Community Conversation: Building Racial Equity into the Walls of Minnesota Medicaid - A focus on U.S.-born Black Minnesotans
Recognition of past trauma and abuse

The state of Minnesota and the Department of Human Services recognize the trauma, medical abuse, and discrimination that have happened to our Black, Native/American Indian, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine and social service providers.

The work of equity and antiracism requires that we are all actively committed to rebuilding trust with communities and bringing community members' voices to the table.
<table>
<thead>
<tr>
<th>Time</th>
<th>Phase</th>
<th>Facilitator</th>
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</thead>
<tbody>
<tr>
<td>6:00-6:35 pm</td>
<td>Welcome and Review of <em>Building Racial Equity into the Walls of MN Medicaid: A focus on U.S.-born Black Minnesotans</em> report</td>
<td>Dr. Nathan Chomilo</td>
</tr>
<tr>
<td>6:35-7:20 pm</td>
<td>Breakout discussions</td>
<td>MN DHS staff</td>
</tr>
<tr>
<td>7:20-7:30 pm</td>
<td>Review next steps, survey and closing</td>
<td>Dr. Nathan Chomilo</td>
</tr>
</tbody>
</table>
Welcome

• Today’s purpose and intention
  • Share out the finalized report
  • Dive-in into our Call-to-Actions and Recommendations
  • Engage in dialogue with and for community
  • Continue building a bridge between public health care programs and the public
  • Receive authentic feedback
  • Open an invitation to join our Community Action Teams
Conversation principles and tips

- Appreciate and respect the value of cross-cultural engagement and conversations
- Be thankful for the stories, facts, and lived experiences shared
- Hold ourselves accountable to practicing active listening and taking turns
- Center our conversation in the principles of community building, systems reformation, and better service delivery
- Understand that our group facilitators are here to engage and promote constructive dialogue and remind us of the session’s intentions
- *If possible/accessible, please turn on your camera when participating.
Overview of the Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans report

Nathan Chomilo, M.D. FAAP, FACP | Medical Director, Medicaid and MinnesotaCare

Gender pronouns: he/him/his
“There has never been any period in American history where the health of blacks was equal to that of whites...Disparity is built into the system.”

- Evelynn Hammonds, historian of science at Harvard University

“Of all the forms of inequality, **injustice in health** is the most shocking and the most **inhuman**.”

– Dr. Martin Luther King, Jr.
Definitions

**Racism:** “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call ‘race’) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.” [Jones]

**Antiracism:** A personal and collective identity which embraces the intentional dismantling of our racialized society and proactively builds racial peace [McKinney and Essenburg]

**Antiracist policy:** Any measure that produces or sustains racial equity between racial groups [Kendi]

**Health Equity:** “Health equity is defined as the absence of unfair and avoidable or remediably different in health among population groups defined socially, economically, demographically or geographically” [World Health Organization]

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*Reconciliation in a Racialized Society* Karen McKinney & Tim Essenburg, Bethel University.


Alignment with our State’s goals

Governor Tim Walz’ very first executive order: 19-01 Establishing the One Minnesota Council on Diversity, Inclusion and Equity

“all Minnesotans are provided the opportunity to lead healthy, fulfilled lives”
The Minnesota Paradox


Minneapolis No. 4 in child well-being, but among worst in racial disparities
Elizabeth Shockman  June 17, 2019 3:57 p.m.
Inequities in Opportunity for Black Minnesotans
Racial INEQUITIES lead to Racial Disparities

• Inequity - an instance of injustice or unfairness

• Disparity - noticeable and usually significant difference or dissimilarity

Structural racism is therefore THE inequity that leads to racial disparities

It is not race driving these disparities but structural racism.


Disparities in Health for Black Minnesotans

- Black Minnesotan adults have increased rates of:
  - Diabetes
  - Asthma
  - HIV
  - High Blood Pressure
  - Cardiovascular Disease
  - Substance Use Disorder
  - PTSD

- Black Minnesotan children have increased rates of:
  - Preterm Birth
  - Low Birth Weight
  - Asthma
  - Obesity
  - Anxiety
  - Suicidal Ideation

Minnesota Medicaid’s Role in Addressing Structural Racism & Health Disparities (1/2)

In 2019 Medicaid was the source of health care coverage for:

- **41.5%** of Black Minnesotans
- **39.0%** of American Indian/Alaskan Native Minnesotans
- **29.5%** of Hispanic/Latino Minnesotans
- **26.1%** of Other/Multiple Race Minnesotans
- **20.2%** of Asian Minnesotans
- **9.0%** of White Minnesotans

Overall Minnesota Health Care Coverage - 2018

Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.
Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018

Overall Minnesota Health Care Coverage - 2018

- Employer: 17%
- Individual: 6%
- Medicaid/CHIP: 59%
- Medicare: 4%
- Uninsured: 14%

Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.
Why focus specifically on Black Minnesotans? (1/3)

- MN has some of the WORST racial inequities
- MN has some of the WORST racial HEALTH disparities
- Black Minnesotans are disproportionately covered by MN Medicaid
- MN Medicaid MUST focus on racial equity
### Why focus specifically on U.S.-born Black Minnesotans?

(2/3)

<table>
<thead>
<tr>
<th>Mortality and Morbidity</th>
<th>Enrollees who were born in the U.S.</th>
<th>Enrollees who immigrated to the U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>American Indians*</td>
<td>African Americans</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Mortality over 2.5 years</td>
<td>1.35</td>
<td>0.8</td>
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<tr>
<td>Type 2 Diabetes</td>
<td>12.37</td>
<td>8.28</td>
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<tr>
<td>Asthma</td>
<td>12.48</td>
<td>16.47</td>
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<tr>
<td>HIV/Hep-C</td>
<td>4.52</td>
<td>2.67</td>
</tr>
<tr>
<td>Hypertension</td>
<td>7.69</td>
<td>9.6</td>
</tr>
<tr>
<td>Heart failure, hospitalized heart conditions</td>
<td>2.05</td>
<td>1.96</td>
</tr>
<tr>
<td>COPD</td>
<td>11.91</td>
<td>8.4</td>
</tr>
<tr>
<td>Lung, Laryngeal Cancer</td>
<td>0.25</td>
<td>0.2</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
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<tr>
<td>Substance Use Disorder</td>
<td>35.37</td>
<td>20.09</td>
</tr>
<tr>
<td>PTSD</td>
<td>10.54</td>
<td>8.64</td>
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<tr>
<td>SPMI</td>
<td>7.36</td>
<td>7.09</td>
</tr>
</tbody>
</table>

“several participants questioned this approach, citing that the data around a healthy immigrant effect was incomplete and therefore inconclusive, making exclusion of Black immigrant and refugee populations unnecessary. Other participants felt strongly that disaggregation was important given what is known about U.S.-born Black persons’ health”
Leading with Racial Equity: Community Strengths + Medicaid Levers

4 Medicaid “Levers”

- Eligibility/Enrollment
- Access
- Quality
- Early Opportunities

Community Conversation Participants

- Minnesota Health Care Program (Medicaid) enrollees
- Health Care Providers
- Community Based Organizations
- County Public Health and Human Service staff
- Managed Care Organization staff
- University of Minnesota School of Public Health and Medical School faculty
- Minnesota DHS and other State agency staff
Medicaid Levers: Eligibility & Enrollment

Income volatility
45% Hispanic households
38% of Black households
32% of white households

Churn
Black Medicaid enrollees were more likely than white enrollees to go off Medicaid for more than six months:
- less likely to have a regular source of care
- more likely to forego health care for financial reasons
- more likely to report problems paying medical bills


Call to Action: Eligibility & Enrollment

- What community members shared:
  - Process is confusing/complicated
  - Communication on status is poor
  - How can we keep people enrolled who are eligible

“"It was difficult to get MA [sic]. The first time I applied for MA it took 2-3 months to get it, but it was a while longer before I got my card. Then I had it and they cut me and my kids off, I don’t know why. I was only on MA a couple months, and they said I needed a renewal, so I did my renewal but went to get my birth control and my MA was inactive.”

- Female, African American, 18-25 years old

“We applied for MNSure, but I didn't do it through there. I did it on paper. They say it's backed up on paper, so I should have done it online because it's quicker. I wonder if I should do it online. But they said what would happen is I would get knocked off the list for already having it. It's confusing.”

- Female, African American
MN DHS should improve racial equity in Eligibility, Enrollment & Renewal by:

1. *Pursue continuous eligibility policies*

   • Implement **12 month Continuous Eligibility for those 0-19 years old**

   • Explore an 1115 Medicaid Demonstration Waiver to trial

     • 72 months (6 years) of continuous eligibility for children on Medicaid up to age 6 and

     • 24-month (2 years) of continuous eligibility for all enrollees age 6 and older
MN DHS should improve racial equity in Eligibility/Enrollment by:

2. **Support navigators and simplify the enrollment and renewal process**
   - Develop and implement a plan to ensure eligible Black Minnesotans gain and/or maintain Medicaid coverage throughout the year but in particular as the federal public health emergency ends.

“In a discussion with the Cultural Wellness Center, their staff lauded navigators as providing people with help to enroll, but also to help guide families to other services they may need. They emphasized that their value comes from their location within the community, and living and working alongside the families they support.”
Based on data from a 2008 survey of adults in the Minnesota Health Care Program (MHCP) population, results showed the following barriers to care and utilization:

- 65% reported financial barriers
- 55% reported access barriers
- 30% reported provider-related barriers
- 49% reported provider discrimination
- 33% reported family/work barriers

Figure 3-70—Race and Ethnicity Comparisons: Percentage of Respondents Who Were Never Told They Showed Up Too Late to an Appointment to Still be Seen

Q41a. In the last 6 months, how often were you informed you showed up too late to an appointment to still be seen?

<table>
<thead>
<tr>
<th>Multi-Racial</th>
<th>White</th>
<th>Hispanic</th>
<th>Black</th>
<th>Asian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>92.31%*</td>
<td>95.08%</td>
<td>95.1%</td>
<td>95.33%*</td>
<td>92.06%*</td>
<td>76.46%</td>
</tr>
<tr>
<td>95.08%</td>
<td>96.32%*</td>
<td>98.00%†</td>
<td>96.13%†</td>
<td>91.43%†</td>
<td>95.14%†</td>
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<tr>
<td>95.00%</td>
<td>90.59%*</td>
<td>87.06%*</td>
<td>91.40%*</td>
<td>85.58%</td>
<td>88.37%</td>
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<td>93.31%</td>
<td>89.54%</td>
<td>86.87%</td>
<td>89.51%</td>
<td>78.80%</td>
<td>84.93%</td>
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<tr>
<td>100.00%*</td>
<td>93.42%*</td>
<td>95.58%</td>
<td>89.71%</td>
<td>86.30%*</td>
<td>91.35%</td>
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</table>
About 80 percent of people enrolled in public health care programs are served by managed care organizations.
Call to Action: Access to Culturally Relevant Care (1/3)

In Minnesota, although Black residents make up 7% of the general population, only 2.6% of Minnesota physicians and 1% of physician assistants identified as Black or African American in 2019.

What community members shared:

- “Culture is missing”
- Access to care that honors culture remains difficult.
- Medicaid and other state agencies can support culturally relevant care in concrete ways, such as incentivizing and building a stronger infrastructure of Black clinicians and clinics centered on care that values culture along with an allopathic approach to health and healing.
Call to Action: Access to Culturally Relevant Care

MN DHS should improve racial equity in Access to Culturally Relevant Care by:

1. **Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans**

“A participant in the Community Conversations reflected, “They [medical practitioners] don’t listen to us [Black people] when we explain our problems; Black patients do not receive the same treatment as white patients.”
# Medicaid Levers: Quality

## MNCM 2020 Annual MN Health Care Disparities by Insurance Type Report

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>2020 MHCP MCO Race Average*</th>
<th>Asian</th>
<th>Black</th>
<th>Indigenous/ Native</th>
<th>Multi- Race</th>
<th>Native Hawaiian/ Other Pacific Islander</th>
<th>White</th>
<th>Chose Not to Disclose/ Declined</th>
<th>Patient Reported Race Unknown</th>
<th>Some Other Race</th>
<th>Unknown Race</th>
<th>2020 MHCP MCO Ethnicity Average*</th>
<th>ETHNICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE HEALTH MEASURES</strong></td>
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<td></td>
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<tr>
<td>Breast Cancer Screening</td>
<td>64.2%</td>
<td>△</td>
<td>△</td>
<td>△</td>
<td>△</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>63.3%</td>
<td>△</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>59.7%</td>
<td>△</td>
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<td>59.7%</td>
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<tr>
<td><strong>CHRONIC CONDITIONS MEASURES</strong></td>
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<tr>
<td>Optimal Diabetes Care</td>
<td>35.6%</td>
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<td>△</td>
<td>△</td>
<td>△</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>35.8%</td>
<td>△</td>
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<tr>
<td>Optimal Vascular Care</td>
<td>47.2%</td>
<td>△</td>
<td>△</td>
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<td>-</td>
<td>47.5%</td>
<td>△</td>
</tr>
<tr>
<td>Optimal Asthma Control - Adults</td>
<td>45.2%</td>
<td>△</td>
<td>△</td>
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<td></td>
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<td>-</td>
<td>45.2%</td>
<td>△</td>
</tr>
<tr>
<td>Optimal Asthma Control - Children</td>
<td>53.4%</td>
<td>△</td>
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<td>-</td>
<td>53.9%</td>
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</tr>
</tbody>
</table>

*Statewide MHCP MCO rates were re-calculated for those with race/ethnicity information available.

NR = Not reportable. Did not meet minimum reporting threshold of at least 30 patients
Black patients whose preferred language is English have significantly lower rates of optimal:

- diabetes care
- optimal vascular care
- depression remission at six months

compared to Black patients whose primary language is not English.
Call to Action: Access to Culturally Relevant Care (3/3)

“One Community Conversation participant noted that there is a need to “proactively identify data — there’s not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing.”

MN DHS should improve racial equity in Access to Culturally Relevant Care by:

2. Continue to prioritize standardization and disaggregation of race, ethnicity and language data
Call to Action: Engaging the communities and families Medicaid serves

• In all our discussions with community members and DHS staff there was a shared desire for meaningful engagement and co-creation.

• Historically engagement has been with enrollees from multiple groups.

• What community members shared:
  • Need for community consultation in general and for culturally specific consultation.
  • Need ongoing, longitudinal engagement. Where can power be shared?

“Participants in Community Conversations expressed a desire for DHS to find ways to incentivize or require larger health care and insurance companies to train their employees and clinicians on how to engage with people of color. They also seek accountability measures around disparities in outcomes and experiences of racial discrimination.”

Minnesota Department of Human Services | mn.gov/dhs
MN DHS should improve racial equity in MN Medicaid by:

- **Funding community conversations with U.S.-born Black Minnesotans on Medicaid**

- DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into routine policy, budget and administrative activities.
Medical Assistance covers 40% of births in Minnesota.

~8 in 10 of MN's Black birthing persons are insured by MHCPS
Medicaid Levers: Early Opportunities (2/2)

Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018

- 64% Black/AA children
- 54% American Indian/AN children
- 52% Hispanic/Latino children
- 31% Asian children
- 28% "Other" children
- 17% White children

~8 in 10 of MN's Black birthing persons are insured by MHCPS
Calls to Action: Early Opportunities

Calls to Action that impact Early Opportunities

• Implement 12 month Continuous Eligibility for those 0-19 years old

• Explore an 1115 Medicaid Demonstration Waiver to trial
  • 72 months (6 years) of continuous eligibility for children on Medicaid up to age 6 and
  • 24-month (2 years) of continuous eligibility for all enrollees age 6 and older
Final Report Calls to Action

i. Simplify and support enrollment and renewal
   i. Implementing 12 month Continuous Enrollment for those 0-19 years old
   ii. Pursue 72 month Continuous Enrollment for those 0-6 years old & 24 months for those >6 years old
   iii. Supporting Navigators

ii. Increase investment in culturally relevant care for U.S.-born Black Minnesotans on Medicaid
   i. Establishing a U.S.-born Black/African-American division within MN Medicaid
   ii. Prioritizing standardization and disaggregation of race, ethnicity and language data

iii. Fund community conversations with U.S.-born Black Minnesotans on Medicaid

“Of all the Calls to Action, participants were most excited about proposals to extend periods of continuous enrollment among enrollees.”

Fall 2021 Community Conversation Survey Results

<table>
<thead>
<tr>
<th>What specific Call to Action proposed for this report are you most excited about?</th>
<th>23 responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Implementing 12 month Continuous Enrollment for those 0-19 years old</td>
<td>13 (56.5%)</td>
</tr>
<tr>
<td>B. Pursuing 72 month Continuous Enrollment for those 0-6 years old &amp; 24 months for those &gt;6 years old</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>C. Improving eligibility for children</td>
<td>9 (39.1%)</td>
</tr>
<tr>
<td>D. A specific plan to ensure eligibility</td>
<td>8 (34.8%)</td>
</tr>
<tr>
<td>E. Establishing a US-born Black division within MN Medicaid</td>
<td>6 (26.1%)</td>
</tr>
<tr>
<td>F. Commitment to longitudinal conversations</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td>G. Required integration of community conversations</td>
<td>6 (26.1%)</td>
</tr>
</tbody>
</table>
Importantly, since Medicaid service eligibility cannot be dependent on an individual’s racial background, none of these calls to action seek to create Medicaid-funded services that are racially exclusive.

Instead, they recognize the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency’s efforts on changes, which will be available to all, and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.
Fall 2021 Community Conversation Reflection

• Clear sense of urgency from community and DHS staff alike

• Widespread agreement that DHS could be doing much more around racial health disparities, and there were many ideas to bring forward to community for further conversation around solutions

• Shared concern that, as in the past, DHS’ current focus on health disparities is again just another flash in the pan.
What will accountability to U.S.-born Black Minnesotans look like for Medicaid in enrollment and coverage renewals?

- Advancing proposals to change Minnesota laws regarding continuous eligibility for those aged 0-19.
- Taking demonstrable steps to improve enrollment and renewal processes.
- Continuing to support navigators.
- Making renewal notices more accessible to enrollees, e.g., available electronically in addition to mailed paper documentation.

Outcome: Minimal disparity in the percent of U.S.-born Black Minnesotans who maintain coverage at the end of the federal public health emergency compared to average Medicaid enrollees.

These call outs intend to present broad outcomes that the Medicaid agency within DHS can be accountable to with the U.S.-born Black community in Minnesota. The aim of that accountability is to be Medicaid-focused and on the outcome of racial equity and not just the process. The Calls to Action are some of the ways proposed to improve racial equity for U.S.-born Black Minnesotans based on the iterative process involving community members and DHS staff. However, many actions can realize racial equity. The process is important, but accountability ultimately comes from a change in outcomes.
Building Racial Equity into the Walls (BREW) report distribution

Presented to

• MN House Health Finance and Policy Committee
• County, Tribal and Urban Indian Health & Social Service Directors
• Medicaid Managed Care Organizations and County-Based Purchasers
• U.S. Congress Medicaid and CHIP Payment and Access Commission report authors
• National Association of Medicaid Directors

Shared with

• White House Senior Policy Advisor for COVID-19 Equity
• Centers for Medicare and Medicaid Services leaders
• Medicaid Medical Directors Network
• Local, Regional and National Health Care leaders
Capturing the moment for change (1/2)

Impact of this report’s process and framework for potential future MN Medicaid reports:

- American Indian & Native/Indigenous Minnesotans
- Hispanic/Latinx Minnesotans
- Asian-Pacific Islander Minnesotans
- New Minnesotans
- Minnesotans who are LGBTQ+
- Minnesotans living with disabilities
- Unhoused Minnesotans
- Incarcerated Minnesotans
Governor Tim Walz’s budget for the legislative session includes several proposals that align with the report’s recommendations:

• Simplified enrollment and renewal processes in Medical Assistance and MinnesotaCare will result in more consistent coverage and fewer gaps in care.

• Offering continuous, stable Medicaid coverage to children for 12 months at a time will bring Minnesota in line with most other states, while improving children’s access to well-child visits, immunizations and other care.

• Funding community engagement conversations will support efforts to make public health care programs more responsive to the communities who make up the state of Minnesota.

• Making it easier to access culturally relevant care, including doulas.

• Support for navigator organizations that play a critical role helping Minnesotans access health care coverage.
Facilitated Reflection Small Group Discussion

Questions to guide discussion:

You do not need to answer them in the order they are presented. Start with the question that most speaks to you

• What stands out to you? What parts got your attention?
• What questions does this raise for you?
• What areas of the report would you like further detail or clarity?
• Does this report and/or presentation provide you with a clear picture of how service delivery will become more culturally competent/responsive? If so, how? If not, how?
• How do you view structural racism impacting public programs and services like Medicaid?
  • How, if at all, does this report and/or presentation change your thinking about Medicaid’s role in addressing structural racism? What should be our first steps?
• How will this knowledge and framing of the report and/or presentation affect you and/or your work? How can this be used to help you or your community?
Conversation principles and tips

- Appreciate and respect the value of cross-cultural engagement and conversations
- Be thankful for the stories, facts, and lived experiences shared
- Hold ourselves accountable to practicing active listening and taking turns
- Center our conversation in the principles of community building, systems reformation, and better service delivery
- Understand that our group facilitators are here to engage and promote constructive dialogue and remind us of the session’s intentions
- *If possible/accessable, please turn on your camera when participating.
Please help MN Medicaid prioritize our next steps!

Interested in joining a BREW Action team?!

• Brief (<2 minute) survey: [https://forms.office.com/g/LPwP0pYHaE](https://forms.office.com/g/LPwP0pYHaE)
Wrap up discussion and next steps

- Community Conversations on 4/19 & 5/9
- Survey open until 5/15
- Plan to launch Action Groups in June/July
- Planning for next report is underway

“Now is the accepted time, not tomorrow, not some more convenient season. It is today that our best work can be done and not some future day or future year.” – W.E.B. Du Bois
BIG thanks!!!

**MN DHS BREW report co-authors**
- Ellie Garrett
- Justine Nelson
- Diego Diaz-Rivero
- Jessica Hultgren

**Community Collaborators**
- Council of Minnesotans of African Heritage leadership
- MDH HEAL council leadership
- DHS Cultural & Ethnic Communities Leadership Council
- Voices for Racial Justice
- African American Leadership Forum
- Cultural Wellness Center
- Center for Economic Inclusion
- Former State Senator Jeff Hayden

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Thank YOU!!

You can find the report here: Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans (state.mn.us)

Questions? Feedback? Want to help us Build Racial Equity into the Walls?

Reach out here: BREWMedicaid.DHS@state.mn.us