DRAFT: Equitable Health Care Task Force Recommendations

Contents

Ensure System Accountability

Recommendation 1.1 Ensure full and equitable health care coverage for American Indian communities and Tribal citizens in Minnesota.

1.1.1 Tribal members and children should be automatically enrolled in a health care plan that provides full coverage (e.g., through Medicaid or MinnesotaCare).

Recommendation 1.2 Minnesota should strengthen and harmonize its approach to health care patient protection.

1.2.1 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 (MDH) 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.

1.2.2 Minnesota should establish an office that assists consumers and patients with access to and quality of health care services, and provides free legal services.

Recommendation 1.3 Health care in Minnesota should have community co-leadership and equity-focused oversight.

1.3.1 Strengthen the State's regulatory role in population health expectations, impact, and accountability of health plan and provider systems.

1.3.2 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.

1.3.3 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.

1.3.4 Ensure that cultural competency information is available to patients (e.g., provider profile information).

1.3.5 Require managed care organizations to fund community-based partnership staffing to increase managed care organizations' capacity for coordinating health-related social needs services.

Recommendation 1.4 Minnesota should strengthen data infrastructure to advance health care equity.

1.4.1 Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ameliorate disparities in health outcomes.

1.4.2 The Minnesota Department of Health (MDH) should implement recommendations from the Health Equity Advisory and Leadership (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, sexual orientation and gender identity, disability status, and social determinants of health.

Meaningful Access

Recommendation 2. Minnesota must ensure all persons in Minnesota have comprehensive health care insurance, timely access to needed health care services, and a baseline understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

Recommendation 2.1 Minnesota should implement universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota.

Recommendation 2.2 Minnesota should support a health care delivery system that patients can access where and when they need it.

2.2.1 Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools and mobile care models.
2.2.2 Create a system for patients that enables patient/provider matching so patients can choose providers they may identify with and/or provide the services they need.
2.2.3 Require and incentivize providers to offer flexible hours for evening and weekend appointments.
2.2.4 Expand school-based health services, including oral health screenings and preventive services.
2.2.5 Expand primary prevention programs through healthy youth development programs.
2.2.6 Enhance policies for coverage of in-home monitoring systems that integrate with health care delivery systems.
2.2.7 Expand use of common referral approaches among cross-sector partnerships.
2.2.8 Expand the use of Community Health Workers or Patient Navigators to provide wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner.
2.2.9 Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics and hospitals.

Recommendation 2.3 Minnesota should establish statewide standards to ensure timely, consistent, and culturally appropriate interpretation and translation services in health care.

2.3.1 Standardize translation services through licensing of translators.

2.3.2 Establish a statewide policy for hospitals to buy into a system of independent contractors for access to interpreter services.

2.3.3 Ensure consistency in reimbursement by payers for interpretation and translation services.

2.3.4 Provide interpretation services for patients who need this immediately upon arrival at a health care facility.

2.3.5 Ensure that patient-facing education and materials are vetted with bilingual clinicians to ensure cultural context is taken into account for some of the languages that are not easily translatable from English, such as Hmong, Somali, and others with different health paradigms.

2.3.6 Require after-visit summaries to be translated, written in plain language, and include after care and follow-up instructions.

2.3.7 Develop a centralized hub for providers to access vetted translated materials in commonly spoken languages across Minnesota to promote consistency and reduce provider costs.

2.3.8 Require providers to adhere to the National Association for the Deaf's, "Minimum Standards for Video Remote Interpreting Services in Medical Settings."

Recommendation 2.4 Minnesota should expand inclusive and accessible telehealth by investing in broadband infrastructure, mobile care, and phone-based services to ensure equitable access in rural and underserved communities.

2.4.1 Expand telehealth and mobile health services especially for rural and underserved areas, implementing technology to provide health care access where there are fewer providers can be a low-cost, immediate solution.

2.4.2 Continue support for audio-only telehealth for people using Medicare and Medicaid, especially in rural areas, where reliable internet access is limited and phone-based care may be the most equitable option.

2.4.3 Develop infrastructure and funding strategies to expand broadband access in rural communities, ensuring telehealth is equitably accessible across the state.

Recommendation 2.5 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.

2.5.1 Establish a cross-agency reimbursement system for transportation and transportation coordination services, using models like Head Start, to reduce access disparities and support equitable health care delivery [e.g., Department of Human Services (DHS), Minnesota Department of Health (MDH), Minnesota Department of education (MDE)].

2.5.2 Expand non-emergency medical transportation benefits under Minnesota Department of Human Services (DHS)/Medicaid.

2.5.3 Ensure that transportation services meet all patient needs (e.g., car seats, adaptive equipment).

Recommendation 2.6 Minnesota should strengthen patient health literacy.

2.6.1 Establish state-wide health literacy and digital literacy education.

2.6.2 Establish a system of patient-owned electronic health records to facilitate care coordination and shared understanding of patient needs.

2.6.3 Develop partnerships with providers, communities, and others to advance health literacy.

2.6.4 Deliver health education and services in community spaces, such as schools, libraries, and other trusted local venues, particularly in Greater Minnesota, to address access gaps and avoid default reliance on telehealth.

2.6.5 Reimburse for patient navigators to help patients understand coverage, billing, and out-of-pocket costs.

Recommendation 2.7 Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.

2.7.1 Increase reimbursement rates for mental and behavioral health services to ensure they are equitable with physical health care, thereby improving provider participation and patient access.

2.7.2 Explore and invest in alternative or supplemental funding streams—such as state surplus funds, community reinvestment strategies, community benefit—to support health care access for populations not covered by public payers, including undocumented immigrants.

2.7.3 Align funding strategies with access goals by addressing regulatory and reimbursement barriers that limit provider participation, particularly for patients enrolled in public programs.

Bolster Primary and Whole-Person Care

Recommendation 3. Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages and events.

Recommendation 3.1 A re-envisioned primary care system should include the integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally concordant care.

3.1.1 Require health care organizations to expand primary care.

3.1.2 Add dental coverage as an essential benefit for adults.

3.1.3 Fund and implement the Collaborative Care Model of integrated behavioral health in primary care.

3.1.4 Require primary care clinics to treat opioid use, alcohol use with FDA approved medications.

3.1.5 Integrate traditional healing practices into clinic education and practice guidelines in a comprehensive way in partnership with indigenous and cultural health practitioners.

Recommendation 3.2 Minnesota should invest in team-based primary care models that coordinate activities with public health.

3.2.1 Design, implement, and maintain a shared directory of social needs resources.

3.2.2 Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care providers and payers.

3.2.3 Incorporate funding for community health workers (CHWs) into state initiatives to address social determinants of health/health related social needs, community care hub infrastructure.

3.2.4 Fund coordination between primary care and public health to improve population health outcomes.

3.2.5 Fund social workers, community health workers (CHWs), and licensed alcohol and drug counselors (LADCs).

Recommendation 3.3 Minnesota should adopt reimbursement and payment models that will support investments in primary care.

3.3.1 Require commercial and public payers to allocate a required proportion of dollars to expanded primary care (i.e., Primary Care Investment Ratio).

3.3.2 Improve Medicaid reimbursement to encourage more dental care providers to participate and increase access to oral care.

3.3.3 Update existing Medicaid reimbursement rates and mechanisms for Health Care Homes care coordination services to reflect the true costs of service.

3.3.4 Explore opportunities to increase funding, resources, support for primary care with a focus on preventive care and culturally appropriate interventions that meet patients where they are.

3.3.5 Provide reimbursement for integrative medicine.

Recommendation 3.4 Minnesota should modernize data sharing among payers, health care providers, researchers, social service providers, and public health.

3.4.1 Establish a single, aggregated patient record via one portal that supports the ability for social services/community organizations to collect and add data to patient records.

3.4.2 Update the Minnesota Health Records Act to provide clarity and alignment with electronic workflows.

3.4.3 Design, implement, and maintain a shared directory of social needs resources.

3.4.4 Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care, and community organizations.

3.4.5 Incentivize health providers and the state to participate with the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing.

3.4.6 Ensure interoperability, data governance, quality standards, and policies to enable seamless data exchange and communication across different electronic health records (EHRs).

3.4.7 Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research, maintain public health surveillance and dashboards, and add additional partners across Minnesota.

Strengthen and Diversify the Workforce

Recommendation 4.1 Foster workplace inclusion, belonging, safety, and well-being to encourage retention of current diverse workforce members.

4.1.1 Minnesota to create a model for inclusion, belonging, safety, and well-being including implementation guidance and resources for health care organizations.

4.1.2 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.

4.1.3 Recommend leveraging employees and employee resource group members from underrepresented groups in the cocreation of workforce equity strategies designed to meet their needs.

4.1.4 Recommend strategies to drive leadership accountability for workforce equity outcomes.

Recommendation 4.2 Enhance workforce skills and cultural responsiveness.

4.2.1 Minnesota to create a mandated or incentivized training for all health care workers. Accrediting bodies can adapt it to their field but need to provide the same content. Include content for members of health care organization boards of directors.

4.2.2 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.

4.2.3 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.

4.2.4 Recommend incentive–based mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.

4.2.5 Outline solutions to address the narrowness of specialization, such as cross-training opportunities, mentorship programs, and professional development resources.

4.2.6 Recommend workforce equity core competencies for employees and leaders.

4.2.7 Recommend workforce equity strategies that are informed by the communities being locally served.

4.2.8 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.

4.2.9 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
- Empathy
- Implicit bias
- Mitigation of unconscious bias
- Patient-centered care
- Teamwork
- Trauma-informed care
- Training programs

4.2.10 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.

4.2.11 Use learnings from experiences training providers (such as JAMA article on mandated implicit bias training; Cooper LA, Saha S, van Ryn M. Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care. JAMA Health Forum. 2022;3(8):e223250).

4.2.12 Partner with local organizations or universities to design culturally appropriate training programs.

4.2.13 Require trauma-informed, equity training for intrapartum and post-partum care.

4.2.14 Implement training and education for providers that cultivates better attitudes toward Medicaid patients.

4.2.15 Create a culture of precepting at systems (e.g., like programs at Essentia and M Health Fairview).

4.2.16 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.

Recommendation 4.3 Address workforce inequities.

4.3.1 Minnesota to outline a framework and model to help health care organizations collaborate with stakeholders to examine and address systemic barriers that contribute to health care workforce inequities. Include guides and implementation resources.

4.3.2 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.

4.3.3 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.

4.3.4 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.

4.3.5 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.

4.3.6 Recommend best practices for collaborating with educational institutions and community organizations to remove barriers to entering the health care workforce.

4.3.7 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.

4.3.8 Encourage health professional education programs to take a holistic approach when screening for potential candidates vs. over reliance on standardized scores such as MCATs.

4.3.9 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.

4.3.10 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.

4.3.11 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 health care.

4.3.12 Support and expand programs focused on increasing culturally specific health care professional training programs, such as the University of Minnesota Duluth's Native Americans in Medicine program.

4.3.13 Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups.

4.3.14 Educate K-12 students on medical professional pathways.

4.3.15 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).

4.3.16 Expand dual-training pipeline programs.

4.3.17 Continue funding the MDH's Mental Health Cultural Community Education Grant program that supports BIPOC mental health supervisors.

4.3.18 Track the retention of health care professionals in underserved areas to identify gaps and opportunities to improve retention.

4.3.19 Improve financial support for health care education including health care loan forgiveness, grants, and scholarships.

4.3.20 Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.

4.3.21 Ensure that some NorthStar Promise funding is dedicated to students seeking health care degrees.

4.3.22 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.

Recommendation 4.4 Optimize the workforce.

4.4.1 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.

4.4.2 Identify workforce gaps and barriers.

4.4.3 Address workforce shortages, especially focused on addressing rural access issues (e.g. dental therapists).

4.4.4 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.

4.4.5 Expand the dental workforce, particularly dental therapists, hygienists, and assistants.

4.4.6 Improve reimbursements and other interventions to support an increased health care workforce.

4.4.7 Pilot a loan forgiveness program as a recruitment incentive to sites that are in health professional shortage areas.

4.4.8 Decentralize physicians where evidence supports it.

4.4.9 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.

4.4.10 Increase the utilization of Health Navigators from underrepresented communities (ex,. Hmong Culture Care Connection, Cultural Society of Filipino Americans, SEWA-AIFW).

4.4.11 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.

4.4.12 Provide legislative authorization to the Minnesota Department of Health (MDH) and Department of Human Services (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.

4.4.13 The Minnesota Department of Human Services (DHS) should recognize Community Health Representatives without requiring duplicative training. Enable Community Health Representatives to bill for services as Community Health Workers, especially given the historical and community-specific role they serve.

4.4.14 Increase the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.

4.4.15 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.

4.4.16 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.

4.4.17 Support the University of Minnesota and CentraCare expansion of medical training programs for rural physicians.

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06/06/25

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