Equitable Health Care Task Force Meeting Summary

Meeting information

- January 17, 2024, 1:00 – 4:00 p.m.
- Place: UROC, 2001 Plymouth Ave N, Minneapolis, MN 55411
- MDH LiveStreamChannel
- Meeting Format: Hybrid in-person and via WebEx

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan Dotts, Mary Engels, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Vayong Moua, Mumtaz Mustapha, Laurelle Myhra, Cybill Oragwu, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Patrick Simon S. Soria, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Task force members heard the Commissioner's vision for their work.
- Task force members had the opportunity to meet each other and hear about their professional and personal backgrounds.
- Insight was gathered regarding priority health care issues that should be discussed as a task force.
- Insight was gathered around structural components for this work, including ground rules for discussion, developing recommendations, and making decisions.

Key actions moving forward

- The next task force meeting date is February 26, 2024, 1:00 – 4:00 p.m. (location to be announced). The general purpose will be to prioritize key discussion topics and discuss a process for gathering information needed.
- DeYoung Consulting Services will interview each task force member individually and share a compilation of emerging themes. The interviews will invite task force members to share the experiences that drive them to this work, their vision for success, their perspective on assets to be leveraged in the work, concerns they have about the work in front of them, and preferences regarding a process.
- DeYoung Consulting Services will synthesize all the insights gathered about key health care issues that the task force should consider discussion. The task force will have the opportunity to prioritize the discussion topics.

Summary of meeting content and discussion highlights

Meeting objectives

The following objectives were shared:

- Begin to establish relationships that will serve as a foundation for the task force's work.
- Gain an understanding of the Commissioner's vision and priorities for this task force.
- Build a shared understanding of the task force's purpose, goals, and phases of the work.
- Begin to explore and identify priorities.

Opening and welcome

Commissioner Brooke Cunningham thanked the task force membership for their commitment and shared her vision. This task force offers a platform to dismantle barriers to equitable health care, to be bold, and to name the carrots, sticks, and policies that need to change.

Overview of today's meeting

The task force reviewed its purpose and charge.

The task force reviewed meeting objectives, agenda, and ground rules. Task force members agreed to the following ground rules and made an additional ground rule, signified with an asterisk (*):

- Limit distractions such as the use of cell phones and side conversations where possible.
- Listen actively – respect others when they are talking.
- Speak from your own experience or perspective instead of generalizing ("I" instead of "they," "we," and "you").
- Speak the truth with kindness and respect the truth in everyone else's perspective and stories.
- This is an opportunity to listen and to be heard. Try not to be defensive or try to validate your position.
- Participate to the fullest of your ability – community growth depends on the inclusion of every individual voice. In this context, we are all equals. All perspectives are welcomed and valued.
- Assume positive intent, while also striving for positive impact.
- Practice self-care (e.g., step away if needed).
- Avoid ascribing motives to behavior – we can't know why people act the way they do.
- Avoid absolutes and exaggerations, such as always, never, etc.

- *Mistakes are good and we will work them out

Introductions

Assistant Commissioner Carol Backstrom introduced herself, as did project team members from Minnesota Department of Health (MDH), Health Policy Division and DeYoung Consulting Services (DYCS).

Task force members each took a few minutes to introduce themselves, share why this work is meaningful to them, and the unique perspective that they bring to the task force. The backgrounds and perspectives they bring included the following:

- Unique needs found in different geographies: Metro, farm country, rural areas, destination clinics
- Unique needs found on reservations
- Mental illness, substance abuse
- Engagement of community partners to find solutions
- Cultural barriers, language barriers, growing diversity, racist practices, disrespectful care
- Equitable access (and lack thereof) to quality of care
- Homelessness
- Disconnect between health care and actual needs, intentional lack of care that causes harm
- Public health, whole-person care
- Governance, policymaking, political power, resources, accountability
- Systems change, organizational learning
- Disability advocacy
- Data/electronic health records
- Clinician/care staff development e.g. unconscious bias training
- Pediatrics, impact on children

Overview of arc of work

A high-level overview of the work plan was shared. The task force had no questions for discussion.

Phase 1: January – March 2024

Project grounding and design

- Discern vision, priorities, objectives, and scope

- Design information collection plan—community and public engagement, expert panels, literature review

Phase 2: April 2024 – March 2025

Information collection, learning, and deliberation

- Implement information collection plan
- Launch subcommittees and work groups
- Synthesize learning—exploration towards recommendations

Phase 3: April– June 2025

Culmination and close-out

- Develop proposed recommendations and invite public comment
- Finalize recommendations
- Summarize task force's work and recommendations in a report

Discussion of priority issues

A pre-meeting poll had been previously sent to the task force that invited their insight into key healthcare equity issues. A summary of the poll results was shared in the meeting (see below). The pre-meeting poll results are partial and reflect the responses of 10 task force members.

Pre-meeting poll themes

Question 1: Given the charge of the task force, what are key issues to be addressed in health care systems that will leverage more equitable health outcomes for patients and communities?

- Enhance data reporting systems, data sharing, coupled with follow-up accountability measures
- Eliminate language, cultural, and accessibility barriers to serving patients and communities
- Improve care provider quality through standardization, training, and support that will result in increased health outcomes in BIPOC and LGBTQ+ communities
- A comprehensive approach to addressing systems change that addresses Social Determinants of Health in health care access and affordability
- Encourage independent health care practices to prevent monopolies

Question 2: What are some high-level ideas for effective solutions to achieving more equitable health outcomes that you'd like to bring into future task force discussions?

- Increase accessibility to health care by addressing Social Determinants of Health in ways that are strategic and provide holistic approaches to solutions

- Advocacy for stalled legislation and organizational policy and practices that impact quality of care issues
- Data: reporting and sharing
- Increasing widespread access to ancillary preventative services that impact health outcomes outside of health treatment

Small group discussion

Task force members broke into small groups to continue exploring priority issues related to health care equity and worked towards compiling a collective list of important discussion topics. Members discussed the following questions: a) What are the highest priority topics from this list that must be part of our discussions? b) What issues must leaders understand before they can enact change in this area? Why?, c) What topics are missing from this list that must be part of our discussions? Why? The insights gathered from this discussion will be used to shape future discussions.

Priority issues identified by task force members

Race, language, and cultural considerations

- 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
- Language access systems
- Challenges for small organizations versus big organizations
- Various dialects including American Sign Language
- How can MDH support queer clinics?
- Culturally congruent care and medical reparations
- Intersectionality

Engagement and relationship building

- Community capacity building needed
- Establish solid partnerships/coalitions with sectoral groups. Many community groups untapped by MDH

Health care accountability

- Understanding fundamental truth of inequities beyond compliance and embeddedness over time
- Start simply; in health care we sometimes start specific and then try to simplify
- If providers aren't responsible for care from birth to death, how do we hold them accountable?

- Health equity needs to be embedded. Need collective responsibility
- Data sharing needed between organizations
- Incentivize providers to take Medical Assistance
- Satellite offices in metro meant to serve rural – doesn't work. Rural community knows itself

Workforce

- Need to promote more diverse workforce:
  - All types and roles
  - Need to develop early
  - More education for everybody
- Expand definitions of "health workers"
- Unfunded navigator positions need to be acknowledged as an important role in building trust
- Legal support for community health workers
- Training should be based on the people who need it most

Services design

- Balance between social services and public health. Services designed with people in mind
- Repository for health literacy (central) between systems and public
- Dearth of models
- Payer type shouldn't matter, pay is pay
- Competition for resources

Funding

- Address funding gaps that manufacture scarcity and paternalism within the system
- Lack of trust for health care systems;
- Symptom of saviorism -assumption that the healthcare system is all good
- Budgets align with principles, principles need to be rethought, define high quality
- Money. Most be allowed to innovate. Funding: where is it going?

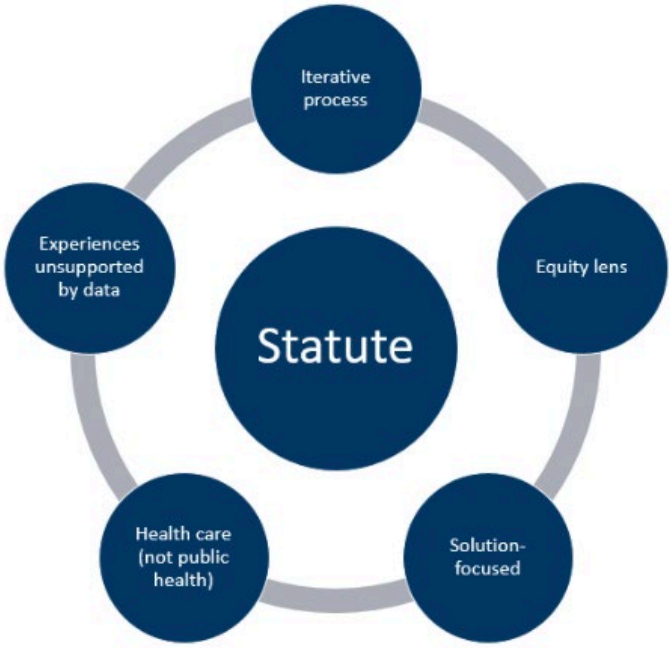
Move to action

- We need to organize around the recommendations that have already been made (not all have teeth-we need to develop them). Work together with shared outcomes
- Key audience for recommendations: Legislature
- Stalled legislation

Task force structure and decision-making

Two visuals were shared to ground a discussion about a framework for making recommendations and principles for decision-making including brainstorming, multi-voting, nominal group technique, gradients of agreement, and majority voting.

Structure



Decision-making

Decision-making approach	Description
Unstructured brainstorm	Discussion is facilitated in a way that group members can offer any and all ideas. Consensus is facilitated organically.
Nominal group technique	Brainstorm is structured in a way to solicit group members' ideas, then discuss and prioritize.
Multi-voting	Prioritization of ideas is facilitated with a structured ranking process.
Gradients of agreement	Group consensus is facilitated by assessing the degree to which each person agrees with one idea, followed by discussion where needed.
Majority voting	One idea is to choose from a number of alternatives by reaching a certain percentage. The percentage may be determined by the group.

Small group discussion

Task force members broke into small groups to discuss the following questions: a) What do you like about the frameworks for developing recommendations? What would you prefer to avoid?

b) What matters to you in a decision-making approach? That is, what values or principles should this group adhere to as you work toward making decisions?

Preferences for task force structure and decision-making

- Like discussions. Risk over discussing, under solutions
- Don't perpetuate inequalities
- Embody racial justice. Represent diversity of perspectives
- Outcomes should be actionable. Simplicity is best.
- Thoughtful use of data. Avoid wrongful grouping
- Decision-making
  - Gradient agreement = Nominal+ discussion
  - Nominal group technique
  - Gradients of agreement takes too much time
- No majority voting. If voting-Anonymous or identified

Public comment

Public comments that were received prior to the meeting were shared. There was no group discussion during the meeting. It was explained that in the February meeting the task force will discuss an approach to incorporating public comment throughout the project.

- As a recently retired provider of care in the pregnancy and childbearing world, I take issue with the representation of members appointed to this Task Force. Not in a personal way (as I am not acquainted with any of the individuals) but rather that the makeup up the task force skews the likely perspective of the findings. It is widely understood that health care disparities, by race in particular, are widest in the childbearing communities. Please seek more representatives from the childbearing communities and avoid those who represent the institutions who have thus far failed to make the necessary reductions in disparities.
- I am just curious as to why there aren't any commission members to advocate for Seniors on this board.
- I have worked in health care / social work for many years. I wanted to put in a plug to the task force to be aware of related to this topic- people in poverty, with addiction and homelessness often receive disparate treatment as well in health care (in addition to the other areas the task force is looking into). I see it all of the time, unfortunately. Socio economic status seems to compound the other factors the task for is looking into.
- As a practicing surgeon, if I have concerns with the current equitability of care, particularly among African-American children in Twin cities, who would I take that concern to? Is there a confidential platform to raise these concerns without risk of backlash from the medical

community? Is there a whistleblower hotline to report medical policies at large medical centers that discriminate against African Americans?

Closing and action items

Commissioner Cunningham closed the meeting by thanking the task force for their engagement in this first meeting.

Reminders:

- Next meeting is February 26, 1:00 – 4:00 p.m.
- Individual interviews: please sign up for a time
- Meeting summary notes to follow
- Post-meeting survey 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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02/15/24

To obtain this information in a different format, call: 651-201-3783.

Health Care and Health Equity Definitions

Health care equity

Health Affairs, https://www.healthaffairs.org/topic/1244

Equity in health care is when every person has the opportunity to attain their full potential of health, and no one is disadvantaged from attaining this potential due to race/ethnicity, age, disability, gender identity, sexual orientation, nationality, socioeconomic status, or geographical background. Changes in health policy can promote or impede advancements in health equity.

NEJM Catalyst, https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0442

Although often used interchangeably with health equity, health care equity more narrowly describes equity in the experience of accessing and interacting with the health care system and its organizations. Health care equity more directly examines whether patients have equitable access, receive equitable care, and have equitable experiences.

Tulane University School of Public Health and Tropical Medicine,
https://publichealth.tulane.edu/blog/healthcare-equity/

The aim of healthcare equity is to ensure that everyone can access affordable, culturally competent health care regardless of: Race, Ethnicity, Age, Ability, Sex, Gender identity or expression, Sexual orientation, Nationality, Socioeconomic status, [and/or] Geographical location (i.e., rural or urban).

Health equity

Centers for Disease Control and Prevention, https://www.cdc.gov/nchhstp/healthequity/index.html

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Minnesota Department of Health,
https://data.web.health.state.mn.us/equity#:~:text=Health%20equity%20is%20a%20state,the%20limits%20of%20structural%20barriers.

Health equity is a state where all persons, regardless of race, creed, income, sexual orientation, gender identity, age or ability have the opportunity to reach their full health potential without the limits of structural barriers.

World Health Organization, https://www.who.int/health-topics/health-equity#tab=tab_1

Health equity is achieved when everyone can attain their full potential for health and well-being.

Integrated Themes from Task Force Insights

February 9, 2024

Author: DeYoung Consulting Services

Summary Outline

I. Introduction
II. Themes: Indicators of success
III. Themes: Identified priority health care equity issues
IV. Themes: Structure, process, and concerns
V. List of identified resources

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

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).

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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02/15/24

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