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:

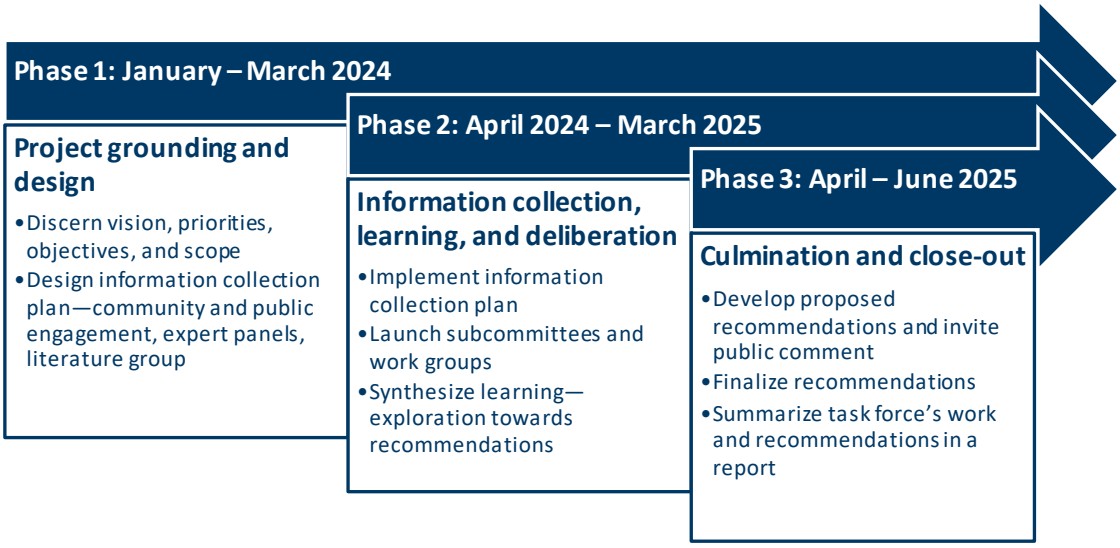
- Continue discerning the vision, priorities, objectives, and scope
- Discuss definition of health care equity
- Dig deeper into key issues
- Discuss process for incorporating public comment during meetings
- Experiential objective: Continue to foster engagement and build trust among task force membership

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.

Minnesota Department of Health
Health Policy Division
625 Robert St. N.
PO Box 64975
St. Paul, MN 55164-0975
651-201-4520
health.equitablehealthcare@state.mn.us
www.health.state.mn.us/communities/equitablehc

03/27/24

To obtain this information in a different format, call: 651-201-4520.