Blue Ribbon Commission Meeting #3: Meeting Minutes
Thursday, October 24, 2019; 1pm – 4pm
Duluth, Minnesota

Participation
Participating members: Jennifer DeCubellis, Senator Rich Draheim, Jennifer DuPuis, Nona Ferguson, Julia Freeman, Commissioner Jodi Harpstead, Sheila Kiscaden, Senator Matt Klein, Gayle Kvenvold, Representative Tina Liebling, Sida Ly-Xiong, Commissioner Jan Malcolm, Shauna Reitmeier, Sue Schettle, Lisa Weed

Welcome and Remarks
Commissioners Jan Malcolm (MDH) and Jodi Harpstead (DHS), co-chairs of the Blue Ribbon Commission, welcomed members to the Commission’s third meeting, and welcomed public participants as well.

Overview of Minnesota Department of Health Programs
Assistant Commissioner Marie Dotseth and Deputy Assistant Commissioner Margaret Kelly presented an overview of Minnesota Department of Health (MDH) programs.

- Marie explained that Minnesota performs very highly on a number of public health measures relative to other states. Overall Minnesota ranked as the 7th healthiest state in the most recent United Health Foundation rankings. Yet, Minnesota ranks poorly on some other measures, e.g., homelessness-related measures, excessive drinking and health disparities for populations of color and American Indians.

- Marie explained that social economic factors are the greatest contributors to health status, with health behaviors ranked second. Clinical care represents a comparatively small contributor. She also explained that the United States spends more on health care and less on social services when compared to other countries. Finally, she observed that public health spending in Minnesota, and in the United States, is dwarfed by health care spending.

- Marie argued that health care treatment alone will not improve population health in Minnesota due to growing prevalence of chronic illness.

- Commissioner Malcolm emphasized that whereas health care focuses on individual-level interventions, public health focuses on community-level interventions.

- Margaret reviewed MDH’s budget, which has grown about one percent annually. Most spending growth has come from larger federal grants and legislative funding. MDH’s budget is not driven by entitlement spending. Margaret explained that 61 percent of MDH spending is for grants, one quarter is for staff compensation, and the balance (13 percent) is for other operating costs.

- Margaret explained that public health in Minnesota is a local responsibility, with 51 Community Health Boards serving the state’s 87 counties. MDH provides guidance, advice, tools, and consultation, but local boards do the work, and also provide resources.
• Commissioner Malcolm noted that public health successes result in public health concerns being kept out of the view of the public. She added that MDH is a leading public health innovator nationally.

Discussion of Minnesota Department of Health Programs
• Julia Freeman asked for disaggregated data by racial population in order to increase equity consciousness, and noted this will be very important during future conversations of spending cuts. She wondered if the reported public health gains were experienced across all racial groups. Julia noted that racial and economic disparities go hand in hand. Julia asked about the working poor and the recidivism rate, e.g., those who go off Medical Assistance, and then cycle back on.
• Shauna Reitmeier reiterated the need for disaggregation of data as a routine practice for all presentations. Shauna noted that the Department of Human Services (DHS) did not provide information on where its total spending goes, including administration, as MDH did. She wondered if there was room to align MDH and DHS work to reduce administrative costs.
• Lisa Weed asked if MDH could estimate the savings that could be achieved through full immunization. Commissioner Malcolm said that such an estimate could be developed.
• Sue Schettle asked how much the Departments work together currently and whether there is room for increased integration. Commissioner Harpstead responded that the Departments were created law by law. She added that more could be done to require DHS contractors to address SDOH, and thereby integrate services and programs.
• Commissioner Malcolm said that there are different programs aiming at the same problems with different populations. She acknowledged that it can be hard to lift one’s head up to look at how efforts can be better integrated, e.g., vaping and teen mental health. She added that the Governor is looking for this type of thinking from the Commission.
• Senator Klein asked for an estimate of potential savings through reduced tobacco use, noting that such a reduction would also address disparities since there is higher tobacco use among people of color.
• Sheila Kiscaden said that the Commission needs to focus on long-term care, since that is the true cost driver, and also at other big cost drivers.
• Jennifer DuPuis asked for information on spending in areas where performance is strong vs. in areas where performance is poor.

Review of Draft Committee Charter
Michael Bailit, Commission co-facilitator, reviewed the Commission’s statutory charge, noting that the Commission has a large scope of work with many charges. The Commission has a general charge of transforming the health and human services system, with multiple more specific charges including identifying $100 million savings in next biennium. Michael reviewed elements of a draft Committee charter, including members’ responsibilities, communications, operating procedures, and consensus process and voting. The Commission will review a revised charter at its next meeting following consideration and incorporation of Commission member input.

Discussion of Draft Committee Charter
• Sheila Kiscaden commented that the charter should include discussion of roles and relationships; the issue is not just efficiencies, but also how things are structured for a longer-term impact. She suggested
that the Commission should look at how other states are structured; for example, in Ohio, the state determines eligibility.

- Sheila Kiscaden commented that in the Commission’s aim to address waste/fraud, there is no mention of “process improvements” or “use and development of data analytics,” noting that both are relevant. She suggested that by using data analytics, we can learn more about the high-cost users.

- Julia Freeman noted that it seems premature to agree to the Commission’s aims without any data to analyze, particularly with regard to “identifying evidence-based strategies.” She said that the Commission needs to hear directly from those impacted, and without this engagement there is a lack of authenticity.

- Lisa Weed noted the importance of increasing transparency, and that at a prior meeting there was discussion of improving purchasing efficiencies and reducing price variation. Michael replied by saying that price variation fell under waste reduction and committed to provide a definition of waste at a future meeting. Lisa suggested that the Commission should look at providers who receive funds from the state – look at those providers who make people come back and get more services and tests that they may not need.

- Another Commission member expressed interest in looking at efficiencies in terms of provider use and pharmaceuticals being prescribed. Michael noted that this topic relates to misuse and overuse.

- In terms of effectiveness of various strategies, a Commission member noted that different divisions within agencies have process improvement data, and it would be helpful to have access to this.

- Another Commission member felt the term “effectiveness” is missing from the Commission’s charge.

- Gayle Kvenvold would like to have the criteria discuss workforce limitations and take into account state agencies and their capacity, as well as the capacities of counties and tribes.

- Sheila Kiscaden asked if there will be time to reconsider a strategy when new information becomes available. There was agreement to make provision for such instances.

- Commission members agreed that a roll call voting process will be important in supporting the transparency of the Commission’s work.

**Discussion of Process for Soliciting and Developing Proposals**

Beth Waldman, Commission co-facilitator, explained that the State expects to receive a large number of proposals, noting the template that was previously distributed to Commission should be used by members and may also be used by the public.

- Sida Ly-Xiong said that the word “proposal” is problematic, as people assume it is a bid solicitation.

- Julia Freeman said the requirement for web-based submissions is a barrier to authentic community engagement.

- Sida Ly-Xiong asked about funding. Commissioner Harpstead clarified that there is no money to fund proposals.

- Sheila Kiscaden suggested asking for strategies and actions for what the Commission should consider. Sheila also shared her experience with another commission that invited people with lived experience to provide comment at the beginning of every meeting, and provided time for public forums as well.

- Beth said the comments regarding use of the word “proposal” were well taken, and what we were seeking was “strategies.”
• Beth explained that the State’s idea is to categorize submitted strategies and combine them with those generated by the State, and then prioritize them for development and presentation to the Commission.
• Gayle Kvenvold asked if the November 3 submission date is final. Beth explained that later submissions won’t necessarily be dismissed, but staff will need to prioritize and start developing strategies this month.
• Commissioner Malcolm said she would rather get a concept, and asked for a supplemental, clarifying communication to the public be distributed by Commission staff.

Discussion of Criteria for Selection of Proposals
Beth described five proposed criteria for the initial review of proposals.
• A few members expressed concern that the criterion “not contribute to health inequities or disparities” was not stated as “contribute to health equity.” Michael Bailit noted that contribution to health equity may not be feasible for every strategy. Lisa Weed said the criterion should be applied to every strategy.
• Julia Freeman expressed concern that there could be no benefit reductions if there were gains elsewhere.
• Sheila Kiscaden expressed interest in a criterion of readiness, i.e., ease of achievement.
• Beth reviewed proposed questions to be asked with respect to each potential strategy.
• Jennifer DeCubellis asked that the Commission members see all of the submitted strategies, including those not selected for further development. Beth confirmed that Commission staff will do so.
• Lisa Weed asked that input be gathered from program participants about strategy impact.
• Gayle Kvenvold asked that the source of the strategies be identified for the Commission.
• Commissioner Harpstead said that she would give more credibility to ideas that reflect community input, and that those ideas would receive more points from her when ranking.
• Julia Freeman asked that there be an effort to identify communities that did not provide strategies.
• In response to a question from Sida Ly-Xiong, Beth indicated that the proposed criteria and key questions would be provided with the supplemental communication requested by Commissioner Malcolm.
• Lisa Weed asked that patients be added to question #6, and Jennifer DeCubellis asked that tribes be added as well.
• Sheila Kiscaden observed that DHS and MDH don’t have the resources to conduct continuous process improvement. Commissioner Harpstead said DHS kicked off a Six Sigma program aimed at developing quality improvement skills within DHS. As a result, she felt the agency was in a good place in terms of process improvement expertise, but agreed that its information systems need to be better.

Proposed Sequencing of Topics for Commission Consideration
Beth reviewed a proposed series of agenda topics for the remaining Commission meetings, and proposed that Commission meetings be held closer to Metro area with exception of one meeting in Rochester. Commissioner Malcolm said that it will be necessary to remain flexible in terms of ordering the future agenda topics.
• Sida Ly-Xiong asked for ability of Commission members to participate in staff-led strategy prioritization process.
• Beth explained that short-term strategies will be discussed first, and long-term strategies later.
• Sheila Kiscaden asked if there will be feedback to those who submitted proposals. She expressed concern about people feeling disrespected, if they don’t receive a response. Others agreed with Sheila.
• Shauna Reitmeier suggested that after strategies are reviewed, scoring be shared with Commission members.
• Julia Freeman expressed interest in participating in strategy review process with respect to equity strategies.
• Lisa Weed said meetings need to take place across the state because rural communities feel ignored.

Meeting Wrap-up
Commissioner Harpstead and Commissioner Malcolm committed to sharing all proposals with Commission members, and to reconsidering Commission member participation in the initial proposal review process.

Next Meeting
Thursday, December 19, 2019; 9:00am – 12:00pm