DRAFT: Equitable Health Care Task Force Meeting Summary

Meeting information

- April 10, 2025, 10:00 a.m.-1:00 p.m.
- Urban Research and Outreach-Engagement Center (UROC)
- Plymouth Room 105
- 2001 Plymouth Ave. N.
  Minneapolis, MN 55411

Members in attendance

Sara Bolnick, Elizete Diaz, Marc Gorelick, Mumtaz (Taj) Mustapha, Laurelle Myhra, Miamon Queeglay, Sonny Wasilowski, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Task force members revised recommendations related to Meaningful Access and Whole-Person Care
- Task force members provided input into the engagement plan that will be implemented by the Alliant team

Key actions moving forward

- Task force Tyler Winkelman volunteered to further develop Primary Care and Whole-Person Care draft recommendations and share feedback with MDH.
- Laurelle Myhra will reach out to Megan Chao Smith regarding the Accountability draft recommendations, and share any updates with MDH.
- MDH and DeYoung teams will organize and share back task force's recommendations and summarize the April meeting.

Summary of Meeting Content and Discussion Highlights

Welcome

The task force was welcomed. The agenda was reviewed and the summary of the March retreat was shared.

Commissioner welcome

The Commissioner addressed the $200 million in rescinded grants, emphasizing the disproportionate impact on diverse and more recently hired staff, as well as on community organization grantees, framing that impact as an example of systemic racism. The loss of programs, staff, and innovation projects has left MDH struggling to maintain critical services, given that the monies rescinded was 25% of its budget.

Despite the challenges, the Commissioner conveyed determination, agreeing with task force members about the need for systemic integration of equity beyond isolated projects. She stressed the importance of evidence-based policies, transparency, and creativity, urging the task force to have the courage to talk to their own leadership about equity. She was appreciative that Minnesota continues to have interest in promising practices, and reaffirmed her commitment to doing what she can to protect MDH from further harm as the state legislature must balance a state deficit in coming years.

During the discussion, task force members acknowledged the discouragement and grief caused by the federal cuts, while also calling for continued urgency and innovation. Members emphasized the need to sustain equity work without reliance on special funding streams and questioned whether current systems can ever fully serve marginalized communities. The Commissioner affirmed these points, calling for a "both/and" approach—working within existing constraints while continuing to push for transformation. The task force discussed with the Commissioner the opportunity to address racism and do equity work without the same resources. Task force members thanked the Commissioner for her compassionate leadership and advocacy.

Recommendation development

The task force had a discussion to build upon the recommendations drafted at the March task force retreat, specifically, the Meaningful Access and Primary and Whole-Person Care recommendations. Prior to today's discussion, the MDH project team formatted and streamlined the content developed by the task force small groups. The facilitator walked through draft recommendations, asking the task force to provide feedback. Their discussion and feedback are summarized below.

Meaningful Access – Review of Draft Recommendations

- Telehealth and interstate licensure parity should be expanded. There is a shortage of mental health providers and a need for more providers of color and those serving rural and Native communities.
- Clarification is needed regarding the specificity of these recommendations.
    - MDH responded that the task force will determine the level of specificity as they continue to refine recommendations.
    - A task force member offered that the draft action steps provide more specificity for the broader recommendations.

- Recommendations should be organized or prioritized. Task force could pick a couple of highly impactful and long-term recommendations, a few low-cost actions for immediate implementation, as well as broader recommendations for when more funding is available. Categorizing recommendations could guide policymakers.
- A focus on long-term planning and recommendations is needed to withstand political changes, including alternative funding strategies such as taxing wealthier individuals and limiting tax exemptions.
- Bold, transformational changes are needed, while addressing root causes like social drivers of health and equity.
- It would be a disservice to prioritize recommendations based on the current climate without community feedback. Funding cuts are not new, and recommendations must address historical barriers that impede progress.
- Everything can be recommended to be done immediately.
- Public health funding will be limited in the near future. Priorities should be clear to avoid overwhelming policymakers.
- Integrating equity into all systems is critical, as well as addressing barriers to equity.
- Efforts toward licensure for interpreters, including community accountability, must continue despite funding shortages.
- Recommendations should be categorized by legislative bills.
    - MDH shared that the UMN research team noted promising policies and practices in the resource guide they produced that could bolster the task force's recommendations.

MDH presented other recommendation ideas from the task force that the task force had not included in their draft recommendations from the March retreat and asked whether the task force would like to include them. Task force members discussed the following:

- There are more creative ways to provide transportation services other than Community Health Workers.
- Remote monitoring should be incorporated, as many organizations are already working toward values-based care, and more patients can be supported at home, especially in rural areas.
- There are uncovered areas that contribute to health disparities. For example, there are efforts to start a birthing center for Native people in Minneapolis. Many high-risk individuals—due to historical trauma and poor services—don't qualify for birth center care. Because of these systemic issues, the team is considering not billing at all and instead creating a tribally licensed and guided medical system, expressing that "the Western system is just so bad." There is a desire to move beyond, "this really awful system that's not working."

- Need to address this on a global scale, not narrowly focusing on small aspects such as in-home monitoring. Integrating community health workers would give us a better understanding.
    - MDH offered the idea of making broader recommendations that could encompass smaller issues
    - Some task force members liked this idea because they don't want to be too prescriptive with recommendations, ensuring providers and other implementers of the recommendations can be creative. Some issues can be framed as examples within a broad recommendation.

Primary and Whole-Person Care – Review of Draft Recommendations

The task force had very limited time to review and discuss these draft recommendations. Task force member Tyler Winkelman volunteered to further review and revise the recommendations, and send them to MDH. Two resources were provided by task force members to consider in this review:

- Collaborative care: https://aims.uw.edu/collaborative-care/
- Standards for video remote interpretation services (including size of screens): https://www.nad.org/about-us/position-statements/minimum-standards-for-video-remote-interpreting-services-in-medical-settings/

The task force was encouraged to continue to look at the draft recommendations, especially areas highlighted in yellow that could use clarification.

Next steps

Task force members agreed that MDH may continue to refine the task force's draft recommendations based on today's feedback and discussion. MDH will share the next version of the recommendations with the task force for further input and refinement. MDH will also work with the UMN research team to incorporate content from the resource guide they developed for the task force into the next version of the draft recommendations. MDH provided the resource guide to the task force for the March retreat and again for the April meeting.

It was shared that the next task force meeting will focus on Workforce and Accountability draft recommendations. The Workforce Workgroup had no additional changes to the revised recommendations. The task force members involved in drafting the accountability recommendations during the March retreat will touch base and communicate back to MDH about whether they have any updates.

Community Engagement

Alliant presented potential community engagement objectives (listed below), methods for engagement such as listening sessions, focus groups, or by plugging into existing meetings, and who could be engaged, such as patients, community groups and others. A list of stakeholders

has already been drafted, drawing from groups and individuals previously identified by the task force. Alliant incorporated many of these stakeholders into their draft engagement plan and presentation, reflecting the input already provided by task force members. They presented examples of how each stakeholder group might be most appropriately engaged, given their perspectives.

Community engagement objectives:

- Confirm the task force's recommendations
- Test assumptions the task force has about recommendations and outcomes they would produce. What would actually change behavior, build trust with the health care system? Would this move engagement? If these recommendations went into effect, would the public have trust in the health care system? Which recommendations are most important to change health equity?
- Ask what is missing from the recommendations
- Ask what health care equity models are/not working and why
- Invite feedback from organizations expected to implement task force recommendations. What are you going to need? What will it take for you to implement and right-size recommendations? What will you need from MDH? How will you balance recommendations with other constraints?

Alliant requests the following information from the task force to move forward:

- What form of recommendations will be shared with stakeholders? Will there be different versions for different stakeholder groups?
- Be thinking about what will be done with feedback and how to describe this to stakeholders
- An alternative means of input will be available for those unable to attend a community engagement event. Need to share details when inviting to engagement events.
- Review of objectives, activities and stakeholder groups
- Member connections to any of the listed groups to facilitate introductions and support engagement events

Task force members gave brief feedback, including the following:

- The importance of engaging broader Tribal community members together beyond Tribal Health Directors, including elders and other leaders, suggesting direct outreach or invitations for participation.
- Include more independent community providers and Federally Qualified Health Centers (FQHC) beyond NorthPoint, and a broader range of payers, not just UCare.

- Connect with Federally Qualified Health Centers (FQHC) community and patient boards, with a member clarifying that the Minnesota Association of Community Health Centers (MNACHC) represents FQHCs, including NorthPoint.

MDH encouraged the task force to suggest community groups that may be interested in participating in engagement activities. MDH is familiar with payers and large provider organizations, and can contribute those suggestions for the next draft.

Alliant will take insight from today to revise engagement plan and invite additional feedback from the task force, with the goal of finalizing the plan in April.

Close

A graphic of the timeline and remaining work was shared. There was some support from task force members for holding another full-day in-person retreat. MDH will move forward with a poll to further gauge interest and possible dates. At this retreat, the task force would immerse themselves in the full set of near-final recommendations to work through any open-ended items and assess their level of agreement with each recommendation.

The task force was reminded of a working session set aside on April 18 from 11:00-12:00 that could be used to continue to revise recommendations and/or collaborate with MDH. The task force did not express a need for this working session and indicated that it may not be necessary to retain this session.

A meeting summary is to follow. The task force was reminded about the next task force meeting: on May 20, from 10:00 – 1:00 p.m. In this meeting, task force members should expect to:

- Discuss and give feedback on draft recommendations regarding workforce and accountability draft recommendations.
- Discuss community engagement with Alliant Consulting

Next Steps

- Task force members agreed that MDH should continue refining the draft recommendations based on the discussion and feedback.
- MDH will share an updated version of the draft recommendations with the task force for additional input.
- MDH will collaborate with the UMN research team to integrate relevant content from the task force's resource guide to support draft recommendations.
- Task force members who drafted the Accountability recommendations during the March retreat will reconnect and inform MDH if they have any updates. MDH offered to compile draft Accountability recommendations based on retreat materials if the members do not propose further revisions.

- Alliant will incorporate Task Force feedback and send the draft engagement plan to Task Force members for review via email.
- Alliant to send finalized engagement plan in April.

Contact to follow-up

With questions or comments about the Equitable Health Care 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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04/24/2025

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DRAFT: Workforce Recommendations

—Navigation key—

- Normal text = Task Force Workforce Recommendations Station output from March retreat.
- Underlined, *italics*, ~~strikeout~~ text = Suggestion from MDH based on health care policy knowledge or examples from UMN Research Team.

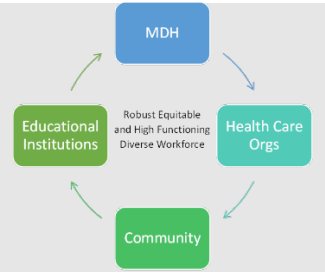
Workforce Work Group Recommendations Guiding Principles

The Workforce Work Group has identified four "high yield recommendations" and a set of sub-recommendations/tactics. Assumptions for these recommendations during implementation:

- MDH will partner with health care organizations to apply rigorous change management practices.
- MDH will connect on implementation with the Minnesota Health Care Workforce Advisory Council.

Group	Role	How
MDH	Create standards and best practices Provide resources	Developing guides, playbooks, and models Provide funding Align MDH accreditation based on action
Health Care Organizations	Implement best practices	Embed into existing structures, processes, and workflows
Community Organizations and Groups	Inform best practices Inform implementation Support implementation	

Leverage the **SHIP Model** as a basis for this approach



Objective 1: Foster workplace inclusion, belonging, safety, and well-being to encourage retention of current diverse workforce members

High Yield Recommendation: Minnesota Department of Health to create a model for inclusion, belonging, safety, and well-being including implementation guidance and resources for health care organizations.

Rationale/Background/Evidence

More than 8 in 10 employees consider psychological safety one of the most valued aspects of the workplace.[1] 9 out of 10 employees want their employer to value their emotional and psychological welfare – and provide relevant support.[2] 60% of employees with low resilience and low psychological safety feel burned out, and 34% are thinking about quitting their job. On the other hand, only 5% of highly resilient employees who feel psychologically safe report feeling burned out, and just 3% are considering quitting.[3]

Employees from underrepresented groups don't feel a sense of belonging in the workplace. ERGs enable organizations to create products and services that resonate with a broader range of customers. This not only enhances organizational reach but also strengthens brand loyalty and reputation.

Sub-Recommendations (Owner)	**Short-term**	**Mid-term**	**Long-term**
1.1 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. 1.1.1 Reauthorize and augment funding for MDH's Workplace Safety Grants for Health Care Entities program that supports long-term improvements in safety, stability, and retention of staff in health care settings. *Rationale: This program has been in high demand but funding ends in FY 27. Grants are awarded to increase safety measures, establish or expand programs to train staff on de-escalation and positive support services in health care settings, and preventing workplace violence. A total of $4,400,000 was allocated for this program through June 30, 2027. In its first year, program has served 35 grantee organizations.*	x		

[1] Employee Disillusionment Report, Oyster HR, 2023
[2] 2023 Work in America™ Survey, American Psychological Association, 2023
[3] Psychological Safety at Work: The Remote Kids are Alright (Maybe Even Better), meQuilibrium, 2022

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
• *To date, the funds have been spent on addressing the physical safety needs of staff and patients, including projects to enhance door security and control clinic access, the addition of internal/external security cameras and lighting to monitor for incidents of violence. MDH is currently collecting the following data from grantees:* • *Changes in perception of safety at work resulting from grant-funded projects.* • *Change in likelihood of staff staying at their current organization following implementation of grant-funded projects.* • *Staff confidence in their ability to prevent, respond to, seek support following, and/or report workplace safety incidents resulting from grant-funded projects.* • *Support for staff and patients to prevent, respond to, recover from, and/or report workplace safety incidents in a timely and satisfactory manner resulting from grant-funded projects.* • *Number and percentage of impacted staff who reported using the grant-funded project to prevent, respond to, or report a workplace violence incident.*			
1.2 Recommend leveraging employees and employee resource group members from underrepresented groups in the cocreation of workforce equity strategies designed to meet their needs.		x	
1.3 Recommend strategies to drive leadership accountability for workforce equity outcomes.			x

Engagement Stakeholders

- People leading diversity, equity, and inclusion
- Members of employee resource groups
- Human Resources employees
- Labor unions representing health care employees

Objective 2: Enhance workforce skills and cultural responsiveness

High Yield Recommendation: Minnesota Department of Health to create a mandated or incentivized training for **all** healthcare workers. Accrediting bodies can adapt it to their field but need to provide the same content. Include content for members of healthcare organization boards of directors.

Rationale/Background/Evidence

TBD

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
2.1 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.	X		
2.2 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. Continuing education requirements may include courses on diversity, practice-based cultural concordance models.		X	
2.3 Recommend mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.			X
2.4 Outline solutions to address the narrowness of specialization, such as cross-training opportunities, mentorship programs, and professional development resources.			X
2.5 Recommend workforce equity core competencies for employees and leaders.	X		
2.6 Recommend workforce equity strategies that are informed by the communities being locally served.	X		
~~5.4~~ 2.7 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.	X		
~~7.1~~ 2.8 Require and implement comprehensive training and continuing education for health care providers (link training to licensure requirements) and other employees (e.g., patient navigators, care coordinators, customer service representatives) to develop essential soft skills including: • Cross-cultural understanding • Cultural competency • Cultural humility • Cultural responsiveness • Culturally appropriate care • Culturally congruent care • Culturally-specific health needs • Diversity, equity, inclusion, and belonging (DEIB) • Effective communication • Eliminating biases and discrimination	X		

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
• Empathy • Implicit bias • Mitigation of unconscious bias • Patient-centered care • Teamwork • Trauma-informed care • training programs.			
~~7.2~~ 2.9 Cultural Competency Training: Rapidly implement training on eliminating biases and discrimination for health care workers. Partner with local organizations or universities to design culturally appropriate training programs in the short term.	X		
~~7.3~~ 2.10 Use learnings from experiences training providers (such as JAMA article on mandated implicit bias training).	X		
~~7.4~~ 2.11 Partner with local organizations or universities to design culturally appropriate training programs.	X		
~~7.5~~ 2.12 Require trauma-informed, equity training for intrapartum and post-partum care.	X		
~~7.7~~ 2.13 Implement training and education for providers that cultivates better attitudes toward Medicaid patients.	X		
~~10.2~~ 2.14 Create a culture of precepting at academic teaching hospitals systems like (e.g., programs at Essentia and M Health Fairview). *Examples:* • *Guarantee a share of provider salary (usually tied to RVUs or productivity) in lieu of clinical training, supervision/precepting.* • *Develop training and guidance for first-time clinical supervisors, and consider offering non-monetary recognition to acknowledge their time investment.* • *Leverage knowledge about graduate medical education (GME) financing and caps to maximize revenue from resident to ensure decisions to expand training result in financially stable outcomes.* 2.14.1 Financial and infrastructure support to develop and sustain clinical training programs, hiring and supporting faculty, community involvement in resident recruitment and retention, in recognition of the responsibility of all to participate in developing the next generation of providers.	X		

Engagement Stakeholders

TBD

Objective 3: Address workforce inequities

High Yield Recommendation: Minnesota Department of Health to outline a framework and model to help healthcare organizations collaborate with stakeholders to examine and address systemic barriers that contribute to healthcare workforce inequities. Include guides and implementation resources.

Rationale/Background/Evidence

TBD

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
3.1 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.			X
3.2 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.	X		
~~4.1~~ 3.3 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. 3.3.1 Increase funding for MDH's International Medical Graduate Residency Grant Program authorized by Minnesota Statutes Section 144.1911 to support immigrant international medical graduates (IIMGs) who are willing to serve in rural or underserved areas of the state. This grant program provides funding to accredited primary care residency programs in Minnesota to support the training of IIMG residents. IIMGs who accept a grant-funded residency position enter into an agreement with MDH to provide primary care for at least five years in a rural or underserved community in Minnesota after graduating from the residency program. IIMGs also make payments into a revolving account that contributes to sustaining MDH IMG assistance programs, including this residency grant program. 3.3.2 Replicate MDH's IMG program to serve other foreign trained health care professionals such as internationally trained dentists, pharmacists to provide supports for clinical training and explore alternate licensure pathways for them. ~~6.5~~ 3.3.3 Increase the utilization of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.		X	
~~4.2~~ 3.4 Recommend best practices for collaborating with educational institutions and community organizations to remove barriers to entering the healthcare workforce.		X	

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
3.4.1 Broaden the membership of admissions committees for medical/dental/pharmacy/nursing schools and other health professional education programs to include staff with expertise in state workforce needs. 3.4.2 Encourage health professional education programs to take a holistic approach when screening for potential candidates vs. over reliance on standardized scores such as MCATs. 3.4.3 Leverage remote learning modalities to grow health-related career and technical education to reach non-traditional learners such as those in greater MN, adults considering second careers.			
~~4.3~~ 3.5 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. Note – Minnesota's immigrant international medical graduates have consistently shared that they do not find MN an immigrant-friendly state. Candidates aspiring to match into a MN-based residency program face discrimination during the interview and selection process.		X	
~~5.2~~ 3.6 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. 3.6.1 Support and expand programs focused on increasing culturally specific health care professional training programs, such as UMD's Native Americans in Medicine program.		X	
~~5.3~~ 3.7 Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups.			X
~~8.2~~ 3.8 Educate K-12 students on medical professional pathways through internships, camps, and other pre-professional experiences. *Examples:* • *Boost funding to MDH's summer health care internship program. This program has an annual appropriation of $300,000. In FY 24 and FY25, this program funded 275 internships at 97 unique host facilities representing 51 Minnesota counties. The number of interested students and host facilities consistently exceeds available funding.* • *Amend the existing language (MN Statutes Sec. 144.1464) to require host facilities to provide a (suggested) minimum 8-hr mentorship with a health care provider for each intern, in a direct healthcare delivery role. Alternatively, add language to require the MDH Grantee to provide a mandatory regional, virtual 'career*			X

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
days' presentation for all participating interns, where a variety of direct care providers are available to discuss educational requirements, wages, typical tasks, and answer other intern questions about specific career tracks. • *If postsecondary students participate, focus on those enrolled in Minnesota colleges. (SHCIP allows students attending college outside of MN but still claiming MN residency to participate.) There is strong demand among MN college students, and they are more likely to remain in MN after graduation.* • *Boost funding to MN State's Scrubs camp, MDH's summer health care internship program, UMN's pre-health advising programs.* • *Focus on high school students, to provide earlier exposure to health care careers before students have chosen a career path.*			
~~8.3~~ 3.9 Expand the development and use of partnerships between K-12 schools and health care providers to sponsor Community Health Worker (CHW) training and increase the pipeline of diverse health care workers (example: WELFIE).			X
~~8.4~~ 3.10 Expand dual-training pipeline programs. *Example: https://www.dli.mn.gov/business/workforce/health-care-services*			X
~~8.6~~ 3.11 Continue funding the MDH's Mental Health Cultural Community Education Grant program that supports BIPOC mental health supervisors. *Example: Continue funding for MDH's Mental Health Cultural Community Continuing Education Grant Program, authorized under MN Statutes 144.1511 Sec. 144.1511 MN Statutes. The program supports continuing education for mental health professionals from communities of color and underrepresented communities to become supervisors for individuals pursuing mental health licensure. ItT has an annual appropriation of $500,000, and has served 432 mental health professionals over the past three years.* *Trainees who have graduated from this program have shared their enthusiasm for the opportunity. We are now tracking the number of professionals who have applied for supervision recognition with their boards. Current grantees are experiencing smaller enrollment numbers and believe it is due to the small number of BIPOC and underrepresented providers in MN; many of the eligible providers may have already completed this coursework. More efforts need to be targeted upstream to recruit more BIPOC candidates into mental health careers and exposing them to supervision.*	X		

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
~~8.7~~ 3.12 Track the retention of health care professionals in underserved areas to identify gaps and opportunities to improve retention.		X	
~~9.1~~ 3.13 Improve financial support for health care education including ~~Increase the use of~~ health care loan forgiveness, grants, and scholarships.	X		
~~9.2 Offer more scholarship funding for potential health care workers to enter the profession.~~ 3.14 Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce. *Example: Quadruple/Increase funding to MDH's traditional loan forgiveness program (this does not include hospital nursing loan forgiveness – that is a separate program). In its last round, MDH awarded 9pprox.. $5millon through FY 26. The total requested amount was $25 million.* *Requested but unawarded amounts due to insufficient funds: $4.8 million requested by physicians, followed by mental health providers ($3.7 million), rural pharmacists ($2.7 million), psychologists ($2.3 million), dentists ($2 million).* *Example: MDH's one-time pilot program with a budget of $550,000 awarded to four training institutions to provide $25,000 scholarships to 20 students enrolled in four professional programs: APRN, DT/ADT, MH, and PA. Each scholarship recipient was selected by their training program through a competitive process and has committed to working in a rural area of Minnesota for two years after graduating. Nine rural counties are represented as employment locations among these 10 scholars. Future programmatic considerations include: services for counseling on financial aid implications for scholarship recipients; readiness for rural work; consequences for scholarship recipients who do not fulfill their post-graduation service commitment.*	X		
~~9.3~~ 3.15 Ensure ~~that some~~ a significant portion of NorthStar Promise funding is dedicated to students seeking health care degrees.	X		
~~9.4 Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.~~ *See 3.14*	X		
3.16 Renew and increase funding for the Mental Health Grants for Health Care Professionals program in recognition of the high demand for this program, the urgent needs it addresses, and the early signs of its success.			

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
Rationale: The program received three appropriations of $1,000,000 in fiscal years 2023-2025. For the 2023 grant cycle, MDH ORHPC received 60 applications requesting over $4.6 million, and 13 were awarded grants. In the 2024 grant cycle, MDH ORHPC received 48 applications requesting nearly $5.7 million, and 12 were awarded grants. Program has served 25 grantee organizations; in the first year of the program, nearly 2,500 health professionals participated in grant-funded programs. Early evaluation results and feedback from grantees after the first cycle of grants have been strongly positive – grantees have seen success with employee wellness programs and peer-to-peer support programs in a range of health care settings, including urban and rural hospitals and clinics, air medical transport, mental health clinics, and long-term care facilities. Many health care professionals participating in grant programs have reported feeling more supported by their employers, supervisors, and peers, and better equipped to recognize and respond to mental health concerns among their colleagues. Some have described how the grant programs have allowed them to do their jobs more effectively and impacted their decision to stay in their health care role.			

Engagement Stakeholders

TBD

Objective 4: Workforce optimization

High Yield Recommendation: Health Care organizations to diversify who and how care is delivered to make it more effective, accessible, comprehensive, holistic, and culturally congruent for patients and members.

Rationale/Background/Evidence

TBD

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
~~6.0~~ 4.1 Identify workforce gaps and barriers	X		
~~6.1~~ 4.2 Address workforce shortages, especially focused on addressing rural access issues (e.g. dental therapists).		X	

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
6.1.1 Establish an independent Minnesota Health Care Workforce Advisory group to provide objective health care workforce research and data analysis; collaborate and coordinate with other entities on health care workforce policies; recommend appropriate public and private sector policies, programs, and other efforts to address identified health care workforce needs. *Example: SF2322/HF3087 in the 2025 legislative session (Minnesota Health Care Workforce Advisory Council) Or an Executive Order authorizing the establishment of a non-lapsing group with appropriate funding.*			
~~6.2~~ 4.3 Expand the dental workforce, particularly dental therapists and hygienists. *Examples:* • *MDH should convene an oral health workforce work group to understand barriers and enablers to growing the advance practice providers.* • *Encourage and expand the use of collaborative practice dental hygiene model to deliver care in non-traditional settings. This will incent more public health-minded dental hygienists to enter this field.* • *Explore scope of practice changes that allow dental hygienists, dental therapists, and non-dental professionals such as school nurses and CHWs to offer oral health services to the full extent of their training and licensure.* • *To grow the rural oral health workforce, Create opportunities for clinical training experience and exposure to rural oral health needs through pipeline programs, on-job training, rotations or opportunity for professional advancement.*	X		
~~6.3~~ 4.4 Improve reimbursements and other interventions to support an increased health care workforce. *Examples:* • *Pilot a loan forgiveness program as a recruitment incentive to sites that are in health professional shortage areas.* • *Create a permanent program with a budget of $550,000 to award funds to provide $25,000 scholarships to 20 students enrolled in an APRN, DT/ADT, MH, or PA professional program who commits to working in a rural area of Minnesota for two years after graduating.*	X		
~~6.4~~ 4.5 Decentralize physicians where evidence supports it.		X	

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
Revisit/expand the scope of practice for professions with diverse representation and increase reimbursement accordingly.			
~~6.5~~ 4.6 Increase the utilization of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.	X		
~~6.6~~ 4.7 Increase the utilization of Health Navigators from underrepresented communities (ex. Hmong Culture Care Connection, Cultural Society of Filipino Americans, SEWA-AIFW). ~~6.8~~ Community Health Workers: More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.	X		
~~6.7~~ 4.8 Provide legislative authorization to MDH and DHS to develop opportunities to advance and sustain the Community Health Worker (CHW) workforce, and establish a state office to implement CHW policies and coordinate stakeholders. Medicaid should recognize Community Health Representatives (CHRs) (INS program of CHW-like providers) without requiring duplicative training. Enable CHRs to bill for services as CHWs in Minnesota, especially given the historical and community-specific role they serve. (https://www.ihs.gov/chr/)	X		
~~6.8 Community Health Workers: More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.~~ *See 4.7.*	X		
~~7.6~~ 4.9 Increase the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively. *See 3.11.*	X		
~~7.9~~ 4.10 Residency Programs in Community Settings: Establish residency and fellowship programs for health professionals to work in underserved, rural, and tribal communities to ensure that they are exposed to the specific needs of these populations. *Examples: Seed funding to explore residency, fellowship and clinical training opportunities, readiness and barriers at MN's FQHCs and CHCs. These are community-based health care delivery centers that primarily cater to the underserved and under/uninsured populations. Training at such centers will expose health professional education students to the needs of such populations.*	X		

Sub-Recommendations (Owner)	Short-term	Mid-term	Long-term
~~7.10~~ 4.11 Diversity in Health Education: Introduce long-term changes to health professional training programs to ensure they reflect the diversity of the populations they serve. This could include more scholarships for people from underrepresented communities, more recruitment into health careers from those communities, and ensuring a robust pipeline into health care fields.	X		
~~7.11~~ 4.12 Support the University of Minnesota and CentraCare expansion of medical training programs for rural physicians.			

DRAFT: Accountability Recommendations

—Navigation key—

- Normal text = Task Force Accountability Recommendations Station output from March retreat.
- Underlined, *italics*, ~~strikeout~~ text = Suggestion from MDH based on health care policy knowledge or examples from UMN Research Team.

Recommendation 1: Ensure full and equitable health care coverage for American Indian communities and Tribal citizens in Minnesota.

Health care coverage and access for American Indian communities and Tribal citizens is fragmented and incomplete, and enrollment in state and federal programs is cumbersome. As part of implementing the federal Indian Health Care Improvement Act, access to coverage should be automated to reduce barriers to enrollment for American Indian communities and Tribal citizens.

Sub-Recommendations
1.1 Full health care coverage for Tribal communities and automatic coverage Tribal members and children • Include automatic coverage Tribal members and children 1.1 Tribal members and children should be automatically enrolled in a health care plan that provides full coverage (e.g., through Medicaid or MinnesotaCare).

Recommendation 2: Minnesota should strengthen and harmonize its approach to health care patient protection.

Patients' awareness of, and ability to, submit grievances, complaints and appeals about care quality, treatment, and coverage decisions are incomplete and fragmented. Patient protection opportunities to make complaints should be more comprehensive, accessible, transparent, and responsive. These systems should be enhanced and coordinated by offering multiple, user-friendly ways for patients to file complaints—such as online platforms, hotlines, and in-person support—while ensuring language accessibility and confidentiality. This includes ease of navigation to the right resource for the type of issue enrollees are experiencing, transparency about what their rights are, and ensuring language accessibility

and confidentiality. Streamlining the review process, providing regular updates to complainants, and publicly reporting outcomes can build trust and accountability. Using complaint data to identify systemic issues and drive policy improvements could ensure that patient voices lead to meaningful change in healthcare quality, safety and care experiences.

Sub-Recommendations
~~1.1.2~~ 2.1 Minnesota should establish a grievance process, a fund to provide free legal services to patients with grievances about the health care system, an Accountability Group of patients and workers.
~~1.1.3~~ 2.2 Minnesota should establish a fund to provide free legal services to patients with grievances about the health care system and ensure compensation is tied to improved health outcomes.
~~1.2.1~~ 2.3 Establish an Accountability Group of patients and workers, supported by the Health Equity Advisory and Leadership (HEAL) Council, to handle grievances and oversee health care accountability. • citizen/advocacy > expand beyond patient and worker to include those without access Tribe, LGBTQ
2.4 Minnesota should establish an office that assists consumers and patients and provides free legal services. *Example: A proposed bill in the Minnesota Legislature (SF 1567) sought to establish an Office of Patient Protection. This office would assist consumers with access to and quality of health care services, aligning with the broader goal of improving accountability and consumer protection: SF 1567 as introduced - 94th Legislature (2025 - 2026).*
2.5 Minnesota should establish an office to coordinate the work of entities that field patient complaints so there is one consumer-friendly entry point for all patients. Entities include the Minnesota Department of Health Office of Health Facility Complaints, Minnesota health licensing boards, Minnesota Department of Health HMO Enrollee External Review and Complaint Process, Minnesota Department of Commerce Consumer Response Team, Minnesota Department of Human Services Office of Inspector General, the Minnesota Department of Human Services Program Integrity Oversight Hotline, and the Minnesota Attorney General's Office.

Recommendation 3: Health care in Minnesota should have community co-leadership and equity-focused oversight.

Health care providers and payers must customize health care to address each community's unique needs, focusing on social determinants of health (SDOH), encourage collaboration between health care systems and community organizations, and set clear, measurable indicators for success in health outcomes, patient satisfaction, and cultural concordance; increase transparency to community accountability measures, track changes (e.g., hospital needs assessments, increase focus on goals)

Sub-Recommendations
3.1 Utilize community health needs assessments as part of accountability (linked to IRS tax-exempt status requirements). 3.2 Strengthen the State's regulatory role in population health expectations, impact, and accountability of health plan and provider systems.
3.3 Involve communities in co-designing health care evaluation and delivery, including non-clinical treatments that reflect needs and values of each community. 3.4 Create patient and community advisory boards to provide ongoing feedback on health care policies and ensure cultural relevance. 3.5 Establish patient and community advisory boards to provide ongoing feedback on health care policies and ensure cultural relevance. This should include co-designing health care evaluation and delivery, non-clinical treatments that reflect community needs and values.
3.6 Support communities in playing a larger role in shaping local health care systems and local partners by prioritizing resources such as walkable spaces, public health services, and community organizations.
3.7 Ensure that cultural competency information is available to patients (e.g., provider profile info).
3.8 Require managed care organizations to fund community-based partnership staffing to increase managed care organizations' capacity for coordinating health-related social needs services.

Recommendation 4: Oral Health Care

Sub-Recommendation
~~1.3.3~~ 4.1 Improve Medicaid reimbursement to encourage more ~~dentists~~ dental care providers to participate and increase access to oral care. • + add providers + market rate or higher

Recommendation 5: Minnesota should strengthen data infrastructure to advance health care equity.

Sub-Recommendations
5.1 Align with Health care Effectiveness Data and Information Set (HEDIS) developed by NCQA. 5.2 Intentionally leverage the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) to advance health equity. 5.3 Support the use of the Minnesota Framework for Health and Equity Measurement and Improvement. 5.4 MDH should expand their evaluation of managed care organizations and their plans. 5.5 Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ameliorate disparities in health outcomes.
5.6 MDH should implement recommendations from the HEAL Council to standardize and disaggregate data. MDH should create a plan and action steps for implementing standards on data collection, data analysis and data dissemination. Within this plan, data disaggregation standards are needed, specifically regarding race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), disability status, and social determinants of health.