colorado's Health Care Future. Even so, the study found that the policy could harm Minnesotans' access to affordable, high-quality health care. A single-payer system would likely have an even more harmful effect on Minnesota families. We urge this task force not to rush into implementing this one-size-fits-all, unpopular, government-controlled health care system. Instead, policymakers should learn from the experiences of other states that have tried to implement single-payer systems and instead build on what's already working here in Minnesota.
- Recommendation **2.3.2**: Establish a statewide policy for hospitals to buy into a system of independent contractors for access to interpreter services. We have concerns regarding this recommendation as currently structured and would appreciate additional clarification of its intended implementation. While we strongly support improving interpreter services and language accessibility for our patients, we believe the payment for covering these essential services should appropriately rest with payors, both public and private, rather than being imposed on hospitals as an unfunded mandate. Additionally, Minnesota's diverse geography creates varying language service needs across different regions of the state. A one-size-fits-all statewide approach may not adequately address the unique demographic and linguistic needs of rural versus urban areas, or the specific language requirements

of different communities. We recommend developing a more flexible framework that allows hospitals to tailor interpreter services to their local patient populations while ensuring adequate payor reimbursement for these critical services.
Recommendation **2.1**: Minnesota should implement universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota. We are deeply concerned about the financial sustainability of the health care system itself with this recommendation. On average, Minnesota hospitals have 64% of our patients enrolled in either Medicare or Medical Assistance. Current government payment rates consistently fall short of covering the actual costs of providing care. Without addressing this gap in reimbursement rates, access to care may actually decline rather than being enhanced. Instead of implementing universal health care coverage, Minnesota should continue to provide coverage in our public health care programs for low-income individuals. In addition, subsidies to help people purchase private insurance should be considered as well.

- Recommendation **2.7.2**: Explore and invest in alternative or supplemental funding streams—such as state surplus funds, community reinvestment strategies, community benefit—to support health care access for populations not covered by public payers, including undocumented immigrants. This recommendation has many options that you are seeking comments on. As we have not yet fully grasped the impact of the “One Big Beautiful Bill Act” on the increases in Minnesota's uninsured rate, or the impact of increased uncompensated care of undocumented adults losing MinnesotaCare coverage, a short-term consideration could be using state dollars to fund a temporary statewide uncompensated care pool for hospitals and clinics. That said, restoring some type of government supported coverage option is still preferable. The state, with ample input from health care providers, should explore new and alternative approaches to health care service delivery. This may be an updated version of the former General Assistance Medical Care (GAMC) Program, which was paid for with state dollars prior to the Affordable Care Act or a revised version of the temporary Coordinated Care Delivery System (CCDS) which provided care to individuals who had lost their GAMC coverage from June 2010 to February 2011. As you know, charity care and bad debt are both part of uncompensated care and are already a significant portion of the overall hospital community benefit. The portion of community benefit that is dedicated to uncompensated care will likely grow, which will inevitably squeeze out other worthy efforts of community benefit that hospitals are engaged in. Hospital community benefit should remain flexible to respond to community needs accordingly.

Bolster Primary and Whole-Person Care

Which recommendations do you think are the highest priority and why?

- **3.3** Minnesota should adopt reimbursement and payment models that will support investments in primary care. Because the problem in the healthcare system in U.S is about unequitable and spiking costs, which must be addressed first before other proposes comes into play
- **3.4.2** - the Minnesota Health Records Act is written in a way that inhibits the ability of technology to advance the care delivery of patients and ability for the department of health to do efficient syndromic surveillance, quality assessment, and even public health care delivery; it needs to be updated.
- **3.4.3** - a shared state-wide directory of social need resources would dramatically improve the efficiency of getting people to the services that can help them with social needs.
- **3.4.5** - incentives for systems to deploy and participate in TEFCA with ability for the state to start to receive specific data from QHIN's related to syndromic surveillance and public health would greatly improve healthcare across Minnesota.
- Recommendation 3.3 Minnesota should adopt reimbursement and payment models that will support investments in primary care. Increasing the "asks" of primary care providers is not possible if they are not adequately reimbursed/provided funding for more people in the clinic to care out the expanded definition of primary care.
- **3.1.2** - dental coverage as essential benefit. 3.1.2 and 3.3.2 - Dental health has a huge impact on overall health, and it does not make sense that it would be separated from health care coverage. There are significant disparities in access to dental care.
- **3.2.1** - centralized, statewide directory of resources. Better coordination of resource access, make it easier for providers to identify relevant resources for their patients, improve wrap-around care.
- **3.3.2** - increase Medicaid coverage of dental care
- **3.4.1** - centralized patient medical record portal. People often access multiple health systems, leading to poorer quality health care when providers do not have all of the information to give patients the best care they can.
- **3.4.4** - improving referral system across payers, health care, and CBO's. We need to close the gap on referrals for specialized care and loss to follow-up.
- **3.1** - A re-envisioned primary care system should include the integration and coordination of care for physical health, mental health, substance use,

complementary care and culturally concordant care. It addresses the uniqueness of treating people of whom they are but not they are perceived to be.

3.4.5 Incentivize health providers and state to participate in the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing and include Tribal Health Leaders' voices. The current data sharing agreement processes for Tribes now is ineffective and inefficient, making it difficult to provide real-time data available to Tribal health decision-makers on priorities for the optimal health for the members of their communities.

- Expansion of primary care and dental care, though the latter will not be possible if payers are not required to cover it (to my earlier comments about requirements for insurers operating in MN). Access to primary care, especially low touch, can improve population health, expand care system reach.
- Recommendation **3.1 and 3.2** (Integration/Coordination and Social/Team-Based Model).
- Support the lead recommendations outlined in the draft to bolster primary and whole-person care. Federal law requires Health Centers to provide primary medical care, dental care, and behavioral health services, including substance use disorder treatment, either integrated, co-located, or through referral relationships that guarantee access and care regardless of ability to pay.
- Agree that task force recommendation **3.3** "Minnesota should adopt reimbursement and payment models that will support investments in primary care," is a priority and this aligns with the Commonwealth fund report findings to "Engage community health centers in payment reform," that strengthens value-based payment models to fill gaps in care and more accurately reflect the true cost of care that is currently provided, (Commonwealth Fund, 2024). Health Centers have built a nationally recognized model of integrated, whole-person, culturally concordant, team-based, community-governed primary health care centers over the last six-plus decades. A 2024 Commonwealth Fund report finds "…amid several major public health challenges — from COVID-19 to the behavioral health crisis — community health centers are continuing to provide millions of patients with accessible, comprehensive, and coordinated health care (Commonwealth Fund, 2024, 27)." Furthermore, the report concluded that Health Centers successfully offer timely appointments, expanded hours, telehealth, and are "making care more comprehensive for their patients by offering behavioral health services, particularly treatment for substance use disorders, and screening patients for social needs."
- Recommendations **3.1 & 3.4**. Dental care is essential for whole body care. If we are to bridge the trust gap between our various communities, it is important to acknowledge cultural and integrative practices that work for our individuals and

families instead of always thinking of the quick fixes and making pharmaceutical companies more money. By acknowledging these issues, Minnesotans will come to agree that health care systems are in place to respect and guide their health, not tell them what to believe. Additionally, having one modernized database will be able to avoid lag time in care, especially for life-saving and critical procedures, but it helps with continuity of care so that various practitioners can have access to the same, complete information.

- I believe the highest priority is Recommendation 3.1: integrating and coordinating care across physical health, mental health, substance use, complementary care, and culturally concordant care. This holistic approach ensures that patients receive comprehensive support tailored to their whole-person needs, which is essential for improving outcomes across life stages. It's especially important that this integration includes partnerships with Indigenous and cultural health practitioners to respect and incorporate traditional healing practices. By expanding primary care to address all aspects of health, Minnesota can create a more effective, inclusive, and equitable health care system. I believe these are the highest priority Primary Care recommendations because they focus on treating the whole person, not just isolated symptoms. Integrating physical, mental, and cultural care ensures that patients receive more comprehensive and personalized support, which leads to better health outcomes. Including traditional healing practices also honors the values and needs of diverse communities, making care more accessible and respectful. Overall, these recommendations build a stronger, more inclusive primary care system that can better meet the complex needs of Minnesotans.
- **3.2**. Because it does the best job of integrating social determinants of health issues, and SDOH are the biggest drivers of poor or good health.
- **3.1.4** Require primary care clinics to treat opioid use, alcohol use with FDA approved medications.
- **3.1.5** Integrate traditional healing practices into clinic education and practice guidelines in a comprehensive way in partnership with indigenous and cultural health practitioners.
- **3.2.2** Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care providers and payers.
- **3.2.3** Incorporate funding for community health workers (CHWs) into state initiatives to address social determinants of health/health related social needs, community care hub infrastructure.

- **3.2.4** Fund coordination between primary care and public health to improve population health outcomes.
- **3.2.5** Fund social workers, community health workers (CHWs), and licensed alcohol and drug counselors (LADCs).

What is missing from the recommendations?

- There should be a direct intersection between food and health care. Health care institutions can get good food into the hands of patients. E.g., Veggie Rx.
- Add **3.1.6**: Fund supportive care for birthing people, including midwifery and doula services.
- Add **3.2.6**: Incorporate funding for community paramedics (CPs) into state initiatives to establish partnerships between primary care and health needs of the community, reducing the burden on EMS systems. funding for community paramedics (CPs) into state initiatives to establish partnerships between primary care and health needs of the community, reducing the burden on EMS systems.
- Extensive funding to conduct continuous research on diseases and symptoms of patients newly arrived in the State.
  Close coordination with the 11 Sovereign Tribal Nations within the boundaries of the State of MN.
- Dental care expansion will not be possible without requirements for insurers, which must be differentiated from health care systems, which can only develop infrastructure within the scope of their operating margins.
- Invest in Upstream Interventions and Services to Bolster Primary and Whole-Person Care. Just as primary care helps make health systems more effective and efficient, so too place-based and socially oriented upstream initiatives are critical to primary and holistic care outcomes. Access to quality education, employment, food, and housing (or lack thereof) drives health outcomes. The call for the health system to move toward a primary care-driven model is an important step. The move must be founded on strategies to increase creativity (outside-the-box thinking) and scale up the state's efforts to invest in prevention and tackle the social determinants of health.
- Please include funding and advocacy at the State and federal levels, as FQHCs are the model of deeply accessible, whole-person primary care for all Minnesotans. Providing payment reform strengthens FQHCs, allowing them to continue serving as the state's core safety-net primary healthcare provider.
- Mental health and developmental education should start sooner/have more emphasis as normal primary care appointments throughout the lifespan.

- Section 3 – Bolster Primary and Whole-Person Care Add:
  - Require primary care clinics and Federally Qualified Health Centers (FQHCs) to provide access to rehabilitation services, durable medical equipment (DME) support, and caregiver counseling as part of whole-person care.
  - Integrate home- and community-based services (HCBS) into care coordination models, especially for dual-eligible and long-term care populations.
  - Explicitly list people with disabilities and aging adults as priority groups in social needs referral systems, care coordination hubs, and resource directories.
  - Incentivize clinics to offer memory care screenings, neuropsychology referrals, and accessible dental services.
  - Recommend incorporating a clear emphasis on the need for sustained funding to support clinical quality measurement. Continued investment is essential to ensure ongoing improvement, accuracy, and reliability in health care quality outcomes. Additionally, the recommendation should advocate for the expansion of quality measurement efforts to encompass additional high-priority areas, thereby ensuring comprehensive and meaningful coverage of critical metrics that reflect the full scope of primary care services.
  - What seems to be missing from the Primary Care recommendations is a stronger focus on addressing workforce challenges, such as recruiting and retaining diverse primary care providers, especially in rural and underserved areas. There could be more emphasis on patient education and empowerment to help individuals actively participate in their care. Finally, clearer plans for measuring progress and accountability would help ensure these recommendations lead to meaningful, lasting improvements.
  - **3.2.3 and 3.2.5** should also include Community Health Representatives.

What will be important to consider when implementing these recommendations?

- **3.4.6** - The interoperability should be developed in a way to leverage improved automation of data flow between state systems and health systems and usage of artificial intelligence in a way that it would allow a data repository accessible to many entities with various controls that would allow improved care delivery for all Minnesotans.
- **3.4.2** Update the Minnesota Health Records Act to provide clarity and alignment with electronic workflows. The Minnesota Health Records Act is written in a way that inhibits the ability of technology to advance the care delivery of patients and ability for the department of health to do efficient syndromic surveillance, quality assessment, and even public health care delivery; it needs to be updated.

- **3.4.3** Design, implement, and maintain a shared directory of social needs resources. A shared state-wide directory of social need resources would dramatically improve the efficiency of getting people to the services that can help them with social needs. Could leverage existing directories from FindHelp, UniteUs or MN211 to create a centralized online directory that pulled from all of these resources with assistance for CBO's to keep their data updated and an API for health systems and CBO's to access this information.
- **3.4.4** Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care, and community organizations. Would need a directory framework from 3.4.3 first before working to develop the referral process.
- **3.4.5** Incentivize health providers and the state to participate with the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing. Incentives for systems to deploy and participate in TEFCA with ability for the state to start to receive specific data from QHIN's related to synd
- **3.4.7** Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research, maintain public health surveillance and dashboards, and add additional partners across Minnesota. Agree with continuing to fund this important resource.
- Recommendation **3.4** Minnesota should modernize data sharing among payers, health care providers, researchers, social service providers, and public health. (found on page 6 and 7)
- **3.4.1** Establish a single, aggregated patient record via one portal that supports the ability for social services/community organizations to collect and add data to patient records. This seems extremely challenging and may be better to promote an existing patient portal or usage of those portals by patients with better integration of data and resources at the state level that can be feed to the many individual portals
- **3.1.4** - Health care facilities will need to be trained to provide this care in a nonjudgmental and supportive manner. Bias against people who use substances is significant, and it requires specific training to support them well.
- The ever-upsurging population of immigrant numbers to merge with funding dispensation.

  Coordination and collaboration with 11 distinct Tribal nations will take time and patience. It is important to make genuine and sincere connections with leaders in the communities who the members of the communities trust.

- Telehealth. Coordination with public health. These things can potentially tap into people's desire for on-demand care that also relates to how the live their lives in their homes and communities.
- Emphasis on upstream interventions (social determinants of health).
- We would like to note the difficulty in achieving expansions with record provider shortages in Minnesota and instead, we would advocate for increased loan forgiveness programs for primary care clinicians that agree to serve a certain portion of Medical Assistance.

  Recommendation **3.3** – Primary care reimbursement. We recognize the importance of primary care but there needs to be more consideration of the impacts of increasing reimbursement, which are paid by premiums collected by health plans. Increasing reimbursement would mean increasing premiums, which most people consider too high already. In order to raise reimbursement and keep premiums stable, reimbursement will need to be lowered for other providers. It is not as simple as saying reimbursement should increase. There are many other considerations that must be evaluated and accepted by providers.

  Recommendation **3.3** – Modernize data sharing. The Minnesota Health Records Act should be amended and aligned with the standards under HIPAA. This standard protects patient data while allowing providers to access records when a patient moves from one system to another.
- For recommendation **3.2.1**, recommend that MDH consider the foundational work completed by Stratis Health in developing an approach for a shared directory of social needs resources. Although the approach has been established, design and implementation have been hindered by a lack of funding.
- For recommendations outlined in Section 3.4, encourage MDH to leverage and expand upon existing initiatives and infrastructure, including: MNCM's Common Health Information Reporting Partnership (CHIRP): A facilitated data-sharing program that enables streamlined, bi-directional exchange of patient-level data between health care payers and providers for specific use cases.
- CMS-0057-F Interoperability Rules and Regulations: These include the Provider Access API and the Payer-to-Payer API. The Provider Access API allows in-network providers to query health plans for clinical, claims, encounter, and prior authorization data for attributed patients, unless the patient opts out, with data access required within 24 hours of adjudication. The Payer-to-Payer API facilitates the transfer of historical data between a patient's former and current health plans, or between secondary and primary plans, promoting continuity of care. Full implementation of FHIR-based APIs for both provider access and payer-to-payer exchange is mandated by January 1, 2027.

- Sustained Funding for the Statewide Quality Reporting and Measurement System (SQRMS): Continued investment in SQRMS is critical to support statewide quality measurement and ongoing improvement efforts. Since the inception of SQRMS, MDH and MNCM have successfully collaborated to collect and report statewide clinical quality data for ambulatory care providers. This partnership has enhanced transparency in performance measurement across key clinical metrics. Additionally, Public Use Files derived from the quality reporting system have enabled community-based organizations and populations affected by health inequities to access and utilize data in support of health equity initiatives. MNCM's planned integration of social risk factor data will further strengthen the ability to identify disparities and target areas for improvement.
- Support statement **3.4.7** recommending sustained funding for the Minnesota EHR Consortium.
- By aligning new initiatives with these existing resources and regulatory frameworks, MDH can enhance efficiency, interoperability, and care coordination while avoiding duplication of efforts.
- When implementing the Primary Care recommendations, it will be important to prioritize strong collaboration with community members and cultural leaders to ensure care is truly patient-centered and culturally respectful. Supporting the primary care workforce with adequate training, resources, and funding will be key to sustaining integrated care models. Establishing clear accountability measures and investing in modern data sharing systems will help track progress and improve coordination across health and social services.

Other comments on Bolstering Primary and Whole-Person Care

- Recommendation **3.1**: Additional language: A re-envisioned primary care system should include the integration and coordination of care for physical health, *oral health,* mental health, substance use, complementary care, and culturally concordant care.
- Include Tribal leaders' voices whenever possible.
- Recommendation **3.2** Additional language: Minnesota should invest in team-based primary care models that coordinate activities with *EMS and* public health.
- Expanding/improving Medicaid reimbursement is going to be difficult without first leaning on private insurers. You've only got so much pie to divy out, and the federal government is shrinking it.
- Recommendations **3.4.1 & 3.4.2:** Establish a single, aggregated patient record via one portal that supports the ability for social services/community organizations to

collect and add data to patient records; and updating the Minnesota Health Records Act to provide clarity and alignment with electronic workflows. These recommendations raise significant concerns about patient privacy and data security. There is strong bipartisan support for protecting private health care data, and our current system—where health care providers maintain ownership and control of patient records—serves this protective function effectively. Allowing multiple external organizations to access and modify patient records creates substantial risks for data breaches, unauthorized access, and compromise of sensitive medical information. We should not further complicate the robust privacy protections that currently exist. Instead, we recommend improving secure data-sharing protocols under the Minnesota Health Records Act. In addition, MHA has long supported having the Minnesota's Health Record Act more closely aligned with the federal HIPAA standards, but these efforts have seen legislative opposition in the past.

- Love seeing inclusion of traditional and alternative medicine. (3.1.5)
- I would encourage ongoing engagement with frontline providers and patients throughout the implementation process to ensure the recommendations remain responsive to real-world needs. It's also important to consider how technology and data sharing can be used to support the work and not replace personal connections in care. Finally, sustained funding and policy support will be critical to maintaining these improvements over time and ensuring they benefit all communities equitably.

Strengthen and Diversify the Workforce

Which recommendations do you think are the highest priority and why?

- Recommendation **4.4** Optimize the workforce. We need to focus on optimizing the workforce and support for the current workforce before adding more people to the system.
- **4.3** - address workforce inequities. 4.3 - We need to diversify the workforce. This is long-overdue, and there are significant barriers for underrepresented communities in accessing this career pathway.
- **4.3** - Address workforce inequities. There is no accountability on how hiring is arrived at or done by HR departments. Minorities do not give views on the hiring procedure or are not the panel. More often they are told, HR has decided this and this.
- Include Tribal Leaders' voices whenever possible. It is the right, honorable, respectful thing to do in 2025.

- Improving the diversity of the workforce. If you improve the diversity of the work force, the cultural competency will come both in workforce culture and in the care provided.
- All the Workforce recommendations are consequential!
- Support the lead recommendations outlined in the draft to Strengthen and Diversify the Workforce, fostering safety and belonging, attracting and retaining a diverse workforce, enhancing skills, and optimizing the healthcare workforce. Among the many recommendations, agree that creating healthcare career pathways to address critical healthcare workforce shortages should remain a priority. Over four years ago, the MNACHC established a Health Center-focused apprenticeship program to train medical and dental assistants. Much of this work is supported by funding from the Minnesota Department of Health (MDH). The program has led to numerous successes, including high retention rates among graduates and participants, as well as a high pass rate on licensing/certification exams. Additionally, over 80% of our graduates identify as indigenous or a person of color. This program remains a priority for our health centers, as it helps fill critical positions to care for our patients.
- Recommendation **4.3**. In order to accomplish all the other recommendations, it will be critical to have health care professionals with lived experience in the communities they represent, especially with the changes for higher education, North Star Promise funds allocated to health care and continued professional development and funding will be so important.
- Strongly supports the workforce development recommendations outlined in this section. Ensuring that Minnesota's hospitals and health systems have access to a diverse, skilled workforce is essential for providing culturally competent care to our increasingly diverse patient populations. We particularly appreciate and support Recommendation 4.3, which addresses workforce inequities through comprehensive strategies, and more specifically Recommendation 4.3.5, which focuses on increasing utilization of International Medical Graduates (IMGs) and expanding access to Conrad 30 waiver opportunities. We recognize the critical importance of training the next generation of health care professionals, and these initiatives will significantly contribute to building a workforce that reflects and serves Minnesota's diverse communities. These recommendations directly address health care workforce shortage areas while bringing valuable diversity, language skills, and cultural competency to our health care workforce. We encourage the task force to prioritize these workforce recommendations and work with hospitals and health systems to streamline implementation processes.

- I believe Recommendation **4.1**: fostering workplace inclusion, belonging, safety, and well-being is the highest priority to retain a diverse workforce. Creating a supportive environment where employees feel valued is essential for long-term stability and effectiveness. This is also a cost saving approach. Equally important is Recommendation **4.2**, which focuses on enhancing workforce skills through comprehensive, culturally responsive training to ensure quality care that respects patients' diverse backgrounds. Lastly, addressing systemic workforce inequities through Recommendation **4.3**, by removing barriers and expanding recruitment pipelines, is critical to building a workforce that truly reflects and serves our communities.
- **4.2**. Because this is so lacking.
- **4.2.2** Recommend best practices focused on suggested requirements for comprehensive training programs for employees and providers to develop essential soft skills, including cultural responsiveness, mitigation of unconscious bias, effective communication, empathy, and teamwork.
- **4.2.3** Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally congruent care. Continuing education requirements may include courses on diversity, practice-based cultural concordance models.
- **4.2.4** Recommend incentive–based mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.
- **4.2.7** Recommend workforce equity strategies that are informed by the communities being locally served.
- **4.2.9** Require and implement comprehensive training and continuing education for health care providers (link training to licensure requirements) and other employees (e.g., patient navigators, care coordinators, customer service representatives) to develop essential soft skills including:
  Cross-cultural understanding
  Cultural competency
  Cultural humility
  Cultural responsiveness
  Culturally appropriate care
  Culturally congruent care
  Culturally-specific health needs
  Diversity, equity, inclusion, and belonging (DEIB)

Effective communication
Eliminating biases and discrimination
Empathy
Implicit bias
Mitigation of unconscious bias
Patient-centered care
Teamwork
Trauma-informed care
Training programs

- **4.2.10** Cultural Competency Training: Rapidly implement training on eliminating biases and discrimination for health care workers. Partner with local organizations or universities to design culturally appropriate training programs in the short term.
- **4.2.11** Use learnings from experiences training providers (such as JAMA article on mandated implicit bias training; Cooper LA, Saha S, van Ryn M. Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care. JAMA Health Forum. 2022;3(8):e223250).
- **4.2.13** Require trauma-informed, equity training for intrapartum and post-partum care.
- **4.2.14** Implement training and education for providers that cultivates better attitudes toward Medicaid patients.
- **4.3.15** Expand the development and use of partnerships between K-12 schools and health care providers to sponsor Community Health Worker (CHW) training and increase the pipeline of diverse health care workers (example: WELFIE).
- **4.3.20** Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.
- **4.3.21** Ensure that some NorthStar Promise funding is dedicated to students seeking health care degrees.
- **4.4.11** More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.
- **4.4.12** Provide legislative authorization to the Minnesota Department of Health (MDH) and Department of Human Services (DHS) to develop opportunities to advance and sustain the Community Health Worker (CHW) workforce, and establish a state office to implement CHW policies and coordinate stakeholders.
- **4.4.13** The Minnesota Department of Human Services (DHS) should recognize Community Health Representatives without requiring duplicative training. Enable

Community Health Representatives to bill for services as Community Health Workers, especially given the historical and community-specific role they serve.

- **4.4.14** Increase the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.
- **4.4.15** Establish residency and fellowship programs for health professionals to work in underserved, rural, and tribal communities to ensure that they are exposed to the specific needs of these populations.
- **4.4.16** Introduce long-term changes to health professional training programs to ensure they reflect the diversity of the populations they serve. This could include more scholarships for people from underrepresented communities, more recruitment into health careers from those communities, and ensuring a robust pipeline into health care fields.
- **4.4.17** Support the University of Minnesota and CentraCare expansion of medical training programs for rural physicians.

What is missing from the recommendations?

- Community health workers may only help patients if the patient has a prescription from medical health care providers; this is a huge barrier for a patient to obtain CHW services. CHWs are helpful support for deaf and hard of hearing patients.
- Timeline requirement/accountability for providers who do not complete the listed training.
- Training and support to improve cultural competency at all levels of education (starting in residency).
- **4.2.13** - add prenatal care
- **4.2.14** - add uninsured patients
- Add **4.1.5**: Support safety awareness by providing public education on safety impacts in health care settings to address societal mistrust and abuse of health care professionals and support upstream mental and behavioral health access to prevent harm in health care settings.
- Add **4.2.17**: Continue funding Minnesota Department of Health's Workplace Safety Grant program that supports safety in the health care workplace.
- Add after **4.4.3**: Encourage communities to create initiatives that welcome rural providers into their communities, such as a community ambassador program which can help tour interested applicants, help providers adapt to the community by finding housing and childcare, and hold community events to include providers.
- Breakdown of different races in MN and how many are hired on replaceable or retiring bases.

- Work closely with Indigenous nursing, pharmacy, medical training programs about the nation to recruit Indigenous providers to work with Indigenous populations.
- Required cultural competency training, which we have at HealthPartners, can potentially spark a backlash and resistance to the same. Focus on diversity in all it's form, particularly class/resources, is essential because rural, mostly white Minnesotans, face access and care issues like many other minoritized groups. It's important to take an approach that covers disparities across the full spectrum.
- Strengthen and Diversify the Health Workforce by Investing in African Americans and African Immigrants. Minnesota gains doubly from investments in health workforce diversification. Efforts to train, recruit, and retain health workers of color help combat labor market shortages as well as persistent gaps in the provision of culturally relevant services. African American and African Immigrant constituents and health leaders continue to report that investments in culturally based workforce development are top priority for overcoming harmful maternal health and mental health outcomes. These investments must also address Black underrepresentation within leadership positions in the health sector.
- What seems to be missing from the Workforce recommendations is a stronger focus on mental health and wellness support specifically tailored for health care workers themselves, given the high stress and burnout rates in the field. More emphasis could be placed on creating clear career advancement pathways and leadership development opportunities for underrepresented groups to ensure sustained workforce diversity at all levels. Lastly, integrating technology training to prepare the workforce for evolving digital health tools would help future-proof the system and improve care delivery.
- Again, every reference to CHWs should also include Community Health Representatives.

What will be important to consider when implementing these recommendations?

- There are programs that incentivize health care providers to work in underserved areas (e.g., Indian Health Services), but those professionals are not in communities past two years. Workforce development and training must be intentional and go beyond incentives to include accountabilities to provide high quality care to the communities served.
- How will Minnesota remove barriers in people's lives that prevent access to degrees and training for health care careers - such as daily living expenses that will not be

adequately covered due to reduced work hours, child and elder care for dependents?

- Workforce decisions be open and public to debate on the committee's constitution and votes be done in the public.
- Include training and perspective on the accurate historical (and present) Indigenous, Inter-generational trauma, such as that which was experienced by many elders during the boarding school era in our region.
- Many of these issues are pipeline issues which require facilitation further upstream. The labor supply of diverse professionals in Minnesota is very limited, making it difficult for institutions to diversify their workforce, even if they would like to.
- It will be important to allocate enough funding to continue training qualified health care professionals that are culturally competent and responsive.
- When implementing the Workforce recommendations, it will be important to prioritize ongoing support for employee well-being and create an inclusive culture that truly values diversity and belonging. Ensuring accessible and culturally relevant training programs that are consistently updated will help maintain workforce competence and responsiveness. The collaboration across educational institutions, health organizations, and communities will be key to addressing systemic barriers and supporting recruitment, retention, and career growth. Finally, adequate funding and clear accountability measures will be essential to sustain these efforts over time.

Other comments regarding Strengthen and Diversity the Workforce

- **4.2.9** - add Disability Includsion Education to list
- **4.3.1**- Additional language: Minnesota to outline a framework and model to help health care organizations *(clinics, hospitals, long term care, independent providers, public health, etc)* collaborate with stakeholders to examine and address systemic barriers that contribute to health care workforce inequities. Include guides and implementation resources.
- **4.3.4** - Additional language: Recommend strategies to incorporate into hiring *and promoting* processes to support the hiring and promotion of underrepresented candidates and to attract and recruit a workforce that reflects the communities we serve, including strategies to support international candidates *and career laddering*.
- **4.3.5** - Additional language: Increase the utilization of international medical graduates (IMGs) and the Conrad- 30/J-1 visa waiver program, and educate health systems on the value of hiring *and retraining* IMGs and providers trained outside the U.S *in MN facilities*.

- **4.3.14 -** Additional language: Educate all K-12 students on medical professional pathways. *Help schools set up grow your own programs in order to assist students with their coursework to earn credit towards a medical professional degree or certification while in school*.
- **4.3.18** - Additional language: Track retention of health care professionals in *rural* and underserved areas to identify gaps and opportunities to improve retention.
- **4.4.4 -** Additional language: Establish an independent Minnesota Health Care Workforce Advisory *Council* to provide objective health care workforce research and data analysis; collaborate and coordinate with other entities on health care workforce policies; recommend appropriate public and private sector policies, programs, and other efforts to address identified health care workforce needs.
- **4.4.11-** Additional language: More resources should be devoted to hiring community health workers, particularly in *rural and* underserved areas, to act as bridges between health care providers and the community.
- **4.4.15 -** Additional language: Establish *clinical*, residency, and fellowship programs for health professionals to work in underserved, rural, and tribal communities to ensure that they are exposed to the specific needs of these populations.
- **4.4.17** - Additional language: Support the University of Minnesota and CentraCare expansion, *as well as development of other medical systems partnerships, especially in Greater Minnesota* of medical training programs for rural physicians.
- Include voices from Tribal perspectives in all cases.
- When it comes to workforce considerations, out-of-state telehealth providers can be a great resource in helping to address provider shortages and fill in coverage gaps in rural areas. ATA Action encourages the Task Force to consider recommendations that would encourage Minnesota to join cross-state licensure compacts and pursue other policies that better facilitate out-of-state telehealth care for Minnesota patients.
- The ability to use/expand IMGs will be limited given the barriers being put up by the Trump administration.
- We recommend that MDH leverage and build upon existing efforts and resources already underway at both the state and national levels. By aligning with and amplifying these ongoing initiatives, MDH can more effectively prioritize and allocate resources toward new, high-impact areas that will advance the development of a more equitable health care system in Minnesota.
- The Workforce recommendations cover a lot of important areas. I think it's important to include feedback from frontline workers and community members as these plans move forward. Also, supporting health care workers' mental health and

preventing burnout should be a bigger focus. Finally, working closely with community groups can help build a stronger and more diverse workforce for the future.

- Prioritizing racial equity in hiring, retention, and promotion reflects a necessary response to disparities in representation across health leadership.
- Clearer accountability frameworks (e.g., equity scorecards, grievance protocols) could enhance follow-through in institutions resistant to change.

DRAFT: Equitable Health Care Task Force Recommendations

Contents

Ensure System Accountability

Recommendation 1.1 Ensure full and equitable health care coverage for American Indian communities and Tribal citizens in Minnesota.

1.1.1 Tribal members and children should be automatically enrolled in a health care plan that provides full coverage (e.g., through Medicaid or MinnesotaCare).

Recommendation 1.2 Minnesota should strengthen and harmonize its approach to health care patient protection.

1.2.1 Minnesota should establish an office to coordinate the work of entities that field patient complaints so there is one consumer-friendly entry point for all patients. Entities include the Minnesota Department of Health Office of Health Facility Complaints, Minnesota health licensing boards, Minnesota Department of Health (MDH) HMO Enrollee External Review and Complaint Process, Minnesota Department of Commerce Consumer Response Team, Minnesota Department of Human Services Office of Inspector General, the Minnesota Department of Human Services Program Integrity Oversight Hotline, and the Minnesota Attorney General's Office.

1.2.2 Minnesota should establish an office that assists consumers and patients with access to and quality of health care services, and provides free legal services.

Recommendation 1.3 Health care in Minnesota should have community co-leadership and equity-focused oversight.

1.3.1 Strengthen the State's regulatory role in population health expectations, impact, and accountability of health plan and provider systems.

1.3.2 Establish patient and community advisory boards to provide ongoing feedback on health care policies and ensure cultural relevance. This should include co-designing health care evaluation and delivery, non-clinical treatments that reflect community needs and values.

1.3.3 Support communities in playing a larger role in shaping local health care systems and local partners by prioritizing resources such as walkable spaces, public health services, and community organizations.

1.3.4 Ensure that cultural competency information is available to patients (e.g., provider profile information).

1.3.5 Require managed care organizations to fund community-based partnership staffing to increase managed care organizations' capacity for coordinating health-related social needs services.

Recommendation 1.4 Minnesota should strengthen data infrastructure to advance health care equity.

1.4.1 Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ameliorate disparities in health outcomes.

1.4.2 The Minnesota Department of Health (MDH) should implement recommendations from the Health Equity Advisory and Leadership (HEAL) Council to standardize and disaggregate data. MDH should create a plan and action steps for implementing standards on data collection, data analysis and data dissemination. Within this plan, data disaggregation standards are needed, specifically regarding race, ethnicity, and language, sexual orientation and gender identity, disability status, and social determinants of health.

Meaningful Access

Recommendation 2. Minnesota must ensure all persons in Minnesota have comprehensive health care insurance, timely access to needed health care services, and a baseline understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

Recommendation 2.1 Minnesota should implement universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota.

Recommendation 2.2 Minnesota should support a health care delivery system that patients can access where and when they need it.

2.2.1 Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools and mobile care models.
2.2.2 Create a system for patients that enables patient/provider matching so patients can choose providers they may identify with and/or provide the services they need.
2.2.3 Require and incentivize providers to offer flexible hours for evening and weekend appointments.
2.2.4 Expand school-based health services, including oral health screenings and preventive services.
2.2.5 Expand primary prevention programs through healthy youth development programs.
2.2.6 Enhance policies for coverage of in-home monitoring systems that integrate with health care delivery systems.
2.2.7 Expand use of common referral approaches among cross-sector partnerships.
2.2.8 Expand the use of Community Health Workers or Patient Navigators to provide wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner.
2.2.9 Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics and hospitals.

Recommendation 2.3 Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.

2.3.1 Standardize translation services through licensing of translators.

2.3.2 Establish a statewide policy for hospitals to buy into a system of independent contractors for access to interpreter services.

2.3.3 Ensure consistency in reimbursement by payers for interpretation and translation services.

2.3.4 Provide interpretation services for patients who need this immediately upon arrival at a health care facility.

2.3.5 Ensure that patient-facing education and materials are vetted with bilingual clinicians to ensure cultural context is taken into account for some of the languages that are not easily translatable from English, such as Hmong, Somali, and others with different health paradigms.

2.3.6 Require after-visit summaries to be translated, written in plain language, and include after care and follow-up instructions.

2.3.7 Develop a centralized hub for providers to access vetted translated materials in commonly spoken languages across Minnesota to promote consistency and reduce provider costs.

2.3.8 Require providers to adhere to the National Association for the Deaf's, "Minimum Standards for Video Remote Interpreting Services in Medical Settings."

Recommendation 2.4 Minnesota should expand inclusive and accessible telehealth by investing in broadband infrastructure, mobile care, and phone-based services to ensure equitable access in rural and underserved communities.

2.4.1 Expand telehealth and mobile health services especially for rural and underserved areas, implementing technology to provide health care access where there are fewer providers can be a low-cost, immediate solution.

2.4.2 Continue support for audio-only telehealth for people using Medicare and Medicaid, especially in rural areas, where reliable internet access is limited and phone-based care may be the most equitable option.

2.4.3 Develop infrastructure and funding strategies to expand broadband access in rural communities, ensuring telehealth is equitably accessible across the state.

Recommendation 2.5 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.

2.5.1 Establish a cross-agency reimbursement system for transportation and transportation coordination services, using models like Head Start, to reduce access disparities and support equitable health care delivery [e.g., Department of Human Services (DHS), Minnesota Department of Health (MDH), Minnesota Department of education (MDE)].

2.5.2 Expand non-emergency medical transportation benefits under Minnesota Department of Human Services (DHS)/Medicaid.

2.5.3 Ensure that transportation services meet all patient needs (e.g., car seats, adaptive equipment).

Recommendation 2.6 Minnesota should strengthen patient health literacy.

2.6.1 Establish state-wide health literacy and digital literacy education.

2.6.2 Establish a system of patient-owned electronic health records to facilitate care coordination and shared understanding of patient needs.

2.6.3 Develop partnerships with providers, communities, and others to advance health literacy.

2.6.4 Deliver health education and services in community spaces, such as schools, libraries, and other trusted local venues, particularly in Greater Minnesota, to address access gaps and avoid default reliance on telehealth.

2.6.5 Reimburse for patient navigators to help patients understand coverage, billing, and out-of-pocket costs.

Recommendation 2.7 Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.

2.7.1 Increase reimbursement rates for mental and behavioral health services to ensure they are equitable with physical health care, thereby improving provider participation and patient access.

2.7.2 Explore and invest in alternative or supplemental funding streams—such as state surplus funds, community reinvestment strategies, community benefit—to support health care access for populations not covered by public payers, including undocumented immigrants.

2.7.3 Align funding strategies with access goals by addressing regulatory and reimbursement barriers that limit provider participation, particularly for patients enrolled in public programs.

Bolster Primary and Whole-Person Care

Recommendation 3. Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages and events.

Recommendation 3.1 A re-envisioned primary care system should include the integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally concordant care.

3.1.1 Require health care organizations to expand primary care.

3.1.2 Add dental coverage as an essential benefit for adults.

3.1.3 Fund and implement the Collaborative Care Model of integrated behavioral health in primary care.

3.1.4 Require primary care clinics to treat opioid use, alcohol use with FDA approved medications.

3.1.5 Integrate traditional healing practices into clinic education and practice guidelines in a comprehensive way in partnership with indigenous and cultural health practitioners.

Recommendation 3.2 Minnesota should invest in team-based primary care models that coordinate activities with public health.

3.2.1 Design, implement, and maintain a shared directory of social needs resources.

3.2.2 Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care providers and payers.

3.2.3 Incorporate funding for community health workers (CHWs) into state initiatives to address social determinants of health/health related social needs, community care hub infrastructure.

3.2.4 Fund coordination between primary care and public health to improve population health outcomes.

3.2.5 Fund social workers, community health workers (CHWs), and licensed alcohol and drug counselors (LADCs).

Recommendation 3.3 Minnesota should adopt reimbursement and payment models that will support investments in primary care.

3.3.1 Require commercial and public payers to allocate a required proportion of dollars to expanded primary care (i.e., Primary Care Investment Ratio).

3.3.2 Improve Medicaid reimbursement to encourage more dental care providers to participate and increase access to oral care.

3.3.3 Update existing Medicaid reimbursement rates and mechanisms for Health Care Homes care coordination services to reflect the true costs of service.

3.3.4 Explore opportunities to increase funding, resources, support for primary care with a focus on preventive care and culturally appropriate interventions that meet patients where they are.

3.3.5 Provide reimbursement for integrative medicine.

Recommendation 3.4 Minnesota should modernize data sharing among payers, health care providers, researchers, social service providers, and public health.

3.4.1 Establish a single, aggregated patient record via one portal that supports the ability for social services/community organizations to collect and add data to patient records.

3.4.2 Update the Minnesota Health Records Act to provide clarity and alignment with electronic workflows.

3.4.3 Design, implement, and maintain a shared directory of social needs resources.

3.4.4 Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care, and community organizations.

3.4.5 Incentivize health providers and the state to participate with the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing.

3.4.6 Ensure interoperability, data governance, quality standards, and policies to enable seamless data exchange and communication across different electronic health records (EHRs).

3.4.7 Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research, maintain public health surveillance and dashboards, and add additional partners across Minnesota.

Strengthen and Diversify the Workforce

Recommendation 4.1 Foster workplace inclusion, belonging, safety, and well-being to encourage retention of current diverse workforce members.

4.1.1 Minnesota to create a model for inclusion, belonging, safety, and well-being including implementation guidance and resources for health care organizations.

4.1.2 Recommend best practices to enhance the sense of safety, trust and belonging among employees, such as employee resource groups, regular assessments or surveys to measure the employee experience with corresponding action based on this feedback, and a culture of accountability for improved outcomes.

4.1.3 Recommend leveraging employees and employee resource group members from underrepresented groups in the cocreation of workforce equity strategies designed to meet their needs.

4.1.4 Recommend strategies to drive leadership accountability for workforce equity outcomes.

Recommendation 4.2 Enhance workforce skills and cultural responsiveness.

4.2.1 Minnesota to create a mandated or incentivized training for all health care workers. Accrediting bodies can adapt it to their field but need to provide the same content. Include content for members of health care organization boards of directors.

4.2.2 Recommend best practices focused on suggested requirements for comprehensive training programs for employees and providers to develop essential soft skills, including cultural responsiveness, mitigation of unconscious bias, effective communication, empathy, and teamwork.

4.2.3 Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally congruent care. Continuing education requirements may include courses on diversity, practice-based cultural concordance models.

4.2.4 Recommend incentive–based mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.

4.2.5 Outline solutions to address the narrowness of specialization, such as cross-training opportunities, mentorship programs, and professional development resources.

4.2.6 Recommend workforce equity core competencies for employees and leaders.

4.2.7 Recommend workforce equity strategies that are informed by the communities being locally served.

4.2.8 Recommend educational opportunities to require board members to actively engage in ongoing professional development to acquire the necessary skills to model inclusive leadership and equitable governance.

4.2.9 Require and implement comprehensive training and continuing education for health care providers (link training to licensure requirements) and other employees (e.g., patient navigators, care coordinators, customer service representatives) to develop essential soft skills including:

- Cross-cultural understanding
- Cultural competency
- Cultural humility
- Cultural responsiveness
- Culturally appropriate care
- Culturally congruent care
- Culturally-specific health needs
- Diversity, equity, inclusion, and belonging (DEIB)
- Effective communication
- Eliminating biases and discrimination
- Empathy
- Implicit bias
- Mitigation of unconscious bias
- Patient-centered care
- Teamwork
- Trauma-informed care
- Training programs

4.2.10 Cultural Competency Training: Rapidly implement training on eliminating biases and discrimination for health care workers. Partner with local organizations or universities to design culturally appropriate training programs in the short term.

4.2.11 Use learnings from experiences training providers (such as JAMA article on mandated implicit bias training; Cooper LA, Saha S, van Ryn M. Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care. JAMA Health Forum. 2022;3(8):e223250).

4.2.12 Partner with local organizations or universities to design culturally appropriate training programs.

4.2.13 Require trauma-informed, equity training for intrapartum and post-partum care.

4.2.14 Implement training and education for providers that cultivates better attitudes toward Medicaid patients.

4.2.15 Create a culture of precepting at systems (e.g., like programs at Essentia and M Health Fairview).

4.2.16 Financial and infrastructure support to develop and sustain clinical training programs, hiring and supporting faculty, community involvement in resident recruitment and retention, in recognition of the responsibility of all to participate in developing the next generation of providers.

Recommendation 4.3 Address workforce inequities.

4.3.1 Minnesota to outline a framework and model to help health care organizations collaborate with stakeholders to examine and address systemic barriers that contribute to health care workforce inequities. Include guides and implementation resources.

4.3.2 Recommend possible solutions to address role inequities, including a pay structure analysis and evaluation of the value, impact and advocacy of care coordinator/community health workers and other similar roles.

4.3.3 Outline a framework, model or resource to help organizations begin to collaborate with key stakeholders to examine and address any systemic biases or barriers that contribute to role inequities.

4.3.4 Recommend strategies to incorporate into hiring processes to support the hiring of underrepresented candidates and to attract and recruit a workforce that reflects the communities we serve, including strategies to support international candidates.

4.3.5 Increase the utilization of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.

4.3.6 Recommend best practices for collaborating with educational institutions and community organizations to remove barriers to entering the health care workforce.

4.3.7 Broaden the membership of admissions committees for medical/dental/pharmacy/nursing schools and other health professional education programs to include staff with expertise in state workforce needs.

4.3.8 Encourage health professional education programs to take a holistic approach when screening for potential candidates vs. over reliance on standardized scores such as MCATs.

4.3.9 Leverage remote learning modalities to grow health-related career and technical education to reach non-traditional learners such as those in greater MN, adults considering second careers.

4.3.10 Recommend strategies to partner with educational and credentialing institutions to reduce representation gaps that hinder culturally concordant care for historically underrepresented groups in health care positions.

4.3.11 Identify and remove barriers for students and employees to obtaining scholarships and resources experienced by underrepresented individuals who aspire to pursue careers and leadership positions in health care.

4.3.12 Support and expand programs focused on increasing culturally specific health care professional training programs, such as the University of Minnesota Duluth's Native Americans in Medicine program.

4.3.13 Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups.

4.3.14 Educate K-12 students on medical professional pathways.

4.3.15 Expand the development and use of partnerships between K-12 schools and health care providers to sponsor Community Health Worker (CHW) training and increase the pipeline of diverse health care workers (example: WELFIE).

4.3.16 Expand dual-training pipeline programs.

4.3.17 Continue funding the MDH's Mental Health Cultural Community Education Grant program that supports BIPOC mental health supervisors.

4.3.18 Track the retention of health care professionals in underserved areas to identify gaps and opportunities to improve retention.

4.3.19 Improve financial support for health care education including health care loan forgiveness, grants, and scholarships.

4.3.20 Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.

4.3.21 Ensure that some NorthStar Promise funding is dedicated to students seeking health care degrees.

4.3.22 Renew and increase funding for the Mental Health Grants for Health Care Professionals program in recognition of the high demand for this program, the urgent needs it addresses, and the early signs of its success.

Recommendation 4.4 Optimize the workforce.

4.4.1 Health care organizations to diversify who and how care is delivered to make it more effective, accessible, comprehensive, holistic, and culturally congruent for patients and members.

4.4.2 Identify workforce gaps and barriers.

4.4.3 Address workforce shortages, especially focused on addressing rural access issues (e.g. dental therapists).

4.4.4 Establish an independent Minnesota Health Care Workforce Advisory group to provide objective health care workforce research and data analysis; collaborate and coordinate with other entities on health care workforce policies; recommend appropriate public and private sector policies, programs, and other efforts to address identified health care workforce needs.

4.4.5 Expand the dental workforce, particularly dental therapists, hygienists, and assistants.

4.4.6 Improve reimbursements and other interventions to support an increased health care workforce.

4.4.7 Pilot a loan forgiveness program as a recruitment incentive to sites that are in health professional shortage areas.

4.4.8 Decentralize physicians where evidence supports it.

4.4.9 Increase the utilization of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.

4.4.10 Increase the utilization of Health Navigators from underrepresented communities (ex,. Hmong Culture Care Connection, Cultural Society of Filipino Americans, SEWA-AIFW).

4.4.11 More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.

4.4.12 Provide legislative authorization to the Minnesota Department of Health (MDH) and Department of Human Services (DHS) to develop opportunities to advance and sustain the Community Health Worker (CHW) workforce, and establish a state office to implement CHW policies and coordinate stakeholders.

4.4.13 The Minnesota Department of Human Services (DHS) should recognize Community Health Representatives without requiring duplicative training. Enable Community Health Representatives to bill for services as Community Health Workers, especially given the historical and community-specific role they serve.

4.4.14 Increase the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.

4.4.15 Establish residency and fellowship programs for health professionals to work in underserved, rural, and tribal communities to ensure that they are exposed to the specific needs of these populations.

4.4.16 Introduce long-term changes to health professional training programs to ensure they reflect the diversity of the populations they serve. This could include more scholarships for people from underrepresented communities, more recruitment into health careers from those communities, and ensuring a robust pipeline into health care fields.

4.4.17 Support the University of Minnesota and CentraCare expansion of medical training programs for rural physicians.

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