DRAFT: 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 versus later.

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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09/08/25

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DEPARTMENT OF HEALTH

DRAFT: Equitable Health Care Task Force

RECOMMENDATIONS

September 15, 2025

Equitable Health Care Task Force Recommendations

Minnesota Department of Health
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A Message From the Commissioner

[PLACEHOLDER: LETTER OF ACKNOWLEDGEMENT AND ACCEPTANCE OF RECOMMENDATIONS FROM COMMISSIONER CUNNINGHAM]

A Word from the Task Force

Dear Commissioner Cunningham:

The Equitable Health Care Task Force (Task Force) is pleased to submit our recommendations to the Commissioner of Health. We are acutely aware of your personal commitment to health care equity and have appreciated the opportunity to work with you and your team.

Simply put, our health care system doesn't work for many people living in Minnesota. Inequities undermine the health and well-being of many individuals as well as entire communities, including racial and ethnic communities, LGBTQIA+ populations, rural residents, and people with disabilities. **Our definition of Health Care Equity means the ability for every person to achieve and sustain self-defined optimal health outcomes throughout their lives supported by our health care policies, resources, and health care systems. Ultimately, the State of Minnesota is accountable for holding all parties accountable to achieve our desired outcomes.** Our vision is that structural and institutional wrongs will be addressed, cultural practices will be newly honored, and new modes of health care delivery will be created.

We have organized our recommendations into four broad areas: meaningful access to health care; primary and whole person care; workforce issues; and system accountability. Some recommendations will be read as more practical in today's environment, while to some, other recommendations may sound too bold for the moment in which we are living. We stand by this entire set of recommendations for what is needed to meaningfully move toward a more equitable health care system. All components of the recommendations are needed and work together to improve health care equity, though they could be implemented through a phased approach.

The road to develop these recommendations has been challenging. Some of us consider ourselves as "outsiders" to Minnesota's health care system and health policy establishment. We brought our lived experience and our communities' voices to the Task Force. Many of us do work in the health care system and these recommendations also reflect the ranges of our professional experience, including caring for people experiencing inequities. Bringing this mix of perspectives together has been both difficult and illuminating. Our process required developing trust and understanding of the ways in which Task Force members could work together and with MDH to support the Task Force's deliberations. Segmenting many interconnected issues into broader categories was difficult, but ultimately helpful in more clearly organizing our discussions and providing context to explain why our recommendations are needed.

Community engagement was also a critical part of the Task Force's work. We extended the timeframe for our work to consult with various interested persons and organizations and conduct a public comment process. Our purpose in doing this was to seek community perspectives on which proposed recommendations would be most likely to have real impact on their health, access to care, and experience with the health care system. Readers will see the results of that engagement process woven throughout this document. While this report is aimed at an audience of public and private sector leaders with the ability to create change inside our health care and public health systems, the communities we represent and/or serve should remain at the center of this document.

The nation's social and political landscape has shifted substantially since the Task Force was first convened. This evolution has impacted the development of our recommendations and, we anticipate, how others will interpret or implement our work. In this uncertain environment, tension emerged around whether our recommendations should focus on incremental changes or wholesale transformational changes across our health care system. We ultimately decided our recommendations should span this continuum and include both more feasible proposals in our current environment and more aspirational ideas to pursue in the future.

We know this Task Force is not the first to consider these issues or to make similar recommendations. We know that communities, state agencies, policy makers, and private organizations have made varying levels of effort to improve health care equity. We recognize and should build on those foundations. However, in our view, efforts to date have barely begun to move the needle to achieve the types of changes we see as needed. This report is intended as an urgent call to action to all those who are part of the public health and health care system – policy makers, public health leaders, health care provider executives, physicians, nurses, other care providers, health insurers, community organizations and others - to embrace and implement these recommendations at the scale required to meaningfully improve health care equity.

We appreciate MDH's support of this work to date. And we expect MDH to take leadership and accountability for its own role in improving health care equity and in providing transparency on progress made by other public and private sector organizations to do the same. Although this Task Force process has concluded, this work is really just beginning. We look forward to MDH keeping us apprised of how the agency is implementing our recommendations within its authorities and how MDH is working with policy makers, other state agencies, and private sector organizations to make progress on them. We can't afford to wait any longer.

Executive Summary

The 2023 Minnesota Legislature directed the Commissioner of Health to form an Equitable Health Care Task Force to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability, and identify strategies for ensuring that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes.

MDH convened the Task Force in January 2024 with 20 members representing a broad array of communities, perspectives, and subject matter expertise. Members participated in an intensive array of full Task Force meetings, a day-long retreat, learning opportunities with subject matter experts, and working sessions to identify issues contributing to health care inequities and develop recommendations to address them. As part of their deliberations, Task Force members established a working definition of Health Care Equity, meaning the health care system is accountable for every person achieving and sustaining self-defined optimal health outcomes throughout their lives.

The Task Force's recommendations encompass a spectrum of approaches, ranging from more specific proposals to build on the state's current health care system to broader, more transformational concepts. Many of the Task Force's recommendations would require adoption of new laws, additional regulatory authorities, and/or budgetary commitments for new or enhanced programs. Virtually all necessitate the active partnership of health care provider organizations and individual health care providers as well as insurers, public health, and community-based organizations.

Input gathered through community listening sessions and a public comment period shaped these recommendations. Members were strongly interested in hearing community perspective about which recommendations, if implemented, would have the strongest positive impact on health care equity and where there might be gaps yet to be addressed.

The Task Force's 24 lead recommendations and more detailed sub-recommendations are organized around four key themes:

- Provide Meaningful Access to Care: These recommendations include strategies to ensure all residents of Minnesota can access health care where and when they need it. They also aim to ensure care is culturally responsive.
- Bolster Primary and Whole Person Care: These recommendations address the need for Minnesota's health care system to move toward a re-envisioned primary care-driven model of health care across life stages and events. While this approach to care would better serve the needs of all Minnesota residents, it is especially needed to improve outcomes for individuals with significant and compounded health-related social needs.
- Strengthen and Diversify the Workforce: These recommendations address the need to enhance diversity of the health care workforce; improve culturally responsive skills among health care workers; address workforce inequities; and optimize the health care workforce.
- Ensure System Accountability: These recommendations aim to ensure the health care system is more accountable to all Minnesotans through strategies related to health care coverage; handling patient grievances; community co-leadership and equity-focused

oversight in partnership with health care organizations and the State of Minnesota; and measurement of health care equity.

Minnesota starts in a relatively strong place with respect to the state's health care and public health system[1]. However, the health care ecosystem has significant work to meaningfully address health inequities that are manifest in our state. Our bar is higher for what Minnesotans expect from the state's health care system.

The Task Force carried out its work amidst a rapidly evolving and uncertain environment at the federal level. Recent federal policy and budget changes will likely further strain already stressed communities and reduce needed federal funding for Minnesota's publicly funded health care programs. The Task Force is cognizant of these significant changes and the challenges they pose to Minnesota's current health care system - and yet mindful of what is needed to improve health care equity in our state. Public and private leadership, commitment, and strategic investment is urgently needed to help build a more equitable health care system and allow all Minnesotans to achieve and sustain optimal health.

Table One: A High-Level Summary of Task Force Recommendations

#	Recommendation
1.	Minnesota must ensure all persons in Minnesota have comprehensive health care coverage, 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.
1.1	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.
1.3	Minnesota should support a health care delivery system that all individuals can access where and when they need it. While these recommendations would benefit all individuals and families, those experiencing health care inequities the most acutely need more flexible access the most due to less flexible work schedules, fewer transportation options, and a greater likelihood of having health-related social needs.
1.4	As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.
1.5	Minnesota should expand inclusive and accessible telehealth by investing in mobile care, phone-based services, and broadband infrastructure to ensure equitable access in rural and underserved communities.
1.6	Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.
1.7	Minnesota should strengthen patient health literacy related to accessing, navigating, and paying for health care.
1.8	Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.
2.	Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages, events and health conditions to help ensure people of all backgrounds get the care they need.

[1] U.S. Health Care Rankings by State 2025 | Commonwealth Fund

#	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.
2.2	Minnesota should invest in team-based primary care models that address health-related social needs and coordinate activities with public health and community-based organizations.
2.3	Minnesota should adopt reimbursement and payment models that will support investments in primary and whole-person care.
3.	Minnesota should build, nurture, and mature an equitable health care workforce to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients, and communities.
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.
3.2	Enhance workforce skills for cultural responsiveness.
3.3	Increase diversity of the current health care workforce through shorter term strategies.
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.
3.5	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 ensure health care professionals may work at the top of their license to meet basic health care needs.
4.	Minnesota should foster an accountable health care system that strengthens patient protections, eliminates discrimination, and ensures fair treatment by integrating community co-leadership, shared data infrastructure, and oversight mechanisms to monitor implementation and promote health care equity through inclusive standards across the health care system.
4.1	Minnesota should strengthen and harmonize its approach to health care patient protection to address health care discrimination and unfair treatment.
4.2	Health care in Minnesota should have community co-leadership and equity-focused oversight.
4.3	Minnesota should strengthen data infrastructure and data support sharing among payers, health care providers, community organizations, researchers, social service providers, and public health.
4.4	Encourage the use of Culturally and Linguistically Appropriate Services (CLAS) standards as a framework to improve and ensure inclusive practices in health care organizations.
4.5	Encourage health equity accreditation for health plans, providers and applicable health care systems, for example under NCQA or The Joint Commission.
4.6	The State should establish a multi-stakeholder Accountability Group to serve in an advisory capacity to the Commissioner of Health. The purpose of the group would be to establish an ongoing forum for keeping health care equity issues on the top of MDH's agenda to improve health care equity on a statewide basis.

Introduction

The nation's health care system, including Minnesota's, is rife with inequities impacting many individuals and communities. The Institute of Medicine's landmark 2003 report "Unequal Treatment" documented what many already knew, but was not yet acknowledged at that time in the public sphere: that institutional racism is pervasive throughout the health care system and undermines the well-being of many diverse populations and results in worse health

outcomes, lower life expectancy, and reduced quality of life[2]. Other individuals, including residents of rural areas[3], LGBTQIA+ populations[4], and people with disabilities[5] also experience inequities in their health outcomes and/or interactions with the health care system. Inequities in the health care system are profound, multi-faceted, and far-reaching.

The 2023 Minnesota Legislature directed the Commissioner of Health to form a task force to study issues related to health care inequities. The Equitable Health Care Task Force (Task Force) was created to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability, and identify strategies for ensuring that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes (see Appendix A). When this report uses the term "diverse", it should be noted the Task Force is referring to all of these characteristics and the unique ways in which diverse populations experience inequities.

MDH convened the Task Force in January 2024 to begin its work. The Task Force is comprised of 20 individuals (see Appendix B) representing various communities, perspectives, and related subject matter expertise. The Task Force had a broad charge and complex set of interconnected issues to address. Its resulting recommendations – and this report – are organized around four themes:

- Provide Meaningful Access to Care
- Bolster Primary and Whole Person Care
- Strengthen and Diversify the Health Care Workforce
- Ensure System Accountability

The Task Force developed its preliminary recommendations and subsequently engaged in a community feedback and public comment process about them (see Appendix E and F for more information). Community feedback included eight listening sessions with specific communities of interest, including providers, community-based and advocacy organizations, health navigators/care coordinators, local public health, and tribal health directors, among others. The public comment process yielded 23 comments.

Each section of this report begins with a high-level description of the types of issues and challenges the recommendations are intended to address. It then includes recommendations and a rationale explaining how that category of recommendations relates to improvement of

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[2] Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Smedley BD, Stith AY, Nelson AR, editors. Washington (DC): National Academies Press (US); 2003. PMID: 25032386.

[3] Thomas, K. L., Dobis, E. A., & McGranahan, D. (2024). *The nature of the rural-urban mortality gap* (Report No. EIB-265). U.S. Department of Agriculture, Economic Research Service. https://dx.doi.org/10.32747/2024.8321813.ers

[4] Lampe NM, Barbee H, Tran NM, Bastow S, McKay T. Health Disparities Among Lesbian, Gay, Bisexual, Transgender, and Queer Older Adults: A Structural Competency Approach. Int J Aging Hum Dev. 2024 Jan;98(1):39-55. doi: 10.1177/00914150231171838. Epub 2023 Apr 25. PMID: 37122150; PMCID: PMC10598237.

[5] Okoro CA, Hollis ND, Cyrus AC, Griffin-Blake S. Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:882–887. DOI: http://dx.doi.org/10.15585/mmwr.mm6732a3

health care equity. Each section concludes with some highlights from public engagement about which of the recommendations are highest priority from a community perspective. The Task Force's recommendations include 24 leading recommendations with more detailed sub-recommendations associated with each. In all, the Task Force has a total of 78 sub-recommendations.

The report also proposes a place to start with respect to implementation of a subset of the recommendations. The appendices include more detailed information, including examples of evidence-based and/or promising strategies to improve health care equity.

Background

The Diversity of Minnesota's Population

Minnesota's population is diverse along a number of dimensions:

- According to the State Demographer's Office, people of Color (those who identify as a race other than White alone, and/or those who are Hispanic or Latin(x)) make up 20% of the total population. Non-Hispanic White Minnesotans represent the remaining 80% of the statewide population. Between 2010 and 2018, the fastest growing racial group in Minnesota was the Black or African American population, which grew by 36%. Second fastest was the Asian population, which grew by 32%, followed by the Hispanic or Latin(x) population, which grew by 24%.6 As we look ahead, Black and Indigenous populations and other communities of Color are expected to continue to grow at a faster rate than the White population.[7]
- In 2018, nearly 12% of people in Minnesota spoke a language other than English at home.[8]
- In 2024, approximately 11% of Minnesotans identified as LGBTQ+.[9]
- While the poverty rate was 10% for Minnesota in 2018, poverty rates were substantially higher for American Indians (34%), Black (27%), and Hispanic (19%), which were three to four times higher than the rates of non-Hispanic White Minnesotans.[10]
- In 2018, 10.4% of individuals ages 35 – 64 had a disability, while 45.1% of individuals 75+ reported having a disability.[11]

[6] State of Minnesota Demographer's Office. https://mn.gov/admin/demography/data-by-topic/age-race-ethnicity/
[7] State of Minnesota Demographer's Office. https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/
[8] State of Minnesota Demographer's Office. https://mn.gov/admin/demography/data-by-topic/immigration-language/
[9] Minnesota Compass. https://www.mncompass.org/data-insights/articles/picture-lgbtq-minnesotans-part-1-what-existing-data-sources-can-and-cant
[10] State of Minnesota Demographer's Office. https://mn.gov/admin/demography/data-by-topic/income-poverty/
[11] State of Minnesota Demographer's Office. https://mn.gov/admin/demography/data-by-topic/health-disability/

Experiences and Impacts of Discrimination in the Health Care System

Discrimination in the health care system was a key topic of Task Force deliberations. Reported discrimination from health care providers based on sexual orientation and gender identity (SOGI) was substantially higher among lesbian/gay (36.1%) and bisexual/pansexual (26.1%) populations compared to the statewide average of 6%. Black Minnesotans also reported high rates of unfair treatment, with 39% reporting discrimination.[12] Experiences of discrimination negatively impact people's experience with the health care system, sowing distrust and concern about whether they will be able to get the care they need. Nearly 40% of bisexual/pansexual adults who reported SOGI-related discrimination had low confidence about their health care.[13]

In order to position the state well for a healthy, thriving future, Minnesota needs a health care system prepared to serve its diverse population. And all people in Minnesota in rural and urban areas alike deserve a health care system that can meet their health and health-related social needs.

Protecting and Building on Recent Progress

It is important to note that policy makers, state agencies, health care organizations, and community-based organizations have made some significant efforts around some of the issues raised in the Task Force's recommendations. The following are illustrative examples:

- The legislature recently simplified and increased dental care reimbursement rates for MinnesotaCare and Medicaid; restored access to dental benefits for adults enrolled in those programs; and established performance expectations for managed care organizations related to ensuring a target percentage of public program enrollees have at least an annual dental care visit.[14] These were long overdue policy and financing changes to improve access to oral health in Minnesota.
- The Department of Human Services collaborated with community members to develop its 2022 report, Building Racial Equity into the Walls of Minnesota Medicaid with a focus on U.S.-born Black Minnesotans and 2025 report, Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota. The reports examined the impact of Medicaid respectively on Black Minnesotans and American Indians and identified opportunities for meaningful collaboration between DHS and community to address racial equity and improve health outcomes for these populations.

The Task Force's recommendations seek to ensure Minnesota preserves recently made investments, builds upon other important foundational steps, and improves upon them moving forward.

[12] https://mn.gov/mmb/one-mn-plan/measurable-goals/health-disparities.jsp
[13] Minnesota Health Care Access Survey, 2021. State Health Access Data Assistance Center. Shadac.org/Minnesota-health-access-survey
[14] Minnesota Department of Human Services. Mn.gov/dhs/Medicaid-matters/population-health/oral-health

See Appendix G for additional background information on various strategies underway at the state level in Minnesota to address topics included in the Task Force's recommendations.[15] Appendix G also includes examples from other states. Please note that information in Appendix G is intended as illustrative background information rather than a comprehensive inventory of related efforts underway in Minnesota and elsewhere.

Recommendations

Recommendation Area One: Provide Meaningful Access to Care

What Challenges do these Recommendations Address?

- Although Minnesota has one of the highest rates of insurance coverage in the nation16, a sizeable proportion of Minnesotans struggle with access to high quality and comprehensive health care. Almost 4% of Minnesotans were uninsured in 2023[17]. Individuals born outside the United States, individuals who are not U.S. citizens, American Indians, people of Hispanic ethnicity, and lower income individuals are more likely than other Minnesotans to be uninsured.[18]
- Almost 25% of Minnesotans reported forgoing some type of health care (routine medical, specialist, mental health, prescription, or dental) in 2023 due to concerns about the cost of care. Rates of forgone care were highest for Indigenous, Hispanic, and Black Minnesotans, as well as those without insurance.[19]
- Many individuals lack essential knowledge of how to access and navigate the health care delivery system or how health insurance coverage works. This is especially true among newer immigrants and other individuals who do not have a strong connection to the traditional health care system.
- Minnesotans face a variety of challenges related to where and when health care services are available. Traditional care models require those in need of care to go to clinics or hospitals that may be outside of their neighborhoods or town, which is especially challenging when those locations are a considerable distance away and/or for families who cannot easily access transportation to get to those care locations. Communities struggle with a lack of access to health care providers due to local closures of clinics and hospitals in both rural and urban areas and due to shortages of health care workers in critical health professions. Individuals and families face challenges in obtaining care when services are not available in the evenings or on weekends, especially for adults with multiple jobs or whose employment may not offer the ability to take paid time off to attend medical appointments.

[15] Some private sector organizations have also made efforts to address equity concerns raised in this report. The initiatives listed in Appendix H include only those led by state government agencies.
[16] State Health Access Data Assistance Center. University of Minnesota. 2023 ACS Tables: State and County Uninsured Rates
[17] Minnesota Department of Health Health Economics Program Chartbook.
[18] Minnesota Department of Health Health Economics Program Chartbook.
[19] Minnesota Department of Health Health Economics Program. Findings from the 2023 Minnesota Health Access Survey.

- Health care provider organizations do not have sufficient capabilities to communicate with patients who speak a language other than English as their first language. This detracts from providers' ability to understand the patient's circumstances and the patient's experience with the care they receive. While federal regulations require health care providers (among other entities) to offer language access services for all patients who need them[20], these rules took effect in July 2024 and both compliance and quality of language access services varies considerably.
- Health care coverage and access for American Indian communities and Tribal citizens is fragmented and incomplete, and enrollment in state and federal programs is cumbersome.

Recommendations

- Recommendation 1. Minnesota must ensure all persons in Minnesota have comprehensive health care coverage, 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 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.
- Recommendation 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 care coverage for Tribal communities.
    - 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 all individuals can access where and when they need it. While these recommendations would benefit all individuals and families, those experiencing health care inequities the most acutely need more flexible access the most due to less flexible work schedules, fewer transportation options, and a greater likelihood of having health-related social needs.
    - 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 Support providers in offering flexible hours for evening and weekend appointments.

[20] Language Access Provisions of the Final Rule Implementing Section 1557 of the Affordable Care Act

1.3.3 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.

1.3.4 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.

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

- Recommendation 1.4 As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.

1.4.1 Increase access to multi-lingual providers and staff.

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

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

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

1.4.5 Consistent with federal civil rights regulations and the protections enforced by the Minnesota Department of Human Rights, providers must ensure language access services are available and effective across all points of care. Staff should be trained and systems established so patients are not burdened to report gaps in access; responsibility for ensuring equitable care rests with providers and the health care team. The State of Minnesota should empower patients with meaningful choice of language access services, respecting communication, privacy, cultural, and gender needs. Beyond regulatory compliance, these actions should affirm Minnesota's commitment to equity, dignity, and person-centered care for people with disabilities and those requiring language access services.

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 mobile care, phone-based services, and broadband infrastructure to ensure equitable access in rural and underserved communities.

  1.5.1 Expand flexible telehealth-enabled 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 update its standard for minimum broadband connectivity speed and continue to update that standard as data-intensive technologies evolve.

- 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.

  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 Build upon existing state-wide health literacy initiative related to health care access, navigation, coverage, billing, out-of-pocket costs, and understanding care plans.

  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.

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

    1.8.3 Minnesota should implement policies to eliminate or reduce out-of-pocket patient costs for insurance premiums, health care services, medications, transportation, and other health care supports.

Rationale

Taken together, these recommendations address a core set of inequities impacting individuals and their ability to obtain health care services. Universal coverage of health care services for all individuals living in Minnesota is a prerequisite to achieving equity in Minnesota's health care system. An equitable health care system requires all individuals to have affordable access; care availability in conveniently accessible locations with some care options available on evenings and weekends; and for all individuals to know how to navigate the health care system.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Universal health care
- Expanding access and receipt of care when, where, and how patients need it
- Interpretation and translation services
- Funding strategies, reimbursement rates, and payment models

Recommendation Area Two: Bolster Primary and Whole Person Care

What Challenges do these Recommendations Address?

- Although primary care is foundational to good health, Minnesota's health care system does not adequately support primary and whole person care. Payment models are designed around diagnoses and sick care, rather than investing sufficiently in upstream preventive care, early detection of disease, identification and treatment of mental health and substance use issues. Health care financing should foster collaboration among patients, providers, and payers where each is appropriately incentivized for preventive care, wellness, and chronic disease management.
- Health care financing does not reflect, account for, or facilitate care that is customized to the social, cultural, and other needs of each member of the population being served to

achieve optimal health. Consequently, individuals and families do not experience culturally inclusive and responsive care, which undermines trust in the health care system.

- Minnesota's health care organizations do not effectively share health information across all providers in the state. Most of the large systems can exchange information because they use a common electronic health record (EHR) system. However, many smaller, independent, specialty, rural, and organizations that provide care to underserved communities do not connect electronically to share a patient's health information. This creates disparities in care coordination that disproportionately impact patients who already experience health inequities.
- Minnesota's health care system does not integrate many aspects of health and public health. It is well understood that social determinants of health – access to healthy food, stable housing, and safe recreational spaces, among others – impact an individual's health status to a much greater extent than their interactions with the health care system. And yet, the health care system has only recently begun to address health related social needs and lacks both the infrastructure and consensus on shared processes needed to effectively do so.

Recommendations

- Recommendation 2. Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages, events and health conditions to help ensure people of all backgrounds get the care they need.
- 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.

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

    2.1.2 Primary care service delivery and reimbursement must integrate mental and behavioral health care.

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

    2.2.1 To ensure that health-related social needs are addressed, primary care clinics should collaborate with social workers, community health workers (CHWs), community health representatives, community paramedics, licensed alcohol and drug counselors (LADCS), and community-based organizations.

    2.2.2 Health care provider organizations, payers, and community-based organizations should expand the use of common referral approaches among cross-sector partnerships to ensure health-related social needs are met. Common referral approaches are a shared strategy to link people with essential and culturally appropriate health care services and health-related social needs like food, transportation, and housing. The community care hub

model provides an example of how this recommendation may be implemented.

2.2.3 Require managed care organizations to fund staffing for health care provider organizations and community-based organizations to increase capacity for coordinating health-related social needs services.

2.2.4 Expand 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 2.3 Minnesota should adopt reimbursement and payment models that will support investments in primary and whole-person care.

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

  2.3.2 Support population health outcomes by promoting and funding coordination between primary care and local public health, comprehensive services around care, and sufficiently reimbursing social workers, community health workers (CHWs), community paramedics, and licensed alcohol and drug counselors (LADCS) for services.

  2.3.3 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.

  2.3.4 Incentivize the integration of dental services into primary care through improved reimbursement for dental care provided within primary care and through reimbursement for preventive oral health services that can be provided by dental hygiene and primary care clinician teams. Incentivize oral health preventive care by improving Minnesota Health Care Program reimbursement policies and rates.

Rationale

While implementing these recommendations would improve Minnesota's health care system for all individuals and families, they would have an especially helpful impact on those experiencing health care inequities. A more robust system of primary care would offer better opportunity to incorporate culturally responsive practices and traditions into the patient experience and build trust between communities and their health care providers. Those experiencing health care inequities are also more likely to have health-related social needs; implementation of these recommendations would substantially improve how Minnesota's health care system addresses those issues.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally responsive care
- Reimbursement and payment models that will support investments in primary care

Recommendation Area Three: Strengthen and Diversify the Health Care Workforce

This category of recommendations addresses the need for a diverse workforce that is representative of and has the skills necessary to provide culturally responsive care to the communities it serves. They encompass strategies to support current members of the health care workforce, especially health care providers from underrepresented communities. This section of the report focuses on the roles of health care provider organizations, institutions of higher education, policy makers, and state agencies in retaining, recruiting, training, and building the size and composition of the health care workforce our state needs in all geographic areas of Minnesota.

What Challenges do these Recommendations Address?

- Minnesota's health care workforce demographics do not reflect the diversity of the state's populations and communities. For example, in 2018, only 2.6% of Minnesota physicians identified as Black and 1.9% identified as Hispanic/Latinx[21]. Representation gaps for historically underrepresented populations among health care providers hinder culturally concordant and culturally responsive care.
- Health care workforce shortages, in combination with other factors, contribute to inequities in access to care in both certain geographic areas of Minnesota and for certain services. For example, it is well established that Minnesota does not have a sufficient dental care workforce (cite source). The available dental workforce is incentivized to serve commercially insured individuals. Historically low reimbursement rates have served as a long-standing barrier for public program enrollees to obtain basic dental care services.
- Historically underrepresented populations face barriers to obtaining the necessary education and training to pursue a career as a health care provider.
- Employees from underrepresented groups don't feel a sense of belonging in the workplace and are therefore at higher risk of leaving their workplace. It is important to retain all health care workers, especially those from underrepresented communities.
- Much of the health care workforce lacks understanding of how patients experience health care inequities. Patients from diverse backgrounds don't experience culturally inclusive and

[21] Minnesota Department of Health. Office of Rural Health and Primary Care Physician Workforce Survey. 2018. health.state.mn.us/data/workforce/phy/docs/cbphys.pdf.

responsive care. People enrolled in Medicaid face discrimination tied to their type of insurance coverage.

- More than eight in 10 employees consider psychological safety one of the most valued aspects of the workplace.[22] Nine out of 10 employees want their employer to value their emotional and psychological welfare – and provide relevant support.23 Sixty percent of employees with low resilience and low psychological safety feel burned out, and 34% are thinking about quitting their job. On the other hand, only 5% of highly resilient employees who feel psychologically safe report feeling burned out, and just 3% are considering quitting.[24]
- While Minnesota has recognized the important roles Community Health Workers play in the health care system, there are opportunities to further support this evolving profession and more effectively leverage the roles played by CHWs, Tribal Community Health Representatives, and care coordinators. These members of the health care workforce bring deep knowledge of community resources, help ensure individuals receive follow up care, and/or assist individuals navigate care and coverage systems. These efforts can inform how to strategically scale up the availability of high quality CHW and patient navigator services in Minnesota.

Recommendations

- Recommendation 3. Minnesota should build, nurture, and mature an equitable health care workforce 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 To support current diverse members of the health care workforce, Minnesota should create a model for inclusion, belonging, safety, well-being, and professional development in health care. This framework should include best practices, regular assessment, and strategies for leadership accountability, and leverage insights from underrepresented employees and employee resource groups. This model should also incorporate mentoring and leadership development exposure strategies for emerging leaders from underrepresented groups.

    3.1.2 Minnesota should maintain and/or increase funding for programs that support health care professionals, such as those encouraging members of the health care workforce to seek mental health care and substance use disorder services or addressing barriers to and stigma among health care professionals associated with doing so. These are key retention strategies for

[22] Employee Disillusionment Report, Oyster HR, 2023

[23] 2023 Work in America™ Survey, American Psychological Association, 2023

[24] Psychological Safety at Work: The Remote Kids are Alright (Maybe Even Better), meQuilibrium, 2022

all health care workers but especially for diverse members of the health care workforce.

- Recommendation 3.2 Enhance workforce skills for cultural responsiveness.

  3.2.1 Minnesota agencies and relevant entities should collaborate to create a common framework and set of core competencies for training, 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.

  To help all members of the health care workforce 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. Partnerships with local organizations and universities can be leveraged to develop culturally appropriate training.

  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 responsive care. Continuing education requirements may include courses on diversity and 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 responsive care.

- 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 served, 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.

  3.3.3 To increase the number of individuals with disabilities in the health care profession, health care organizations should work to make more roles available to and meaningfully accessible for people with disabilities.

- 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 MDH should facilitate collaborations with educational institutions, credentialing entities, and community organizations to identify and remove barriers for underrepresented individuals aspiring to pursue careers and leadership positions in health care. These efforts should incorporate increased funding for grants, scholarships, and loan forgiveness for underrepresented students and employees. 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.

    3.4.2 Support and expand health care professional training programs focused on providing health care for specific populations, such as American Indians. 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.

    3.4.3 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.

    3.4.4 Expand dual-training pipeline programs, which pairs on-site training with classroom education to provide “earn while you learn” training, thereby reducing cost barriers to education.

    3.4.5 Health professional schools should align the numbers of individuals they are training for medical, nursing, pharmacy, dental and other health professions commensurate with state health care workforce needs. Admissions committees should broaden their membership to include individuals with knowledge of state health care workforce needs. Admissions committees should take a holistic approach when screening potential candidates to balance out admission criteria that currently heavily weight admissions on the basis of standardized test scores and grade point averages while not accounting for professional and lived experience.

    3.4.6 Utilize career and college readiness programs in Minnesota’s high schools to raise awareness and understanding of medical professional pathways.

- 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 ensure health care professionals may work at the top of their license 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. Use a variety of care professionals and paraprofessionals to improve equitably delivered care. Enable all providers to practice at the top of their license.

3.5.2 Build on recent investments in oral health care in Minnesota and identify strategies to further expand the dental workforce by training additional dental therapists, hygienists, and assistants. Address workforce shortages by incentivizing newly trained dental professionals to work in rural and underserved urban areas.

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

3.5.5 Policy makers should augment the range of the MDH-administered loan forgiveness program and other training incentives to include health care professions for which such relief doesn't currently exist. The State should promote both current and new financial relief opportunities as a recruitment incentive to sites that are in health professional shortage areas.

3.5.6 Increase the number and utilization of patient care coordinators in Minnesota through the following strategies:

3.5.6.1 Expand the use of Community Health Workers (CHW) and Representatives (CHR), and other patient care coordinators in underserved areas to coordinate wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner. Ensure these roles are reimbursed for helping patients understand insurance coverage, billing, and out-of-pocket costs.

3.5.6.2 The state should explore and act on opportunities to advance and sustain the CHW and CHR workforce. DHS should seek federal approval to allow CHRs to bill for services as CHWs. These efforts should establish a state office to implement CHW policies and coordinate stakeholders.

3.5.6.3 Expand the development and use of partnerships between high schools and health care providers to sponsor CHW training and increase the pipeline of diverse health care workers. Provide financial aid and funding for CHW training and apprenticeship programs and offer specialization pathways to expand the CHW workforce.

3.5.6.4 MDH should assess responsibilities, roles, training requirements, and utilization of CHWs, CHRs, and other care coordinator roles within health care organizations. Examine the value and impact of these roles and any differences in how they are compensated in Minnesota's health care system. Recommend solutions to resolving identified inequities.

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

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

Recommendation Area Four: Ensure System Accountability

This category of recommendations addresses the need for Minnesota's health care system to more effectively provide accountability at an individual and system-wide level for fair and equitable access to health care. They include strategies ranging from how individuals can make complaints to the establishment of infrastructure needed to effectively measure and monitor how Minnesota's health care system makes progress in eliminating health care inequities.

What Challenges do these Recommendations Address?

- Public awareness of how, and ability to, submit grievances, complaints and appeals about care quality and coverage decisions is limited. It isn't clear where to bring complaints related to discrimination and unfair treatment, which contributes significantly to a lack of information about how frequently Minnesotans experience these problems. The current system for accepting and investigating consumer complaints is fragmented, confusing, and uncoordinated when issues cross the jurisdiction of multiple agencies.[25]
- Patient protection opportunities to make complaints should be more comprehensive, accessible, transparent, and responsive. These systems should be enhanced and coordinated by offering multiple, user-friendly ways for patients to file complaints—such as online platforms, hotlines, and in-person support. This includes ease of navigation to the right resource for the type of issue enrollees are experiencing, transparency about what their rights are, and ensuring language accessibility and confidentiality.
- Minnesota's health care system doesn't encourage sufficient focus on local needs or community-based partnerships. Health care providers and payers must engage local communities to address each community's unique needs, focusing on health-related social

[25] Entities responsible for investigating 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.

needs, and encouraging collaboration between health care systems and community-based organizations.

- Providers and payers need clear, measurable health equity-focused indicators for success in health outcomes, patient satisfaction, and cultural responsiveness. Greater public transparency should be available about these metrics and the health system's progress (or lack thereof) toward achieving them over time.
- Minnesota's health care data infrastructure needs to adequately support patients as they receive care across multiple providers and health care organizations. Further, data on race ethnicity, and language, sexual orientation and gender identity, disability status, and social determinants of health need to be collected and analyzed at disaggregated levels. This information is essential to understanding demographic characteristics of patient populations and identifying which populations are experiencing inequities.

Recommendations

- Recommendation 4. Minnesota should foster an accountable health care system that strengthens patient protections, eliminates discrimination, and ensures fair treatment by integrating community co-leadership, shared data infrastructure, and oversight mechanisms to monitor implementation and promote health care equity through inclusive standards across the health care system.
- 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 ensure a "no wrong door" approach so that individuals are provided appropriate service interventions regardless of where they enter the system. 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 assists patients with concerns about health care discrimination, access to, and quality of health care services 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 the accountability of payors, health plans and provider organizations.

    4.2.2 Health care provider organizations should ensure patient and community advisory boards represent underserved members of the community and provide input on addressing inequities in how organizations provide complementary and culturally responsive care.

4.2.3 Minnesota should continue to ensure resources are available for local communities to establish healthy environments such as walkable spaces, access to nutritious foods, and other public health services.

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

- Recommendation 4.3 Minnesota should strengthen data infrastructure and data support sharing among payers, health care providers, community organizations, researchers, social service providers, and public health.

  4.3.1 MDH should accelerate its implementation of recommendations to standardize data regarding race, ethnicity, language, sexual orientation, and gender identity. These recommendations also call for disaggregation of data, especially related to race and ethnicity, in order to understand inequities among different communities (e.g., Hmong, Lao, or Vietnamese rather than Asian).

  4.3.2 Minnesota should implement comprehensive, forward-looking policies, sustainability plans, and implementation strategies that advance health data interoperability, governance, and secure information exchange across all electronic health record (EHR) systems in Minnesota. These recommendations should align with national interoperability standards and ensure compliance with federal and state data privacy laws, patient consent protocols, and equity considerations in data access and use. Emphasis should be placed on identifying funding mechanisms and assistance needed to support successful implementation, particularly for under-resourced organizations.

  4.3.3 Minnesota's health care organizations, payers, and CBOs should collaborate to develop common specifications and workflows for capturing and using information on health-related social needs, including share directories of community-based organizations and electronic closed-loop referral processes.

  4.3.4 Minnesota should provide state-level funding to sustain and enhance organizations and collaborations that aggregate electronic health data to inform the public on health equity indicators related to conditions that adversely impact equitable health. These efforts should inform public health, policy makers, health providers, and community-based organizations to understand health disparities in their communities and design targeted programs and interventions.

- Recommendation 4.4 Encourage the use of Culturally and Linguistically Appropriate Services (CLAS) standards as a framework to improve and ensure inclusive practices in health care organizations.

- Recommendation 4.5 Encourage health equity accreditation for health plans, providers and applicable health care systems, for example under NCQA or The Joint Commission.
- Recommendation 4.6 The State should establish a multi-stakeholder Accountability Group to serve in an advisory capacity to the Commissioner of Health. The purpose of the group would be to establish an ongoing forum for keeping health care equity issues on the top of MDH's agenda to improve health care equity on a statewide basis. Proposed responsibilities could include the following:

    4.6.1 Advising MDH on how to oversee implementation of these recommendations.

    4.6.2 Regularly assess how health care equity is being advanced and build on any successes.

    4.6.3 Develop and recommend an approach for identifying effective strategies to achieve desired outcomes over time and measuring overall State progress toward health equity goals.

Rationale

Implementation of these recommendations would improve health care equity at both the individual and system level. Individuals experiencing health care inequities need an accessible venue to express concerns related to discrimination and disparate treatment; having an effective investigation and resolution process around these and other types of grievances can lead to meaningful change in healthcare quality, safety and care experiences for diverse populations. Streamlining the review process and providing regular updates to complainants can build trust and accountability, while using complaint data to identify and publicly report on systemic issues can drive policy improvements. In addition, the creation of an Accountability Group would create public visibility and a standing forum to shine a sustained light on the state's efforts to eliminate health inequities.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Strengthen approach to patient protection
- Community co-leadership and oversight
- Data infrastructure for measurement and reporting to hold responsible parties accountable for advancing health equity
- Data interoperability for the benefit of patients to promote care coordination and quality

Moving Ahead with Implementation

The Task Force's recommendations include a broad spectrum of strategies, inclusive of both tactics that build on Minnesota's current health care system and others that would fundamentally remake that system. Public feedback suggested the Task Force's recommendations would be strengthened by creating a more actionable plan for which

recommendations to move forward with first. This section of the report addresses that feedback by suggesting a place to start with implementation.

Criteria

Criteria for selecting this subset of recommendations include the following:

- The recommendation is more straightforward to implement and seeks to improve the current health care system rather than require a fundamental restructuring of it.
- Implementation of the recommendation could build on existing efforts or partnerships, which may lend energy and momentum to accomplishing the work.
- Compared with other recommendations, implementation does not require significant policy changes or significant additional financial resources. This is important as we think about current budget challenges and an uncertain policy environment, both of which make it difficult to pursue fully transformational change or invest substantial new resources into the health care system in the short-term.
- Implementation of the recommendation is highly valued by community and/or Task Force members.

Taken as a group, this proposed list of recommendations to initially move forward with is broadly representative of different areas of recommendations.

Table Two: A List of Recommendations to Initially Move Forward On

Area (#)	Recommendation	Suggested Next Steps
Access (1.4.7)	Develop a centralized hub for providers to access vetted translated materials in commonlanguages across Minnesota to promote consistency and reduce provider costs.	MDH could explore current state of activity related to translation resources, consult health system stakeholders, and propose a path forward, including a funding proposal.
Access (1.7.1)	Build upon existing state-wide health literacy initiative related to health care access, navigation, coverage, billing, out-of-pocket costs, and understanding care plans.	MN Health Literacy Partnership is an active network focused on this issue. Add action/explanation.
Primary care (2.2.2)	Health care provider organizations, payers, and community-based organizations should expand the use of common referral approaches among cross-sector partnerships to ensure health-related social needs are met. Common referral approaches are a shared strategy to link people with essential and culturally appropriate health care services and health-related social needs like food, transportation, and housing. The community care hub model provides an example of how this recommendation may be implemented.	Build upon efforts at DHS and other organizations to streamline community-based organization referral processes, such as collaborating on directories, administrative processes, and developing electronic workflows.
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 payers and Minnesota Health Care Programs to increase primary care spending as a percent of total medical expense (e.g., Primary Care Investment Ratio).	Work through MDH's Center for Health Care Affordability to learn about what other states' experiences have been in implementing a similar policy. Explore how this could be designed and what steps would be needed to establish a requirement for Minnesota's health care

Area (#)	Recommendation	Suggested Next Steps
		system to spend a set percentage of health care spending on primary care.
Workforce (3.2.1)	Minnesota agencies and relevant entities should collaborate to create a common framework and set of core competencies for training, 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.	MDH could convene an advisory body to establish proposed training requirements
~~Workforce (3.4.1)~~	~~MDH should facilitate collaborations with educational institutions, credentialing entities, and community organizations to identify and remove barriers for underrepresented individuals aspiring to pursue careers and leadership positions in health care. These efforts should incorporate increased funding for grants, scholarships, and loan forgiveness for underrepresented students and employees.~~	~~MDH can convene agencies and health organizations to explore the scope and deliverables, and determine resources needed for full implementation.~~
Workforce (3.5.6.2)	DHS should seek federal approval to allow CHRs to bill for services as CHWs	DHS could explore next steps needed to seek approval
Workforce (3.5.6.4)	MDH should assess responsibilities, roles, training requirements, and utilization of CHWs, CHRs, and other care coordinator roles within health care organizations	MDH could explore the methods, scope, and budgetary needs to conduct this assessment in order to recommend a legislative funding proposal
~~Accountability (4.2.4)~~	Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ameliorate disparities in health outcomes.	MDH could convene community conversations to inform an approach to health care quality measurement with the goal of addressing disparities in health outcomes
Accountability (4.3.1)	MDH should accelerate its implementation of recommendations to standardize data regarding race, ethnicity, language, sexual orientation, and gender identity. These recommendations also call for disaggregation of data, especially related to race and ethnicity, in order to understand inequities among different communities (e.g., Hmong, Lao, or Vietnamese rather than Asian).	MDH will address barriers to implementation.
~~Accountability (4.4)~~	Encourage the use of Culturally and Linguistically Appropriate Services (CLAS) standards as a framework to improve and ensure inclusive practices in health care organizations.	These are existing standards health care organizations should use to learn and improve their practices related to cultural responsiveness and language access.
Accountability (4.6)	The State should establish a multi-stakeholder Accountability Group to serve in an advisory capacity to the Commissioner of Health. The purpose of the group would be to establish an ongoing forum for keeping health care equity issues on the top of MDH's agenda to improve health care equity on a statewide basis.	MDH could convene an Accountability Workgroup to monitor implementation of recommendations

Community and public engagement comments included a number of insights about implementing the Task Force's recommendations. Comments included the following:

- It is important to consider any existing requirements related to cultural responsiveness training in development of any new required training. For example, licensed mental health providers already have cultural responsiveness training requirements.
- Implementation of recommendations will be especially challenging in the context of federal budget and policy changes.
- Community health workers and community health representatives each play critical roles and are highly valued. It is important to be thoughtful about complexity of their respective training requirements.
- Patient health literacy is critical. One important aspect is people understanding whether they have commercial or public coverage through Medicare or a Minnesota Health Care Program.
- Local public health agencies shared they have difficulty in accessing in-person interpreter services, especially in Spanish and for post-partum visits. Commenters urged the importance of having in-person interpreters.
- All of the recommendations are deeply interconnected.

Conclusion

This report identifies myriad fundamental flaws in Minnesota's health care system related to lack of health care access, insufficient focus on whole person care, workforce issues, and a need for stronger accountability mechanisms at the individual and system levels. While some of these problems affect all Minnesotans, they especially impact those from diverse racial and ethnic communities, American Indians, people with disabilities, rural residents, and LGBTQIA+ populations. These populations struggle to access the health care system or obtain care that is designed to meet their specific needs. Our recommendations propose numerous strategies to provide all Minnesotans with the care they need to achieve and sustain optimal health as well as mechanisms to monitor the extent to which our state makes substantial inroads to improve health care equity.

As Minnesota looks ahead to future changes in its health care system, it will be important to creatively and intentionally leverage technology as a tool to reduce health care inequities – and equally important to guard against the possibility of its use in ways that exacerbate the issues raised in this report. Emerging tools can support better access to care with application-based services to support transportation, translation, scheduling, and navigating the system. The health care system must look for opportunities to leverage existing and emerging technologies to provide better care in more efficient ways and also support the workforce to perform at the top of their license. This will involve integrating innovative, accessible service delivery models alongside more traditional ones, utilizing data in better ways, rethinking how information is communicated, and how to optimize community-based resources. Within this context Minnesota's health care organizations must ensure that patient privacy and consent preferences are honored, that their data are protected from cybersecurity threats, and artificial intelligence machine learning tools are applied judiciously.

As members of the Health Care Equity Task Force, we recognize Minnesota is at an important crossroads with some fundamental aspects of our state's health care system. We are concerned

about what recent federal funding and policy changes will mean for health care coverage and access in our state and how these changes may impact communities already experiencing deep health inequities. We urge Minnesota policy makers to center improving health care equity as a cornerstone of their deliberations in moving forward to address these new challenges.

We urge Minnesota policy makers, state agencies, health care provider organizations, payers, institutions of higher education, and community-based organizations to take our recommendations seriously and see their role in implementing them. Addressing the scope and scale of concerns raised in this report will take concerted effort, resources, and our collective will.

Appendices

Appendix A: Legislative Authorizing Language

Minnesota Session Laws 2023, Chapter 70

Sec. 105. EQUITABLE HEALTH CARE TASK FORCE.

Subdivision 1. Establishment; composition of task force. The equitable health care task force consists of up to 20 members appointed by the commissioner of health from both metropolitan and greater Minnesota. Members must include representatives of:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x/ communities;

(4) American Indian communities and Tribal Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, queer, intergender, and asexual (LGBTQIA+) communities;

(7) organizations that advocate for the rights of individuals using the health care system;

(8) health care providers of primary care and specialty care; and

(9) organizations that provide health coverage in Minnesota.

Subd. 2. Organization and meetings. The task force shall be organized and administered under Minnesota Statutes, section 15.059. The commissioner of health must convene meetings of the task force at least quarterly. Subcommittees or work groups may be established as necessary. Task force meetings are subject to Minnesota Statutes, chapter 13D. The task force shall expire on June 30, 2025.

Subd. 3. Duties of task force. The task force shall examine inequities in how people access and receive health care based on race or ethnicity, religion, culture, sexual orientation, gender identity, age, or disability and identify strategies to ensure that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes, to include:

(1) identifying inequities experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age, or disability status;

(2) conducting community engagement across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care;

(3) identifying promising practices to improve the experience of care and health outcomes for individuals in these population groups; and

(4) making recommendations to the commissioner of health and to the chairs and ranking minority members of the legislative with primary jurisdiction over health policy and finance for

changes in health care system practices or health insurance regulations that would address identified issues.

Appendix B: Equitable Health Care Task Force Membership Roster

Sara Bolnick

Representing: Advocacy Organizations

Elizete Diaz

Representing: Latina/o/x communities

Elijahjuan (Eli) Dotts

Representing: General member

Mary Engels, MS, RD, PCC

Representing: General member

Marc Gorelick, MD

Representing: General member

Bukata Hayes

Representing: General member

Joy Marsh

Representing: African American communities

Maria Medina

Representing: General member

Vayong Moua

Representing: Health Coverage Organizations

Mumtaz (Taj) Mustapha, MD

Representing: General member

Laurelle Myhra, PhD, LMFT

Representing: American Indian communities

Cybill Oragwu, MD, FAAFP

Representing: Health Care Providers

Miamon Queeglay

Representing: African Heritage communities

Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM

Representing: General member

Megan Chao Smith, BSN, PHN, RN

Representing: LGBTQIA+ communities

Patrick Simon S. Soria, DNP, MAN, MHA(c), RN

Representing: Asian American and Pacific Islander communities

Sonny Wasilowski

Representing: Disability communities

Erin Westfall, DO

Representing: General member

Tyler Winkelman, MD, MSc

Representing: General member

Yeng M. Yang, MD, MBA

Representing: General member

Appendix C: Glossary of Terms

Collaborative Care Model (CoCM) is a specific type of integrated care developed at the University of Washington to treat common mental health conditions in medical settings, like primary care. Behavioral health conditions such as depression, anxiety, PTSD, alcohol or substance use disorders are among the most common and disabling health conditions worldwide. Based on principles of effective chronic illness care, CoCM focuses on defined patient populations who are tracked in a registry to monitor treatment progression. The treatment plan focuses on measurement-based treatment to target, to ensure the patient's goals and clinical outcomes are met."[26]

Community transportation infrastructure

Culturally congruent or concordant care

Culturally responsive care

Social determinants of health "are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks".[27]

Health-Related Social Needs are "social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation."[28]

Universal health care

[26] About Collaborative Care - AIMS Center
[27] Healthy People 2030, U.S. Department of Health and Human Services. Social Determinants of Health
[28] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Health-Related Social Needs

Appendix D: Description of Task Force Process

The Equitable Health Care Task Force carried out its work in three phases, each building on the previous stage to move from vision-setting to final recommendations.

Phase 1: Project grounding and design

The task force began by clarifying its vision, priorities, objectives, and scope. Early planning included designing an information collection approach that combined community and public engagement, subject matter experts, and an environmental scan of promising policies and practices. Four work groups were formed to focus on health care access, workforce, finance, and delivery. Each work group developed a detailed work plan to guide its contributions.

Phase 2: Information collection, learning, and deliberation

The task force launched its work groups and implemented the information collection plan. Members developed problem statements. These problem statements were analyzed and organized into an opportunity matrix to aid in the identification of solutions. The matrix was co-developed by the task force and the Minnesota Department of Health.

A recommendation framework was created to group solutions into four broad categories: meaningful access, primary care and whole-person health, workforce, and accountability. Draft recommendations were developed within these categories and refined over time. The Minnesota Department of Health hosted monthly learning and solution sessions with subject matter experts for the task force to deepen understanding and inform recommendation development.

An environmental scan was initiated and conducted by the University of Minnesota to identify evidence of promising policies and practices related to the problems identified by the task force. The findings were presented during this phase.

Phase 3: Culmination and close-out

The task force prepared its proposed recommendations and sought community engagement through listening sessions and public comment opportunities. Feedback from these engagements informed the final recommendations. The task force completed its work by summarizing its process and delivering its final report, which includes recommendations aimed at advancing equitable health care in Minnesota.

Appendix E: Community Engagement Process

Project Background

In 2025, MDH contracted Alliant Consulting to assist in engaging community feedback on the Equitable Health Care Task Force's draft recommendations to inform the task force's finalization of them before submitting them to the Commissioner of Health. Interested parties in this engagement process include people and organizations representing Minnesota's diverse cultural communities, Tribal Nations and American Indians, people with disabilities and LGBTQIA+ populations, health care providers, and organizations that provide health coverages.

Methodology

Task force members were asked during regular meetings and outside of regular meetings to provide their recommended community groups and networks to engage in the recommendation feedback process.

The final list of communities and perspectives to engage with included:

- Community and Advocacy Groups
- Community Health Clinic Patient Boards
- Health Navigators and Care Coordinators
- Health Care Providers Serving Communities Impacted by Disparities
- Local Public Health Association of Minnesota
- Urban American Indian Community
- General Public

Based on the list of communities to engage with, an Engagement Plan was developed with various engagement options such as plugging into existing meetings of these groups and organizations and holding virtual or in-person listening sessions. Engagement activities were recommended for each stakeholder group to keep similar perspectives together for more focused feedback. Tools and resources in the form of discussion guides were created for interested Task Force members and MDH to host similar engagement events with communities and groups. In parallel to these efforts, MDH hosted a written public comment period to capture feedback on the Task Force's proposed draft recommendations. A draft engagement plan of events was presented to the Task Force for their input.

Engagement Plan

The final engagement plan included 60 and 90-minute events held during both daytime and evening times to allow for maximum participation.

Participating Perspective	Event	Date and Time	Facilitator	Attendance
Health Equity and Advisory Leadership (HEAL) Council	Plug-in meeting	June 11th 3:20 – 4:00 p.m.	MDH project team	13
Community and Advocacy Groups	Listening session	July 10th 1:00 – 2:00 p.m.	Alliant	2
Community Health Clinic Patient Boards	Listening session	June 24th 10:00 – 11:00 a.m.	Alliant	3
Health Navigators, Care Coordinators, and Community Health workers	Listening session	June 26th 2:00 – 3:00 p.m.	Alliant	1
Health Care Providers Serving Communities Impacted by Disparities	Listening session	July 8th 11:00 a.m. – 12:00 p.m.	Alliant	32
Local Public Health Association of Minnesota (LPHA)	Listening session	July 22nd 10:00 – 11:00 a.m.	Alliant	20
Urban American Indian Community	Listening session	July 22nd 5:30 – 6:30 p.m.	Alliant and MDH Tribal Liaison	0
Tribal Health Directors	Listening session	July 24th 12:00 – 1:00 p.m.	MDH Tribal Liaison and MDH project team	2
Tribal Health Directors	Plug-in meeting	August 21	MDH Tribal Liaison and MDH project team	tba
General Public	Listening session	July 15th 5:30 – 7:00 p.m.	Alliant	7

Participating Perspective	Event	Date and Time	Facilitator	Attendance
Written public comment	Written public comment	Available from June 14th until July 23rd	MDH	23

Event Coordination and Execution

Alliant Consulting crafted invitation communications in partnership with the task force and MDH, to be sent to the various identified communities including the offer of accommodations. Alliant and MDH partnered to coordinate the final engagement event schedule. The task force members and MDH staff leveraged relationships and connections with community partners to help promote the engagement events. Forty-four organizations were contacted to gauge interest and invite to participate in the listening sessions.

The full draft recommendations were provided to participants prior to the feedback events. The engagement events also provided a brief history of the task force and their recommendation development process as well as respectful participation guidelines and feedback options (verbal and chat) prior to the solicitation of input. All comments and questions of participants were documented. Participants were provided with information on the public written comment process and a link to the form both during and following the events to invite further input. Event participants received post-event communications notifying them of other engagement events and the public comment period and thanking them for their participation.

In addition to the engagement efforts, Alliant developed a communication to provide feedback to those who contributed to these efforts, thanking them and acknowledging the input as well as highlighting the outcomes of the final recommendations.

Participation

Task Force members, along with other organizational leaders, helped distribute calendar and email invitations for the engagement events to more than 300 people, ensuring broad representation at the events.

Nearly 100 people representing diverse perspectives, communities, and organizations provided feedback during the listening sessions and through the written public comment process.

Analysis and Feedback Summary

All input during the engagement events and the full public written comments, were captured and analyzed to identify themes and to provide feedback to the Task Force. Analysis was done by perspective group, engagement question, recommendation category, and overall to identify themes by frequency. All comments had equal weighting and were given equal consideration.

Contributing organizations include:

1. Adolescent School Health and School-Based Health Centers
2. Advocates for Better Health

3. American Academy of Physician Associates
4. American Indian Development Corporation
5. American Telemedicine Association – ATA Action
6. Anonymous (including private citizens)
7. Blue Cross and Blue Shield of Minnesota
8. Carver County Public Health
9. City of Minneapolis
10. Community Health Worker Concepts
11. Council for Minnesotans of African Heritage
12. DHS Cultural and Ethnic Communities Leadership Council (CECLC)
13. eHealth Advisory Committee
14. Essentia Health
15. Great Lakes Inter-Tribal Epidemiology Center
16. HealthPartners
17. Hennepin County
18. Hennepin County Public Health
19. Hennepin Health
20. Horizon Public Health
21. Local Public Health Association
22. Mayo.edu
23. MDH Health Equity Advisory and Leadership (HEAL) Council
24. Medica
25. Minnesota Academy of Family Physicians
26. Minnesota Association of Community Health Centers
27. Minnesota Association of Community Mental Health Programs
28. Minnesota Community Health Care Worker Alliance
29. Minnesota Community Measurement
30. Minnesota Council of Health Plans
31. Minnesota Council on Disability
32. Minnesota Department of Health
33. Minnesota Department of Human Services
34. Minnesota Health Centers

35. Minnesota Hospital Association
36. Minnesota Medical Association
37. Minnesota School-Based Health
38. Minnesota's Health Care Future
39. MN Care
40. Mower County Public Health
41. National Alliance of Mental Illness
42. Open Cities Health Center
43. Open Door Health Center
44. OutFront Minnesota
45. Pennington & Red Lake County Public Health & Home Care
46. Polk County Public Health
47. Quin County Community Health Services
48. Renville County Public Health
49. Tribal Health Directors
50. University of Minnesota School of Nursing
51. Washington County Public Health
52. Wright County Public Health

General Themes Overall

Overall themes across all contributors, and number of times mentioned included:

- Equity and inclusion for underserved populations – 191 mentions
- Concerns about funding and feasibility requiring prioritization and a considered phased approach to implementing recommendations – 147 mentions
- Support for universal and meaningful access to health care – 70 mentions
- Rural health infrastructure including transportation, digital, mobile, telehealth solutions – 69 mentions
- A focus on Community Health Workers (CHWs) and Community Health Representatives (CHRs), a need for culturally and linguistically diverse providers, concerns about barriers to enter into health professions and the importance of funding, career pathways and education to strengthen and diversify the workforce – 60 mentions
- Centralized complaint and support offices and holding insurers, providers and health systems accountable plus the importance of transparent data, better metrics and community co-leadership – 50 mentions

- Support for primary care that integrates mental health, substance use and complementary care plus care coordination and wraparound services for whole-person and integrated care - 44 mentions
- Concern about the quality and availability of interpretation and translation services, alongside support for health literacy initiatives – 37 mentions

~~Appendix F: Engagement and Public Comment Results~~

Appendix G: Illustrative Examples of Implementing Recommendations

Theme	Program/Initiative	Description	Recommendation to Which It is Related
Access	Minnesota School-based Health Center Grant Program	Grant program to support new or existing school-based health centers. https://www.health.state.mn.us/people/childrenyouth/schoolhealth/healthctrs.html	
Access	Mechanism for hospitals to buy into a system of independent contractors for access to interpreter services	Emergency Statewide Sign Language Interpreter Advocacy and Training Project and partners created a business model to address the delivery of interpreting services for emergent requests. Hospitals decided to join together as a "consortium" to share the costs of a 24/7 ASL interpretation referral service. https://accesspress.org/consortium-of-minnesota-hospitals-enters-agreement/	Recommendation 1.4 As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.
Access	Universal health care	The Minnesota Health Plan (Senate File No. 2740/House File No. 2798)	Recommendation 1.1 Minnesota should implement universal health care to provide comprehensive coverage for all persons in Minnesota, including undocumented immigrants
Primary Care & Whole Person Health	Co-creating a social needs common referral approach in Minnesota	Exploration of a shared approach for connecting people in Minnesota to needed and culturally responsive resources to health care and health-related social needs (HRSN) such as food, transportation, and housing. https://stratishealth.org/initiative/co-creating-a-social-needs%E2%80%AFcommon-referral-approach-in-minnesota/	
Workforce	MDH Mental Health Grants for Health Care Professionals		3.1.3 Maintain and/or increase funding for programs that support health care professionals
	University of Minnesota Duluth's Native Americans in Medicine program		
	MDH Mental Health Cultural Community Education Grants	Supports BIPOC mental health supervisors	3.1.3 Maintain and/or increase funding for programs that support health care professionals
	NorthStar Promise funding	Provides scholarships for students from income-eligible families for many Minnesota public colleges and universities, is dedicated to students seeking health care degrees.	3.4.1. MDH should facilitate collaborations with educational institutions, credentialing entities, and community organizations to identify and remove barriers for underrepresented individuals aspiring to pursue careers and leadership positions in health care.

Theme	Program/Initiative	Description	Recommendation to Which It is Related
	Hmong Culture Care Connection, Cultural Society of Filipino Americans, SEWA-AIFW		3.5.1 Increase the number and utilization of patient care coordinators in Minnesota.
	WELFIE	Platform that helps schools meet mental health education requirements, improve attendance, and create a more connected, engaged school community.	3.5.6.2. Expand the development and use of partnerships between high schools and health care providers to sponsor Community Health Worker (CHW) training and increase the pipeline of diverse health care workers. Provide financial aid and funding for CHW training and apprenticeship programs and offer specialization pathways to expand the CHW workforce.
	University of Minnesota and CentraCare medical training programs for rural physicians		
	Create a culture of precepting at systems	Essentia Health M Health Fairview	Recommendation 3.2 Enhance workforce skills for cultural responsiveness.
		Recommendations for the Minnesota Health Care Workforce Advisory Council	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.
Accountability	SF1567 – Office of Patient Protection	Proposed bill to establish an Office of Patient Protection to assist consumers with access to and quality of health care services.	4.1.1 Minnesota's system for accepting consumer complaints should ensure a "no wrong door" approach so that individuals are provided appropriate service interventions regardless of where they enter the system.
	Cedars-Sinai Community Connect Program	Strategic Partnerships and Innovative Grantmaking	4.2 Health care in Minnesota should have community co-leadership and equity-focused oversight.
	Minnesota Electronic Health Record (EHR) Consortium	Consortium provides robust information on health equity indicators (e.g. gender, race, ethnicity, rurality, language, age, and other important social determinants of health) related to COVID-19, substance use disorders, and other	4.3

Theme	Program/Initiative	Description	Recommendation to Which It is Related
		chronic conditions such as cardiovascular disease and hypertension.	
	Trusted Exchange Framework and Common Agreement (TEFCA)	National framework for health information sharing	4.3.2.4 Minnesota should implement comprehensive, forward-looking policies, sustainability plans, and implementation strategies that advance health data interoperability, governance, and secure information exchange across all electronic health record (EHR) systems in Minnesota. These recommendations should align with national interoperability standards and ensure compliance with federal and state data privacy laws, patient consent protocols, and equity considerations in data access and use. Emphasis should be placed on identifying funding mechanisms and assistance needed to support successful implementation, particularly for under-resourced organizations.
	State privacy law	Update the Minnesota Health Records Act to provide clarity and alignment with electronic workflows	4.2 Minnesota should implement comprehensive, forward-looking policies, sustainability plans, and implementation strategies that advance health data interoperability, governance, and secure information exchange across all electronic health record (EHR) systems in Minnesota. These recommendations should align with national interoperability standards and ensure compliance with federal and state data privacy laws, patient consent protocols, and equity considerations in data access and use. Emphasis should be placed on identifying funding mechanisms and assistance needed to support successful implementation, particularly for under-resourced organizations

Appendix H: Bibliography

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Public Comment

These are comments that were sent to health.equitablehealthcare@state.mn.us between August 28 and September 19, 2025.

Comment

From a clinical supervisor of a recovery unit.

[F]or the past 7 years [I] have been actively campaigning to ensure that clients are not rejected from substance use treatment due to not speaking English. I currently have a client who has been waiting 5 weeks to gain access to residential care, where if he was an English speaker he would have been able to access care immediately. He is street homeless and this has lead to significant issues for his health overall. On average our clients who do not speak English are waiting an average of 6 weeks to engage in care. This is a literal matter of life and death in regards to the opiate epidemic. We have applied to multiple spaces, and talked to multiple coalitions, tasks forces and advocates.

I would love to see that we are honoring the 1964 Civil Rights Act as well as the basic human right to access care in a language you can speak and understand.

Please let me know how you can assist in this matter. I deeply concerned that this will be lost in another series of committees without action which leaves my clients facing death for not speaking English.