Equitable Health Care Task Force
Meeting Summary

Meeting information

August 27, 2025, 1:00 a.m. – 4:00 p.m.
In-person location: UROC, 2001 Plymouth Ave. N., Minneapolis, MN 55411
Online meeting format: WebEx
MDH LiveStreamChannel

Members in attendance

Sara Bolnick, Elizete Diaz, Mary Engels, Marc Gorelick, Vayong Moua, Mumtaz (Taj) Mustapha, Laurelle Myhra, Sonny Wasilowski, Erin Westfall, Yeng M. Yang

Key meeting outcomes

- Task force members provided feedback and suggested changes to the recommendations and overall report.

Key actions moving forward

- MDH will review the report and make revisions, if any, based on the task force's insight.
- All task force members are encouraged to continue to review the report. They can contact MDH with questions and feedback at health.equitablehealthcare@state.mn.us.
- MDH will send communications to the task force to gather final feedback.

Summary of Meeting Content and Discussion Highlights

Welcome

The task force was welcomed for their final meeting, and appreciation was expressed for their work and commitment.

The tragic shootings in Minneapolis were acknowledged, and gratitude was expressed for health workers who are supporting families and children.

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

Finalizing Recommendations and the Report

General feedback

The task force was asked for general reactions to the report. Highlights of their discussion include:

- The report captures what the task force has discussed and it is well written.
- There is a question of whether to strive for more consistency among the recommendations in terms of descriptive details. Some felt that the inconsistency is understandable due in part to some recommendations being more aspirational and others more pragmatic, and that the report could draw attention to that, e.g., indicating which recommendations are immediate goals or low-hanging fruit and which are more long-term and aspirational. Metrics and measures are needed for recommendation implementation.
- . It would be helpful to include a description of the lenses task force members wear, that is, acknowledge that many task force members work inside the health care system, and they represent intersectional identities and perspectives including cultural communities, payers, and care delivery.

The task force discussed how the level of support for each recommendation could be expressed in the report. Highlights of their discussion include:

- It is important to note dissenting opinions. However, it wouldn't be sufficient to include a general disclaimer stating that not all task force members fully supported all recommendations. It is important to emphasize which recommendations enjoyed strong support or full agreement.
- The appendices could be expanded to include information about decision-making, dissent, gradation of agreement, etc.

Transmittal letter

The task force revised their definition of "health care equity" that is included in the transmittal letter. Highlights of this discussion include:

- Several members felt the definition needed a stronger focus on health outcomes.
- The definition as drafted appears to put the accountability solely on the health care system. Several members emphasized that the State needs to be called out as responsible for enacting and enforcing policy. The goals cannot be achieved without resources, and the state bears a responsibility to regulate and resource the work.

- Several alternative definitions were offered to address this point that included content on health care policies, resources, health care systems, reparations for past harms, and the State.
- There is also an opportunity to call out the State's responsibility elsewhere in the report.

Recommendations for Meaningful Access

The task force walked through the recommendations and rationale for Meaningful Access. Highlights of their discussion include:

- The recommendation about "universal health care" lacks a recognition of Treaty obligations. Several members emphasized that there should be a specific and separate call-out to uphold Treaty obligations, as they provide health care to Tribal communities and American Indian people.
- "Universal health care" has preconceived notions and may trigger opposition. Task force members supported rephrasing to "comprehensive health care coverage for all persons in Minnesota". Additionally, coverage must augment – not replace – services provided by Tribal health systems and Indian Health Services (IHS).
- Where there is a requirement without resources, that is problematic, e.g., "require and/or incentivize providers to offer flexible hours for evening and weekend appointments." We could change this to, "support providers in offering flexible hours for evening and weekend appointments."
- On interpreter choice (Rec. 1.4.5), members expressed different perspectives. Some cautioned that a blanket recommendation to always provide patients with a choice of interpreter could create challenges, since systems cannot realistically meet every possible preference. There was also concern that framing choice too broadly could unintentionally reinforce personal biases. Others strongly argued that patient choice must remain a top priority to protect autonomy, especially for people with disabilities, trauma survivors, and cultural communities. A possible alternative was to recommend and support a standard practice that ensures interpreter services meet the needs of people being served, while also preserving patient autonomy.
- Providing a choice of interpreter should be a top priority to avoid damaging consequences. The current recommendation language is powerful and should stay as is.
- Members suggested adding "health numeracy" alongside health literacy.

Additionally, MDH said that the project team met with Tribal Health Directors during their August meeting and sought input on relevant recommendations. MDH shared proposed

updates to recommendations based on this consultation. Task force members agreed with these updates.

- Minnesota should implement comprehensive coverage for all persons in Minnesota. This coverage should augment—rather than supplant or replace—the Tribal health systems of the 11 Tribal nations within Minnesota and the services provided by Indian Health Services.
- 1.2 There should at least be comprehensive health care coverage for American Indian communities and Tribal citizens in Minnesota.
- 1.2.1 Tribal members and children should be automatically eligible for a health care plan that provides coverage.
- 1.2.2 Uphold federal treaty agreements with Tribes to ensure comprehensive health coverage for Tribal communities.

Recommendations to Bolster Primary Care

The task force walked through the recommendations and rationale for Bolstering Primary Care. Highlights of their discussion include:

- Care coordination often feels like checking a box, and there are loopholes around practicing this well. Some organizations do care coordination that doesn't align with patients' needs. To be more aspirational, we should recommend that it be a required benefit. We should recommend that organizations be required to invest dollars in care coordination to ensure universal good practice.
- There was debate about whether to soften "require" language (to "require and/or incentivize"), but several members strongly advocated to keep "require" in place for care coordination to prevent specific actors, such as payors, from avoiding responsibility. One member said that incentives exist and do not go far enough; requirements are needed.

Recommendations to Strengthen and Diversify the Workforce

The task force walked through the recommendations and rationale for Strengthening and Diversifying the Workforce. Highlights of their discussion include:

- The current climate, executive orders, and policy changes limit how organizations can advance equity and belonging—that should be called out here. There are very real legal threats.
- We should not change the recommendations. This is a moment to stand up for the work that must continue. The transmittal letter may be a place for acknowledging the current

challenges. It may take longer to reach our goals, and there may be an opportunity to call out in the report which recommendations may be easier to implement now versusl ater.

Recommendations for Accountability

The task force walked through the recommendations and rationale for Accountability. Highlights of their discussion include:

- The recommendation about accreditation feels too prescriptive. The accreditation process is comprehensive and good, but onerous. Members offered different language to encourage providers to evaluate policies and procedures against health equity standards, offering the accrediting bodies as examples only. A member suggested removing it entirely.
- The recommendation to create a new accountability group lacks definition, including what they would do and how they would enforce accountability. Other accountability bodies exist, and it is confusing to recommend the creation of another one. It should be removed as a recommendation.
    - The original intent behind the recommendation was for a group to have oversight over complaints that are brought forward, especially egregious harms that have no appearance of accountability. It makes more sense to frame this language around ensuring that progress is made toward the task force's overall recommendations.
    - There was a suggestion to follow up with task force member, Megan Chao Smith, who helped draft this recommendation, to clarify its original intent to make a final decision.
    - One idea is to embed this oversight into the Board of Medical Practice, which governs clinicians.
    - Additional discussion is needed to finalize or remove this recommendation.

Close

Commissioner Cunningham made closing remarks. She expressed appreciation to the task force members for their time and long-standing commitment, and for showing up today amidst the community's tragic current events. She expressed appreciation for the consultants and the MDH project team. She also acknowledged the need for further conversation about how to implement the recommendations. Finally, the Commissioner stressed the need for courage to fix broken systems.

To close, the task force was reminded about the final steps in the process:

- MDH will incorporate feedback from this meeting into the recommendations and the overall report and share for final feedback via survey or another online asynchronous method.
- Task force members are encouraged to offer final feedback via survey or another method as communicated by MDH.

Task force members expressed gratitude to each other and to the Commissioner, with some saying it has been a meaningful experience and a great opportunity to share their perspectives to help serve their communities.

Contact to follow-up

With questions or comments about the Equitable Healthcare Task Force, please reach out to the Health Policy Division at health.equitablehealthcare@state.mn.us.

Meeting summary note

All task force members' comments are represented, identities are intersectional, and discussions reflect barriers and solutions that affect many communities at once

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