Integrated Themes from Task Force Insights

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Summary Outline

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I. Introduction

Background

The Equitable Health Care Task Force, consisting of 20 members appointed by the Commissioner of Health, convened on January 17, 2024, to kick-off its work toward meeting its charge of:

- 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 and/or disability status.
- 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.
- Identifying promising practices to improve experience of care and health outcomes for individuals in these population groups.
- Making recommendations for changes in health care system practices or health insurance regulations that would address identified issues.
- Purpose of this report
- Initial insight was sought from task force members to inform the overall project scope, including priority discussion topics as well as a structure or process that will guide the task force's work. This report is a summary of that insight gathered overall thus far in the project.

Methodology

Insight from the task force was gathered through three methods:

- A survey was sent to task force members prior to the kickoff meeting. They were asked about their perspectives on priority issues and solutions in health care, as well as their meeting availability and preferences. Ten members responded.
- Task force members discussed priority health care issues in small groups at the kickoff meeting. Twenty members participated.
- Individual interviews were conducted with task force members to explore their perspectives around health care inequities, priority issues, barriers facing the task force, assets to leverage, and their preferences regarding meeting structure. As of February 8, 2024, 18 members have been interviewed.

Reading this report

Overall insight is summarized in this report as a collection of themes. Each theme is supported by a short description as well as specific comments made by individuals.

II. Themes: Indicators of Success

Clear plan with actionable strategies

The majority of task force members said that success would be a clear plan or road map of recommendations that are implementable, feasible, and measurable. Some offered additional components of a successful plan, including:

- Policy priorities, policy overhaul with racial equity lens
- Buy-in from people who need to implement it, including bipartisan support
- Long-term plan and short-term next steps
- Tracking
- Outcomes linked to resources
- Backed up by data
- Objectives, key results and concrete actions/tactics
- Include a very strong narrative that the health care system is broken and perpetuating inequities
- An accountability system - clear responsibilities for all stakeholders
- Clear guidance and tools/resources to succeed

Specific solutions

Some task force members thought success would be recommendations in specific areas, including:

- Addressing inequities in the financial model
- Improving infrastructure
- Legislation
- Programs

Authentic community engagement

A few task force members believe that success is tied to community engagement, particularly in ways that authentically represent their voices.

Transparency

Two task force members mentioned transparency as an indicator of success. Specifically, they want transparency from the Minnesota Department of Health (MDH) regarding their policy work, and transparency in messaging.

The following were mentioned once during task force interviews as additional indicators of success:

- Shared database of best practices
- A collaborative model that will propel health equity work forward
- Get legislation passed this season

III. Themes: Identified Priority Health Care Equity Issues

The following themes emerged as priority issues to address as a task force. Each is supported below with a description and direct comments.

- Health care financing
- Support for community models
- Measurement and accountability
- Workforce structure
- Workforce development
- Rural-urban disparities
- Eliminate language barriers
- Address systemic racism
- Systemic approach to addressing social determinants of health
- Access to health care
- Other health care equity issues

Health care financing

Task force members see a need to address the cost and reimbursement system in health care; affordability is a barrier. They are concerned about a scarcity of and competition for resources, which can perpetuate inequities. They also said that equity-centered work must be funded and incentivized.

- Reimbursement for closing inequities is huge, improving reimbursement rates for things like connecting to food is medicine programs
- Addressing financial barriers to health care access, including the cost of insurance, medications, and preventive services.

- Address funding gaps that manufacture scarcity and paternalism within the system
- Budgets align with principles, principles need to be rethought
- Money. Most be allowed to innovate. Funding: where is it going?
- Incentivize providers to take medical assistance
- Payer type shouldn't matter, pay is pay

Support for community models

Task force members want to build the capacity of smaller models such as queer clinics and community health centers that are more likely to meet unique cultural and community needs. Investment and partnerships are needed.

- Encourage independent health care practices to prevent monopolies
- Need for smaller clinics, focusing on marginalized communities
- Advocate for more investment into successful preventative models like community health centers, community mental health centers, community-based organizations and social service agencies to serve more patients and communities
- Establish solid partnerships /coalitions with sectoral groups. Many community groups untapped by MDH

Measurement and accountability

Task force members see a strong need to enhance data reporting systems and data sharing. This perception was often coupled with a desire for accountability measures, including a definition of high quality care. In addition, task force members emphasized the importance of supporting their final recommendations with data.

- Transparent data outcome reporting and collective goal setting (with incentivization), stratified by race/ethnicity/language/sexual orientation and gender identity (SOGI), etc.
- Health Information Technology: Invest in health information technology to improve data collection, analysis, and reporting, enabling a more targeted and data-driven approach to addressing health disparities.
- Data sharing needed between organizations
- Accountability of provider companies/insurance companies

Workforce structure

Task force members see workforce solutions to the address the lack of culturally responsive care, including support for specific roles, licensure pathways, etc. They said the integration of, and investment in, community health workers and navigator roles is important. Additionally, collaboration across sectors is important.

- Address the need for licensure in the field of service providers, including captioners, interpreters, and transliterators, to uphold quality standards and enhance accessibility.
- Legal support for community health workers

- Integrate community health workers into the health care system to serve as liaisons between health care providers and communities, providing culturally sensitive support and education"
- Innovative, cross sector collaboration to remedy inequities in the health care financial model, delivery of care and service

Workforce development

Task force members want to see the provider and system-wide workforce developed to be able to provide culturally responsive care. They mentioned training to impact targeted communities, diversifying the workforce, and standards for service delivery.

- Implement comprehensive training programs for health care professionals to enhance cultural competency, fostering better communication and understanding of diverse patient populations.
- Advocate for the development and refinement of systemic standards within health care systems to ensure uniform and equitable service delivery.
- Promote more diverse workforce: all types and roles and need to develop early. Need to educate everyone.
- Lack of awareness about the urgency and impact of health care inequities on society

Rural-urban disparities

Some task force members see a need to address disparities that negatively impact rural areas. They mentioned technology specifically as a barrier.

- Expand access to telehealth services, particularly in underserved areas, to overcome geographical barriers and increase access to health care resources.
- Satellite offices in metro meant to serve rural- doesn't work. Rural community knows itself

Eliminate language barriers

Some task force members want to focus on access to health care for people with interpretation needs. This is related to cultural barriers as well, which intersect with other themes below.

- Prioritize initiatives aimed at ending language deprivation, ensuring that linguistic barriers do not hinder access to quality health care services.
- Ensuring that language is not a barrier to accessing health care services, with the provision of interpreters and translated materials.
- For culturally appropriate care, one area that exists that is not working well is improved support for interpreters.
- New immigrants accessing system inequitably, especially in greater Minnesota

Address systemic racism

Some task force members said it is necessary to call out racism in order to address inequities. Anti-racism efforts are needed, they said.

- Race is part of the algorithm of care. Need to name race and include how intersectionality of racial justice plays across different racial groups
- Create and build measures to combat white supremacy in health care systems
- Tribal health outcomes, anti-racism efforts

Systemic approach to addressing social determinants of health

Task force members see a need for a comprehensive approach to removing barriers that negatively impact marginalized communities, including additional screening, addressing access and affordability, and addressing reimbursement for removing these barriers. Community engagement was also mentioned as needing attention in large organizations.

- Supporting interventions that address the social determinants of health (SDOH) needs of patients in primary care
- Reimbursement for care team members to address SDOH, and flexibility in coverage - including variety of staff [community health workers (CHW), social workers (SW), Health equity coordinator, nursing, etc.] and type of contact (synchronous to visits, asynchronous, via phone/video/2 way texting)
- Community engagement in large mainstream organizations
- Repository for health literacy (central) between systems and public

Access to health care

Task force members felt access to care is an important issues. Factors leading to inequitable access include transportation, lack of education to navigate the system, and technology.

- Patient/Family caregiver education on how to navigate the health care system
- Ease of access to care: Transportation, alignment of services, technology (wifi, smart phones)

Other health care equity issues

Task force members also mentioned specific areas of health that they would like to prioritize:

- Maternal health/infant health, and post-partum care and insurance
- Infertility, and access to IVF treatments in the Black community
- Oral health
- Elder care/Age-at Home, disparities in care
- High quality care
- Queer community: more access to better care and better insurance, including coverage for trans youth, more queer clinics
- Youth mental health, school-based health care centers
- Sexuality health, intersexuality, inclusivity
- Mental health/diseases of despair, including substance use and HIV risk (Commissioner)

IV. Themes: Structure, Process, and Concerns

Diversity of expertise and experience a clear strength of the task force

Many task force members acknowledged the multiple perspectives in the group, and saw that as a strength to leverage.

- There is a great deal of expertise in the room! Lots of passion for improving health equity. Initial idea generation ranged from fairly narrow and specific suggestions to complete system overhaul.
- Excellent group of talents and perspectives on the committee
- We have an excellent group of passionate, activated community members and leaders who are ready to do the work.

Critical to ground the task force in existing recommendations

Task force members felt strongly that their work not start from scratch; they want to know what previous groups have already done to propose strategies and what has been done to implement them. They felt the work of compiling this groundwork is a critical early step.

- Clarify and share with the group any currently existing recommendations people have coming into the task force for their constituency
- We need to organize around the recommendations that have already been made (not all have teeth-we need to develop them).
- Find research that has already been done about solutions, instead of recreating them

Clarity of scope and goals is necessary

To begin their work, task force members want clarity of scope and what they are trying to achieve. They want the group to be able to come together across differing perspectives and objectives around a shared understanding of a vision and priorities. Some expressed caution about seemingly opposing interests and felt the need to communicate respectfully.

- Would like clear communication from the Commissioner and MDH regarding scope, the capability of the task force
- Be specific about what we're trying to achieve, a shared vision, and ground ourselves in that, especially to navigate polarities.
- Vision and goals of our groups ultimate product; what would impact look like; what are threats to our work
- The scope of the task force needs a bit more clarity. Some folks seem to be focusing on traditional non-profit health care delivery systems only. Others are including private equity and for-profit companies. Others are also including health providers not typically covered by health insurance like dentistry, integrative medicine, rehabs. Others are including the payors. Others are including med-tech, pharmacy, health informatics (e.g., EPIC). Others are including public health services like housing and education. We need

to define the scope soon so that we don't veer off, and also so we don't miss crucial players that are within scope.

- Ask what lens people bring to each topic/focus area
- It will be important to communicate clearly and respectfully with one another in order to be efficient and effective

Buy-in from outside interested parties critical

A number of task force members expressed a desire to involve agencies and institutions whose buy-in will be needed to implement change, particularly legislators, Minnesota Department of Human Services (DHS), and experts who have already proposed solutions.

- What is being done to involve DHS in the process? No one from that agency was present, and I worry about their buy-in if they are not somehow brought in.
- Need to engage legislators along the way
- Involve members of MDH's HEAL Council (specifically the two directors, one of whom is Sara Chute, and their community engagement supervisor, Marisol)

Concerns for safety and preparation for disruptions

Some task force members were concerned about their personal safety and the safety of other task force members in doing the work of the task force. They described experiencing disruptions in public meetings, and trolling on social media when they were doing similar race equity work on other public task forces. See representative quotes below.

- I expect we'll all be docked. What is the state willing to do? Be mindful of that.
- Be prepared for a real well-financed white supremacist response over forums, campaigns against Critical Race Theory (CRT), groups surveilling us, pushing agenda items and disrupting the task force. The strength of the group will draw attention and opposition.

Appreciation for the tone that the Commissioner has set for the work

Some people mentioned their appreciation for the tone set by the commissioner and the importance of bringing authenticity to the work. See representative quotes below.

- Appreciates the Commissioner's tone and energy that she set. She gave the group leeway to be bold.
- Relationship building is key, and real talk.

In-person and virtual preferences

Task force members mostly indicated a preference for in-person, at least in the early phase of the project, while being open to virtual meetings. Several recognized the challenge of travel for people who are outside the Twin Cities Metro, and some preferred virtual overall.

One idea for facilitation was to have to conduct hybrid meetings by requiring everyone who participates in person to bring a laptop and join online as well.

Facilitation suggestions

Based on their experience in the kick-off meeting, task force members offered ideas to enhance the facilitation of future meetings.

- Small group work is most engaging for task force members; limit large group sharing to maximize time
- Tighter facilitation may be needed of small group discussions to enforce ground rules and ensure voices are heard equitably
- Enhance participation from those who join virtually (e.g., meet in non-metro locations, require that all in-person participants bring a laptop and join online with speakers/microphones off, etc.)

V. Resources

Prior work that task force members mentioned as helpful resources include:

- State of Minnesota Working Group on Police-Involved Deadly Force Encounters
- Existing equitable health care recommendations made by other task forces
- Heal Council (prior group established within MDH by legislation)
- DHS Health Equity Council
- Governor Walz One Minnesota subcommittee that focused on racism as a public health crisis
- Dr. Chomilo's Building Equity group
- Minnesota Department of Human Rights data report that addresses demographics and outcomes
- "Shared Language for Shared Work and Population Health" by CJ Peak, who's at the University of Minnesota
- European Public Health Association ("political determinants of health" addresses levers to change inequities)
- Practice spending time on problem identification 7 Whys to delve into core disparities to determine task force purview

DEPARTMENT OF HEALTH

Public comments

These are excerpts of comments that were sent to health.equitablehealthcare@state.mn.us between January 11, 2024 and February 19, 2024

- 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).

DEPARTMENT OF HEALTH

Equitable Health Care Task Force Meeting Schedule

The following dates and times have been confirmed and Outlook appointments sent. Appointments will be updated with virtual, hybrid, or in-person location information.

2024

March 28 from 1:00 p.m. - 4:00 p.m.

April 25 from 1:00 p.m. - 4:00 p.m.

June 26 from 1:00 p.m. - 4:00 p.m.

August 21 from 12:00 p.m. - 3:00 p.m.

October 24 from 1:00 p.m. - 4:00 p.m.

December 9 from 12:00 p.m. - 3:00 p.m.

2025

February 12 from 1:00 p.m. - 4:00 p.m.

April 10 from 10:00 a.m. - 1:00 p.m.

June 17 from 10:00 a.m. - 1:00 p.m.

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