Equitable Health Care Task Force Meeting Summary

Meeting information

- February 26, 2024, 1:00-4:00 p.m.
  Place: Wilder Foundation, 451 Lexington Pkwy N, St Paul, MN 55104
  MDH LiveStreamChannel
  Meeting Format: Hybrid in-person and via WebEx

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engels, Bukata Hayes, Joy Marsh, Maria Medina, Vayong Moua, Mumtaz (Taj) Mustapha, Laurelle Myhra, Cybill Oragwu, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- The task force's discussion of the term "health care equity" will inform the development of a shared definition for their work.
- The task force's deep dive into health care equity issues explored a vision of success as well as current inequities. Their insight will inform the finalization of objectives, scope, and methodology for the task force's efforts.
- The task force's preferences for incorporating public comment into this work will inform the design of future meetings.

Key actions moving forward

- Based on the insight provided by task force members, DeYoung Consulting Services and MDH will collaboratively draft a definition of "health care equity." The task force will be asked to review and give feedback.
- Given the task force members' insight that was captured during the discussions of health care equity issues, MDH and DeYoung Consulting Services teams will collaboratively draft project objectives, scope, milestones, timeline, methodology, and a framework for recommendations. The task force will have the opportunity to review these elements, which will be integrated into the final project charter.

Summary of meeting content and discussion highlights

Meeting objectives

The following objectives were shared:

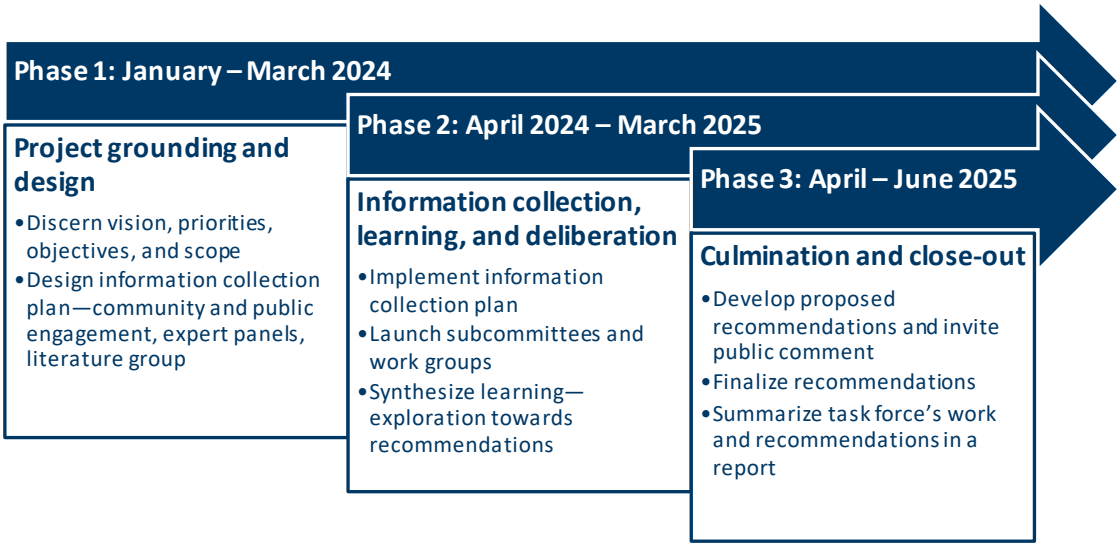
- Continue discerning the vision, priorities, objectives, and scope
- Discuss definition of health care equity
- Dig deeper into key issues
- Discuss process for incorporating public comment during meetings
- Experiential objective: Continue to foster engagement and build trust among task force membership

Pre-meeting socializing

Task force members were welcome to arrive early and socialize with other task force members.

Welcome and grounding

The task force was welcomed and thanked for their commitment and work thus far. The following graphic was presented as a reminder of the project milestones, highlighting the foundational work being done in phase 1.



Health Policy Division Director Diane Rydrych briefly presented to speak to the vision and scope of the task force, reminding the group of the expectation to focus on health care, and to deliver recommendations that are actionable. She spoke to the importance of the perspectives among the task force members, which were carefully selected because of their lived, consumer and user experiences with the system, both internally and externally. Task force (tf) members were invited to ask questions of Ms. Rydrych. Those questions, and Ms. Rydrych's responses, are listed below.

- TF member: What does the outcome look like? What is the target message and expectation of the outcome being implemented and addressed?

  - Ms. Rydrych: We envision a set of recommendations aimed towards the public, the legislature, provider systems, and insurance companies. The task force should identify where they see the opportunities and actors. It will be MDH's responsibility to engage legislators throughout this process so they are aware of the direction the task force is heading and have opportunities to weigh-in.
- TF member: How does this work launch off of Health Equity Council work?
  - Ms. Rydrych: MDH is working on an update to the Advancing Health Equity Report from 10 years ago and connecting with Health Equity Advisory Leadership (HEAL) Council. In future meetings when the task force discusses community engagement, the task force and MDH can think about how we connect with some of those bodies that MDH, DHS, and other organizations convene.
- Two task force members recommended inviting the HEAL Council and program within DHS to learn about their work and opportunities to move that work forward.
  - Ms. Rydrych: We are in talks with DHS about how to connect. This task force and the advisory bodies will want to hear from each other about what the other is doing.
- TF member: Bold suggestions offered from last meeting; where are we at now? Do we focus on actionable changes or offer suggestions that legislature will adopt?
  - Ms. Rydrych: The task force should find its footing around this. Identify different levels of action that might address a particular issue, some of which might be longer term, others may have an iterative process. What isn't possible now may be possitlbe in five years, so try to bring that spirit into your conversations to think about what would need to happen to get to those bigger, bolder solutions and make them actionable. What does that mean about who we need to work with and how we need to get others on board to drive that change?
- A task force member commented that they would like a briefing on what legislators are thinking about.

The January meeting summary was referenced; questions and concerns were solicited and none were expressed.

Definition of "Health Care Equity"

To inform the development of a shared definition of "health care equity," some task force members openly brainstormed important concepts and terms. Others reviewed example definitions and highlighted what they like and what changes they would make. All task force members were invited to suggest other key terms that the task force should define.

The insight gathered will inform the development of a draft definition, which the task force will have the opportunity to review and provide feedback. Their insight includes the following highlights:

- Improved health outcomes for communities who are consistently and negatively impacted by systemic inequities (BIPOC, disability communities, LGBTQ+, etc.)

- Community assets are leveraged, community voices and relationships are valued
- Access
- Healing, safety, belonging
- Awareness, responsiveness are embedded (interpreters are available, intersectionality is embraced, providers are trained and aware of specific community needs e.g., disability accommodations, cultural norms, etc.)
- Acknowledge root of the problem, holistic approach
- Importance of taking action

Other terms that task force members suggested defining include:

- Health care
- Community health (including a definition of which communities are included)
- Population health
- Social determinants of health (SDOH)
- Health inequity
- Access
- Institutional racism
- Structural racism
- Difference between equity and equality
- Payment system (acknowledging its capitalist nature and that the quality of care varies with ability to pay)
- Affordability

Existing definitions of health equity the group offered as examples came from Hennepin Health Care and Healthy People 2030.

Exploration needed into each issue

The objective of this activity was to dig deeper into the issues the task force identified in the January meeting, a pre-meeting survey, and individual interviews that were conducted with 18 task force members. Prior to this meeting, all insight was analyzed and synthesized into a summary of themes, which was provided to task force members.

Four topics were selected to discuss during this meeting:

- **Health care financing** (includes reimbursement)
- **Health care workforce** (includes non-traditional providers, diversification)
- **Health care access and quality** (includes insurance, mental health, oral health, maternal and infant health, chronic disease)

- **Health care delivery** (includes community models, primary care)

The task force members split into groups and rotated to discuss two of the four topics. The questions they were given to discuss were:

1. If inequities were eliminated, what would (health care topic) look like?
2. How does the current state compare with that ideal? Be specific.
3. How does the health care system contribute to these problems?
4. What specifically must be different about health care to achieve the desired state?
    a. What are the incentives (carrots and sticks) to get the health care system to change?
    b. Who is responsible for enabling those changes?
5. What information is needed for this task force to move from discussions of the problem toward proposed solutions, specific to health care (e.g., engagement with experts, patients, communities, literature review)?
6. Task force members have been clear they don't want to start from scratch. What data or other efforts exists – specific to health care – do you know of that will ground our conversations about solutions?

Highlights of the discussions of each health care issue are summarized below. A thorough analysis of all comments will continue, the results of which will inform future task force meetings.

Health care access and quality

- Importance of continuity of care, proactive care, preventative care, prenatal care
- Insurance coverage, funding systems (e.g., affordability of medication, inequities in coverage)
- Need for increased awareness, information (about costs, reimbursement, etc.)
- Opportunities for provider training (incentives, certification, etc.)
- Cultural responsive/inclusive care (e.g., lift up community voices, who is providing care, etc.)
- Importance of leveraging other models, community-based care
- Front-end solutions (e.g., language access/interpretation, medication pickup)
- Accountability systems
- Other efforts to build upon

Health care financing

- Need for payer-centered system, uniformity of costs
- Current silos and lack of collaboration (many layers of bureaucracy, division, etc.)
- Need for leveraging community-led care (community health clinics, etc.)

- Current structures have ineffective and misplaced incentives (currently incentivizes sick care, middlemen create waste)
- Accountability needed of regulators and health care orgs
- Existing inequities (e.g., lower income patients cannot see a doctor)
- Importance of health care literacy
- Examples to build upon

Health care delivery

- Community-based care, smaller models, collaboration (e.g., FQHC, pharmacy, etc.)
- Develop workforce (training, apprenticeship, etc.)
- Importance of valuing user experience (e.g., 24/7 access, transportation, accommodating different abilities)
- Accountability, regulation of payment structure (e.g., legislative mandate, state/federal leaders need to help pay for services, etc.)
- Build on other examples of what's working

Health care workforce

- Importance of inclusive environment
- Need for addressing wage inequities among roles
- Place more value on other roles, address wage inequities (e.g., social workers, CHWs, non-traditional, etc.)
- Need for valuing soft skills
- Address pipeline barriers, increase workforce diversity at all levels (structural barriers, intentional efforts, investment in education system, etc.)
- Importance of leadership accountability, system-wide solutions (legislation, policy change, standards, etc.)
- Invest strategically, incentivize real outcomes
- Value other practices, models, wellness (culturally rooted practices, care with an equity lens)
- Research, build on what is working

Approach to public comments

Two public comments that had been received previously were shared:

- Upon review of the selected health equity committee, it seems as we are missing input from the community members/patients/caregivers directly, instead we have c-suite leaders and doctors to make decisions about health equity and we do not have a voice from individuals

impacted by such barriers, how will this task force identify barriers and access limitations if the committee primarily consists of providers?

- I encourage the task force to examine quality data elements (Quality Data Plays Key Role in Defining and Addressing Health Inequities | The Pew Charitable Trusts) that are critical in defining and addressing Minnesota health inequities in a wholistic way and examine/dialog how the World Health Organization's Health Inequality Monitor monitoring tools, resources can be utilized to inform and equip our communities to bring lasting solutions (World Health Organization).

In order to move the task force toward consensus around a model of inviting and incorporating public comment during meetings, task force members were directed to an online live poll. The results are described below.

Poll question #1: How would the task force like to be informed of public comments?

- The majority of task force members who responded to the poll preferred that public comments be shared prior to the meeting and that there is discussion time allotted on the agenda.

Poll question #12: How may public observers comment during meetings?

- The majority of task force members who responded to the poll suggested that the public submit questions via email or comment card.

Closing and action items

The task force was thanked and reminded of the next meeting on March 28, 2024. A post-meeting survey and meeting summary are to follow.

Contact to follow-up

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

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03/27/24

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DRAFT: Foundational Definition and Vision

Health Care Equity

Health care equity is achieved when people who have historically been marginalized and socioeconomically disadvantaged receive the necessary resources and opportunities to access culturally congruent systems of care, resulting not necessarily in equal care delivery but to achieve and sustain optimal health outcomes throughout their lives.

This requires the health care system to actively acknowledge and address racism as a threat to public health, and the history and vestiges of unethical practices in health care that perpetuate inequitable access, care, and health outcomes.

Through partnering with communities, both internally and externally, to imagine and achieve their fullest health potential, providers, insurers, leaders, and other personnel in the health care system take responsibility to actively work to eliminate barriers due to racism, social isolation or any other consequence of social position or socially influenced circumstances experienced by people regardless of race, ethnicity, age, disability, gender identity, sexual orientation, nationality, socioeconomic status, or geographical background.

Vision

The Equitable Health Care Task Force envisions a bold and long overdue future in which the health care system guarantees care that is high-quality, accessible and respectful of everyone's racial and cultural backgrounds, languages, locations, abilities, genders, sexual preferences, ages, and other intersecting identities. They envision health care organizations actively working against racism and other systems of oppression, and health care leaders who accept accountability for equitable outcomes.

In the pursuit of this vision, the Equitable Health Care Task Force intends to engage with entities that will be called upon to act on the set of measurable and actionable recommendations the task force creates.

Equitable Health Care Task Force Pre-Meeting Survey Findings

MARCH 28, 2024

Survey description

Task force members (n=8) provided thoughtful feedback in response to reviewing a drafted definition of "health care equity." The following is a high-level summary of their feedback with supporting excerpts of their comments, as well as recommended next steps.

Recommended next steps based on feedback

- Some of the language provided may fit into the vision statement that is being devised.
- Task force members should review a revised and an alternative definition that are drafted from the language they provided in this survey.
- Project leaders should draft a definition of "health care" based on the example definitions provided in the survey responses, for the full task force to review.

Task force members' overall perceptions of drafted definition

While the majority of survey respondents felt the definition meets our needs overall, it is not an overwhelming majority and the themes on the following page summarize potential changes needed.

Themes from pre-meeting survey responses

The definition is well drafted.

- "This meets my needs for the most part - very well done!"
- "The first paragraph is a nice definition of health care equity."
- "I like that there is a clear requirement for healthcare providers and system to acknowledge the need to address racism as a public threat."

Name the desire to develop accountability measures in health care systems.

- "It also lacks specificity on the accountability of systems to address the harms of structural forms of oppression."

- “there must be clear mechanisms for accountability, including a robust system for reporting and resolution of accessibility issues. Without this emphasis on accountability, the definition remains incomplete and fails to fully capture the essence of true healthcare equity.”

Grant greater visibility to specific needs, such as in the disability community as well as mental health.

- “Disability knows no boundaries—it affects every population, either presently or in the future. Thus, it's imperative that the definition explicitly addresses the unique challenges faced by individuals with disabilities. This includes prioritizing accessibility, dismantling discrimination, and ensuring inclusivity across all aspects of healthcare delivery.”
- “There needs to be addressed the reality and provision of mental healthcare. Currently the mental health system is in its own silo.”

Adopt asset-based language to enhance the tone of the definition.

- “it's very heavy in it’s focus of "removing barriers for BIPOC and other”, when health equity is also about leveraging our cultural and community assets, diversity and perspectives to attain the shared goal of optimal outcomes.”
- “Maybe incorporate something like, "Their identities, backgrounds, and experiences will no longer be barriers; instead, they’ll be gateways to tailored solutions.”?”

Describe commitment to learning from community.

- “some communities will need to be reached out to, and it will take time to build trust in order to ""partner"" to imagine and achieve their fullest health potential"".
- “I want it clear that people/recipients of care (not the care providers) get to define what ""optimum health outcomes"" are for each person.”
- “The one thing I think is missing is a commitment to educating ourselves and those in the organization - it can't solely be done through partnership.”

Call out root causes and structured systems of oppression.

- “doesn’t speak to the root cause of why people have been historically marginalized or experience socioeconomic disadvantage.”
- “consider adding something like ""due to structured systems of oppression.”

The following definitions were offered as alternatives

#1

- Healthcare equity is the principle that every individual, regardless of their race, ethnicity, age, disability, gender identity, sexual orientation, socioeconomic status, or geographical background, should have equitable access to high-quality healthcare services that meet their unique needs. This encompasses not only physical access to healthcare facilities but also factors such as affordability, cultural and linguistic competency, and respectful treatment.
- Central to achieving healthcare equity is the recognition that when addressing the needs of the most severely marginalized individuals, everyone benefits. Therefore, there must be a concerted effort to prioritize raising the quality of care and life for people with disabilities. Disability knows no bounds—it does not discriminate based on identities, socioeconomic backgrounds, or age. It can affect individuals from all walks of life, whether they are born with a disability or acquire one later in life.
- In addition to ensuring accessibility and inclusivity, healthcare equity requires a commitment to cultural competency in care delivery. This involves understanding and respecting the diverse cultural backgrounds, beliefs, and preferences of patients, and adapting care practices accordingly to ensure that healthcare services are appropriate and effective for all individuals.
- Furthermore, achieving healthcare equity necessitates accountability within the healthcare system. There must be clear mechanisms for identifying and addressing disparities in access to care, as well as robust reporting and resolution processes for addressing accessibility issues and instances of discrimination or bias. Providers, institutions, and policymakers must be held accountable for their actions and decisions, and efforts to promote healthcare equity should be regularly evaluated and monitored to ensure progress is being made. Ultimately, true healthcare equity requires a comprehensive approach that addresses the intersecting factors that contribute to disparities in access to care and health outcomes. By prioritizing accessibility, inclusivity, cultural competency, and accountability, we can work towards a healthcare system that is fair, just, and equitable for all individuals.

#2

- Equity in health care is a continuous state that allows all people access to health and wellness care that makes them feel safe and that can successfully help people achieve their idea of optimal health. This must begin with people who are currently, (and who have been historically) marginalized and socioeconomically disadvantaged to receive the necessary resources and opportunities to access the culturally responsive care system of their choice, resulting not necessarily in equal care delivery but one that will sustain their self-identified optimal health outcomes throughout their lives.
- This requires the American healthcare system to actively acknowledge the role racism had in forming the American healthcare system and acknowledge racisms threat to public health and the history and vestiges of unethical practices in health care that perpetuate inequitable access, care, and health outcomes. In partnership with communities (both internally and externally) to imagine and achieve their fullest health potential - providers,

insurers, leaders, and other personnel in the healthcare system must actively and continuously work to eliminate barriers to care due to racism, social isolation or any other consequence of social position or socially influenced circumstances experienced by people regardless of race, spiritual beliefs language, ethnicity, age, ability, gender expression, sexual orientation, country of origin, socioeconomic status, or geographical background.

Definitions of "health care" were also offered

- From Wikipedia (https://en.wikipedia.org/wiki/Health_care): Health care, or healthcare, is the improvement of health via the prevention, diagnosis, treatment, amelioration or cure of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals and allied health fields. Medicine, dentistry, pharmacy, midwifery, nursing, optometry, audiology, psychology, occupational therapy, physical therapy, athletic training, and other health professions all constitute health care. The term includes work done in providing primary care, secondary care, and tertiary care, as well as in public health.
- Healthcare involves creating systems that ensure mandated reporters report instances of abuse or neglect, and that these reports are promptly and effectively addressed to safeguard the well-being of vulnerable individuals. This commitment extends from birth to death, encompassing care across the lifespan and addressing the unique needs of individuals at every stage of life. It requires robust mechanisms for identifying and responding to instances of abuse, neglect, or exploitation, particularly for vulnerable populations such as children, the elderly, and individuals with disabilities. Healthcare providers, social workers, educators, law enforcement personnel, and other professionals play critical roles as mandated reporters, responsible for identifying and reporting suspected cases of harm. These reports must be taken seriously and followed up with appropriate interventions to ensure the safety and welfare of those involved. Importantly, healthcare is not limited to traditional healthcare institutions; it extends to various settings such as workplaces, schools, restaurants, grocery stores, community centers, and even virtual platforms through telehealth services. This holistic approach recognizes that health is influenced by a multitude of factors beyond medical interventions and necessitates collaboration across sectors to promote the health and well-being of individuals and communities. For example, workplace wellness programs, school-based health clinics, and community outreach initiatives all contribute to improving health outcomes and reducing disparities. Telehealth services have become increasingly important, providing convenient access to healthcare services remotely, particularly for underserved or rural populations. By expanding the reach of healthcare beyond traditional settings, we can ensure that all individuals have access to the care and support they need to thrive.
- Health Care: Efforts made to maintain, restore, or promote someone's physical, mental, or emotional well-being especially when performed by trained and licensed professionals.
- The provision the full range of services intended to help people achieve a complete state of health.

- Health care means:
  - a clear, public welcome and actual directions to care that all state residents can see.
  - Clearly stated commitment to address racism and other bias in the care process.
  - A commitment to address mental health alongside physical healthcare.
  - Easy to understand statements of cost by insurance or clinic that is not later changed.
  - Clear referral to specialized care or treatment, without starting from scratch to again determine costs of care and insurance.
  - Care providers who will make eye contact and check that the client health record is accurate.
  - A diverse health care workforce of healthcare and insurance providers in all levels of care.

DEPARTMENT OF HEALTH

Key Health Care Equity Issues

WORKGROUP DISCUSSIONS

The table below is a high-level synthesis of content generated by task force members during the February meeting. Content is grouped into the areas of health care access and quality, delivery, financing, and workforce.

The force has also identified communities, features, and issues that are relevant across all content areas and the task force will continue to take these topics into account in their work to develop short- and long-term recommendations to achieve the group's vision of equitable health care.

- BIPOC community
- LGBTQIA+ community
- Disability community
- Systemic racism
- Social determinants of health
- Geography, rurality, urbanity

Key Health Care Issues and Emerging Workgroups

	Topic	Content
1	**Workgroup: Health Care Access and Quality**	
1.1	Accountability of decision-makers	state/federal leaders, health care leaders, supporting mandates with funding, setting standards, legislation, power to make policy change, metrics, strategic investment in equity
1.2	Community-based models of care, community-led care	smaller/regional/community health clinics/systems, community input/leadership, FQHCs, hubs, collaboration and trust between systems, integration of health care and public health, pharmacies, reaching people outside clinics
1.3	Continuity of care	prenatal, maternal/infant, screenings, primary, preventive, holistic approach
1.4	Cross-sector collaboration	competition/division, systems funded individually vs collaboratively, layers of bureaucracy
1.5	Awareness, health care literacy	information about services and costs/reimbursement
1.6	Front-end solutions	robust processes, language access/interpretation, medication pickup
2	**Workgroup: Health Care Delivery**	
2.1	Value placed on user/patient experience	transportation, walk-in access, sense of safety, emphasis on personnel as much as systems
2.2	Increase advocates/reps	ease and visibility of available help
2.3	Value placed on other practices	culturally rooted practices, non-traditional providers
3	**Workgroup: Financing**	
3.1	Insurance/reimbursement systems	what is/isn't covered, inequity of who gets good coverage, setting rates based on cost of care, universal coverage, ethical responsibility to see health care as a human right

	Topic	Content
3.2	Misplaced incentives, incentivize real outcomes/improved care	Waste created by middlemen, sick vs. health care, value-based care
3.3	Need for payer-centered system	uniformity of costs
4	**Workgroup: Workforce**	
4.1	Inclusive workforce environment	sense of safety and belonging
4.2	Workforce skills including cultural responsiveness, other soft skills	provider training, certifications, incentives, provider accountability, address narrowness of specialization
4.3	Role inequities	pay inequities including what roles are reimbursed, examining value of care coordinators, social workers, community health workers
4.4	Workforce pipeline barriers, diversity at all levels including senior leadership	cost and awareness of education, intentional recruitment/hiring, rural physicians, acceptance of prior training, apprenticeships

Public comments

These are comments that were sent to health.equitablehealthcare@state.mn.us between February 26 and March 21, 2024.

Comment #1

I have been watching the event online from the YouTube channel. I learned of the event from the MDH mailing list (by email) and did not receive a Webex invitation, so I cannot comment through Webex. The following is my comment for the Group 1 question asked: When I think of health care equity, I think of similar costs for various populations. What concepts come to mind – for individuals with disabilities healthcare costs are based on higher need and therefore higher consumption (such as increased copays every time the doctor is visited). The current healthcare system, unless if someone qualifies for Medicaid, charges more for the medically fragile or disabled populations than the healthy populations. In other words, the disabled or medically fragile are more likely to achieve their out-of-pocket maximum rather than healthy populations. Innovations, such as capping co-pays, or other innovations that are possible in computer claims processing systems to make healthcare more equitable for individuals with disabilities not yet on Medicare are my thoughts. I was thinking of applying co-pay caps more as an example for individuals who receive coverage through private plans, rather than through public plans. Considering reducing MA-EPD premiums would also benefit the population of individuals with disabilities. MA-EPD is MA for Employed Persons with Disabilities.

Comment #2

Recommendation that people take a look at this, “The Patient Revolution”. It’s inclusive in that everyone is welcome Including Patients. It’s free and there a learning group (A cohort). And once finished, can be a “Fellow”. There’s a Minnesota connection too In that Dr Montori (Mayo Clinic) Is a co-founder. Please consider collaborating with this group and please let people know about this resource. And Please remember for your efforts to work well Patients and family members Need to be fully included. (Will you have subcommittees that include people from the public?). Including Older people and People with disabilities (the biggest equity group and often left out of equity efforts).