DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

- March 28, 2024, 1:00-4:00 p.m.
- Meeting format: WebEx
- MDH LiveStreamChannel

Members in attendance

Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engles, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Mumtaz (Taj) Mustapha, Cybill Oragwu, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- The task force came to general consensus around how to review/discuss a recent publication about strategies to address racial and ethnic disparities in health and health care.
- The task force determined that a small group (four volunteers) will finalize the vision statement and definition of health care equity.
- Four small groups, each assigned to four key health care issues, began to identify "Starting places" for their ongoing workgroup.
- The small groups identified which outside voices are needed in the process toward developing recommendations within each key health care issue.

Key actions moving forward

- Four task force members will meet separately to discuss changes needed to finalize the task force vision statement and definition of health care equity.
- Each of the four workgroups will meet or otherwise collaborate to develop a vision for the group, as well as identify objectives and a draft engagement plan.
- MDH will collaborate with DeYoung Consulting Services to update the draft charter to include a project purpose statement, objectives, scope, methodology, timeline, and milestones; parameters for external engagement and an environmental scan/literature review will be further informed by the workgroups.

Summary of meeting content and discussion highlights

Meeting objectives

The following objectives were shared:

- Learn about some aspects of MDH's health care equity work and gaps
- Share what you would like to learn about DHS's health care equity work in preparation for the April meeting
- Discuss grounding statements: vision and definition
- Launch workgroups based on primary key health care equity content

Welcome and grounding

Task force members were welcomed and the agenda was reviewed. The current process for developing meeting summaries was also shared to the task force to ask any questions or express concerns. The process is to thematically analyze all notes taken during discussions, which are then discussed and summarized collaboratively by the planning team to deliver a high-level summary. Upon receiving important feedback about the February meeting summary, additional detail was added to that meeting summary. An idea offered to the task force was to add a footnote to future meeting summaries that explains all task force members' comments are represented, that identities are intersectional, and that the discussion reflects barriers and solutions that affect many communities at once. There were no questions or concerns from the task force about this process. Several expressed support.

Other relevant work

Because the task force has asked to learn what other work has been or is being done in health care equity, Commissioner Cunningham and the MDH team provided an overview of other work.

Relevant work at MDH: The Commissioner stressed that this task force's work and recommendations will not likely be duplicative of MDH's work. There is a lot of opportunity in the health care space for the task force to develop new recommendations. She briefly presented where MDH is making relevant efforts, including:

- Grantmaking to clinics and community-based organizations, local public health, and others
- Inclusion of race and ethnicity in payors' claims if the data is available
- Research into barriers to access
- Conducting network adequacy evaluations (to create more equitable provider networks)
- Discussions about NCQA health equity accreditation for health plans
- Grantmaking for people to become community health workers

- Loan forgiveness for rural providers
- Developing Maternal Mortality Data Report and continuing education in that area
- Support for primary care and community clinics through grants to federally qualified health centers (FQHCs)
- Vaccination program for uninsured and underinsured
- Grantmaking to address disparities through Division for Health Equity
- The HEAL Council advises the Commissioner and Division for Health Equity about strategies that advance health equity
- Inclusion of Office of American Indian Health and Office of African American Health into budget
- Established a new Office of African American Health
- Hiring of health equity strategists in every division of MDH

There was one question for the Commission from the task force:

- **TF member**: What sorts of things can MDH make happen based on recommendations so that we can make the recommendations that fit what you are able to do in the state?
- **Commissioner**: Don't even focus on MDH. Focus on whatever strategy that you all feel will be impactful, because what we can do as a convening agency is get people around the table to push on the whom, the who in terms of making the strategy happen. It can be on policymakers to do a policy lever or it can be on employers if it's about employer based insurance. We can work with the table with the Council of Health Plans. I want people to go bold and to not really be limited in any way. I anticipate the group considering what are things that we can do today, what is the next step for the next legislative session, and I would encourage you all to be bold enough to say 'this probably realistically may not happen next legislative session or the next year, but we have this longterm vision' … We will convene partners. We will move something through the health and human services budget, if we can, but we will also draw on whatever levers, in partnership I hope with you all on the task force, to say here are the next steps… These may not be MDH, maybe they'll be DHS, maybe they'll be Commerce. Maybe they won't be the state. Maybe at the Department of Health's planning tables with sort of grassroots organizing to say this is what we think needs to happen for Minnesota… I want us to be free to really imagine how we can get to that state where we are not seeing the healthcare disparities that we have been struggling with for decades, centuries even.

Relevant work at DHS: MDH briefly shared that they are in conversation with the Department of Human Services (DHS). A DHS representative plans to attend the April task force meeting to give an introduction to their health care equity work. DHS administers the state's Medicaid program, so they can talk about how Medicaid serves as a policy lever to greater reforms in health care, including building equity into that work specifically.

Additional relevant resource: At the suggestion of a task force member, prior to the meeting, MDH shared an article, Strategies to Address Racial and Ethnic Disparities in Health and Healthcare: An Evidence Map, with the task force. Authors concluded that, "most studies aimed to improve care for a target group, and very few directly addressed the question of whether disparities between groups were reduced or eliminated to improve health outcomes. This leaves the important issue of improving health equity largely unaddressed."

Task force members generally agreed that reviewing this article will be helpful. They discussed whether to invite the author to a task force meeting. Several expressed interest in learning from the author, but there wasn't general consensus around the appropriate format (presentation, brief Q&A, discussions outside of a meeting, etc.).

Foundational groundwork

The definition of "health care equity," revised with task force input via the pre-meeting survey, was shared. The group was asked to indicate their support for this revised version, and while there was general support overall, there were some remaining concerns to address. A draft vision statement was shared as well. The task force gave feedback, including to emphasize disability and to change language referring to sexual orientation. and to balance brevity with language inclusive of many identities. There was also a specific request to have an intentional dialogue about balancing the importance of brevity with the importance of referencing specific communities being represented, within a context of implied "prioritization" of communities. Three task force members volunteered to meet and incorporate feedback into a revised definition and vision statement.

Overview of roadmap and topics

MDH reviewed the phases of the project overall, as well as a high-level look at the flow of meetings and milestones. Workgroups will be launched during this meeting and confirmed at the April meeting. Workgroups are to meet in between full task force meetings and report out highlights from their discussions to the full task force. Workgroups are responsible for exploring and identifying key gaps, barriers, opportunities, and recommendations within the purview of their workgroup topic.

The four topics, which have emerged from task force discussions as priorities, are health care access and quality, delivery, financing, and workforce.

Task force members indicated their preference for one to two workgroups and were split into breakout rooms to discuss.

Small group discussions of four key health care equity issues

The objectives of this discussion were to:

- Begin prioritizing key topics within each focus area

- Begin identifying information and engagement needs to move toward developing recommendations for this focus area

The insight gleaned from each group will inform MDH's parameters of an environmental scan of leading and best practices, and effective models of improving health care equity. This environmental scan proposal will be shared with the task force in April to finalize the objectives and scope.

Because of time limitations, there was no large group share-out from small groups. A summary of each group discussion, as well as raw notes, will be shared in the new shared Teams workspace for task force members to review as they wish.

Workgroups were asked to identify two co-leads who will be responsible for keeping the workgroup on track and moving forward, serving as a point of contact for MDH and DeYoung Consulting Services, and preparing workgroup updates for future task force meetings.

The following are high-level summaries of each small group discussion.

Health care access and quality

Participants were Elizete Diaz, Nneka Sederstrom, Megan Chao Smith, and Yeng M. Yang.

- Priority areas to further discuss were identified as:
  - Mental health (particularly models of combined primary care/mental health)
  - Continuity of care (chronic, preventive, sick care, etc.)
  - Health care literacy
  - Culturally responsive/inclusive care (how providers meet with people and culturally concordant clinicians)
  - Equitable insurance coverage (including under- and uninsured populations)
  - Maternal/prenatal/postnatal health
  - Accountability systems
- "Starting places" for moving their discussions forward were identified as:
  - Explore existing accountability systems
  - Explore examples of systems using best practices to be culturally responsible
  - Research community-based clinics (e.g., queer, homeless youth)
  - Build our understanding of legislation
  - Identify key stakeholders
  - Explore successful primary care models that meet definition of continuity of care
  - Research data on uninsured people
- Areas of further discussion include homecare/telemedicine/remote monitoring, disability populations, language access, and housing

- Promising practices identified were Northpoint Health, Southside clinic, FQHC, and the Institute for Healthcare Improvement
- Voices needed in this process include:
  - Community members (e.g., parents, young people, queer community, women)
  - Leaders health care orgs and agencies (e.g., FQHCs, MDH, DHS, clinics)
  - Health care personnel (e.g., nursing, physicians, community health workers, doula)
  - Community clinics not recognized as traditional medical centers
  - Payer leaders
  - Queer Caucus in legislature
  - Insurance companies
- Workgroup co-leads identified will be Nneka Sederstrom and Yeng M. Yang. The group's goal is to meet virtually before the April task force meeting.

Health care delivery

Participants in this group were Marc Gorelick, Miamon Queeglay, Sonny Wasilowski, Erin Westfall, and Tyler Winkelman.

- "Starting places" for discussing health care delivery include:
  - Building up primary care (including ensuring access, meeting people where they're at, mental health)
  - Making sure experiences are equitable (making navigation easier, addressing stigma, addressing concerns around interpretation including for disability community)
- Areas of further discussion include:
  - Collaborative care models
  - Intersection with health care financing (resources for more interpreters, cost of overhead, etc.)
  - Concerns around mandated reports
  - Difficulty for patients to see a real person
  - Culturally congruent health care
- Voices needed in this process include:
  - Legislature
  - Payers
  - State/federal policymakers
  - People and institutions who need to address solutions

- Community needs health assessment

Workgroup co-leads include Miamon Queeglay and TBD. The group has not determined when to meet again.

Health care financing

Participants in this group were Bukata Hayes, Taj Mustapha, and Cybill Oragwu.

- "Starting places" for discussing health care financing include:
  - Identifying a framework for what is incentivized for health care
  - Identifying opportunities for more transparency around reimbursements
- Areas of further discussion include:
  - Setting intentional goals that avoid punishing some populations
  - Looking for a middle ground between public health and health care
  - Identifying differences between reimbursement models
  - Exploring how to even the playing field regarding the among paid for care
- Promising practices identified were value-based care models
- Voices needed in this process include:
  - Ontario's health system representative
  - TF member Dr. Nneka Sederstrom
  - Clinics that have value-based contracts with insurers
  - Actuary in health care
  - Private insurance person e.g., Dr. Susan Pleasants
  - Community input needed (either via interviews or review studies that have gotten broader community insight)
  - Employee(s) of insurance companies, health systems (physicians, providers, etc.)
  - Commonwealth Fund representative who does systems research

Workgroup co-leads will be Bukata Hayes and Taj Mustapha. The group will meet again on April 10, 2024.

Health care workforce

Participants were Mary Engels, Joy Marsh, and Maria Medina.

- "Starting places" for moving their discussions forward were identified as:
  - Inclusive workplace environment (sense of safety and belonging)
  - Workforce skills including cultural responsiveness, other soft skills

    - Intentional recruitment and hiring practices (e.g., *requirements to recruit from diverse sources*
- Areas of further discussion include:
    - Role inequities
    - Workforce pipeline barriers to diversify all levels including senior leadership (provider network credentialing, barriers to new American providers, cost/awareness of education, rural physicians, apprenticeships, etc.)
- Voices needed in this process include:
    - Human resources
    - Folks hiring international nurses/physicians
    - Whomever is determining credentialing requirements for providers
    - Social workers, community health workers, care coordinators
    - Labor unions representing affected groups
    - Cultural awareness trainers
    - People leading DEI work within organizations
    - Language interpreters
    - Employee Resource Groups
    - NCQA and the accreditation organizations are seeking

Workgroup co-leads identified will be Mary Engels and Joy Marsh. They are looking at several potential dates in April to meet again.

Public comments

Public comments that had been received previously were shared:

- 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.
- 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).

Closing and action items

Each workgroup was charged with collaborating before the April task force meeting to develop a vision statement, overall objectives, and a draft engagement plan for their group.

The task force was thanked and reminded of the next meeting on April 25, 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.

Meeting summary note

All task force members' comments are represented, identities are intersectional, and discussions reflect barriers and solutions that affect many communities at once.

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04/22/24

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DRAFT Equitable Care Task Force Charter

UPDATED 04/22/2024

Purpose and Charge

The Equitable Care Task Force (task force) will examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability, and identify strategies for ensuring that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes. The task force performs the work as established by Minnesota Session Laws 2023, Chapter 70, Section 105.

Background

Minnesota has a strong system for ensuring access to health insurance, one of the lowest uninsurance rates in the nation, and a national reputation for delivering high-quality care. Most Minnesotans report a very high level of trust in their providers and a high level of satisfaction with their care. And yet, not everyone has the same type of experience when they seek care or try to navigate their insurance coverage. We know that communities of color and Indigenous communities, persons who identify as lesbian, gay, bisexual, transgender, queer, intergender, and asexual (LGBTQIA+), people with disabilities, and others experience discrimination and unfair treatment. Disproportionately, these persons also have low confidence in their ability to receive care and some forego care due to costs.

These inequities impact health outcomes and trust in the health care system overall. When people do not feel that they will be respected and receive the care they need within the system, they may delay seeking care, or may not seek care at all. Physicians, other health care providers, and insurers need to be confident that they are employing best practices and strategies to ensure that all patients and families are receiving optimal care and are regarded and treated equally.

Vision

[Placeholder for vision and health care equity definition pending subgroup's meeting and review by task force.]

Objectives and Scope

The task force will:

- Identify 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, disability status, and/or geographic location.
- Conduct engagement across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care.

- Identify promising practices to improve experience of care and health outcomes for individuals in these population groups.
- Make recommendations for changes in health care system practices and/or health insurance regulations that would address identified issues.

The task force will strive to deliver recommendations that meet the following aims:

- Short-term and long-term solutions including policy, legislation, programs, and other strategies, with outcomes, supporting data, and tracking mechanisms, and
- Directed towards entities that are accountable and responsible to take action.

The task force will also strive to meet the following objectives throughout the process:

- Authentic engagement with interested parties and the public,
- Transparency around the process, and
- Buy-in from entities that will be called upon to take action.

The task force will focus on the following health care equity areas: access and quality, delivery, financing, and workforce.

[*Placeholder for what is out of scope.* It is not within the scope of this task force to…]

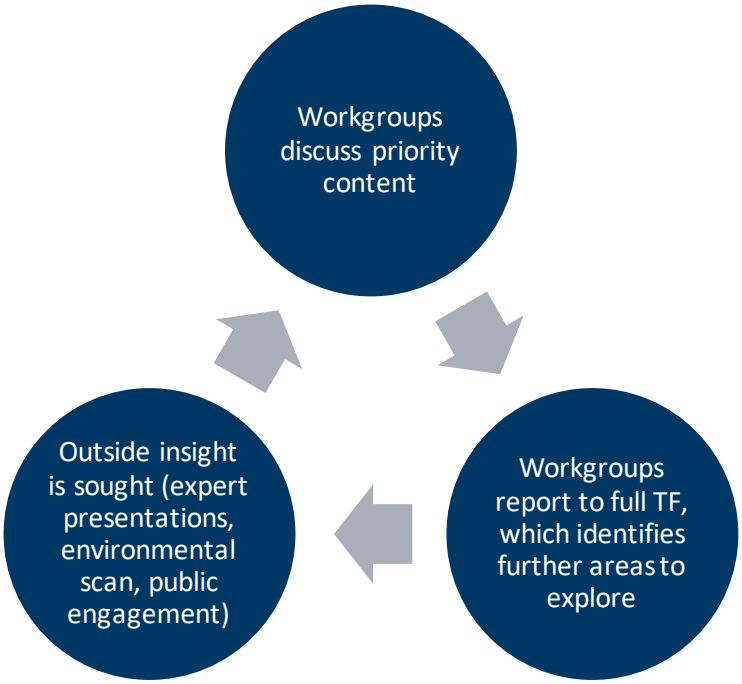
Methodology

To achieve the stated objectives, the task force will establish four workgroups in alignment with its scope: access and quality, delivery, financing, and workforce. The workgroups will identify priorities, information and engagement needs, and milestones in consultation with the task force. Workgroups will develop plans to guide their work with the aim of creating recommendations for the task force's consideration.

Workgroups' information and engagement needs will inform the approach to an environmental scan of best and leading practices and policies in other states, and engagement with subject matter experts, communities, the public, and others.

The graphic below (see next page) represents an iterative process for the task force to discuss key questions and develop recommendations.

Iterative learning and ideation



Engagement with interested parties and the public

[Placeholder for engagement plan.]

Environmental scan

[Placeholder for environmental scan of best/leading practices and policies description.]

Membership

Members

The Minnesota Commissioner of Health appointed 20 members from metropolitan areas and greater Minnesota that represent a diversity of perspectives, and lived and professional experiences. Task force members are listed below with the community they represent.

- **Sara Bolnick**, MPH, Director of Communications and Partnerships, Minnesota Association of Community Health Centers

  Representing: Advocacy Organizations

- **Elizete Diaz**, MSW, Senior Social Worker, Hennepin County: Long term services and supports

  Representing: Latina/o/x communities

- **ElijahJuan** (Eli) Dotts, Health Equity Manager, Prime West Health

  Representing: General member

- **Mary Engels**, MS, PCC, CDE, Senior Director of Organizational Learning and Development, Essentia Health

  Representing: General member

- **Marc Gorelick**, MD, President and Chief Executive Officer, Children's Minnesota

  Representing: General member

- **Bukata Hayes**, Vice President, Racial and Health Equity & Chief Equity Officer, Blue Cross and Blue Shield of Minnesota

  Representing: General member

- **Joy Marsh**, Vice President, Equity & Inclusion, UCare

  Representing: African American communities

- **Maria Medina**, System Director of Equity Initiatives, Fairview Health Services

  Representing: General member

- **Vayong Moua**, Racial and Health Equity Advocacy Director, Blue Cross and Blue Shield of Minnesota

  Representing: Health Coverage Organizations

- **Mumtaz (Taj) Mustapha**, MD, Chief of Equity Strategy, M Health Fairview

  Representing: General member

- **Laurelle Myhra**, PhD, LMFT, Director, Mino Bimaadiziwin Wellness Clinic

  Representing: American Indian communities

- **Cybill Oragwu**, MD, FAAFP, Attending Physician, CentraCare Health

  Representing: Health Care Providers

- **Miamon Queeglay**, Assistant Director of Outreach and Engagement, University of Minnesota, School of Dentistry

  Representing: African Heritage communities

- **Nneka Sederstrom**, PhD, MPH, MA, FCCP, FCCM, Chief Health Equity Officer, Hennepin Healthcare

  Representing: General member

- **Megan Chao Smith**, BSN, PHN, RN, TaikoArts Midwest

  Representing: LGBTQIA+ communities

- **Patrick Simon S. Soria**, DNP, MAN, MHA(c), RN, President-elect, Phillipine Nurses Association of Central Minnesota

Representing: Asian American and Pacific Islander communities

- **Sonny Wasilowski**

  Representing: Disability communities

- **Erin Westfall**, DO, Program Director and Director of Osteopathic Education, Mayo Clinic Family Medicine Residency – Mankato

  Representing: General member

- **Tyler Winkelman**, MD, MSc, Co-Director - Health, Homelessness, and Criminal Justice Lab, Hennepin Healthcare Research Institute Past-President, Minnesota EHR Consortium

  Representing: General member

- **Yeng M. Yang**, MD, MBA, Medical Advisor and Co-Chair of Health Equity, Diversity, Inclusion, Belonging and Anti-Racist Cabinet, HealthPartners

  Representing: General member

Roles and Responsibilities

Group	Responsibilities
Task force members	▪ Attend and engage in meetings from January 2024 through June 2025. ▪ Review meeting materials in advance and be prepared to contribute insights and expertise. ▪ Bring the perspective of the represented community group or sector to discussions and decisions. Confer with represented communities, sectors, and interested parties and groups in-between meetings. ▪ Serve on subcommittees and workgroups established by the task force as needed. ▪ Adhere to the established ground rules that provide the framework for learning, collaboration, and decision-making.
MDH project team	▪ Support information and engagement needs ▪ Technical assistance ▪ Communications ▪ Meeting accommodations and logistics ▪ Workgroup support
DeYoung Consulting Services	▪ Meeting facilitation ▪ Workgroup support

Milestones and Timeline

The following summarizes high-level project milestones. It is assumed that workgroups will meet in-between full task force meetings, to build upon what is discussed and decided by the task force.

Month	Milestones
January 2024	Meeting on the 17th Launch task force
February 2024	Meeting on the 26th Begin identifying priorities
March 2024	Meeting on the 28th Launch workgroups
April 2024	Meeting on the 25th Workgroups meet and draft workplans DHS presentation
May 2024	Workgroups meet and refine workplans Design environmental scan Design engagement plan
June 2024	Task force meeting on the 26th Final draft of workgroup workplans Finalize environmental scan parameters and engagement plan DHS presentation
July 2024	Workgroups meet
August 2024	Meeting on the 21st Expert panel(s)
September 2024	Workgroups meet
October 2024	Task force meeting on the 24th Expert panel(s)
November 2024	Workgroups meet
December 2024	Task force meeting on the 9th Legislative panel
January 2025	Workgroups meet
February 2025	Task force meeting on the 12th Expert panel(s)
March 2025	Workgroups meet
April 2025	Task force meeting on the 10th Draft recommendations and call to action
May 2025	Task force meeting on the 20th Discuss public comments
June 2025	Task force meeting on the 17th Finalize recommendations, call to action, and report

Meeting Ground Rules

- 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.

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DRAFT Access and Quality Workgroup Workplan

Members: Elizete Diaz, ElijahJuan Dotts, Nneka Sederstrom, Megan Chao Smith, Patrick Soria, Yeng M. Yang**

Objectives or key questions ***What is our goal or what questions do we need to answer to get to a recommendation?***	**Information needs and methods** ***What do we need to know? Where is this information?***	**Interested parties and engagement methods** ***Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?***
Mental health, particularly model of combined primary care/mental health	Institute for Healthcare Improvement (IHI) – integrated model of mental health with primary care	NorthPoint Health HealthPartners uses IHI model

• Integrated records of behavioral/mental health and primary care
  ○ Impacts both mental and physical health Current state: Review claims, piecemeal approach
  ○ Intellectual, developmental disabilities
	Workforce development of mental health providers. Gap is culturally diverse workforce. Language access not the same as culturally congruent clinicians to patients. Can more effectively address stigmas within cultures.	

Continuity of care: chronic, preventive, sick care, etc	Primary care models	

• Lack of coordinated care.
  ○ Implementation care managers/coords. Wrap-around services. Help patients transition place-to-place, e.g., hospital, rehab, home, nursing home
  ○ Patients get what they need, medication reconciliation, mutual understanding care plans, proper follow-up
  ○ CMS provides some reimbursement, not all payers do, reimbursement varies
  ○ Increasing need, esp w/ senior population
  ○ Case worker reimbursement is related
  ○ Break-down silos to support/enable coordinated care, within care systems, and between payers and health care providers
	Coordinated care models
	
	We know of several complex care model clinics that work in terms of getting patients the care they need but the model is not sustainable since it is so resource heavy w/o proper reimbursement from payors.
		Fairview/M Health had the complex care clinic that closed due to nonsustainablity
		
		HealthPartners is piloting several models including: hospital at home, integrated primary care from hybrid care to traditional primary care with care coordination and team-based care.
		Would like to hear from Essentia Health and Mayo as well as other systems around the country.

• Maternal health, prenatal and postnatal care	• Different cultural traditions. E.g., Native American, American Indian, https://www.mewinzha.com/	

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	• Models of post-partum care in delivery systems (those that have better outcomes for mothers); e.g., HealthPartners Healing Circles (emerging) • What services are provided, what is the variation by health care system and payer/insurance product? Information for patients/beneficiaries is disparate and confusing.	
• Different needs among patients and families, e.g., complex medical needs ○ Transitions of care (e.g., aging out of peds; teen/confidential care)		
Health [care?] literacy		
• Unclear where to do, what to do, to access care, how to make appts. • Opportunity for partnership to advance health literacy between MDH and others, e.g., providers, communities	Collaboration between healthcare delivery providers and community members. Trust building is key before informational bridge can be establish for more education.	• MDH, providers, communities, health plans, trusted messengers • Community health workers (from communities they are servicing)

• Digital literacy.
  ○ Virtual care becoming part of standard care (difficulties for rural).
  ○ Interfacing w/ providers		

• Do the education of medicine as a whole, role of primary care, internal med, specialists. How health care delivered. ○ Beyond written materials, translated materials		
• Different needs among patients and families, e.g., complex medical needs		
Culturally responsive, inclusive care (how providers meet with people), culturally concordant clinicians	Examples of systems using best practices	
Language barriers, access, other accessibility issues (tech, etc.)		

Objectives or key questions ***What is our goal or what questions do we need to answer to get to a recommendation?***	**Information needs and methods** ***What do we need to know? Where is this information?***	**Interested parties and engagement methods** ***Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?***
Community health workers (from communities they are servicing)		
Equitable insurance coverage, under- and uninsured populations	Data on the uninsured population	
Advocacy for SDOH factors to count towards complexity risk adjustment:	Changes in coverage or loss of coverage of Medical & Dental due to redetermination activities going on now. Data indicate that compared to the lowest social risk class, a person with high SDOH risk factors can more than double the TCOC and has more than double their future morbidity risk. (Milbank Q. 2022 Sep; 100(3); 761-784)	CMS, DHS and commercial payors need better data to understand both the health outcome and financial cost to take care of those medical morbidities. Health care delivery systems need to continue to code for SDOH factors to show the disease burdens of these high risk populations
Maternal health, prenatal and postnatal care	Different cultural traditions. E.g., Native American, American Indian, https://www.mewinzha.com/	
Adequate prenatal care	Poor prenatal care leads to higher rates of infant mortality and morbidity	
Adequate post-partum care	A whole host of problems such as: Post partum depression, inadequate parenting skills, social support. Need consistent support and access to post-partum medical and behavioral and social care	
Wrap around services such as public health nurse visits to new couplets (new parents and babe)		
Best practice equitable and trauma-informed intrapartum care	Black moms are still experiencing higher levels of intrapartum and post-partum hemorrhages	
Accountability systems	Minnesota policies and laws, legislature and MDH	
CMS, DHS need to provide more support for the system that take care of patients with higher risks including SDOH factors that contribute greatly to healthcare disparities now. Systems are not properly compensated for taking care of these		

Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*
populations. Doing the right thing is not enough when there is no financial backing for doing the right right.		
Home care (people inability to reach care institutions)		
Telemedicine		
In-home monitoring systems that integrate with health care delivery systems	Who has done this well?	CMS and payors to enhance policies for coverage of these services.
Other ideas, parking lot		
Homeless population		
Rural populations		

DRAFT Delivery Workplan

Members: Marc Gorelick, Miamon Queeglay, Sonny Wasilowski, Erin Westfall, Tyler Winkelman**

Objectives or key questions ***What is our goal or what questions do we need to answer to get to a recommendation?***	**Information needs and methods** ***What do we need to know? Where is this information?***	**Interested parties and engagement methods** ***Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?***	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**
What is the current state (inventory) of navigation of health care systems? (Comparing provider networks)		Options for financing: culturally appropriate care	How does MDH/DHS describe effective "delivery."	
Any successful examples of collaborative work between health care entities? (Start with HCMC?)	What are the barriers? How does this look in rural MN?	UMN?	Is MDH aware of successful collaborations they've been part of?	
There are several domains of health care that we need to address to ensure equity: access to care, provision of care, care coordination	1. Where are the biggest gaps in equitable care in each of these domains? 2. Are there examples of best practices in equitable care in each of these domains?	These can be informed by: health systems and other providers, key healthcare recipient groups, state agencies (MDH, DHS, perhaps others)	MDH identify relevant data sources and literature DeYoung do structured interviews of task force members who are either providers or members of healthcare consumer stakeholder groups	Marc Gorelick
What are the levels that affect health care? Even if system is perfect, if patient interaction is stigmatized/biased it will hinder service.				Tyler Winkelman
What community-centered social media platforms or technologies are available for patient use?				Miamon Queeglay
How do we increase the availability and quality of ASL and other interpreters? Any Interpreter choices and access.	What are the laws and regulations/expectations for healthcare entities to provide interpreting services?	ADA attorneys?	DeYoung/MD: State of Minnesota standard for interpreting?	Erin Westfall
What can we do to help children with hearing loss?				Miamon Queeglay
How much should traditional and non-traditional health care partner?				

Health Care Financing Workgroup

Members: Bukata Hayes, Joy Marsh, Taj Mustapha**

Draft Vision Statement:

To create recommendations on how to achieve a health care finance system:

1. **That** eliminates arbitrary health care costs and pricing including price discrimination and is truly equitable and easily accessible to all parties including patients regardless of their health or social background or status, providers, and payers.
2. **That** reflects, accounts for, and caters to the social, cultural, and other needs of each member of the population being served to achieve optimal health.
3. **That** eliminates waste by streamlining processes and communication to remove unwanted redundancy in administrative and clinical work (such as when patients get repeat care from different providers, repeat paperwork processing, the seemingly endless back-and-forth between payers and providers on prior authorizations, and other excess administrative overhead costs).
4. **That** fosters collaboration among patients, providers, and payers where each is appropriately incentivized for preventive care, wellness, and chronic disease management, not acute or sick care while continuing to fund the provision of quality acute care to sustain overall patient and population well-being and prevent the reoccurrence or exacerbation of illnesses.
5. **That** is structured by policies and processes at the state level and becomes a model for other states interested in advancing healthcare equity.

DRAFT Health Vare Financing Workplan

Objectives or key questions ***What is our goal or what questions do we need to answer to get to a recommendation?***	**Information needs and methods** ***What do we need to know? Where is this information?***
Understanding of how current players operate together in health care financing: private equity, government and private insurers, self-insured employers, health care systems, independent practices, market disrupters, etc.	Consultants/analysts in health care finance to do a deep dive (need to select consultants with different perspectives, including someone with a non-capitalist lens) Physicians for a National Healthcare Program, state chapter
Understanding the current state of value-based plans and cost-sharing.	What are the elements that have facilitated and hindered equitable health care How do the contracts impact care Explore different methodologies
Understanding the current state of financing for culturally appropriate care, including language services.	
Understanding of what other states interested in this work have done, e.g., Marland, Massachusetts, California	How did they improve equitable access, reduced administrative burden/cost? Explore dental, doula services, language services
Understanding of fee-for-service and RVUs.	AMA? System of reimbursement Bring RVU system into context to understand how it plays into the future of health care.

EHCTF Workforce Subcommittee – Members

Joy Marsh (Co-Lead), Mary Engels (Co-Lead), Maria Medina and Sara Bolnick

EHCTF Workforce Subcommittee – Vision Statement

Our vision is to provide strategic guidance to Minnesota health care organizations in building, nurturing, and maturing an equitable workforce. Through these efforts, we aspire to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients and communities.

EHCTF Workforce Subcommittee – Objectives

Objective 1: Foster Workplace Inclusion and Belonging

- Recommend best practices to enhance the sense of safety, trust and belonging among employees, such as employee resource groups, regular assessments or surveys to measure the employee experience with corresponding action based on this feedback, and a culture of accountability for improved outcomes.
- Recommend leveraging employees and employee resource group members from underrepresented groups in the cocreation of workforce equity strategies designed to meet their needs.
- Recommend strategies to drive leadership accountability for workforce equity outcomes.

Objective 2: Enhance Workforce Skills and Cultural Responsiveness

- Recommend best practices focused on suggested requirements for comprehensive training programs for employees and providers to develop essential soft skills, including cultural responsiveness, mitigation of unconscious bias, effective communication, empathy, and teamwork.
- Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally congruent care.
- Recommend mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.
- Outline solutions to address the narrowness of specialization, such as cross-training opportunities, mentorship programs, and professional development resources.
- Recommend workforce equity core competencies for employees and leaders.
- Recommend workforce equity strategies that are informed by the communities being locally served.

Objective 3: Address Role Inequities

- Recommend possible solutions to address role inequities, including a pay structure analysis and evaluation of the value, impact and advocacy of care coordinator/community health workers and other similar roles.
- Outline a framework, model or resource to help organizations begin to collaborate with key stakeholders to examine and address any systemic biases or barriers that contribute to role inequities.

Objective 4: Overcome Workforce Pipeline Barriers

- Recommend strategies to incorporate into hiring processes to support the hiring of underrepresented candidates and to attract and recruit a workforce that reflects the communities we serve, including strategies to support international candidates.
- Recommend best practices for collaborating with educational institutions and community organizations to remove barriers to entering the healthcare workforce.
- Recommend strategies to partner with educational and credentialing institutions to reduce representation gaps that hinder culturally concordant care for historically underrepresented groups in health care positions.

Objective 5: Promote Diversity at all Levels, including Sr. Leadership and Boards of Directors

- Recommend requirements for reviewing and updating board membership to ensure adequate representation from underrepresented groups on organizational boards and committees.
- Identify and remove barriers for students and employees to obtaining scholarships and resources experienced by underrepresented individuals who aspire to pursue careers and leadership positions in healthcare.
- Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups.
- Recommend educational opportunities to require board members to actively engage in ongoing professional development to acquire the necessary skills to model inclusive leadership and equitable governance.

Notes:

Build in definitions of terms (e.g. trust, belonging, workforce equity, etc.).

EHCTF Workforce Subcommittee Workplan

Workgroups may augment this template as needed or use a preferred tool with that includes the same content.

Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
April 2024 (Small Grp Mtg)			**Meeting date: 4/3/24** Create vision, objectives, and draft engagement/work plan. Schedule meetings for May, July, September, November, January, March	Joy Marsh Mary Engels Maria Medina Sara Bolnick	4/3/24	4/8/24 Done Due 4/19/24
April 2024 (Lg Grp Mtg)			**Meeting date:4/25/24** Final workplans drafted. Environmental scan defined. Engagement plan drafted.	Joy Marsh Mary Engels Maria Medina Sara Bolnick	4/25/24	
Key questions to address between meetings:						
May 2024 (Small Grp Mtg)			**Meeting date: 5/13/24 -8-9** Final workplans completed. Final engagement plans completed.	Joy Marsh Mary Engels Maria Medina Sara Bolnick	5/13/24	

Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
			Begin environmental scan if time.			
Key questions to address between meetings:						
June 2024 (Lg Grp Mtg)			**Meeting date:4/25/24** Final workplans drafted. Environmental scan defined. Engagement plan drafted.	Joy Marsh Mary Engels Maria Medina Sara Bolnick	4/25/24	
Key questions to address between meetings:						
July 2024 (Small Grp Mtg)			**Meeting date:7/8/24 10-11 am** Work on environmental scan (collection of best practices).	Joy Marsh Mary Engels Maria Medina Sara Bolnick	7/8/24	

Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
Key questions to address between meetings:						
August 2024 (Lg Grp Mtg)			**Meeting date: 8/21/24** Environmental scan: Results	Joy Marsh Mary Engels Maria Medina Sara Bolnick	8/21/24	
Key questions to address between meetings:						
September 2024 (Small Grp Mtg)			**Meeting date: 9/9/24 -10-11** Begin to identify prospective solutions (1:1 with key partners, key gaps and ideal solutions, BE BOLD).	Joy Marsh Mary Engels Maria Medina Sara Bolnick	9/9/24	
Key questions to address between meetings:						
October 2024 (Lg Grp Mtg)			**Meeting date: 10/24/24** Identify prospective solutions	Joy Marsh Mary Engels Maria Medina Sara Bolnick	10/24/24	

Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
Key questions to address between meetings:						
November 2024 (Small Grp Mtg)			**Meeting date: 11/14/24 – 3-4** Continue to identify prospective solutions	Joy Marsh Mary Engels Maria Medina Sara Bolnick	11/14/24	
Key questions to address between meetings:						
December 2024 (Lg Grp Mtg)			**Meeting date: 12/9/24** Solutions: Digging Deeper	Joy Marsh Mary Engels Maria Medina Sara Bolnick	12/9/24	

Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
Key questions to address between meetings:						
January 2024 (Small Grp Mtg)			**Meeting date: 1/9/25 – 1-2** Begin to synthesize solutions and potential recommendations (voices of key partners are integrated into recommendations)	Joy Marsh Mary Engels Maria Medina Sara Bolnick	1/9/25	
Key questions to address between meetings:						
February 2024 (Lg Grp Mtg)			**Meeting date: 2/12/25** Solutions and potential recommendations synthesized	Joy Marsh Mary Engels Maria Medina Sara Bolnick	2/12/25	
Key questions to address between meetings:						
March 2024 (Small Grp Mtg)			**Meeting date: 3/10/25 10-11** Begin working on Initial Draft – Recommendations and call to action	Joy Marsh Mary Engels Maria Medina Sara Bolnick	3/10/25	

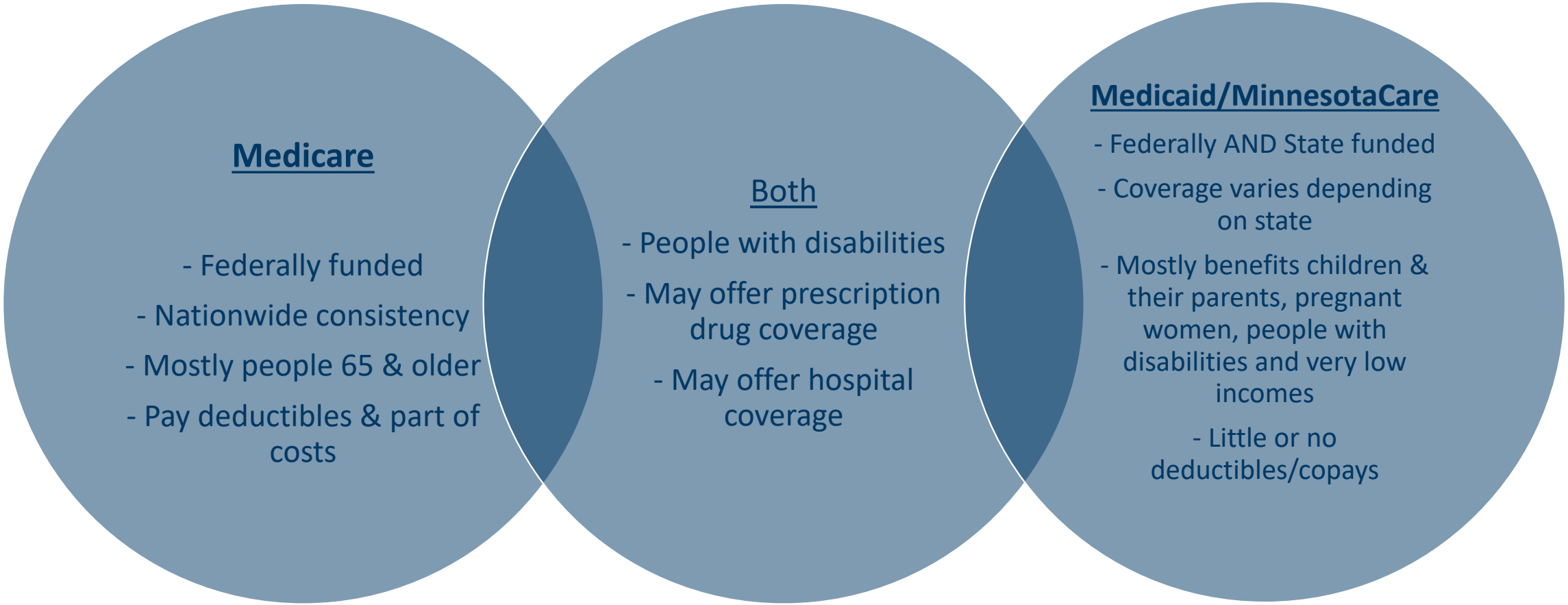
Objectives or key questions *What is our goal or what questions do we need to answer to get to a recommendation?*	**Information needs and methods** *What do we need to know? Where is this information?*	**Interested parties and engagement methods** *Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?*	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
Key questions to address between meetings:						
April 2024 (Lg Grp Mtg)			**Meeting date: 4/10/25** Initial Draft: Recommendations and call to action	Joy Marsh Mary Engels Maria Medina Sara Bolnick	4/10/25	
Key questions to address between meetings:						
May 2024 (Lg Grp Mtg)			**Meeting date: 5/20/25** Public Input: Recommendations and call to action	Joy Marsh Mary Engels Maria Medina Sara Bolnick	5/20/25	

Objectives or key questions ***What is our goal or what questions do we need to answer to get to a recommendation?***	**Information needs and methods** ***What do we need to know? Where is this information?***	**Interested parties and engagement methods** ***Who do we need to talk to, hear from, and how? Who has responsibilities and accountabilities in this area? Whose perspectives are important?***	**Other tasks, considerations, asks of DeYoung and MDH**	**Responsible members**	**Start date**	**End date**
Key questions to address between meetings:						
June 2024 (Lg Grp Mtg)			**Meeting date: 6/17/25** Recommendations and call to action finalized	Joy Marsh Mary Engels Maria Medina Sara Bolnick		

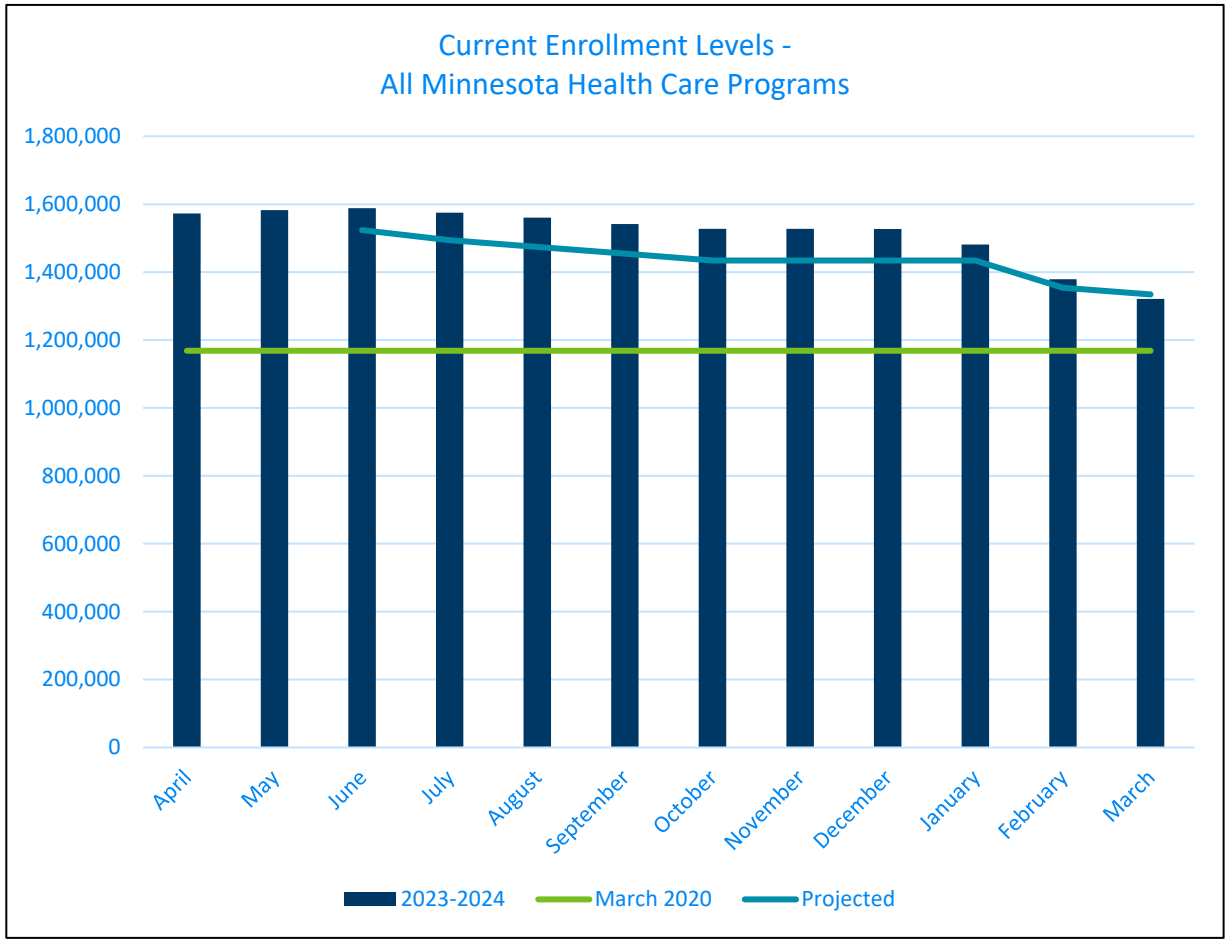
Structural Racism, Health and Medicaid: Addressing Minnesota's Disparities in Health Outcomes

John Connolly, Assistant Commissioner| Health Care Administration

Background: Medicaid vs. Medicare



Minnesota Health Care Programs total enrollment

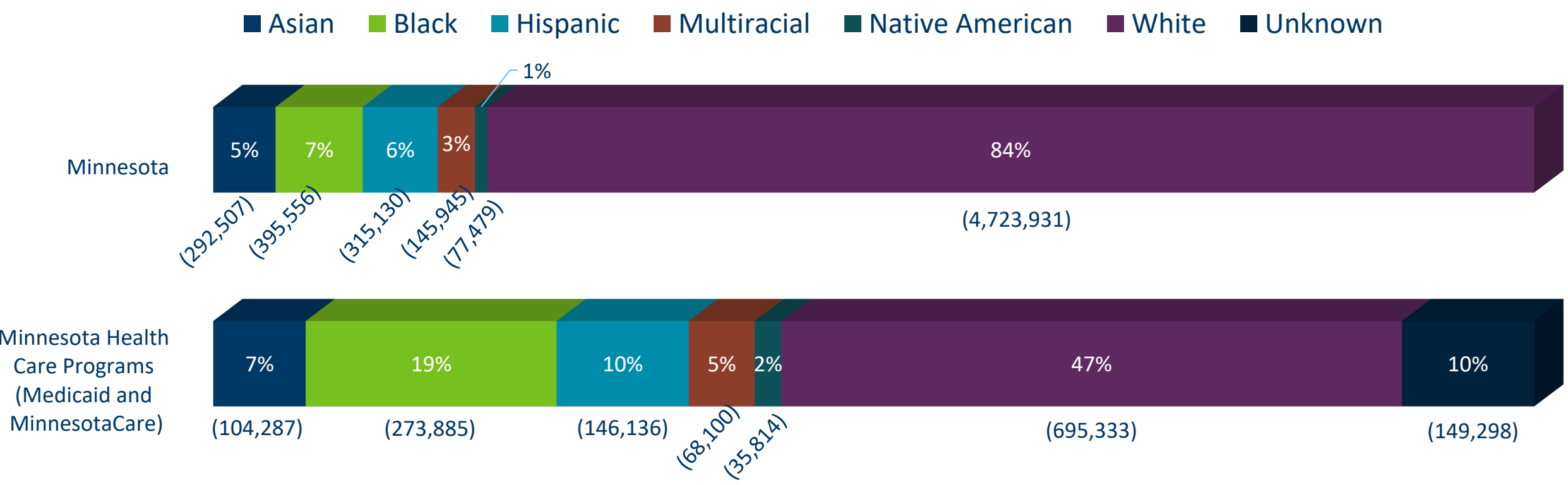


This information is based on data as of **04/09/24**

- Current MN Health Care Program enrollment is at 1,321,000 people.
- This is a 16% decline from June 2023 when enrollment peaked at 1,588,000 people.
- This chart shows the total number of people enrolled across all Minnesota Health Care Programs (MHCP).
  - The programs included are MA, MinnesotaCare, Family Planning and Medicare Savings Programs.
  - It includes MA enrollees not subject to renewal, such as hospital presumptive eligibility, Refugee Medical Assistance and children in foster care.
- Data reflects the aggregate of newly enrolled, re-enrolled and those no longer enrolled.
  - A decrease in enrollment cannot be solely attributed to the procedural terminations. It includes other closure reasons unrelated to renewal processing.

How Minnesotans get health care

Race and ethnicity of Minnesota population vs. population of enrollees in Medicaid and MinnesotaCare



Source: U.S. Census Bureau, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin: July 1, 2019 at https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-total.html; Minnesota Department of Human Services Medicaid Matters renewal dashboard at https://mn.gov/dhs/medicaid-matters/renewal-dashboard/

How Minnesotans get health care

Medical Assistance, MinnesotaCare, CHIP are the source of health care coverage for:

Minnesotans 64 and younger

- **43% of Black/African American Minnesotans**
- **41%** of American Indian/Alaskan Native Minnesotans
- **24%** of Hispanic Minnesotans
- **20%** of Asian Minnesotans
- **9%** white Minnesotans
- 22% of “other” Minnesotans

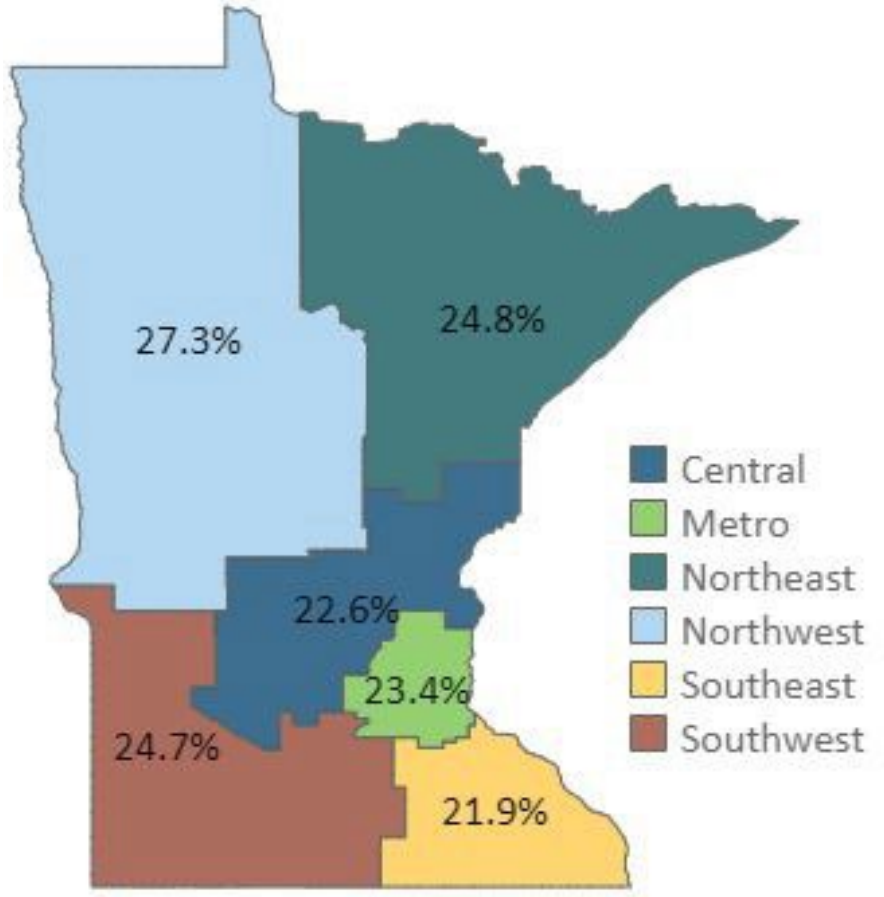
Minnesotans 18 and younger

- **64% of Black/African American children**
- **64%** of American Indian/Alaskan Native children
- **41%** of Hispanic children
- **33%** of Asian children
- **17%** of white children
- 32% of “other” children

Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files..

How Minnesotans get health care

Percentage of the population enrolled in Medicaid regionally

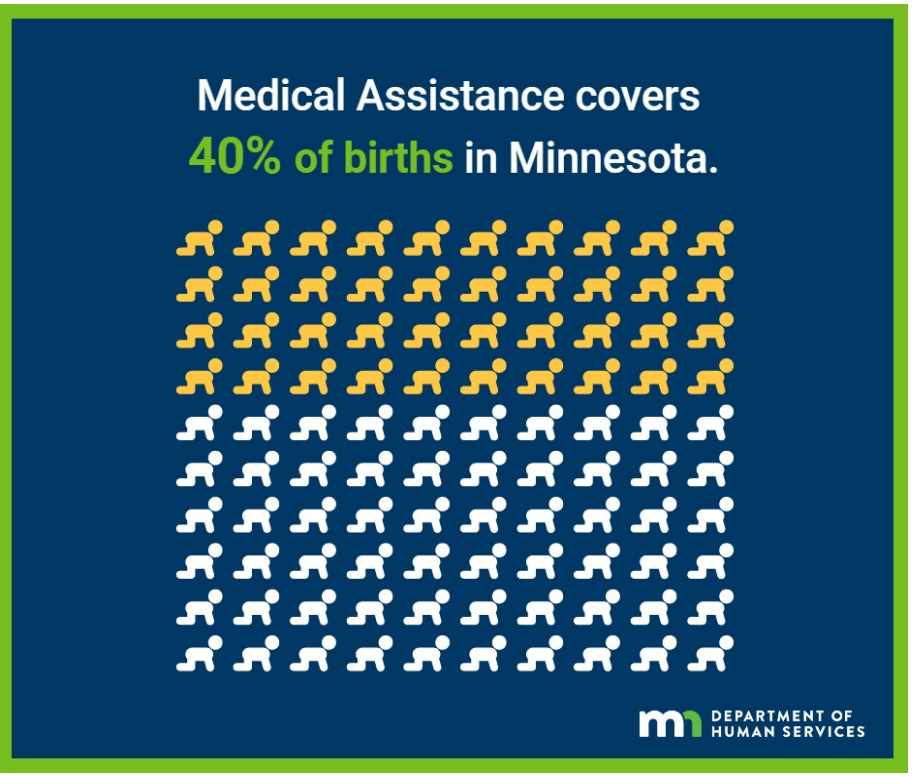


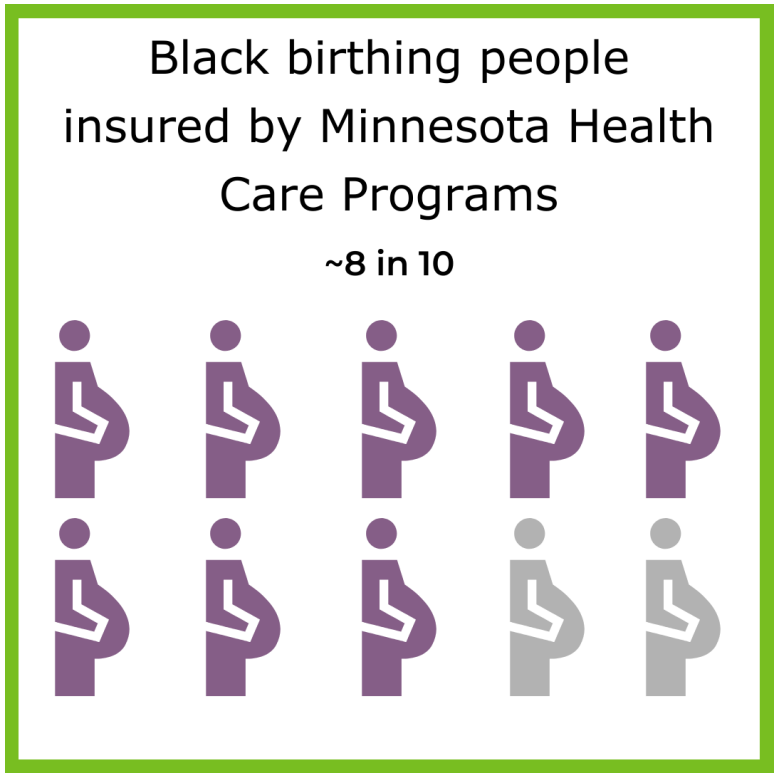
Minnesotans who access care via Medicaid	7-county metro	Greater Minnesota
American Indian/Alaska Native	24%	**38%**
Black/African-American	**41%**	**41%**
Hispanic/Latinx	23%	**25%**
Asian	**23%**	16%
"Other"	17%	**23%**
White	8%	**11%**

Source: SHADAC analysis of the 2021-2022 American Community Survey Public Use Microdata Sample files.

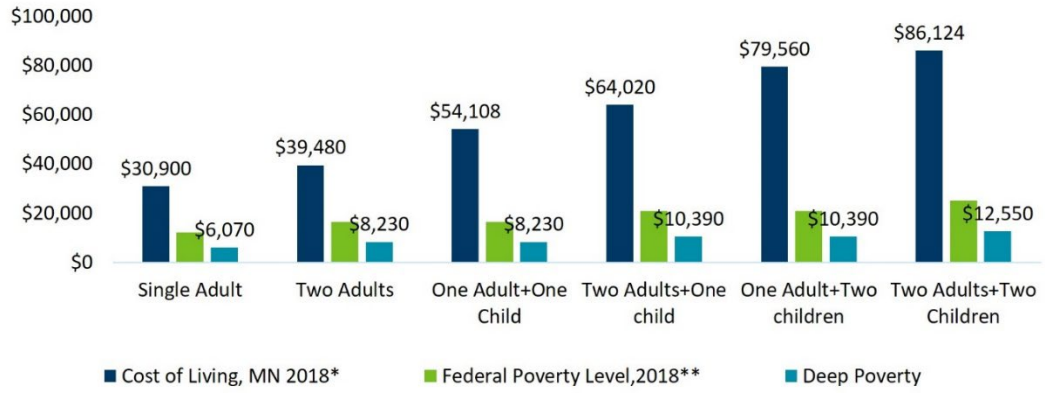
Source: https://mn.gov/dhs/medicaid-matters/who-medicaid-and-minnesotacare-serves

How Minnesotans get health care

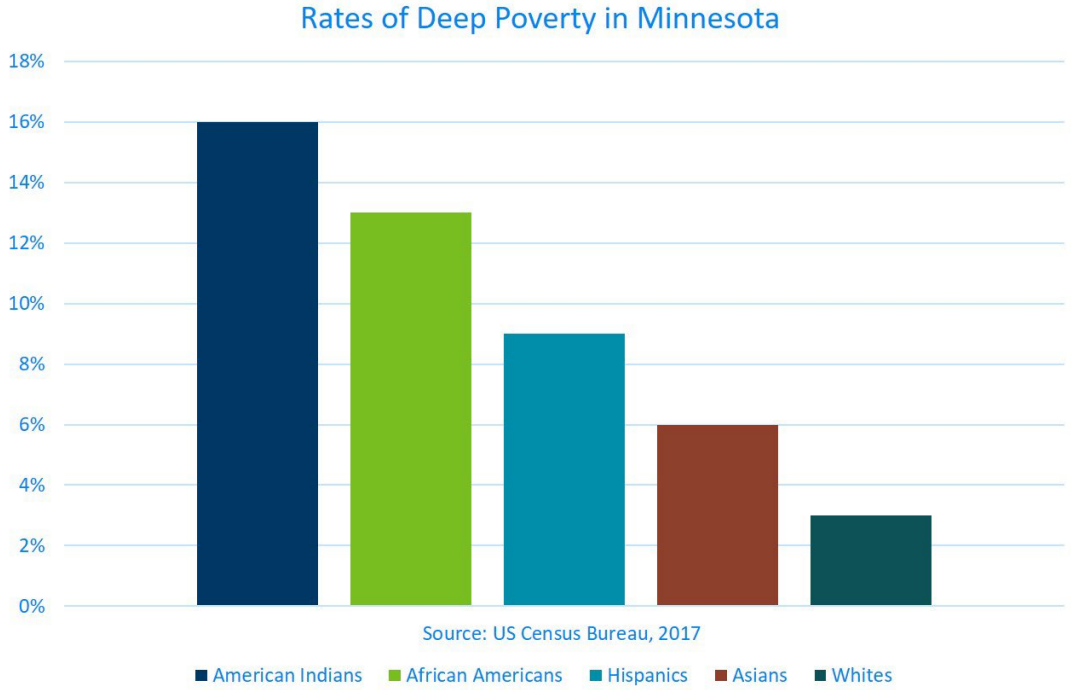




Social drivers of health measures: Deep poverty



*https://mn.gov/deed/data/data-tools/col/ (housing, transportation, food, health care, child care, taxes, and other necessities (e.g., clothing, personal care products)
**https://aspe.hhs.gov/poverty-guidelines

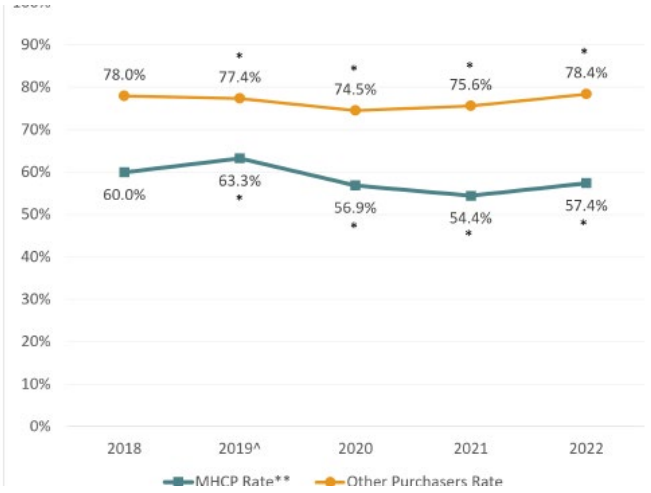


Minnesota Department of Human Services report "Improving the health of people living in deep poverty." December. 2020 Retrieved at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG.

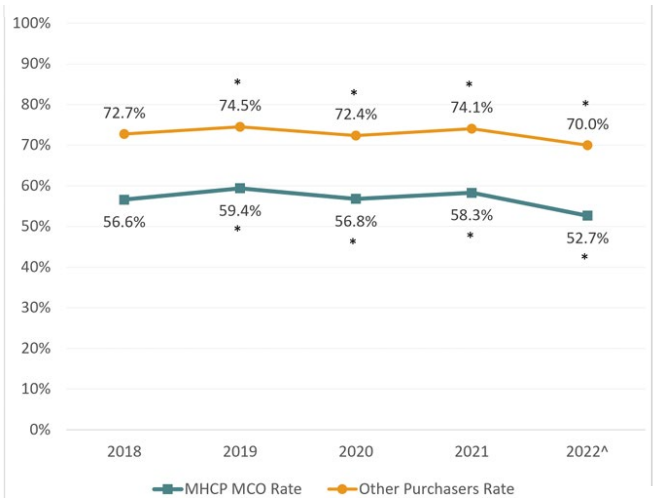
Minnesota health care quality metric payer disparities trends

Minnesota Community Measurement's Annual Minnesota Health Care Disparities by Insurance Type Report

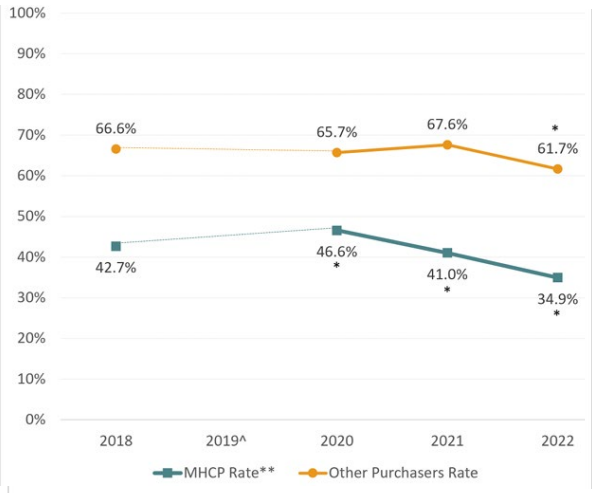
Breast cancer screening



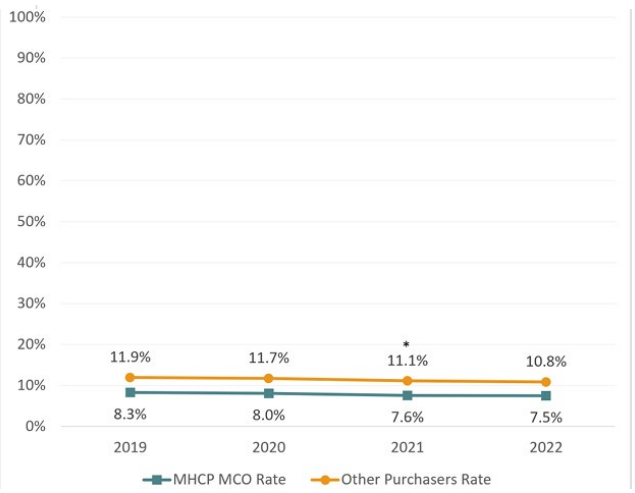
Colorectal cancer screening



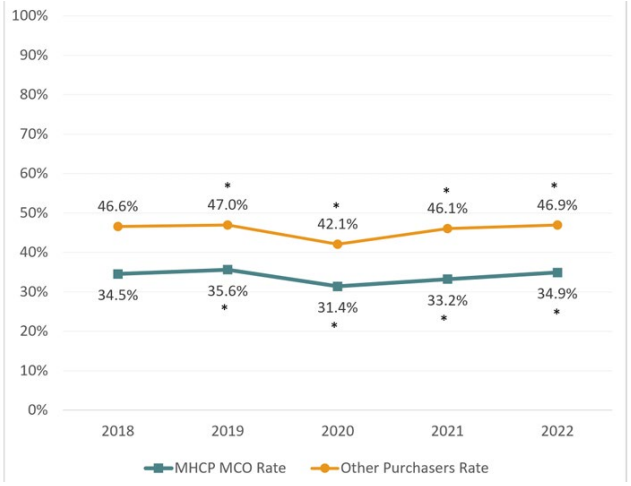
Childhood immunization



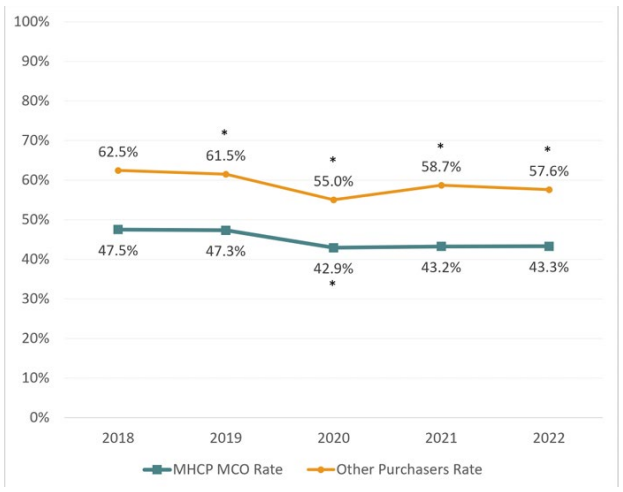
Adult depression remission



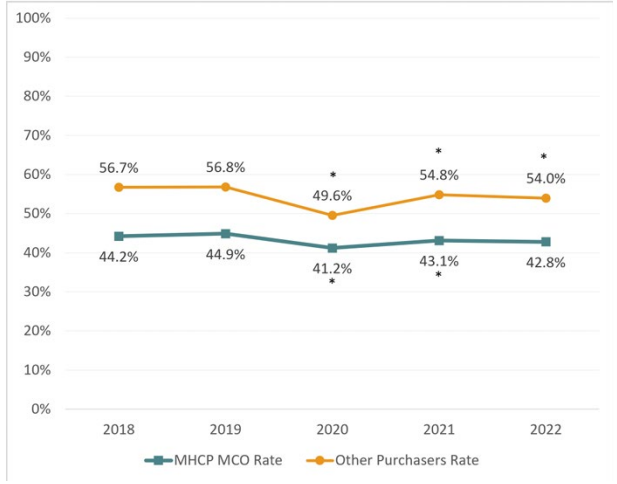
Optimal diabetes care



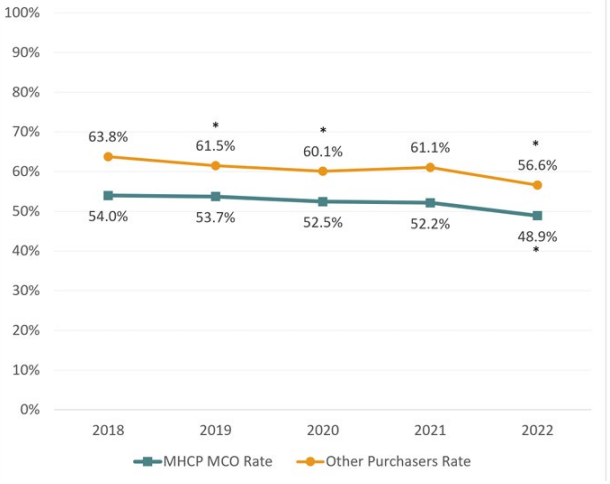
Optimal vascular care



Optimal asthma: Adults



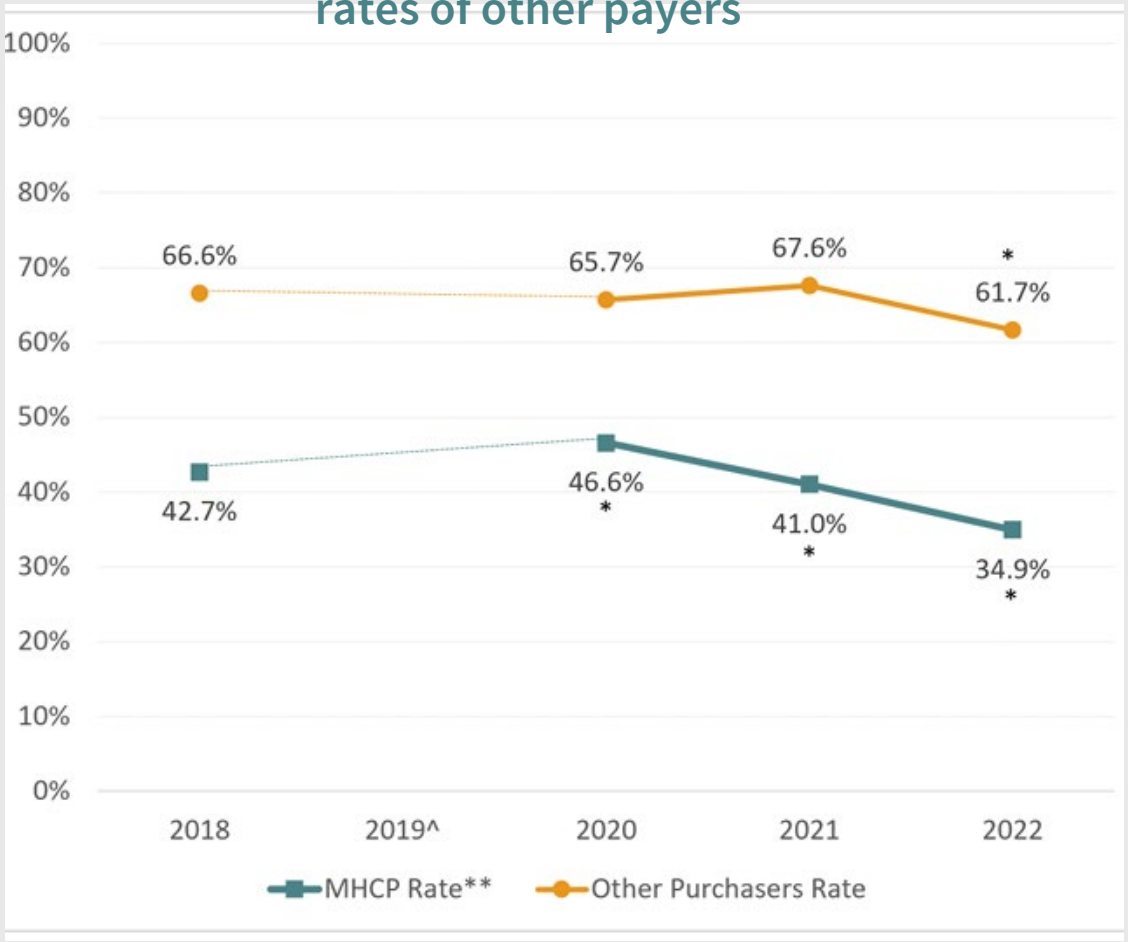
Optimal asthma: Children



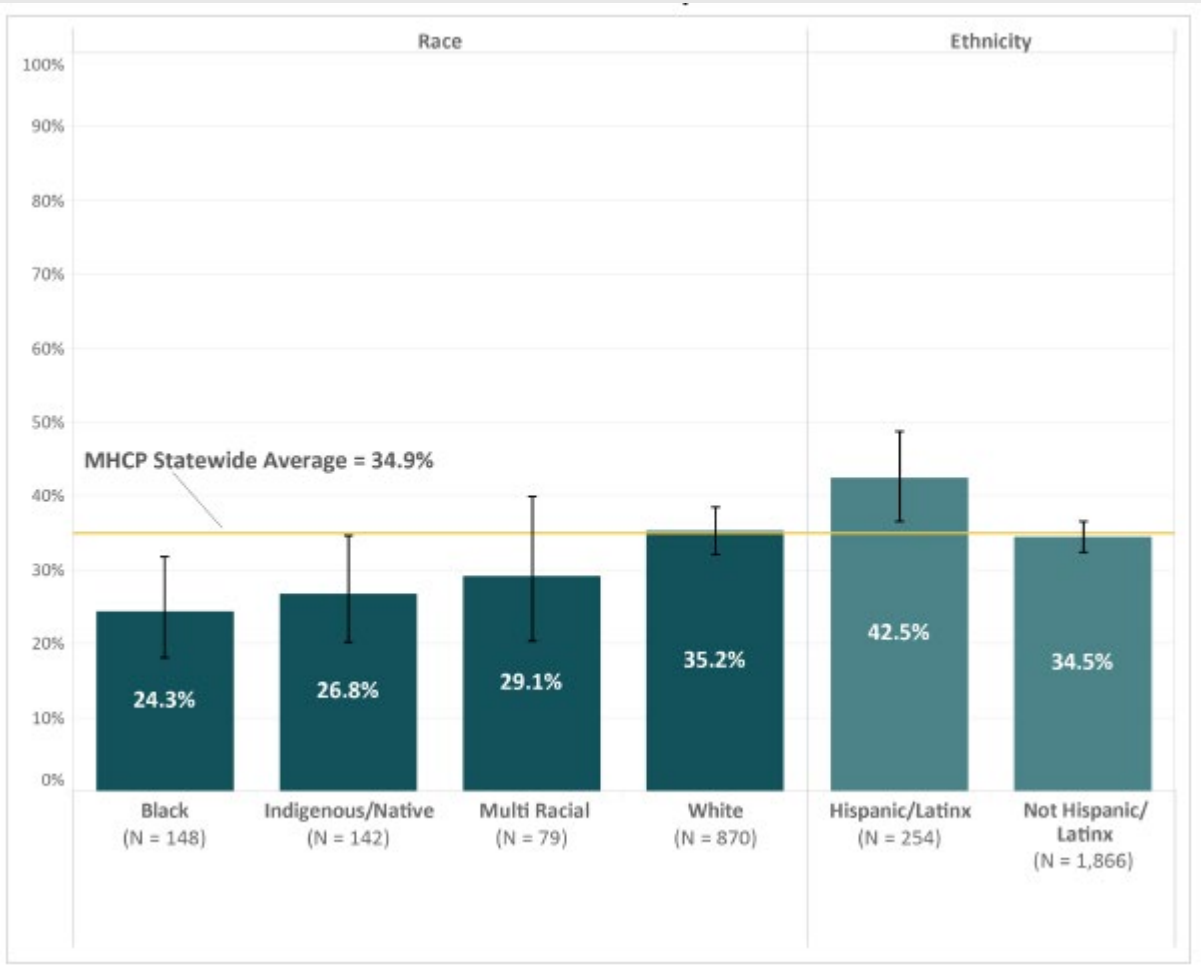
Childhood immunization screening

Minnesota Community Measurement's 2024 Annual Minnesota Health Care Disparities by Insurance Type Report

Minnesota Health Care Programs rates vs. rates of other payers



Minnesota Health Care Programs rates by race/ethnicity



We've measured, studied, analyzed and admired Minnesota's disparities in health outcomes enough

Medicaid's role in eliminating health inequities

- **Minnesota Department of Human Services as a service provider.**
  - Fee for service provider. Contracts with Managed Care.
- **Minnesota Department of Human Services as an employer**.
  - Increasing diversity in recruitment, retention and advancement. Developing employee curriculum.
- **Minnesota Department of Human Services as an engaged and accountable community partner.**
  - Scaling up models with sincere community engagement → ex. Integrated Care for High-Risk Pregnancies (ICHRP), Medicaid Equity forums, unwinding work, co-creation of Medicaid equity reports
- **Minnesota Department of Human Services as a leader in process transformation among state agencies and other state Medicaid agencies**
  - Racial & health equity assessments of ALL policy & budget development processes.

Medicaid managed care RFPs and contracting

Addressing structural racism/assessing antiracism

- *How does your organization address structural racism? What steps have you taken to become an antiracist organization? How do you plan to improve your systems and processes to be more antiracist?*
- *How does your organization use value-based purchasing or other incentive arrangements to improve racial equity in quality of care and health outcomes?*
- *Describe how your organization solicits and/or receives enrollee feedback regarding enrollee satisfaction, communications, service delivery, provider networks, and health plan operations. Describe how that feedback is used in your organization's operations.* ***Describe efforts to use this feedback to assess how structural racism impacts enrollees' experiences and to improve health outcomes for the MHCP population.***

Highlighting community co-created solutions and community investment

- *Describe your organization's approach to addressing social drivers of health to improve population health and prevention. Describe your organization's work regarding community collaboration efforts, provider and other stakeholder partnerships, and data collection including social drivers of health and analysis.*

Quality Measures, contracting and structural racism

- Quality Measures in Contracting to incentivize addressing structural racism
  - Current:
    - Performance Improvement Projects
      - “Healthy Start for Mothers and their Children”
    - Each health plan also works to decrease gaps in outcomes by race/ethnicity on certain HEDIS measures and gain points for overall improvement

Contract requirements

Each health plan works to decrease gaps in outcomes by race/ethnicity on certain HEDIS measures and gain points for overall improvement

Table 1: List of Withhold Measures (Performance and Compliance) and related details

Measure	Age Group	Points Allocated	Contract
*Childhood Immunization Status (CIS) – (i) Combo 10	2 years	16	F&C
*Well Child Visits in First 30 Months of Life (W30) – (i) W15; (ii) W30	0 to 15 months; 15 to 30 months	16 (8+8)	F&C
*Child & Adolescent Well-Visits (WCV)	All (3 to 21 years)	16	F&C
*Prenatal and Postpartum Care (PPC) – (i) Postpartum Care; (ii) Timeliness of Care	All Child-bearing age	16 (8+8)	F&C
*Initiation & Engagement of Alcohol, Opioids, & Other Drug Dependence Treatment (IET) – (i) Total Engagement; (ii) Total Initiation	All (13 to 65+ years)	16 (8+8)	F&C
*Follow-up After Hospitalization for Mental Illness (FUH) – (i) 7 day; (ii) 30 day	All (6 to 65+ years)	16 (8+8)	F&C
*Emergency Department Utilization Rate (EDV)	All (0 to 64 years)	1	F&C
*Hospital Admission Rate (ADM)	All (1 to 64 years)	1	F&C
*30 Day Readmission Percentage (RDM)	All (1 to 64 years)	1	F&C
*Annual Dental Visit (ADV)	18 to 64 years; 65+ years	15	SNBC & Seniors
*Initial Seniors Health Risk Screening or Assessment (SHRA) – *[DHS developed]*	64+ years	30	Seniors
Service Accessibility / Care Plan Audit	Not applicable	15	SNBC & Seniors
Stakeholders Group Reporting	Not applicable	15	SNBC & Seniors
No Repeat Deficiencies on the MDH QA/TCA Examination	Not applicable	1 point for F&C; 15 points for SNBC & Seniors contracts.	All 3 contracts

Addressing Structural Racism: Bringing a Racial Equity Lens to Policy & Budget proposals

I. Which population groups are impacted by this practice, policy, or budget proposal?

1. Which groups (racial/ethnic, LGBT, individuals with disabilities, and veterans) are likely to be most affected by/concerned with the issues related to this proposal/policy? American Indian MHCP enrollees

2. *For policy that is currently being developed* - Were representatives of the groups most likely to be affected by this practice, policy, budget proposal at the table in its development? Yes

3. *For review of existing policy as well for policy currently being developed* – Which representatives of the groups most affected by this policy participated in this equity analysis?
Equity Coordinator, tribal benefit admins, central office benefit admins, county

4. Who is/was missing from the table, and how can they be engaged at this point? None

II. What are the desired outcomes of this practice, policy, or budget proposal?

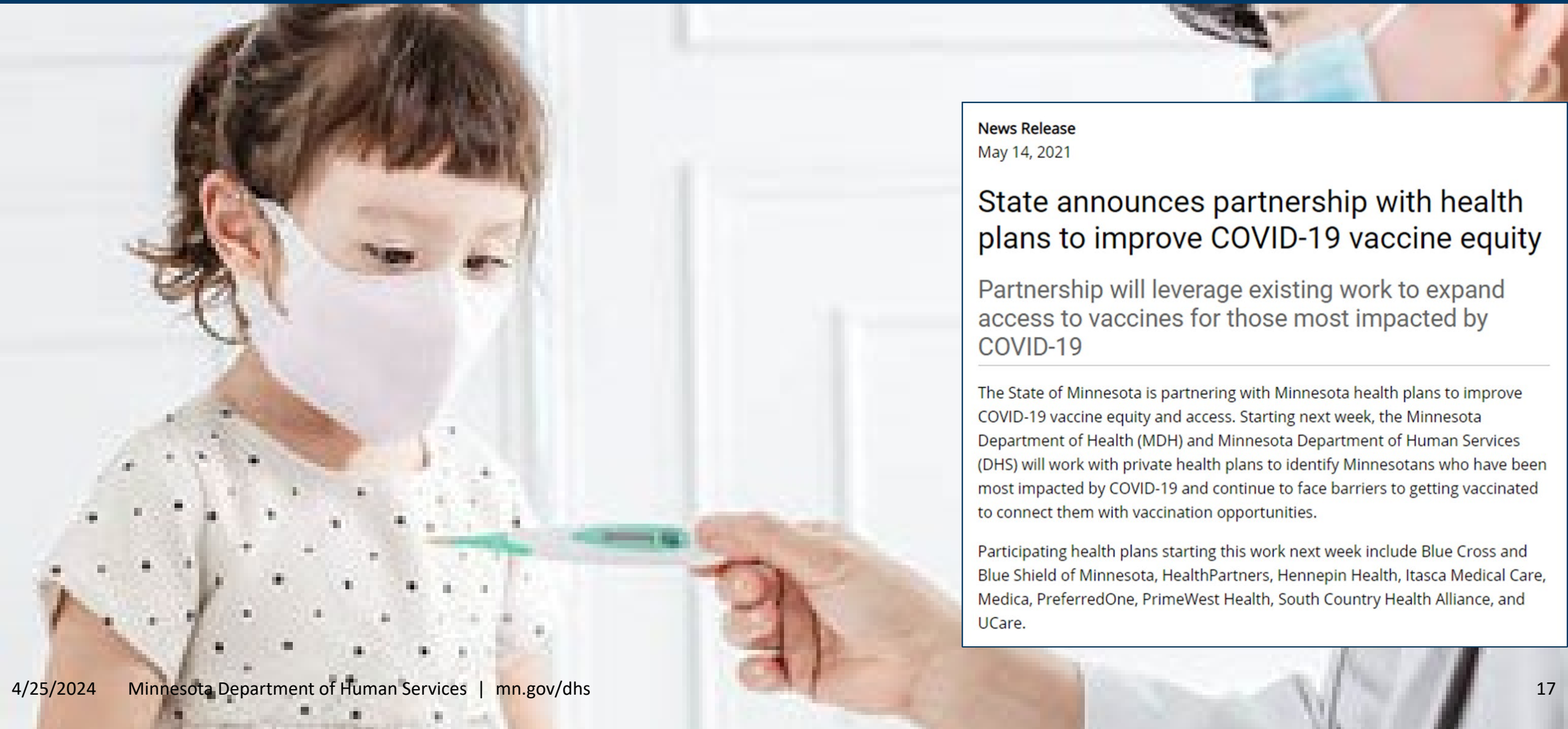
1. What is the purpose of this policy/budget/practice proposal?
MA and MinnesotaCare are subject to complex federal rules pertaining to American Indians. Currently, METS (Minnesota Eligibility Technology System) is not designed to implement these nuanced rules. DHS is currently processing applications for Red Lake. This proposal would expand the support to all tribes.

2. How will each group be positively and/or negatively impacted by this policy/budget/practice? What data or evidence supports that conclusion? Providing eligibility support to tribes will lead to more timely eligibility determinations/coverage for tribal members. It also establishes an ongoing relationship between DHS and tribes.

III. How will the adverse/positive effects identified in the analysis be prevented/maintain or minimized/maximized in order to reduce disparity?

1. What goals and measures have been/will be established to prevent or minimize adverse impacts and/or maximize positive impacts of this policy/budget/practice? Compliance with federal rules. Pilot (?) with Red Lake.
2. What actions will be taken to achieve these goals?
Increased access to enrollment support in tribal areas and health care for American Indians

Equity-focused COVID-19 vaccine outreach



News Release
May 14, 2021

State announces partnership with health plans to improve COVID-19 vaccine equity

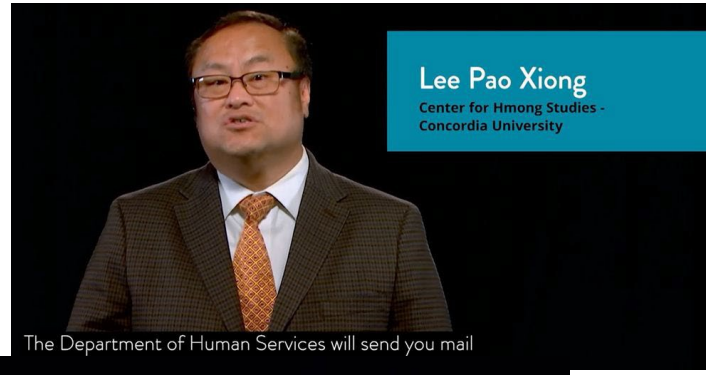
Partnership will leverage existing work to expand access to vaccines for those most impacted by COVID-19

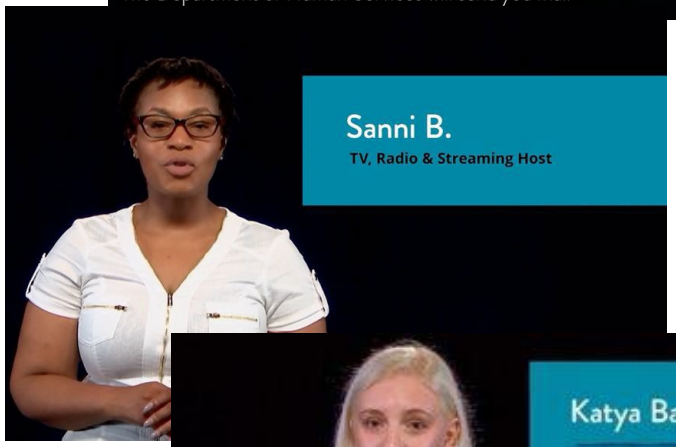
The State of Minnesota is partnering with Minnesota health plans to improve COVID-19 vaccine equity and access. Starting next week, the Minnesota Department of Health (MDH) and Minnesota Department of Human Services (DHS) will work with private health plans to identify Minnesotans who have been most impacted by COVID-19 and continue to face barriers to getting vaccinated to connect them with vaccination opportunities.

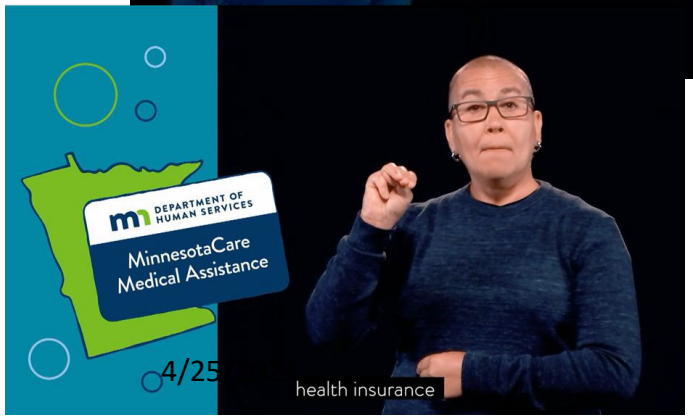
Participating health plans starting this work next week include Blue Cross and Blue Shield of Minnesota, HealthPartners, Hennepin Health, Itasca Medical Care, Medica, PreferredOne, PrimeWest Health, South Country Health Alliance, and UCare.

Unwinding outreach

English—Spanish—Somali—Hmong—Russian—Vietnamese—ASL—American Indian—Black—New to America





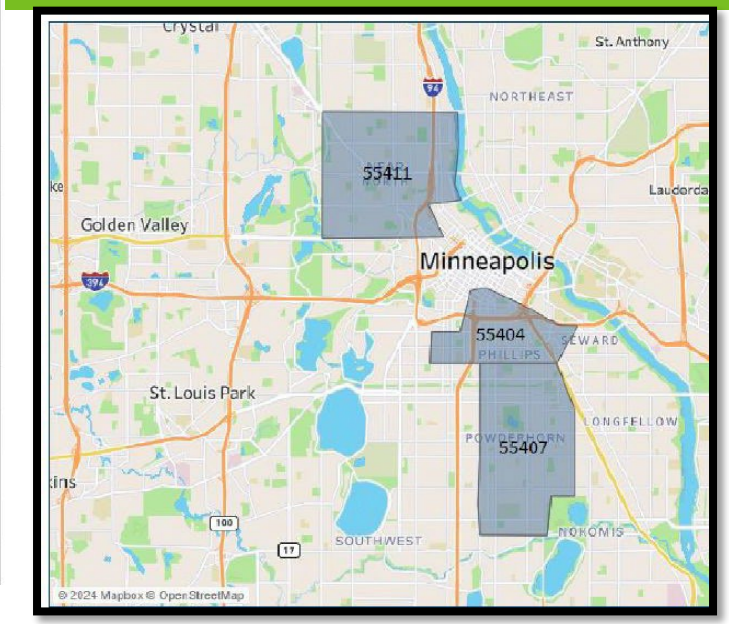


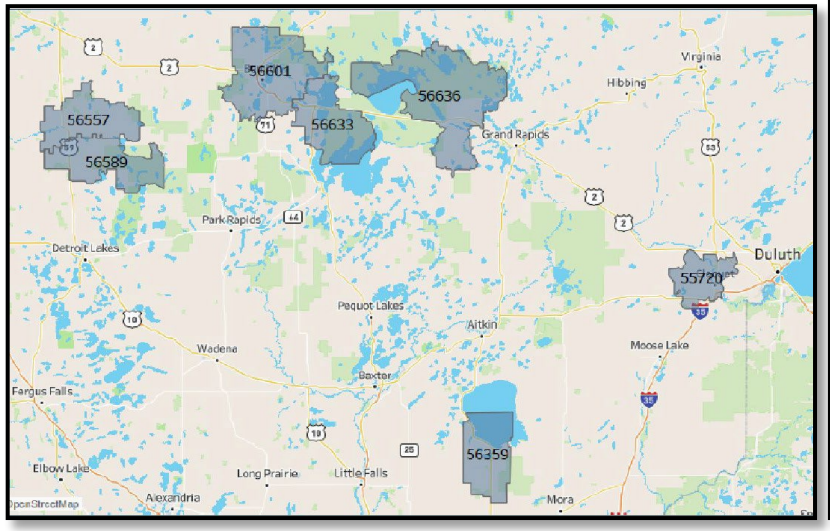
mn.gov/dhs/renewmycoverag

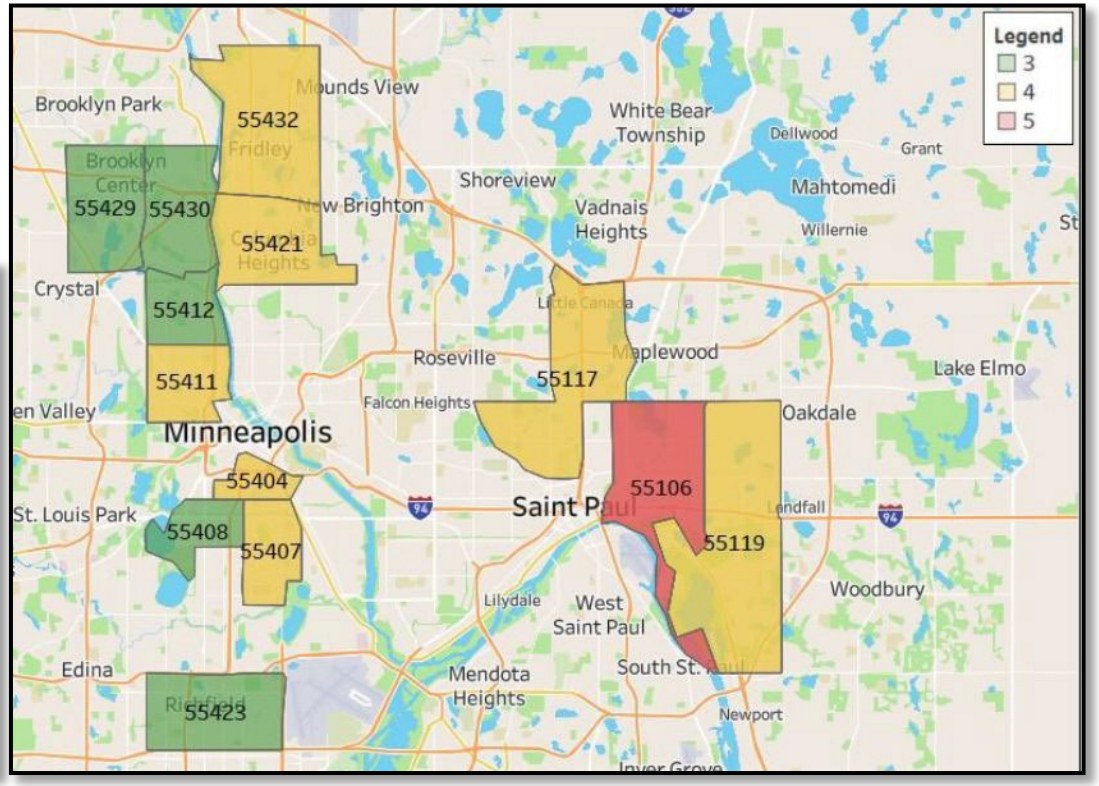
Unwinding outreach

ZIP Code	Groups	Number of Enrollees due for Renewal Quarter 2 2024
55106	All	6,007
55117	Black, API, Hispanic, White	4,117
55119	Black, API, Hispanic, White	3,808
55404	Black, Hispanic, AIAN, White	3,551
55407	Black, Hispanic, AIAN, White	3,441
55421	Black, API, Hispanic, White	2,514
55411	Black, API, Hispanic, AIAN	4,307
55432	Black, API, Hispanic, White	2,603
55412	Black, API, AIAN	2,729
55423	API, Hispanic, White	2,553
55429	Black, API, Hispanic	3,033
55430	Black, API, Hispanic	2,848
55912	API, Hispanic, White	2,791
55408	Black, Hispanic, White	2,655
56007	API, Hispanic, White	1,838

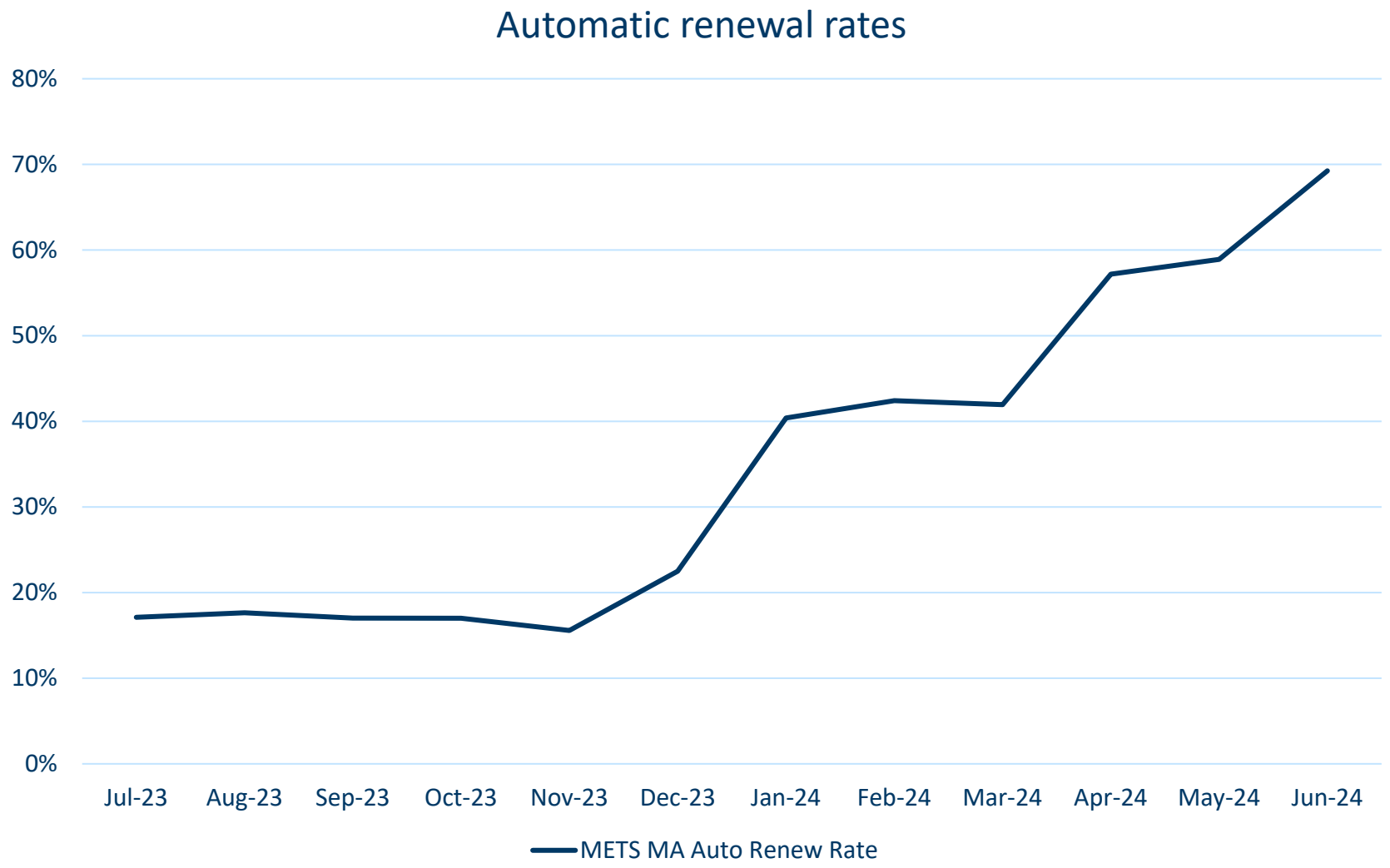
Zip	Number of Enrollees due for Renewal Quarter 2 2024
56633	713
56601	611
55720	312
55404	311
56557	223
56636	193
56359	167
56589	145
55411	136
55407	135





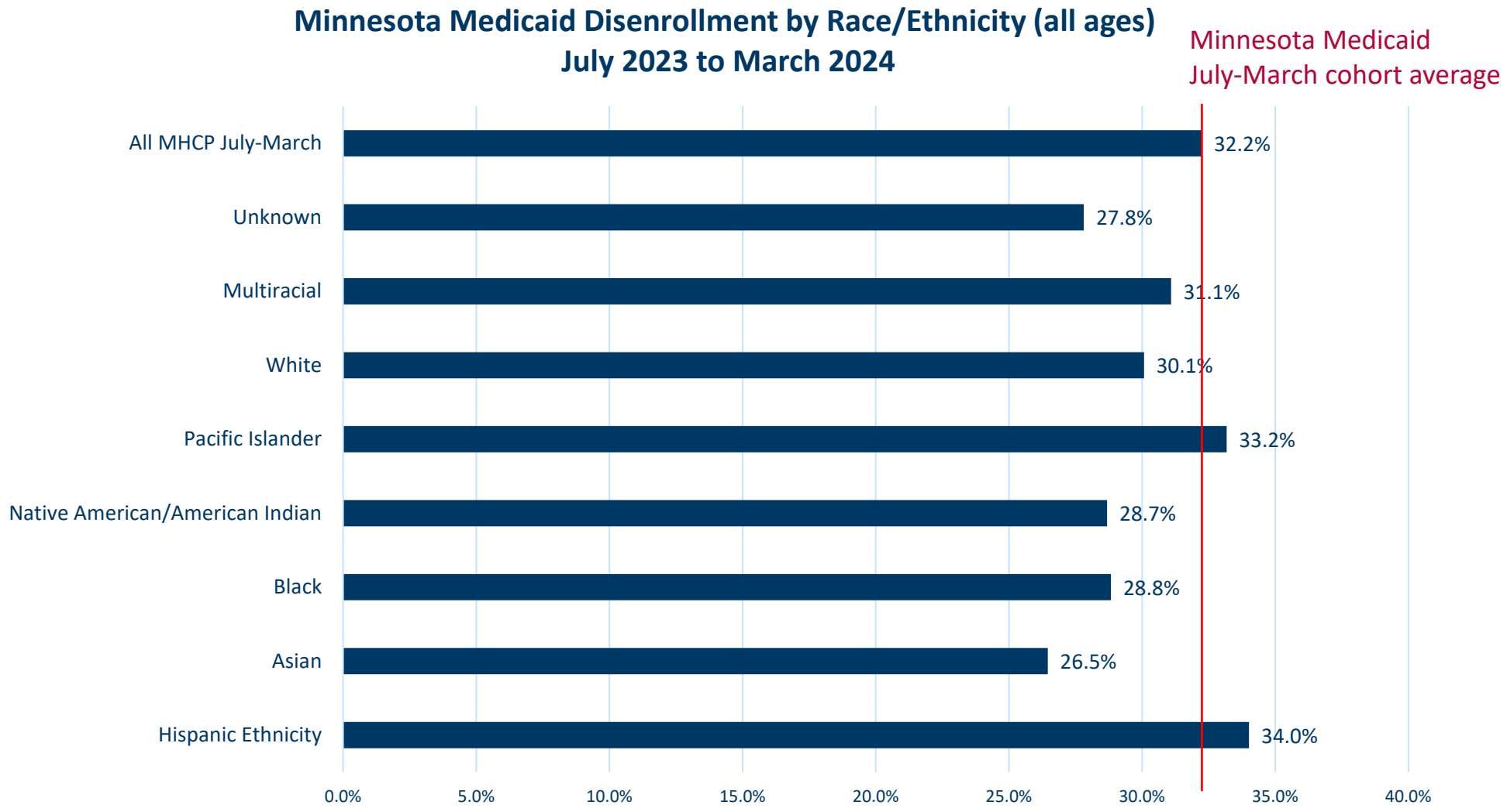


Making it easier for eligible enrollees to keep coverage



For the June cohort, **60,205 out of 86,937** enrollees were auto renewed!

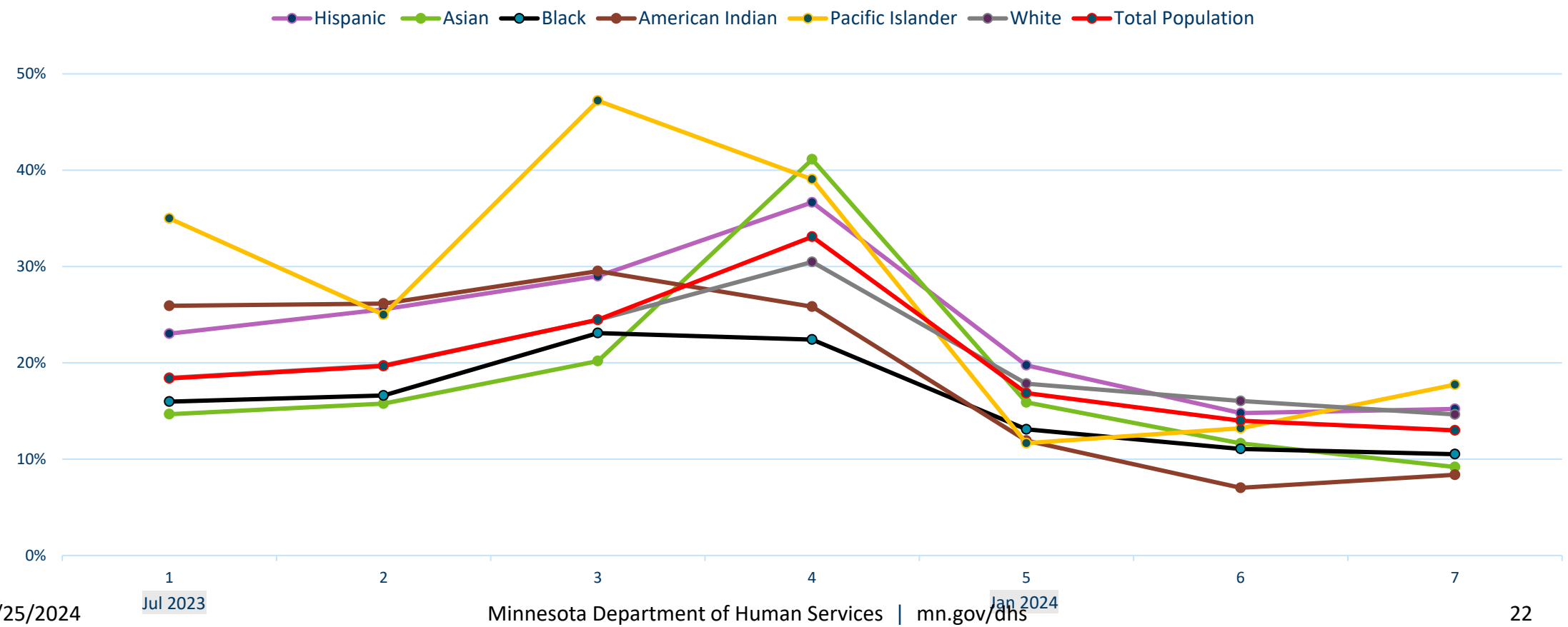
Unwinding disenrollment rates by race and ethnicity



Unwinding disenrollment rates by race and ethnicity for children

Data as of 3/4/2024

% of enrollees ages 0-17 disenrolled by race/ethnicity, July 2023 to March 2024 cohorts

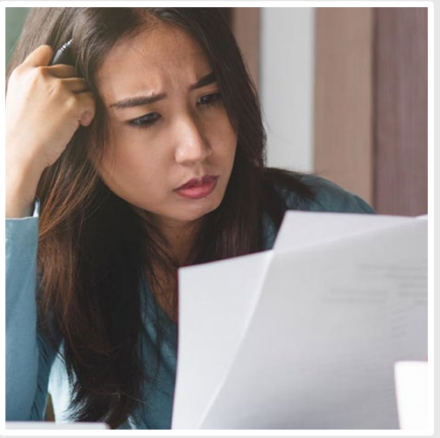


Health equity work

Investments in

Continuous eligibility for kids

MinnesotaCare coverage for undocumented Minnesotans



Cost sharing eliminated in Medical Assistance

IT systems

Comprehensive care and access: e.g., doulas and NEMT

Addressing disparities in birth outcomes

- Coverage for pregnant people for 12 months after giving birth
- Integrated Care for High-Risk Pregnancies
- Doula services

Looking ahead: re-entry waiver

Helping Minnesotans re-enter the community successfully after incarceration

- Provides services in the 90 days before a person re-enters the community.
- Services would include care coordination, prescription drug coverage, substance use disorder assessments and treatment, mental health assessments and treatment, family planning and other health care.

Thank You