Structural Racism, Health Policy & Viral Hepatitis

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Recognition of past trauma and abuse

It is important that we personally and professionally recognize the trauma, medical abuse, and discrimination that have happened to our Black, Indigenous, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine.

The work of equity and antiracism requires that we acknowledge the many legacies of violence, displacement, migration, and settlement that bring us together here today and we remain actively committed to rebuilding trust with those who have had it violated.

Disclosure Slide

No conflicts of interest to disclose

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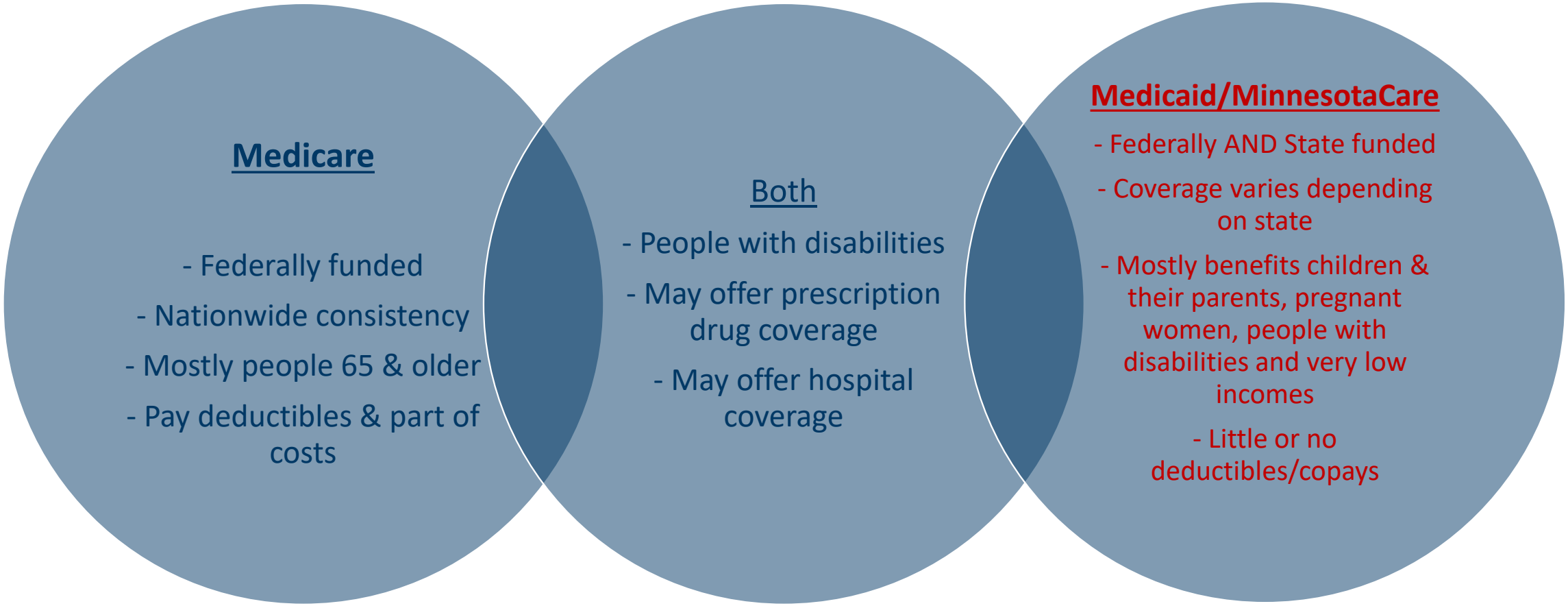
This talk is, at best, a ***brief*** overview of this content

Objectives

- Review the role/impact policymaking has on health & health equity
- Examine the opportunity there exists to build health and racial equity into our health care systems and policymaking
- Reflect on the process of policymaking around medications covered by MN Medicaid

Definitions: Medicaid vs. Medicare



Definitions: Racism & Antiracism

- Institutionalized Racism
- Personally Mediated Racism
- Internalized Racism

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]

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

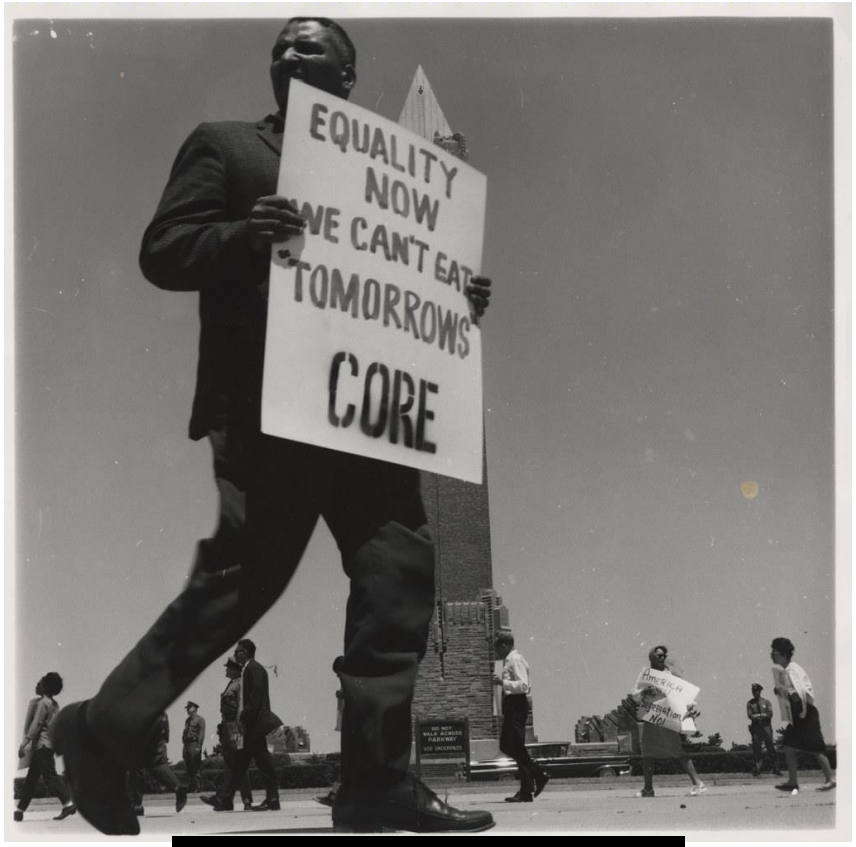
How to Be an Antiracist. New York: One World. Kendi, Ibram X. 2019.

Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardeners tale. *American Journal of Public Health*, *90*(8), 1212–1215. doi: 10.2105/ajph.90.8.1212

Health, Racial Equity and Systems

"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."

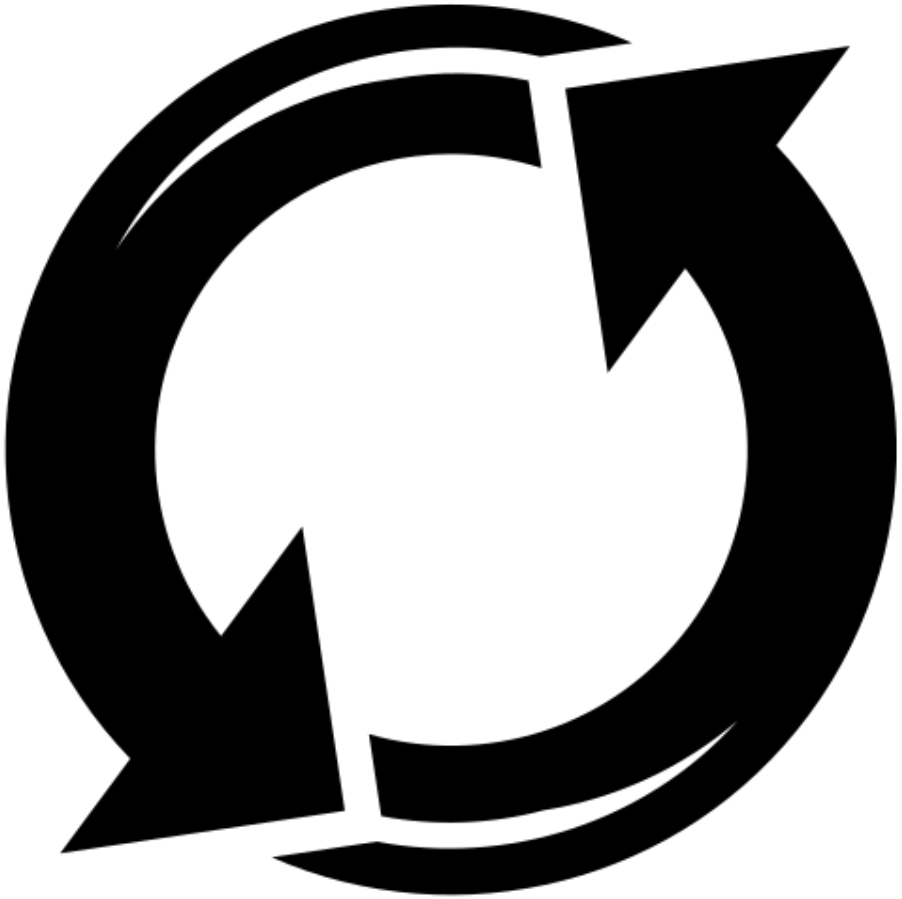
- Evelynn Hammonds, historian of science at Harvard University



"Of all the forms of inequality**, injustice in health** is the most shocking and the most **inhuman**." – Dr. Martin Luther King, Jr.

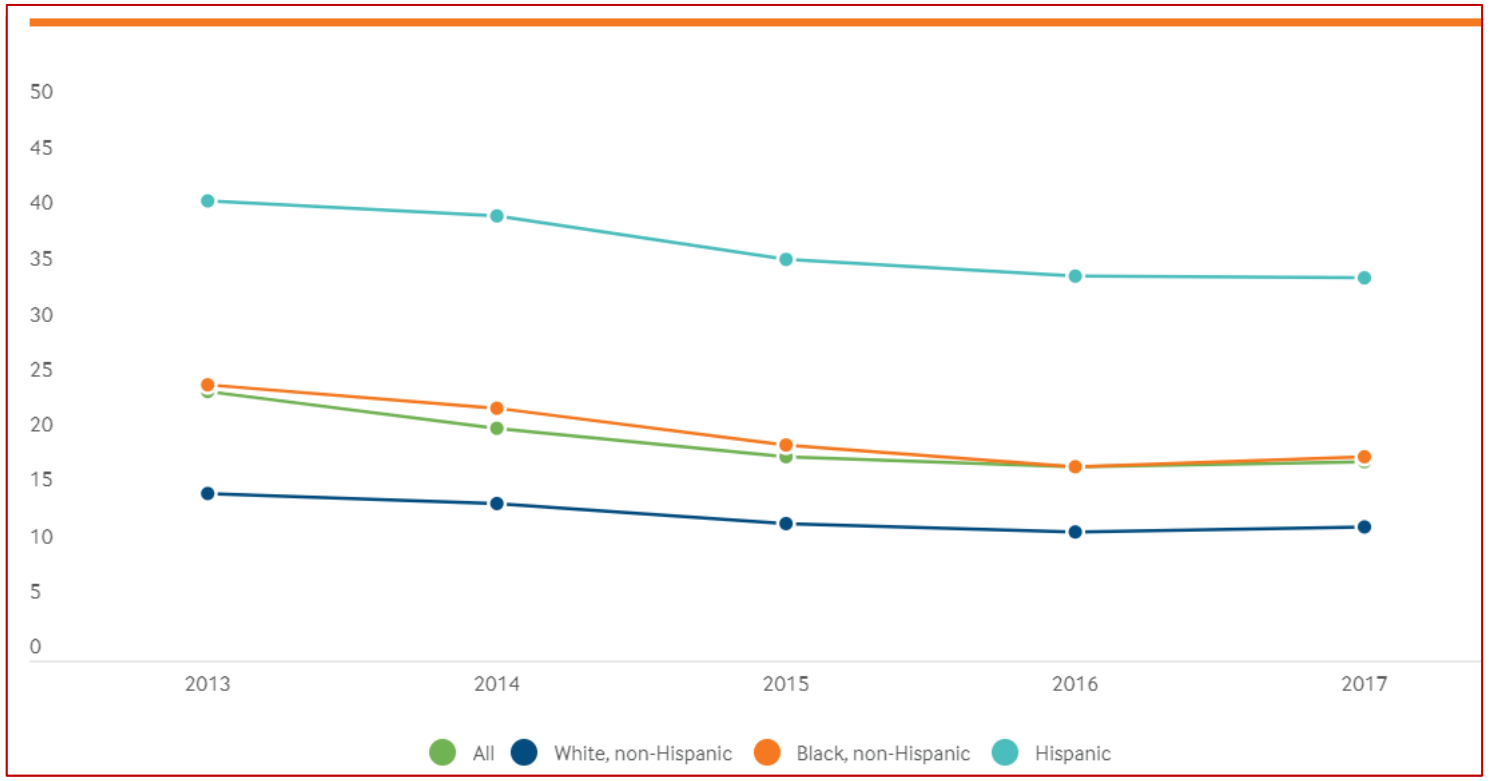
Interlandi, J. (2019, August 14). Why Doesn't America Have Universal Health Care? One Word: Race. Retrieved from https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html?smid=nytcore-ios-share

Institutional/Structural Racism: Medicine & Health Care's Roots



- Medical Schools
- AMA
- Most hospitals and health clinics
- Federal health care policy
- Employer-based insurance
- Access

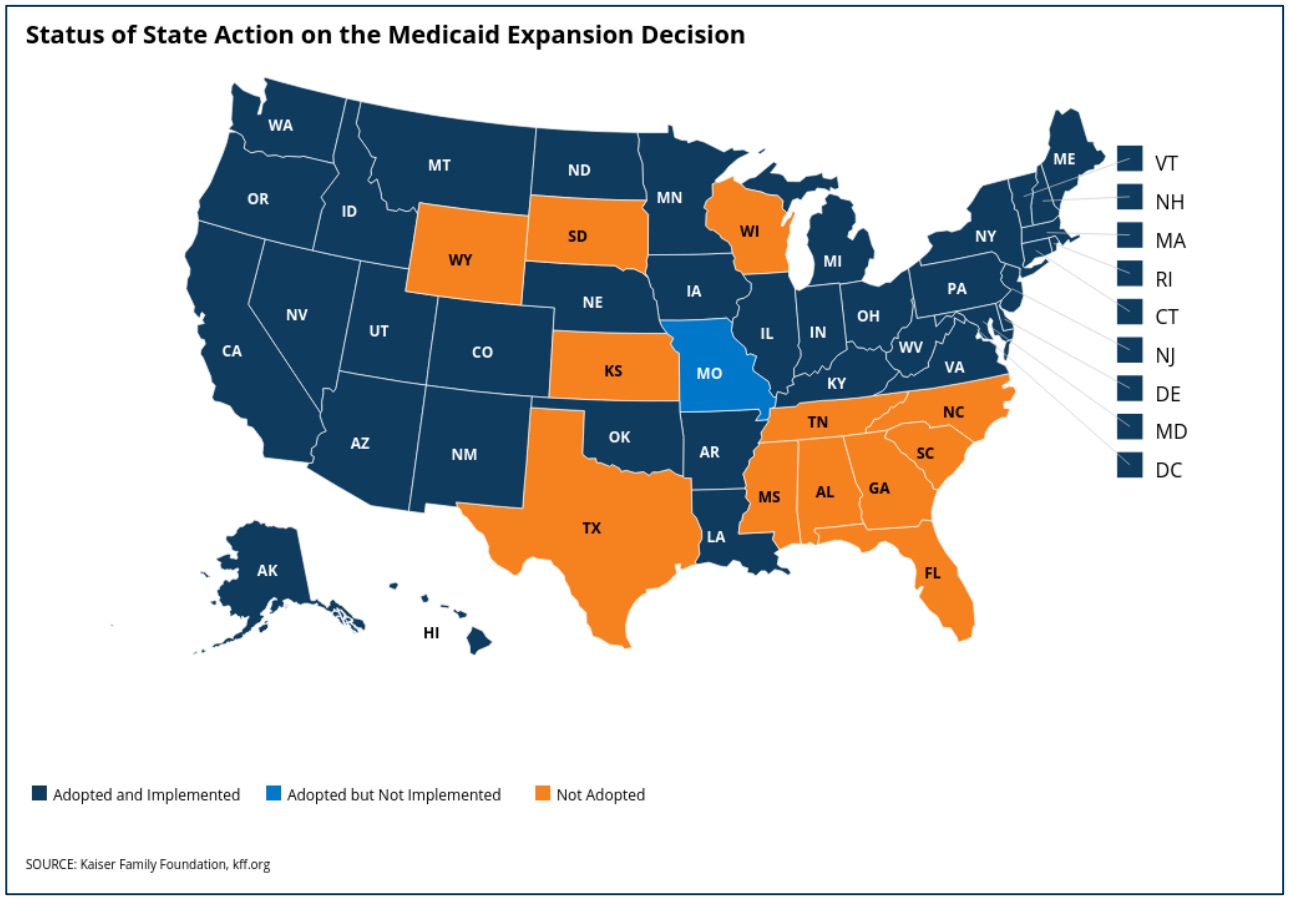
Institutional/Structural Racism in Health Policy : Current Day - Medicaid Expansion Under the ACA



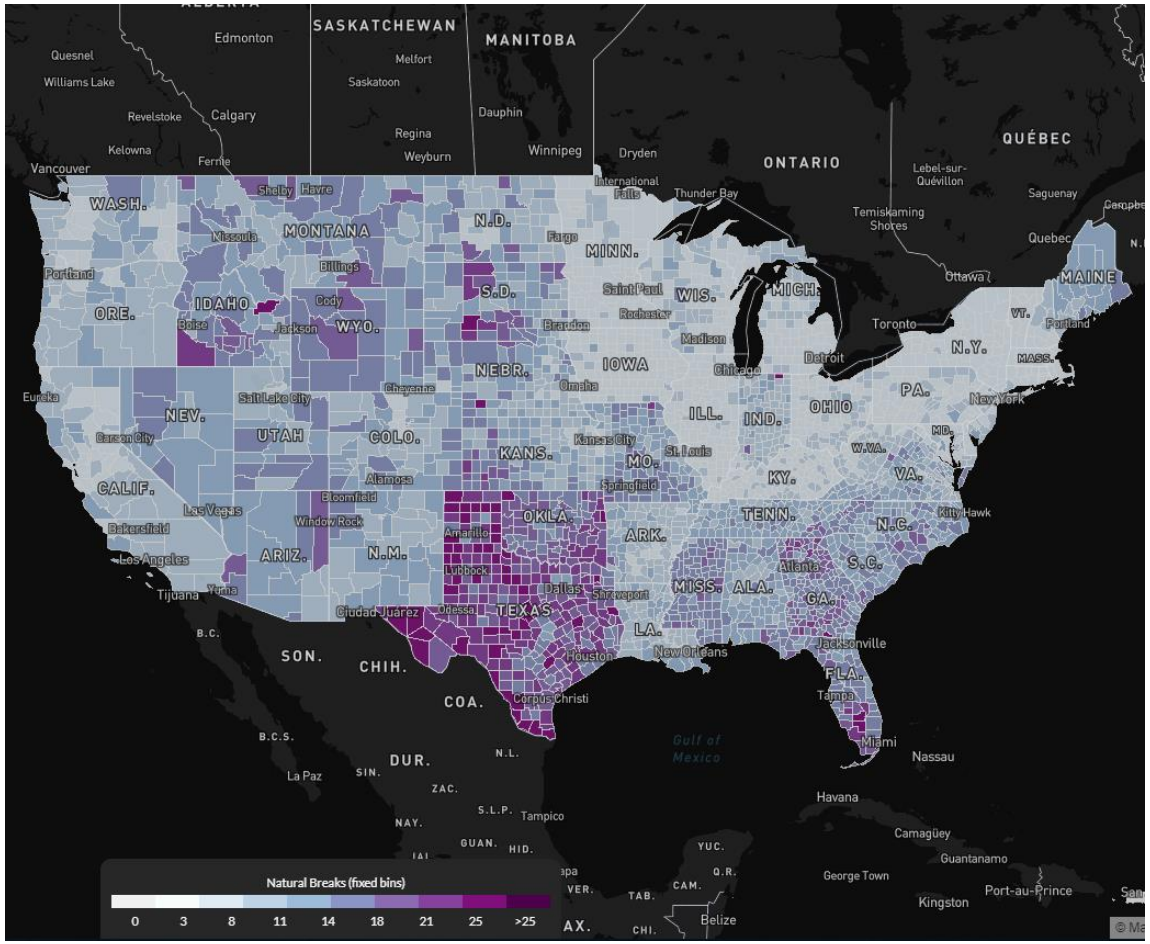
Chaudry, A., Jackson, A., & Glied, S. A. (2019, August 21). Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage? Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage

Institutional/Structural Racism in Health Policy: Current Day - Medicaid Expansion Under the ACA & COVID-19

Medicaid Expansion Status- 2020



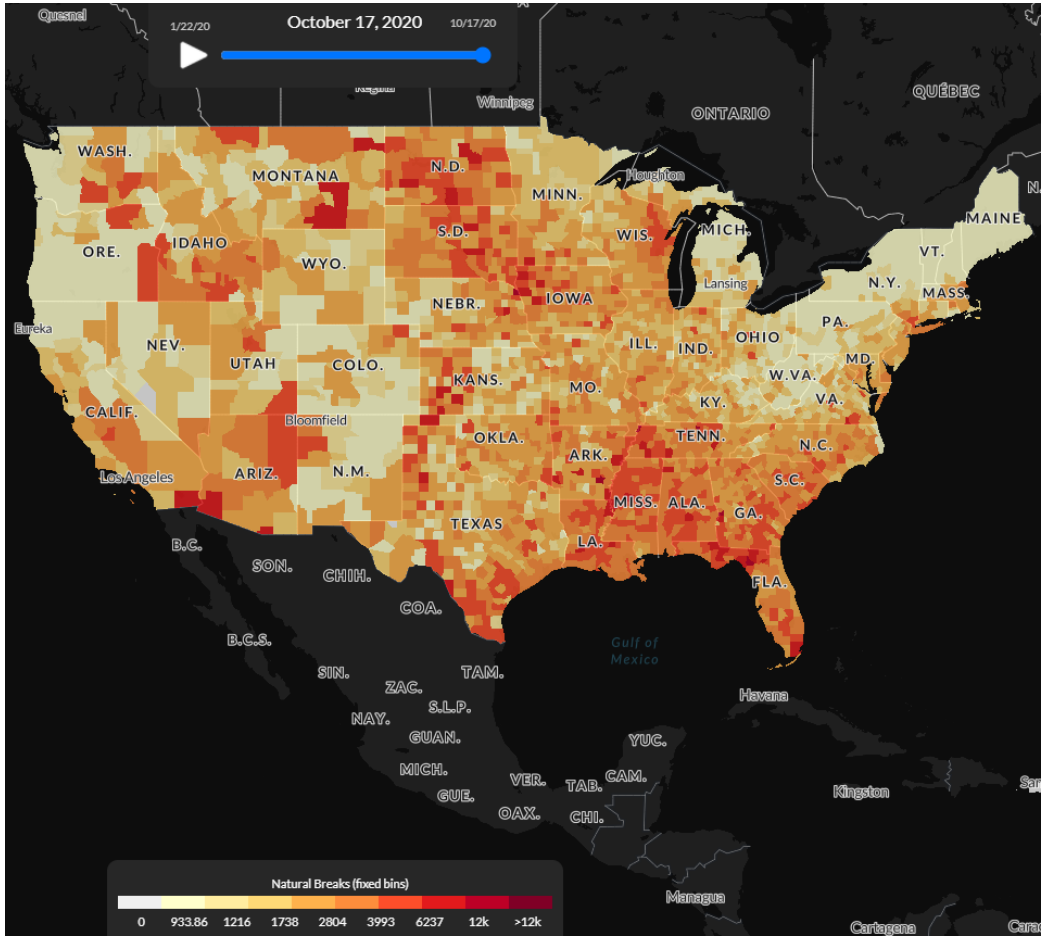
Uninsured - 2020



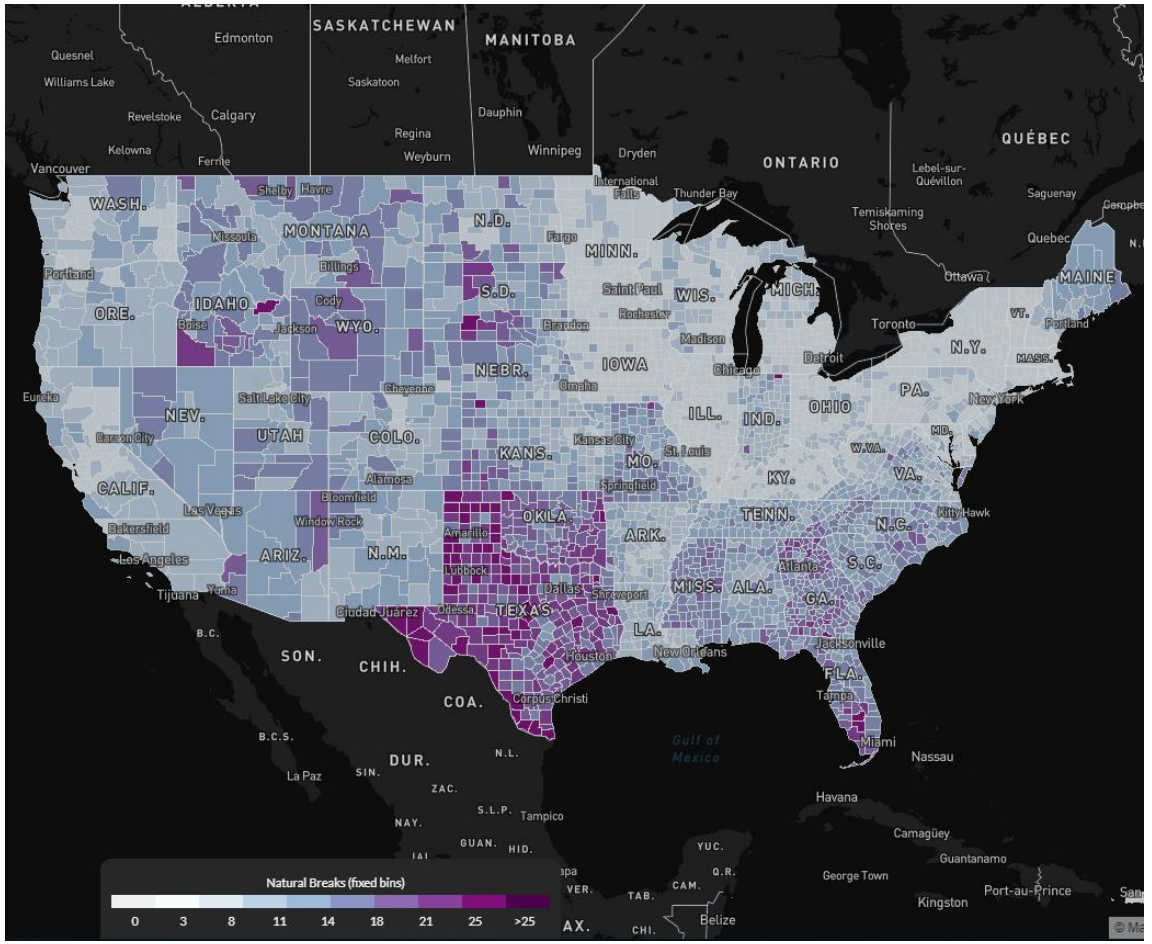
The US COVID Atlas. (n.d.). Retrieved July 19, 2020, from https://geodacenter.github.io/covid/map.html

Structural Racism:
Medicaid Expansion Under the ACA & COVID-19

COVID Infection Rates – Oct 2020



UnInsured - 2020



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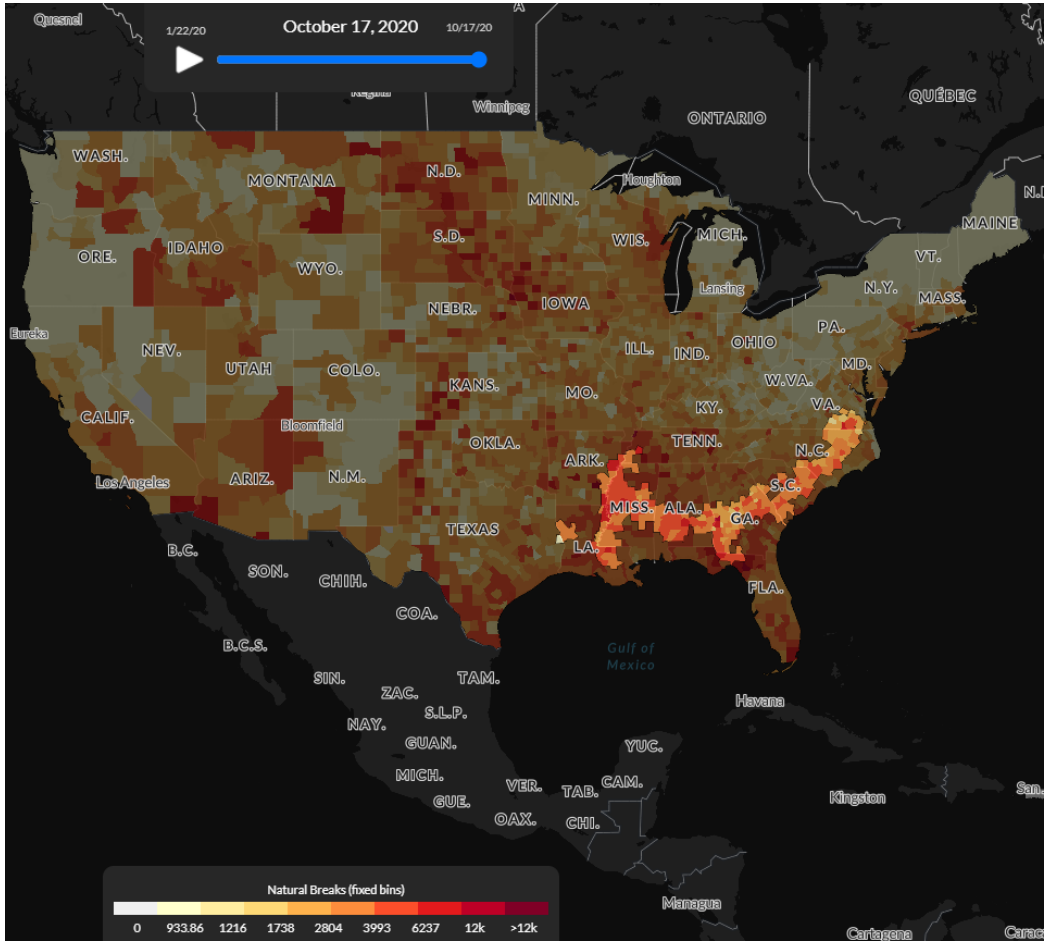
Structural Racism:
Medicaid Expansion Under the ACA & COVID-19

COVID Infection rates in the "Black Belt" – Oct 2020



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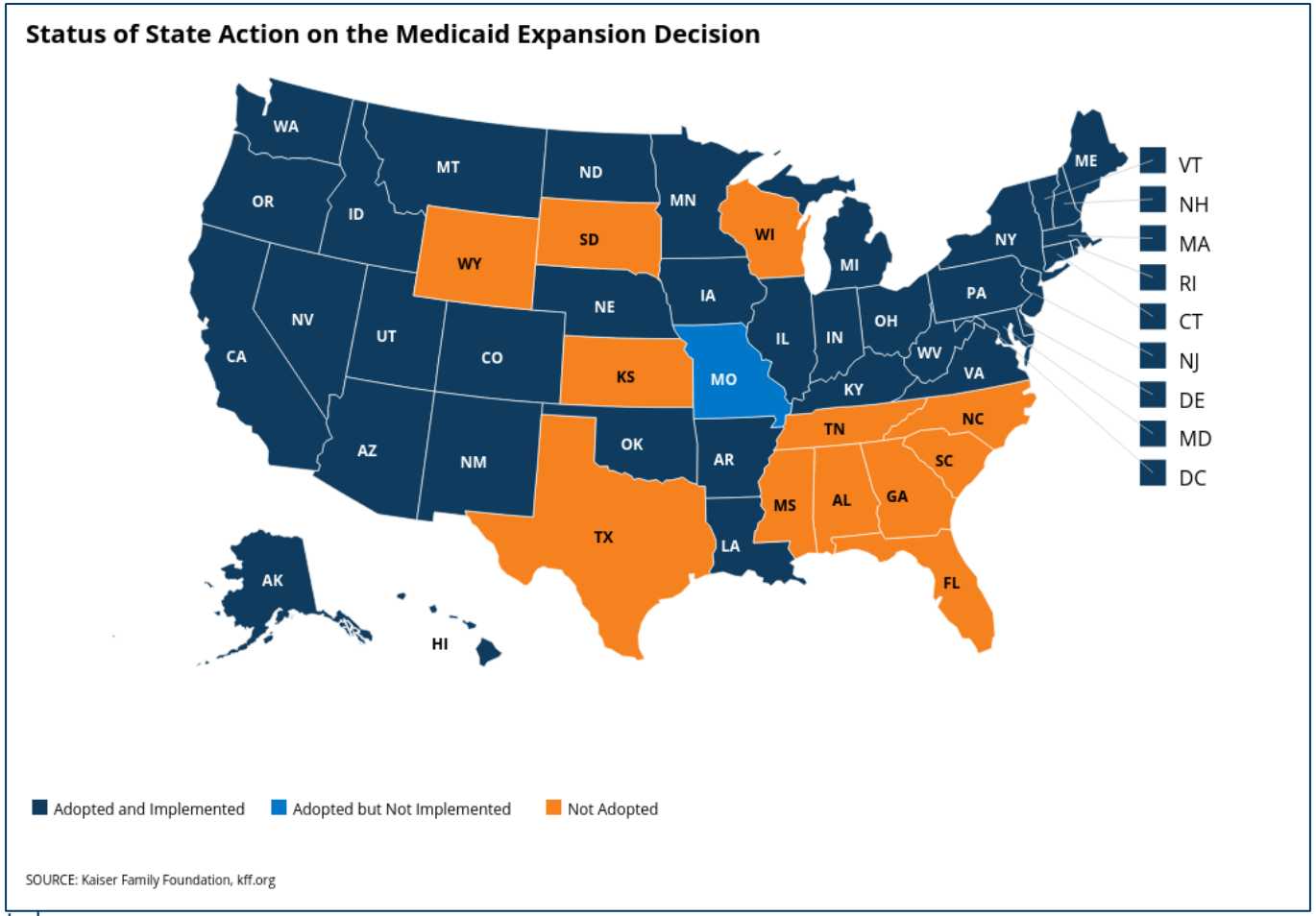

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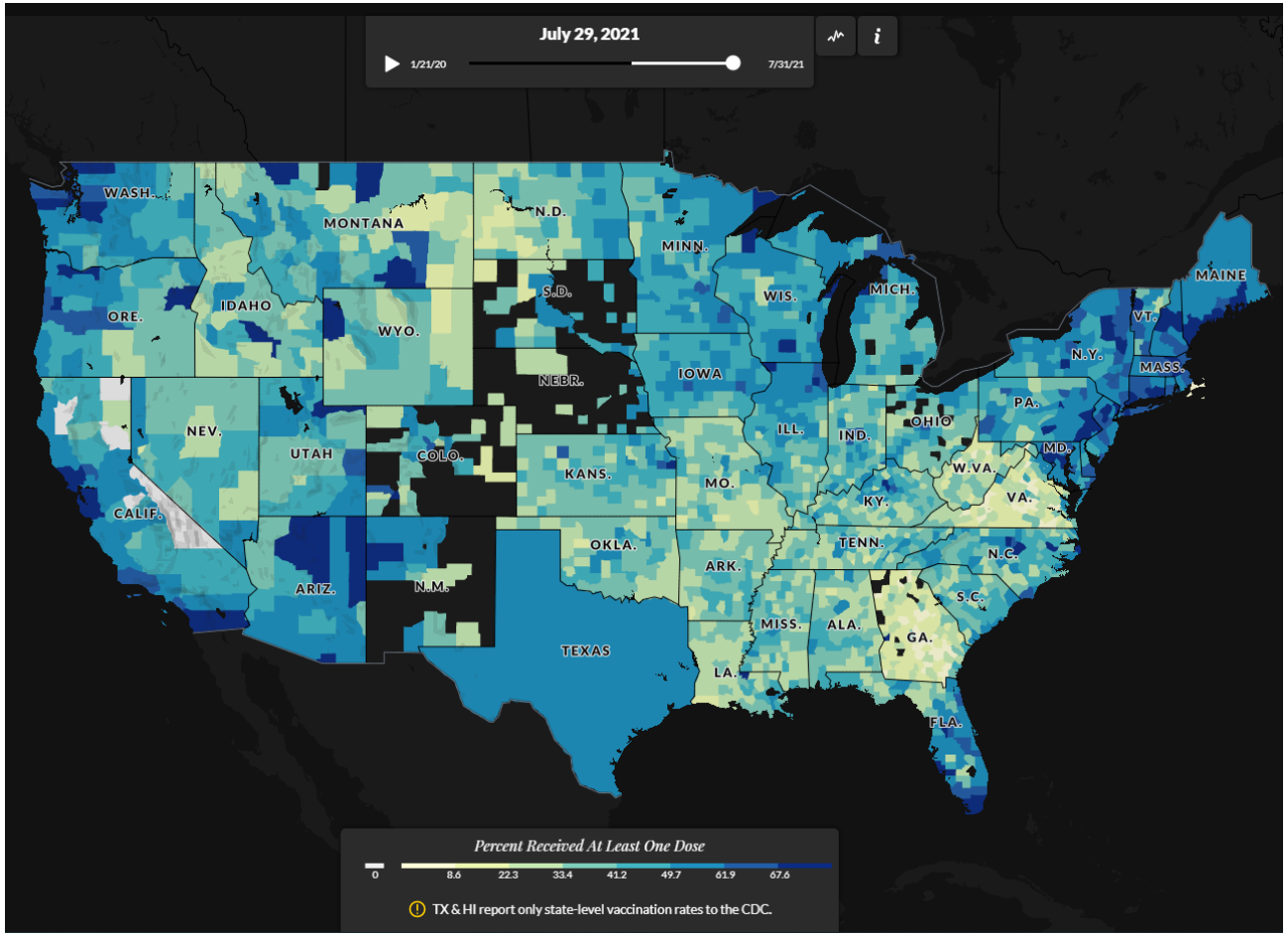
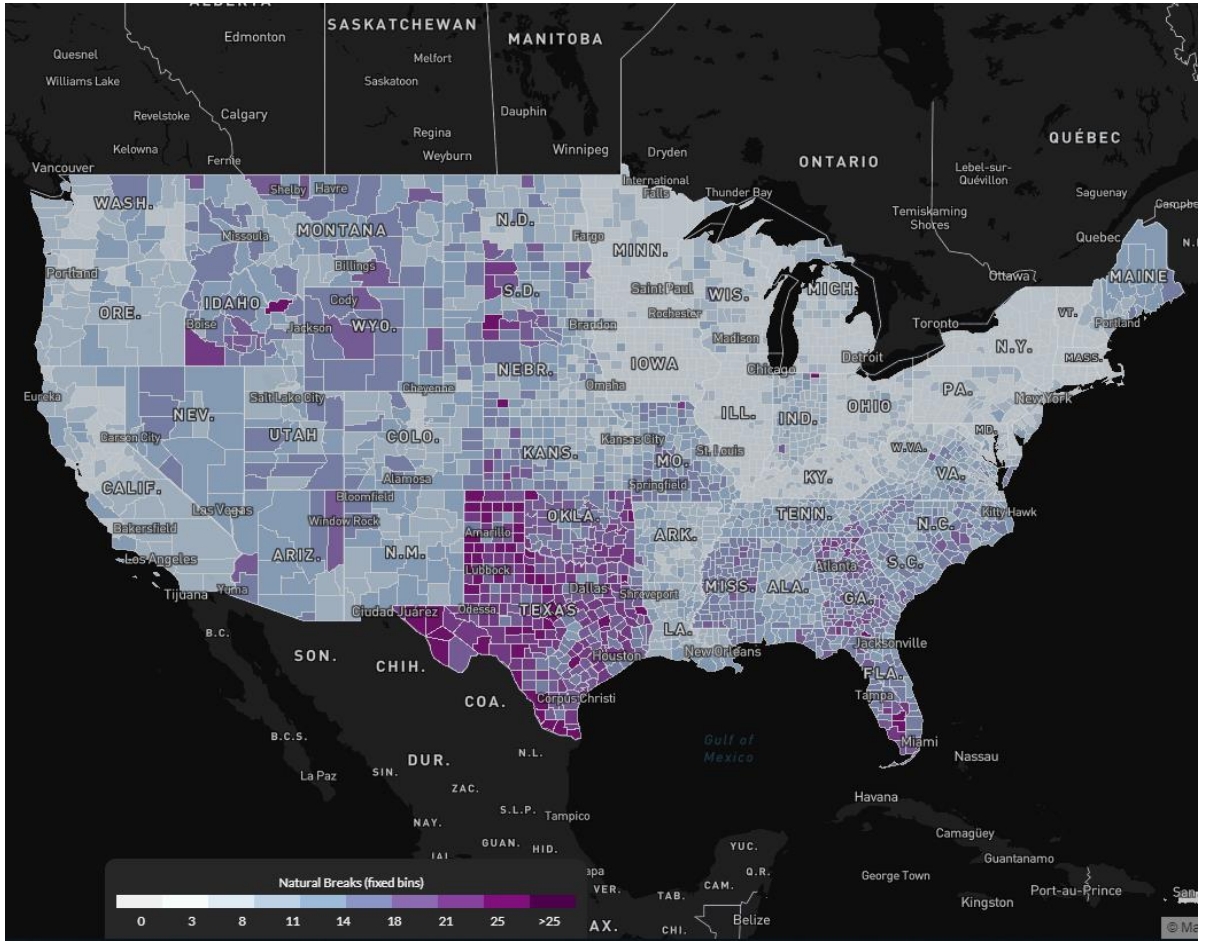
Structural Racism:
Medicaid Expansion Under the ACA & COVID-19

At least 1 COVID-19 vaccine dose – July 2021



UnInsured - 2020



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Medicaid Expansion Under the ACA & COVID-19

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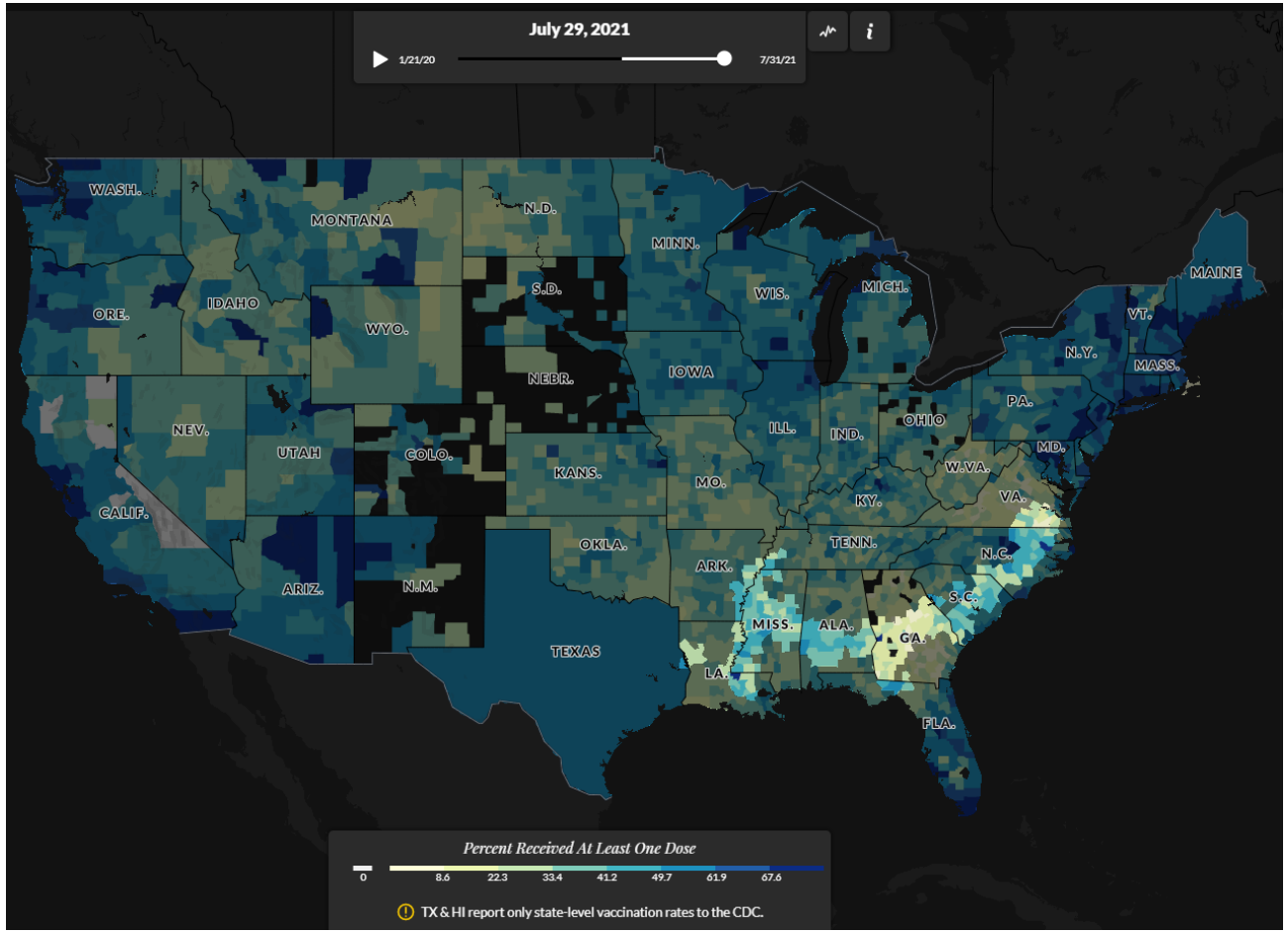

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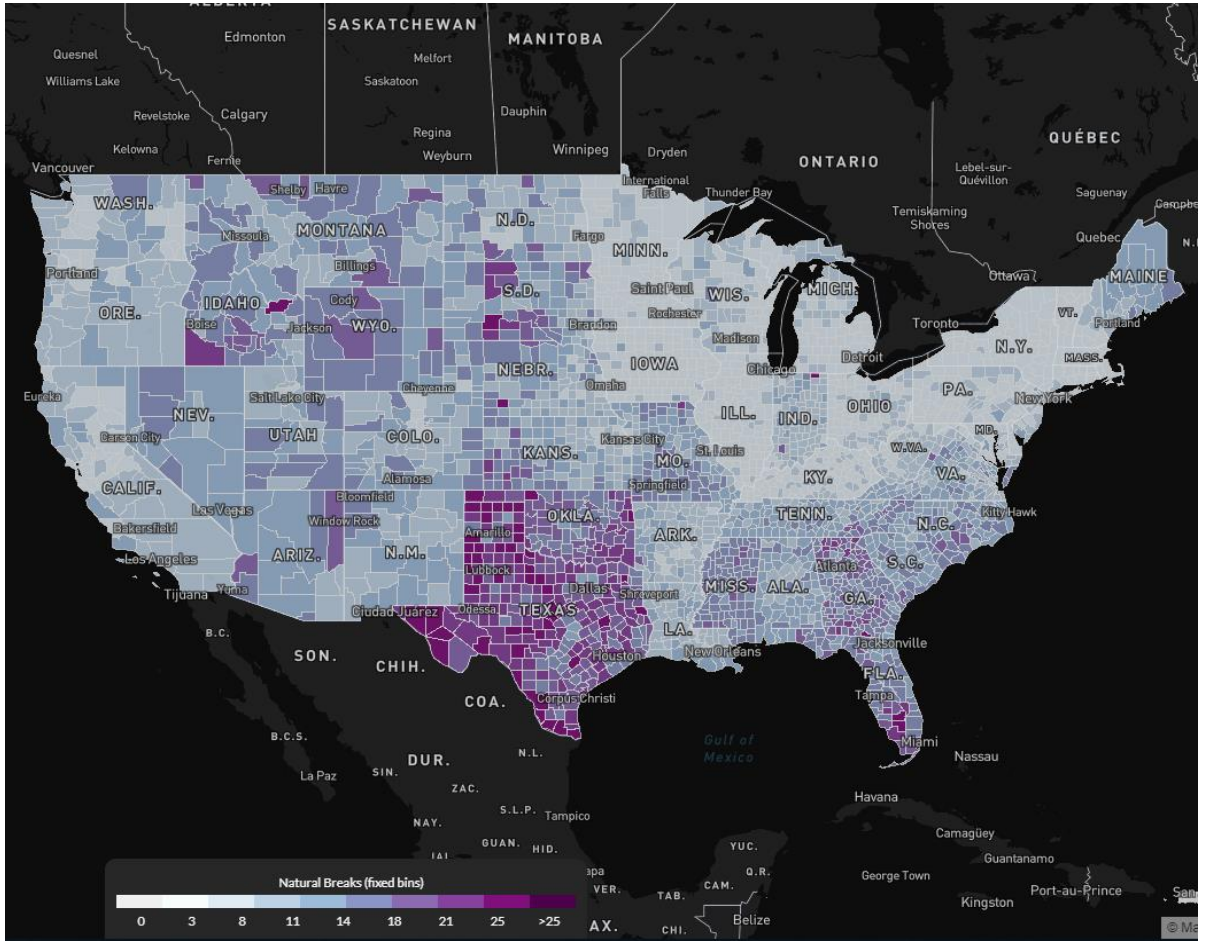

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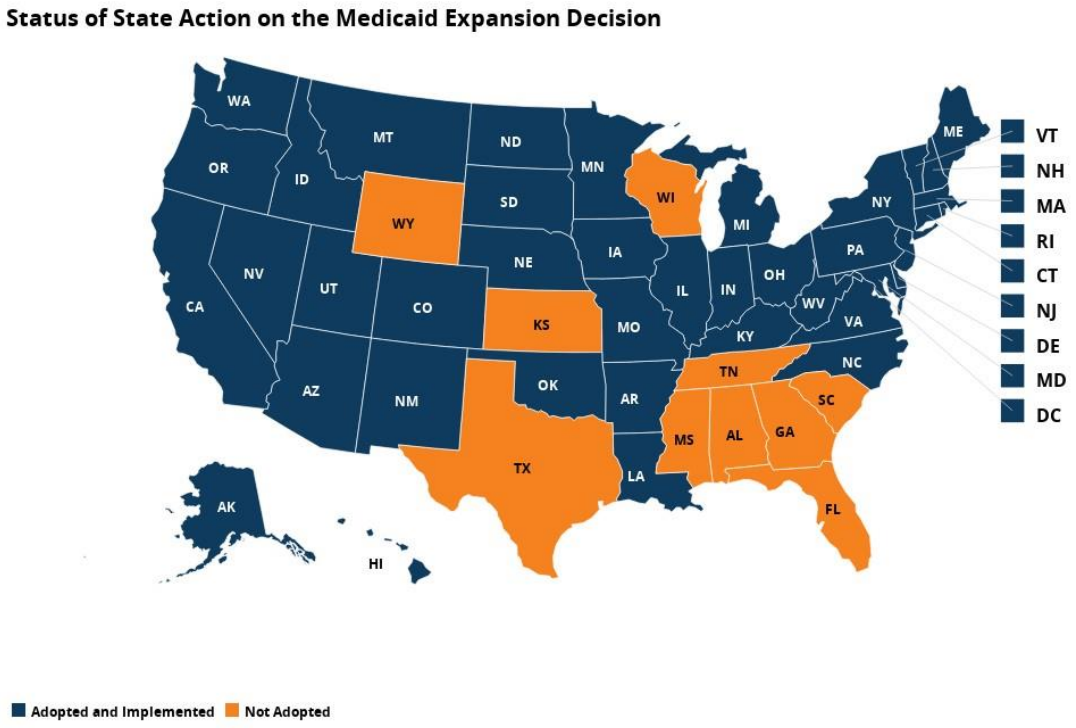
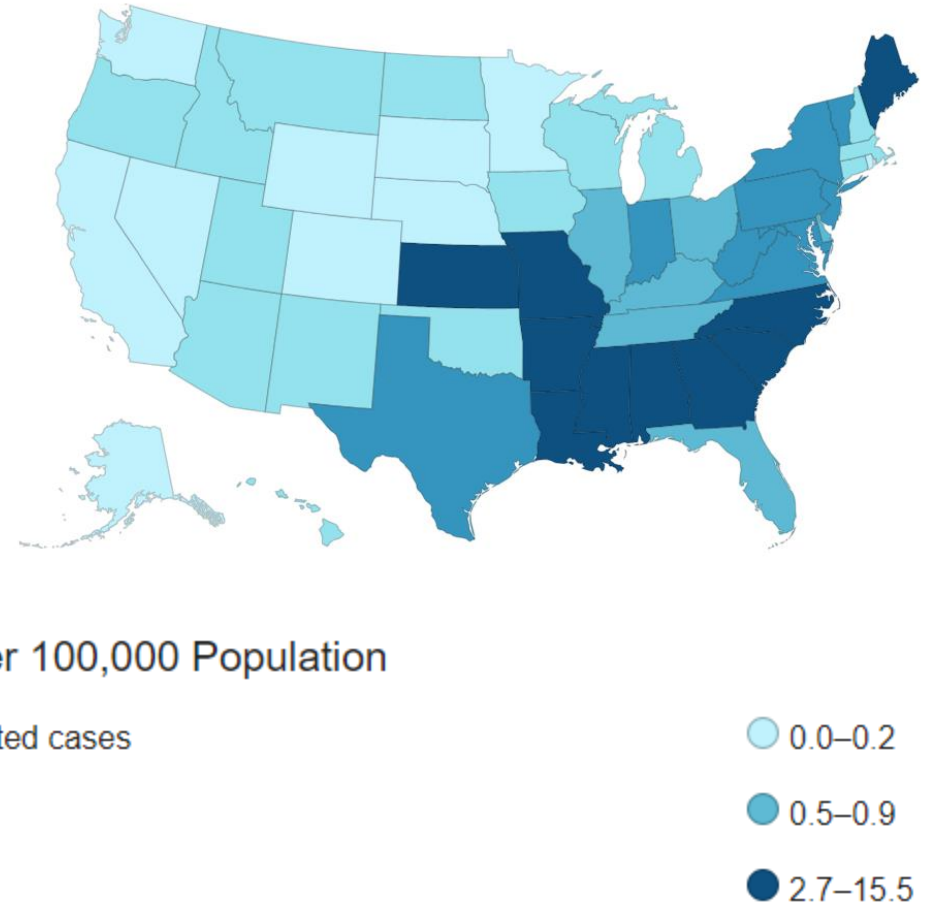
Medicaid Expansion Under the ACA & Viral Hepatitis

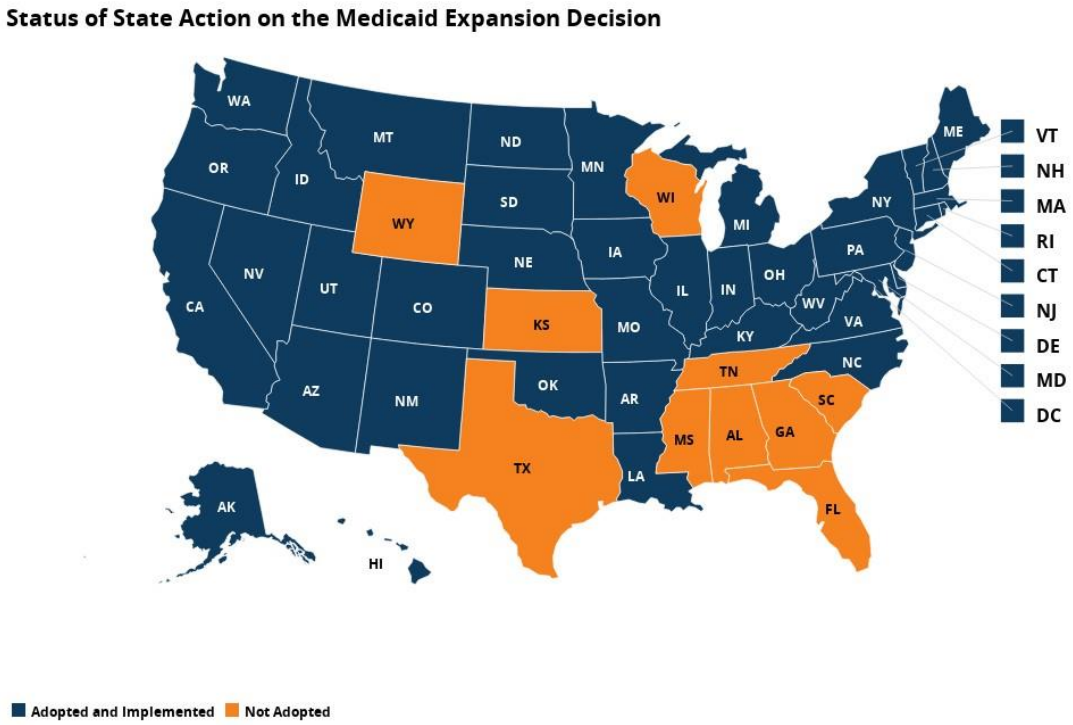
Rates* of reported cases† of acute hepatitis A virus infection, by state or jurisdiction, United States, 2021

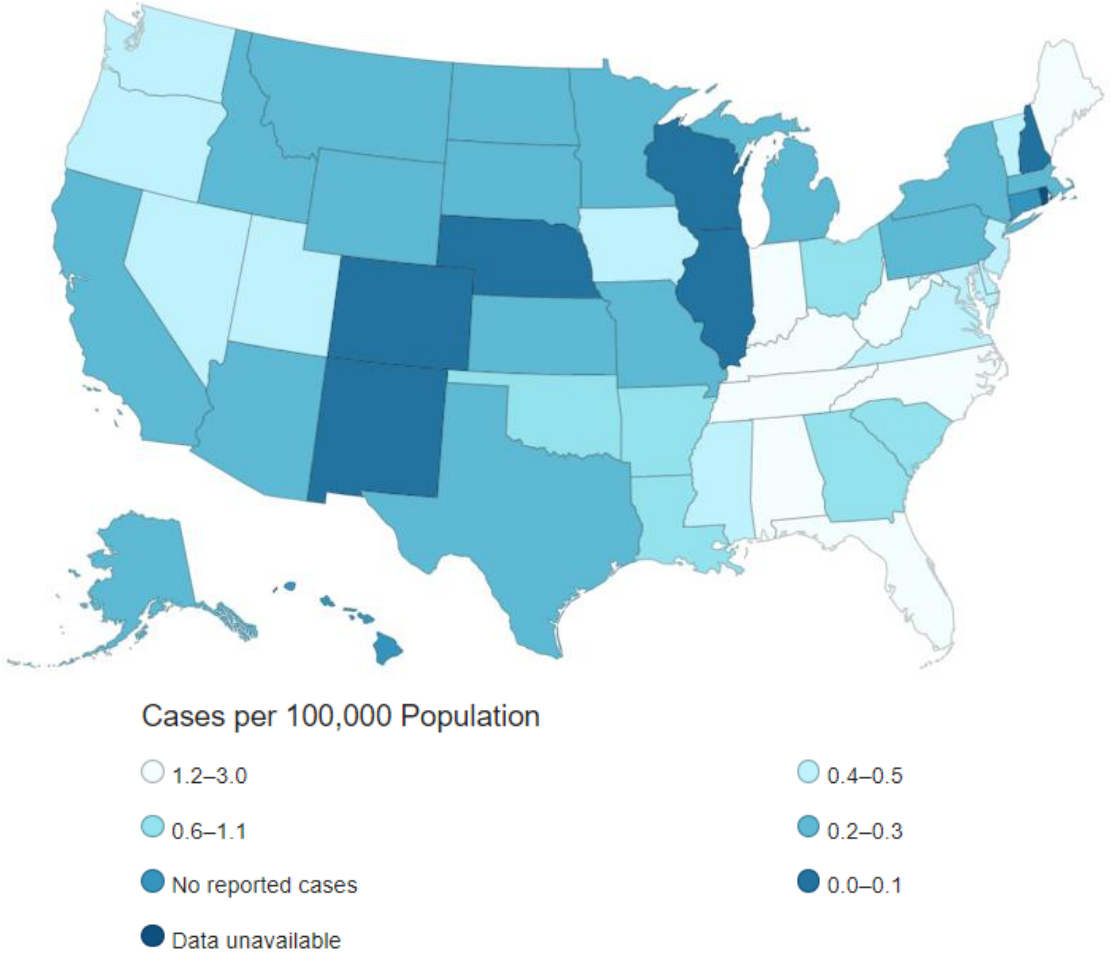




Medicaid Expansion Under the ACA & Viral Hepatitis

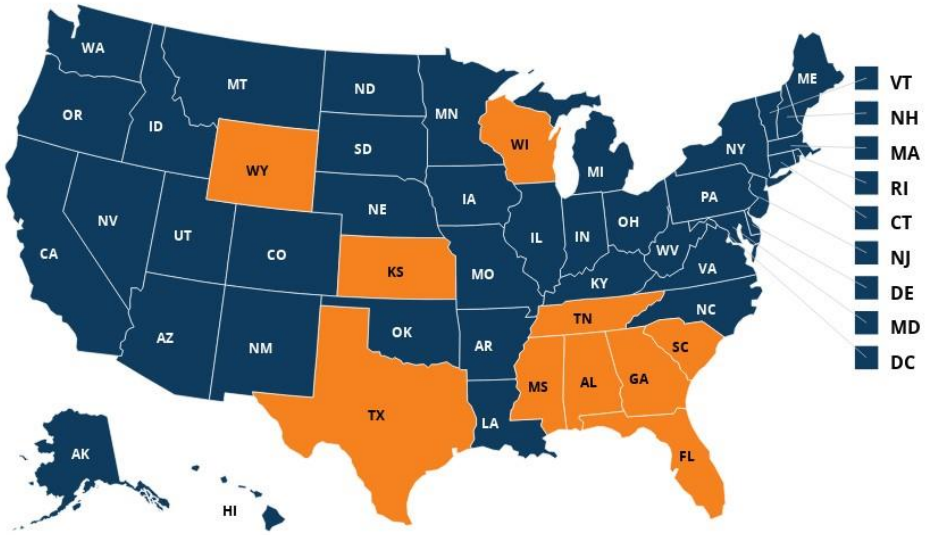
Rates* of reported cases† of acute hepatitis B virus infection, by state or jurisdiction, United States, 2021





Medicaid Expansion Under the ACA & Viral Hepatitis

Status of State Action on the Medicaid Expansion Decision

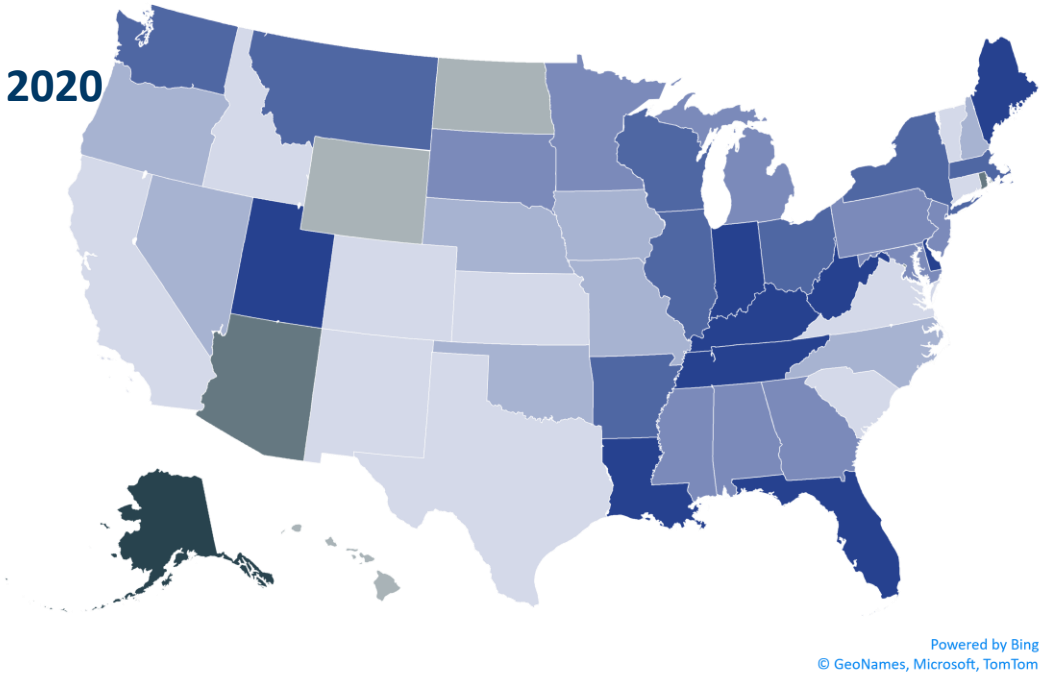


Adopted and Implemented Not Adopted

SOURCE: KFF, kff.org

3/5/2024

Rates* of reported cases† of acute hepatitis C virus infection, by state or jurisdiction
United States, 2020



Color Key	Cases/100,000 Population	State or Jurisdiction
	0.0–0.3	NM, CA, ID, SC, TX, CO, VT, CT, KS, VA
	0.4–0.7	MO, NH, NV, IA, NE, OK, NC, OR
	0.8–1.3	MD, SD, AL, MN, PA, MI, GA, MS, NJ
	1.4–2.3	WA, IL, MT, OH, WI, NY, AR, MA
	2.4–11.9	TN, KY, UT, IN, DE, WV, LA, FL, ME
	No reported cases	HI, ND, WY
	Data unavailable	AZ, DC, RI
	Not reportable	AK

Racial INEQUITIES lead to Racial Disparities

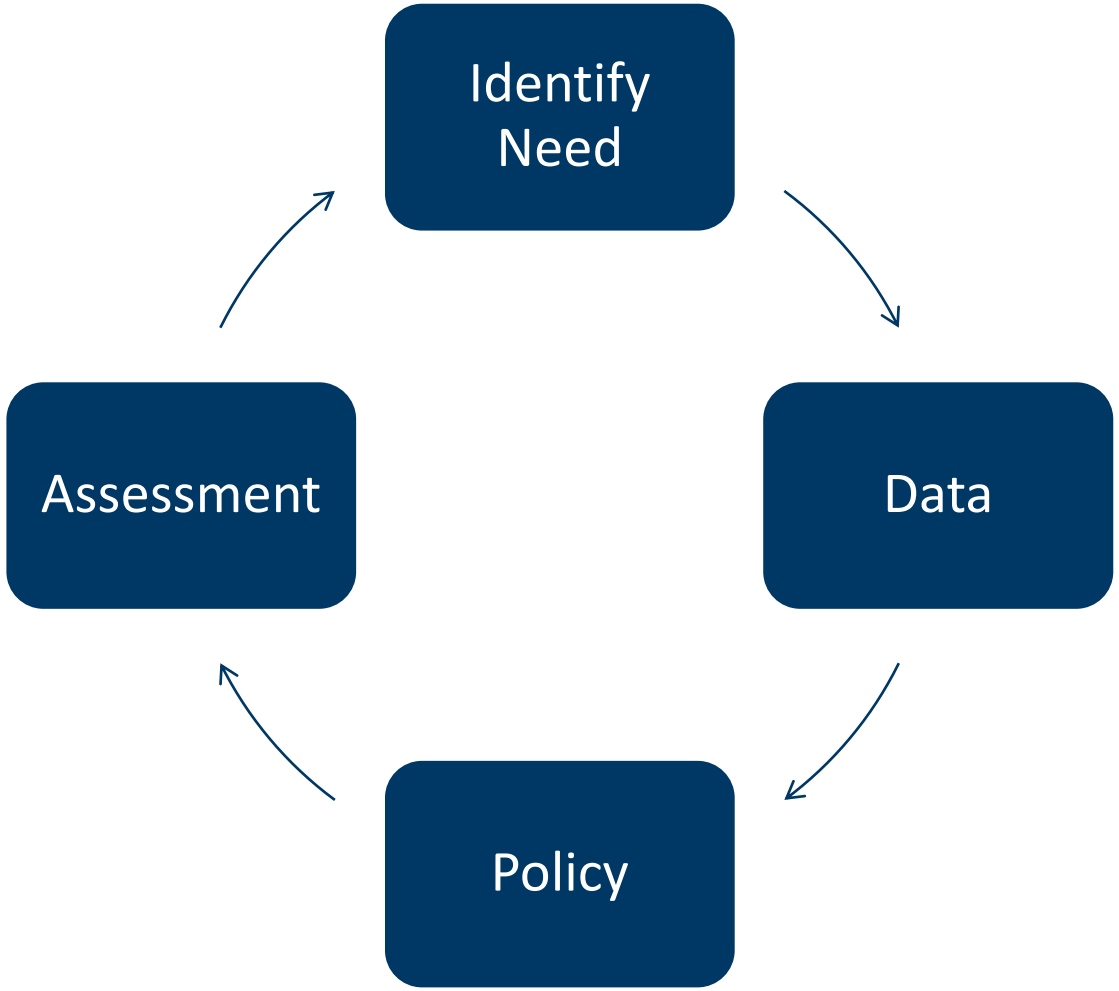
- Inequity - an instance of injustice or unfairness

- Disparity - noticeable and usually significant difference or dissimilarity

Structural racism is therefore THE inequity that leads to racial disparities

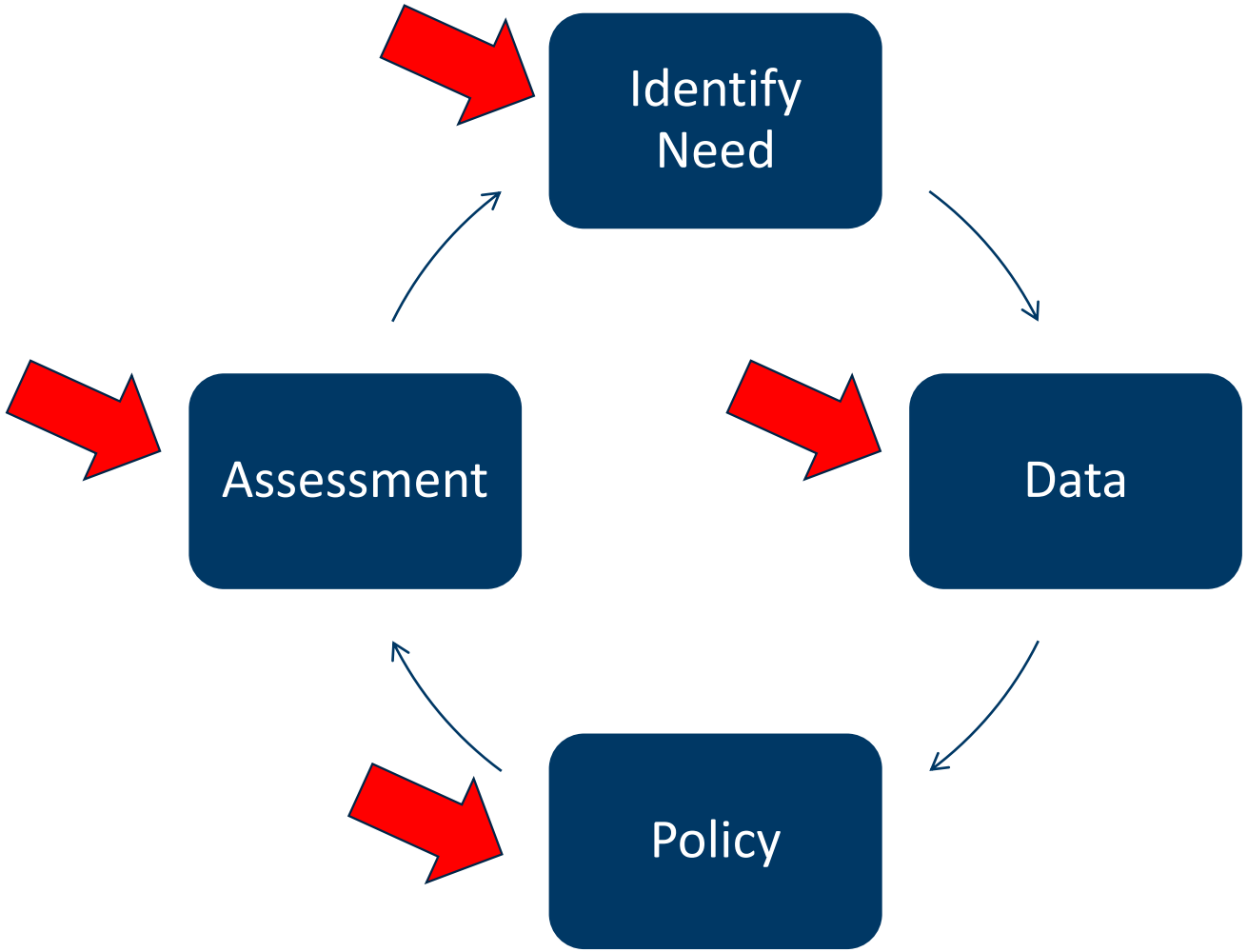
"Inequity." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/inequity. Accessed 20 Feb. 2021.
"Disparity." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/disparity. Accessed 20 Feb. 2021.

Policy “PDSA” Cycle



Community-Centered Policy Cycle

Community Co-Creation



The opportunity Policy has to lead with community

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Bringing a Racial Equity Lens to Policy

Racial Equity Toolkit
to Assess Policies, Initiatives, Programs, and Budget Issues

RACE & SOCIAL JUSTICE INITIATIVE

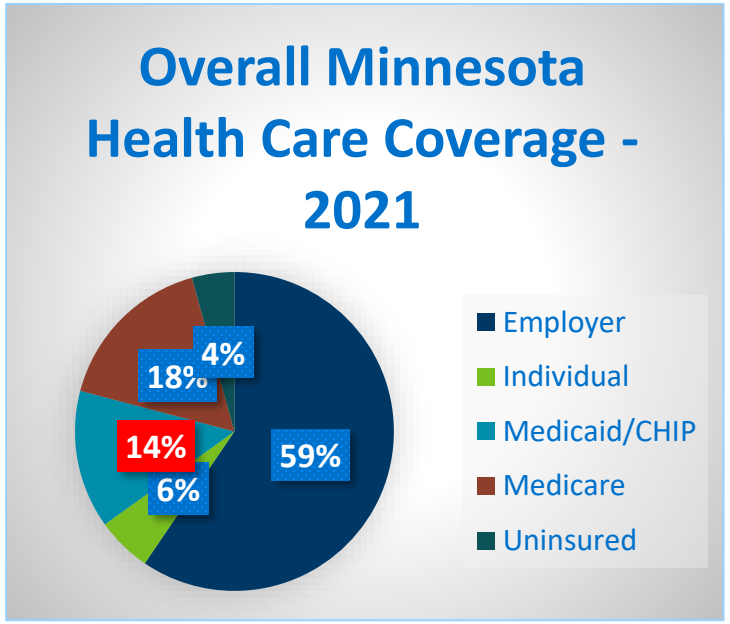
LOCAL AND REGIONAL
GOVERNMENT ALLIANCE ON
RACE & EQUITY

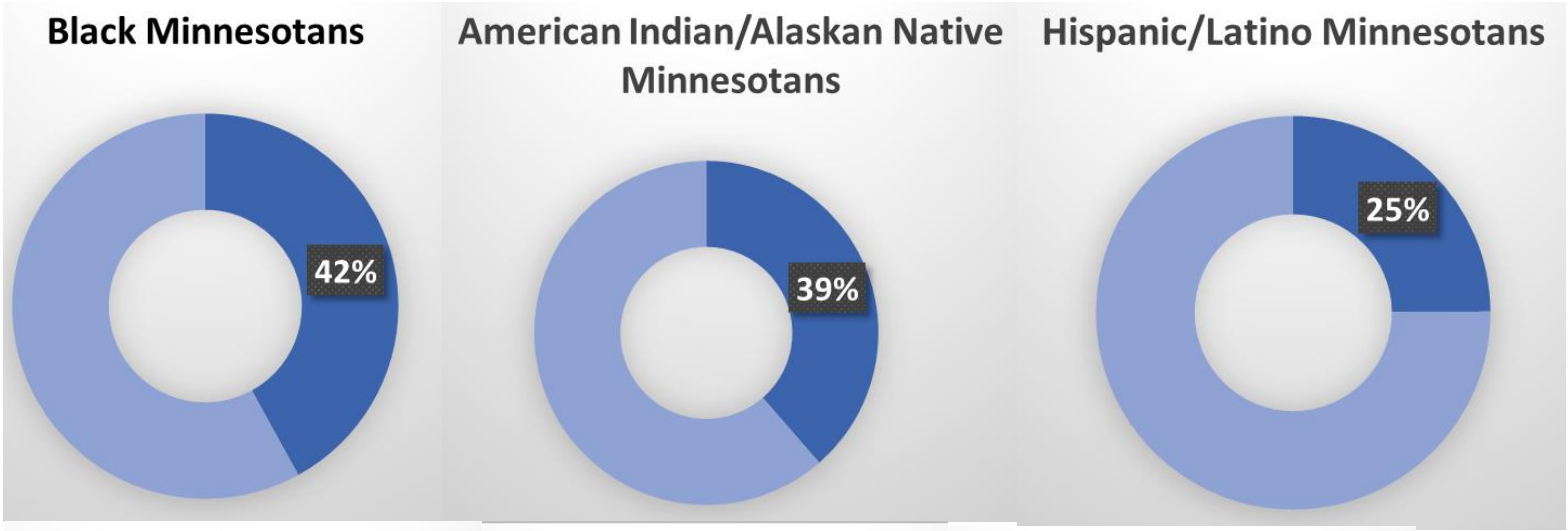
- What does data tell you about existing racial inequities that influence people's lives and should be taken into consideration?
- What are the root causes or factors creating these racial inequities?
- How will the policy, initiative, program, or budget issue increase or decrease racial equity?
- How will you address the impacts (including unintended consequences) on racial equity?
- How will you be held accountable for the impacts on communities?

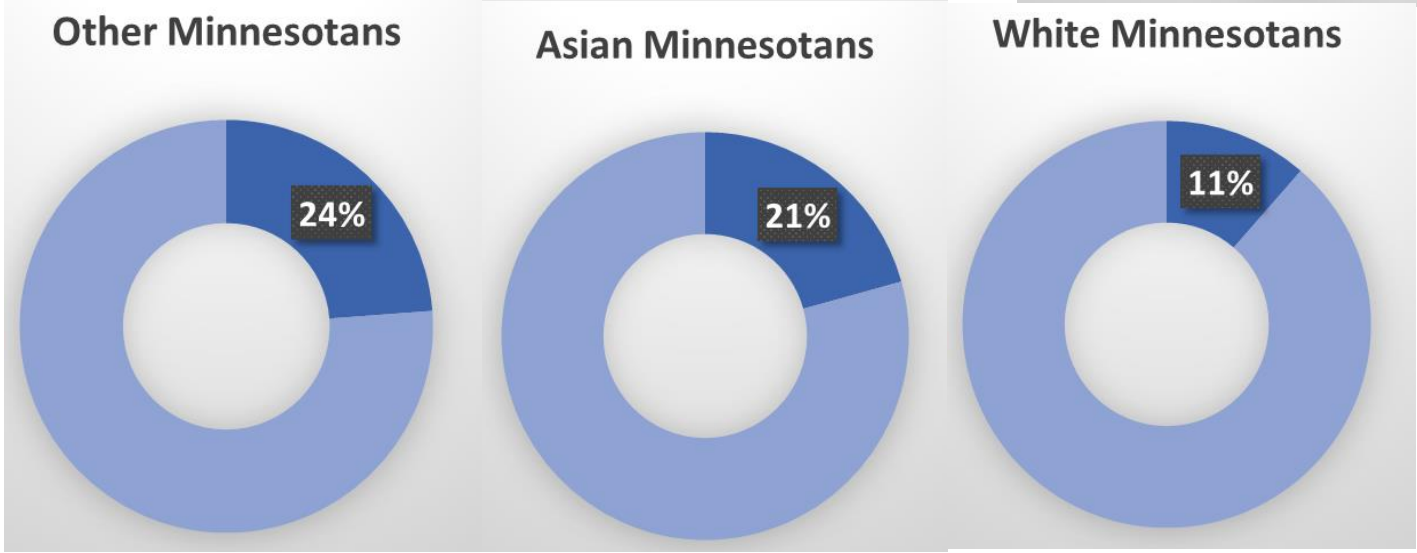
Tools & Resources | Government Alliance on Race and Equity. (2021, October 6). Government Alliance on Race and Equity. https://www.racialequityalliance.org/tools-resources/

How do Minnesotans get health care (1/2)

% of community members <65 on Medicaid or MNCare







Source: SHADAC analysis of the 2020-2021 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

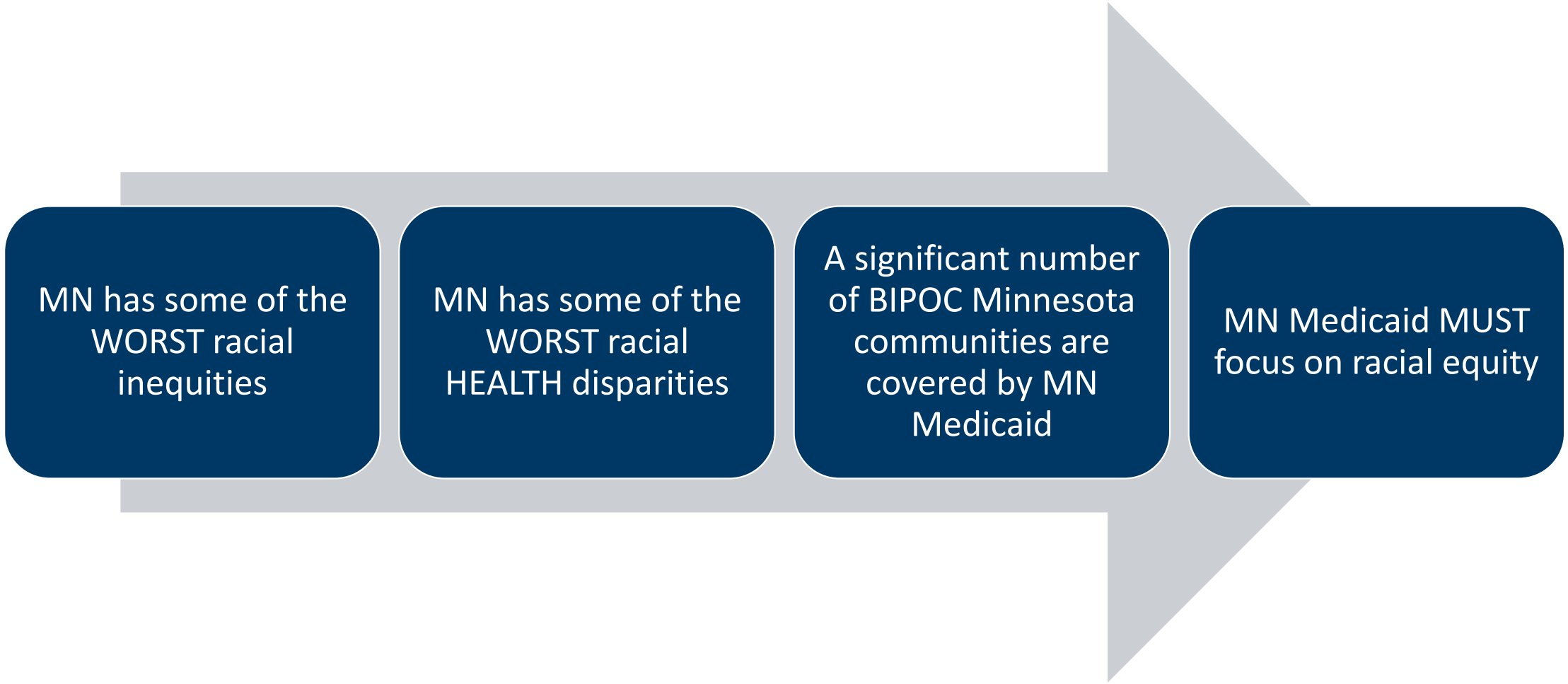
How do Minnesotans get health care (2/2)

% of community members <65 on Medicaid or MNCare

Minnesotans who access care via Medicaid	7-County Metro	Non-Metro Minnesota
American Indian/Alaska Native	29%	**37%**
Black/African-American	39%	**45%**
Hispanic/Latinx	22%	**27%**
Asian	**20%**	16%
"Other"	20%	**27%**
White	7%	**12%**

Source: SHADAC analysis of the 2020-2021 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

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



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

	Enrollees who were born in the U.S.						Enrollees who immigrated to the U.S.					
Mortality and Morbidity	**American Indians***	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Others/ Unknown**	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Other/ Unknown**	**All MA Enrollees**
Mortality over 2.5 years	1.35	0.8	0.95	0.51	0.28	0.49	0.21	0.37	0.31	0.58	0.09	0.78
Type 2 Diabetes	12.37	8.28	6.19	7.6	4.9	5.32	7.66	7.54	10.88	9.71	6.52	6.95
Asthma	12.48	16.47	9.56	9.97	4.55	7.53	4.82	4.61	3.79	4.02	2.86	9.4
HIV/Hep-C	4.52	2.67	1.48	1.66	0.36	0.9	1.09	0.8	0.72	1.02	0.96	1.6
Hypertension	7.69	9.6	3.93	5.55	3	3.61	8.03	5.34	6.74	4.5	5.07	5.14
Heart failure, hospitalized heart conditions	2.05	1.96	1.46	0.65	0.57	1.08	0.64	0.96	0.79	1.27	0.59	1.37
COPD	11.91	8.4	10.17	6.72	2.98	6.33	5.1	5.65	3.92	4.46	2.74	8.53
Lung, Laryngeal Cancer	0.25	0.2	0.27	0.07	0.07	0.17	0.1	0.19	0.05	0.18	0.1	0.22
Behavioral Health												
Substance Use Disorder	35.37	20.09	15.64	14.12	4.33	12.34	2.56	3.75	3.97	2.78	2.37	14.42
PTSD	10.54	8.64	5.62	6.06	2.41	3.58	6.31	6.76	3.09	6.05	2.51	5.9
Depression	30.27	20.58	22.4	19.23	7.53	15.33	6.78	12.36	10.32	9.65	5.39	19.22
SPMI	7.36	7.09	6.19	4.77	2.94	3.68	2.73	4.47	1.59	5.48	1.38	5.55

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

Focus of Building Racial Equity into the Walls of MN Medicaid Report: Community Strength + Medicaid Levers

- Co-create with community involvement, highlighting both community strengths & impact of structural racism

- Medicaid "Levers"
  - Eligibility/Enrollment
  - Access
  - Quality
  - Early Opportunities

2022 BREW Report's Calls to Action → Demonstrated Impact

2022 Building Racial Equity into the Walls (BREW) of MN Medicaid: a focus on US-born Black Minnesotans report Calls to Action

1. **Simplify and support enrollment and renewal**

2. **Increase investment in culturally relevant care for U.S.-born Black Minnesotans on Medicaid**

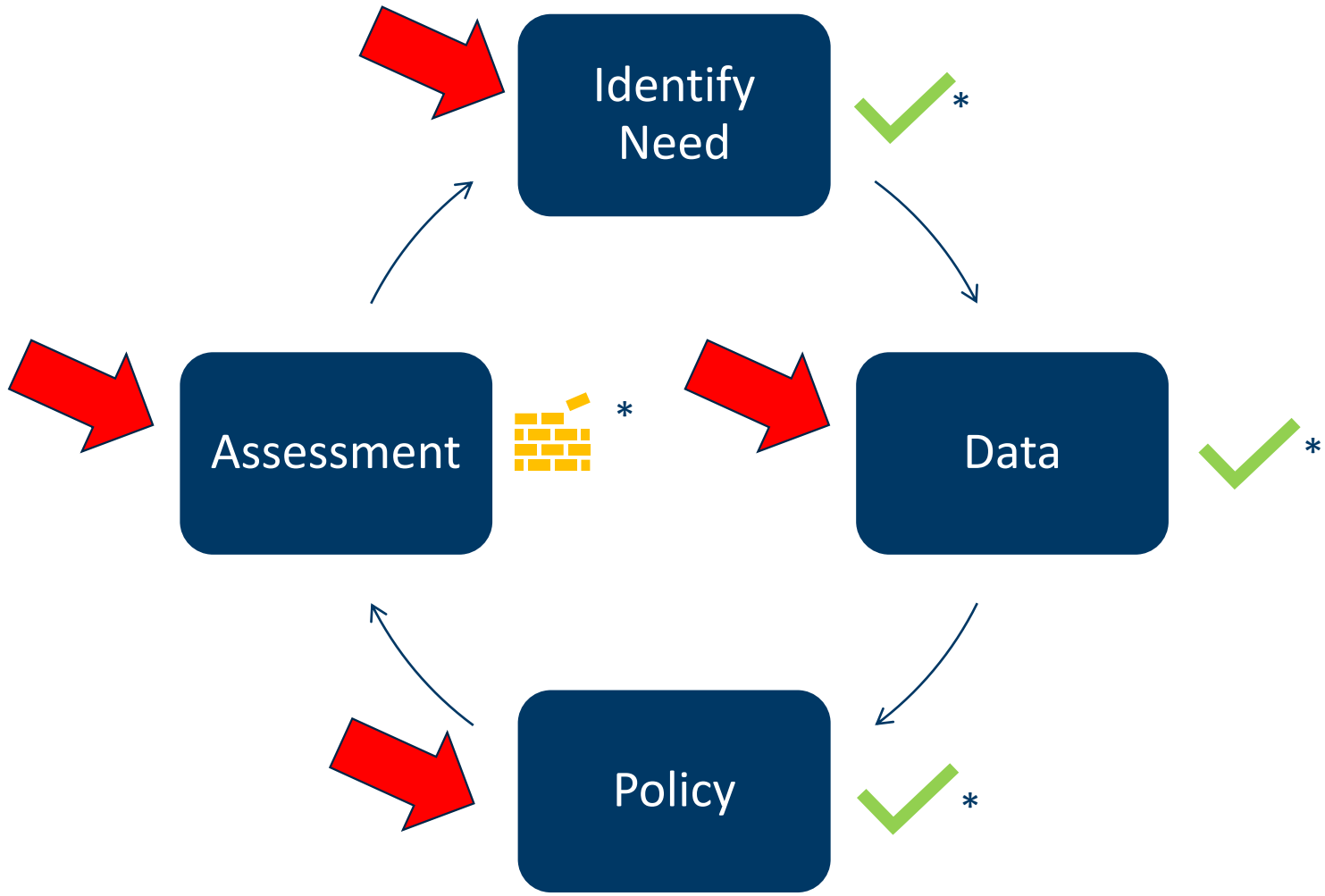
3. Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Governor Tim Walz's budget for the 2023 legislative session included several proposals that aligned with the 2022 report's recommendations & were passed into law:

- **Starting in 2024 will have 12 months of continuous, stable Medicaid coverage for Minnesotans 0-19**
- **Starting in 2025 will have continuous Medicaid coverage for children 0-6 years of age!!!**
- **Simplified enrollment and renewal processes in Medical Assistance and MinnesotaCare**
- **Increased support for community-based navigator organizations**
- **Improved payment and decreased barriers for doulas**

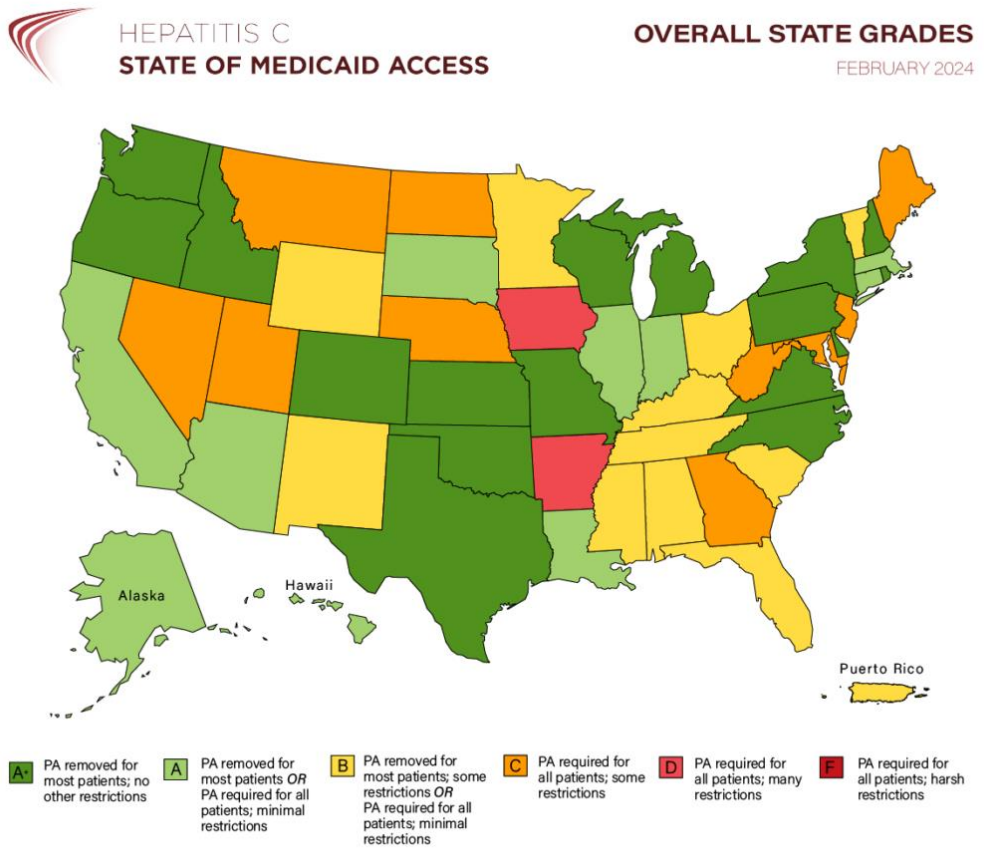
Community-Centered Policy Cycle

Building Racial Equity into the Walls: a focus on US-born Black Minnestoans



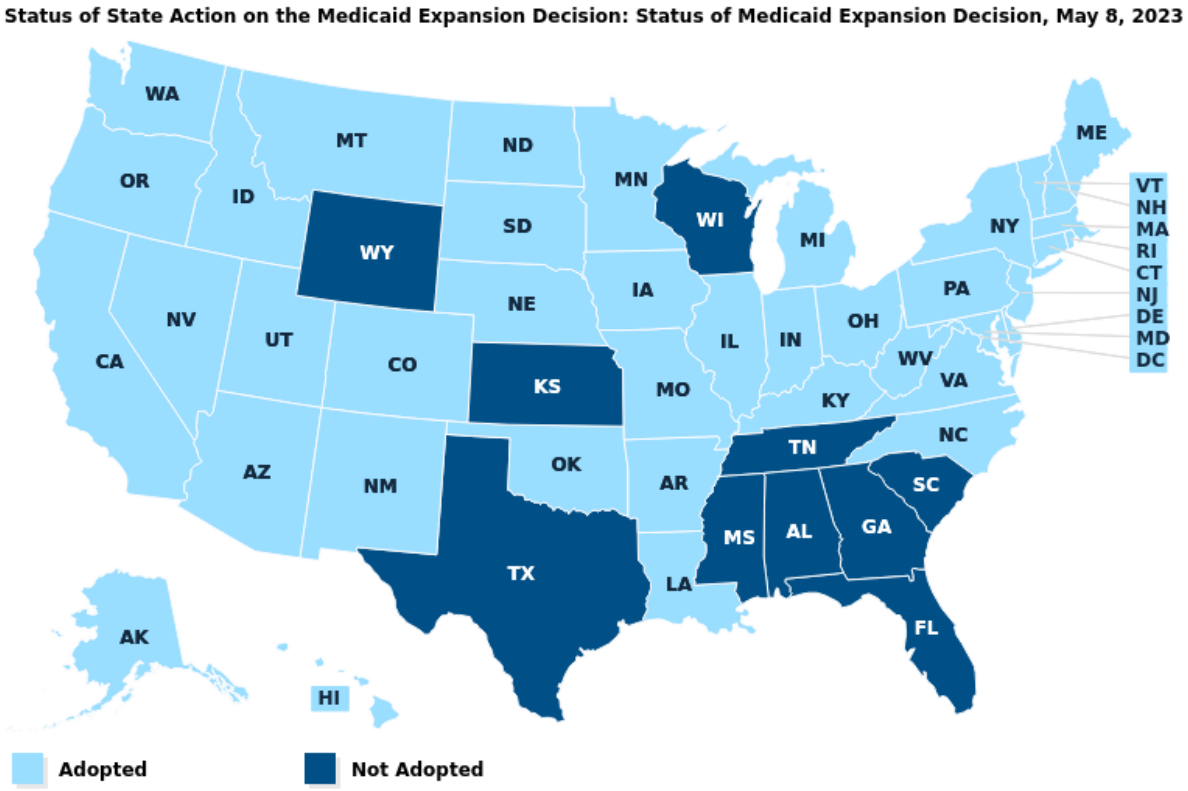
Medicaid Expansion Under the ACA & Hepatitis C

Hepatitis C State Medicaid Access - 2024



Todd, J. (2024, February 29). *It's official: more than half of state Medicaid programs no longer require prior authorization for first-time hepatitis C treatment*. Hepatitis C: State of Medicaid Access. https://stateofhepc.org/its-official-more-than-half-of-state-medicaid-programs-no-longer-require-prior-authorization-for-first-time-hepatitis-c-treatment/?emci=17134fc7-8dd6-ee11-85f9-002248223794&emdi=ed54f924-28d7-ee11-85f9-002248223794&ceid=3861740

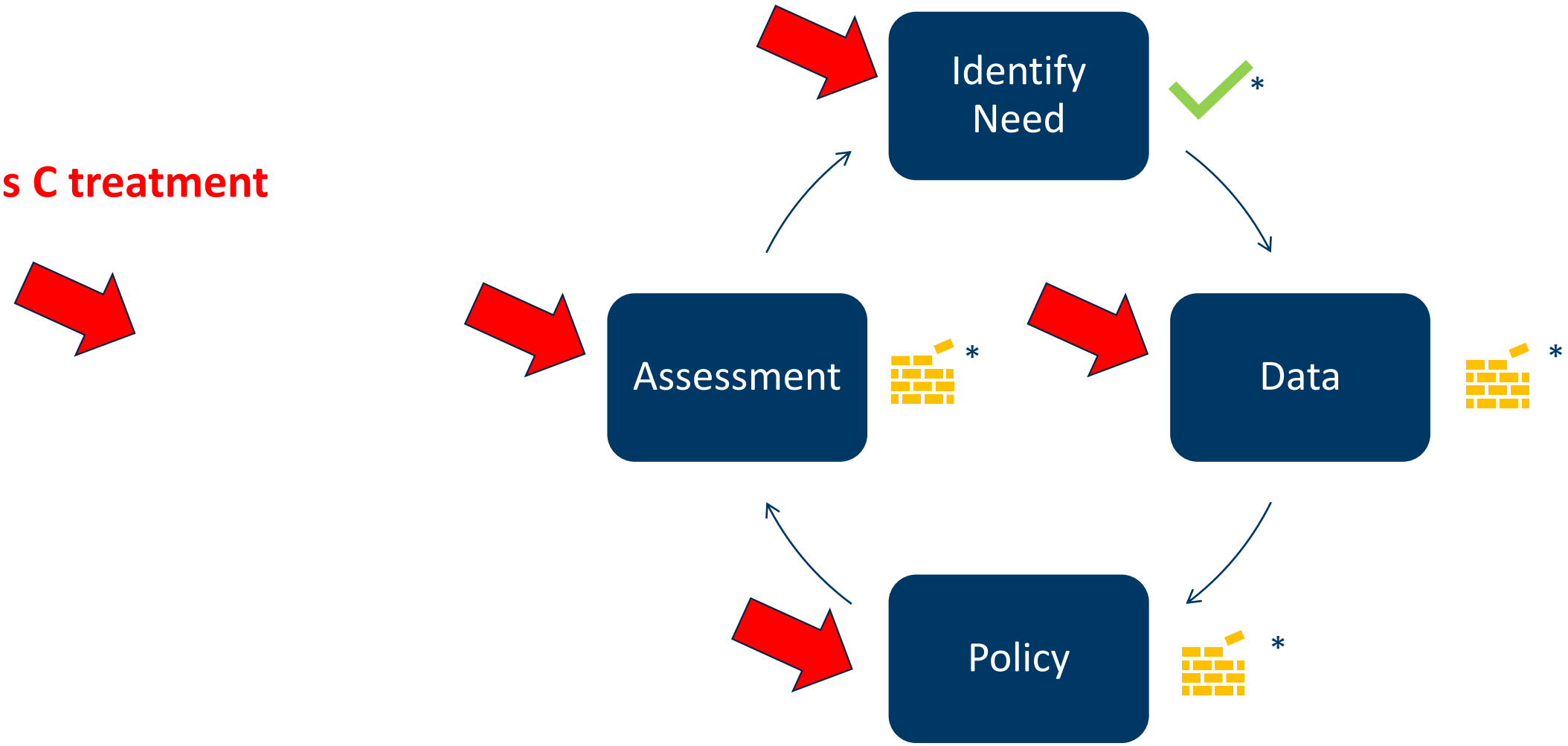
Medicaid Expansion Status- 2024



SOURCE: KFF's State Health Facts.

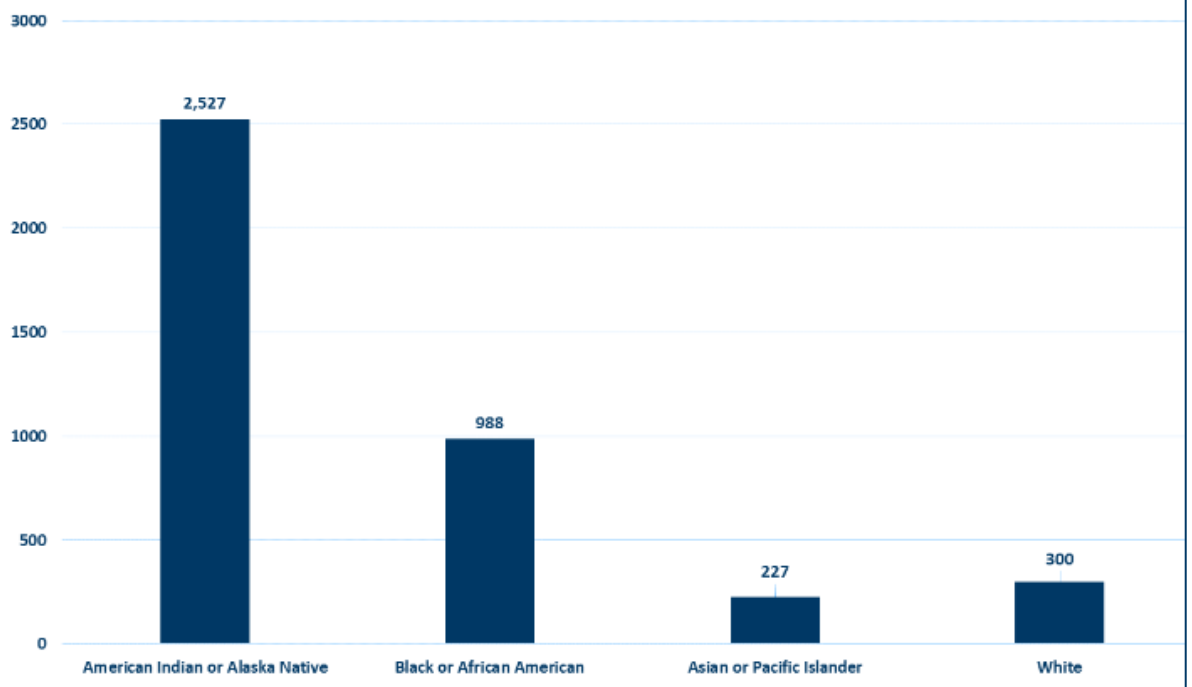
Community-Centered Policy Cycle

Hepatitis C treatment



Background: Hep C in MN

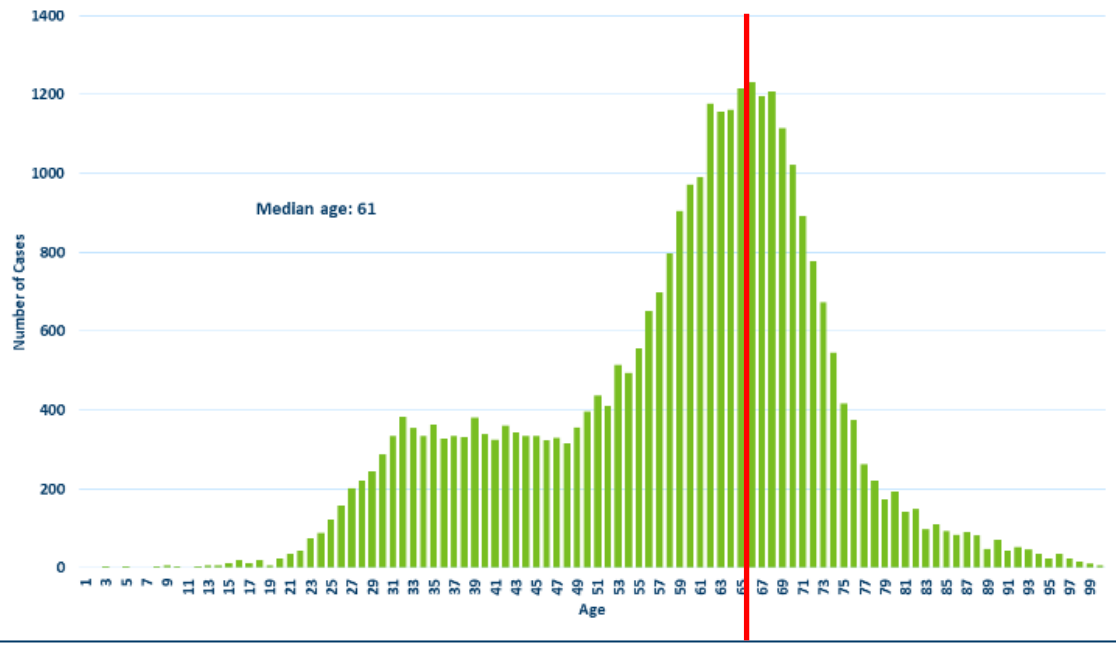
Persons Living with HCV in MN by Race Rates (per 100,000 persons*), 2022



Downloadable data: Persons Living with HCV in MN by Current Race (CSV)

*Rates calculated using 2020 U.S. Census ACS data. Excludes persons with multiple races or unknown race, n=10,961.

Persons Living with HCV in MN by Age, 2022



https://www.health.state.mn.us/diseases/hepatitis/c/stats/current.html

Hep C CDC recommendations

CDC recommends testing for everyone 18+

Testing for HCV should include an HCV antibody test that reflexes to an HCV RNA test

There is a cure for HCV and treatment is recommended for nearly all persons living with HCV infection

Recommendations for testing, managing, and treating hepatitis C | HCV Guidance. (n.d.). https://www.hcvguidelines.org/

Data: Minnesota Medicaid (MA) & Hep C

	Enrollees who were born in the U.S.						Enrollees who immigrated to the U.S.					
Mortality and Morbidity	**American Indians***	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Others/ Unknown**	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Other/ Unknown**	**All MA Enrollees**
Mortality over 2.5 years	1.35	0.8	0.95	0.51	0.28	0.49	0.21	0.37	0.31	0.58	0.09	0.78
Type 2 Diabetes	12.37	8.28	6.19	7.6	4.9	5.32	7.66	7.54	10.88	9.71	6.52	6.95
Asthma	12.48	16.47	9.56	9.97	4.55	7.53	4.82	4.61	3.79	4.02	2.86	9.4
HIV/Hep-C	4.52	2.67	1.48	1.66	0.36	0.9	1.09	0.8	0.72	1.02	0.96	1.6
Hypertension	7.69	9.6	3.93	5.55	3	3.61	8.03	5.34	6.74	4.5	5.07	5.14
Heart failure, hospitalized heart conditions	2.05	1.96	1.46	0.65	0.57	1.08	0.64	0.96	0.79	1.27	0.59	1.37
COPD	11.91	8.4	10.17	6.72	2.98	6.33	5.1	5.65	3.92	4.46	2.74	8.53
Lung, Laryngeal Cancer	0.25	0.2	0.27	0.07	0.07	0.17	0.1	0.19	0.05	0.18	0.1	0.22
Behavioral Health												
Substance Use Disorder	35.37	20.09	15.64	14.12	4.33	12.34	2.56	3.75	3.97	2.78	2.37	14.42
PTSD	10.54	8.64	5.62	6.06	2.41	3.58	6.31	6.76	3.09	6.05	2.51	5.9
Depression	30.27	20.58	22.4	19.23	7.53	15.33	6.78	12.36	10.32	9.65	5.39	19.22
SPMI	7.36	7.09	6.19	4.77	2.94	3.68	2.73	4.47	1.59	5.48	1.38	5.55

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

Medicaid Policy Levers: Pharmacy Benefit

- Is a medication covered by Medicaid?

Medicaid Policy Levers: Pharmacy Benefit Federal restrictions

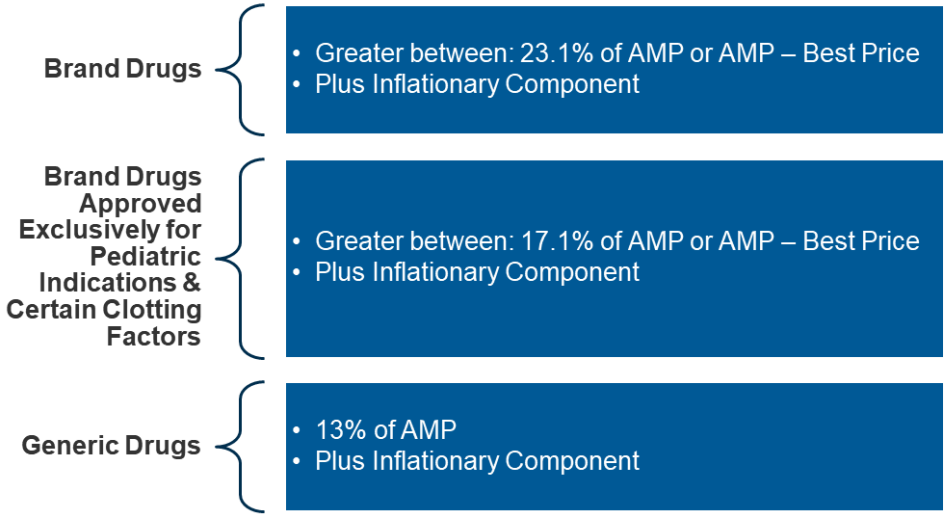
- Federal law prohibits state Medicaid programs from talking about drug prices and rebate amounts

- Only allows sharing of aggregate information

- Prevents transparency on actual costs of drugs

Figure 1

Medicaid Statutory Rebate Amounts



NOTE: AMP is average manufacturer price.
SOURCE: 42 U.S.C. 1396r-8 (c)

KFF
HENRY J KAISER FAMILY FOUNDATION

Dolan, R. (2021, March 16). *Understanding the Medicaid Prescription Drug Rebate Program | KFF*. KFF. https://www.kff.org/medicaid/issue-brief/understanding-the-medicaid-prescription-drug-rebate-program/

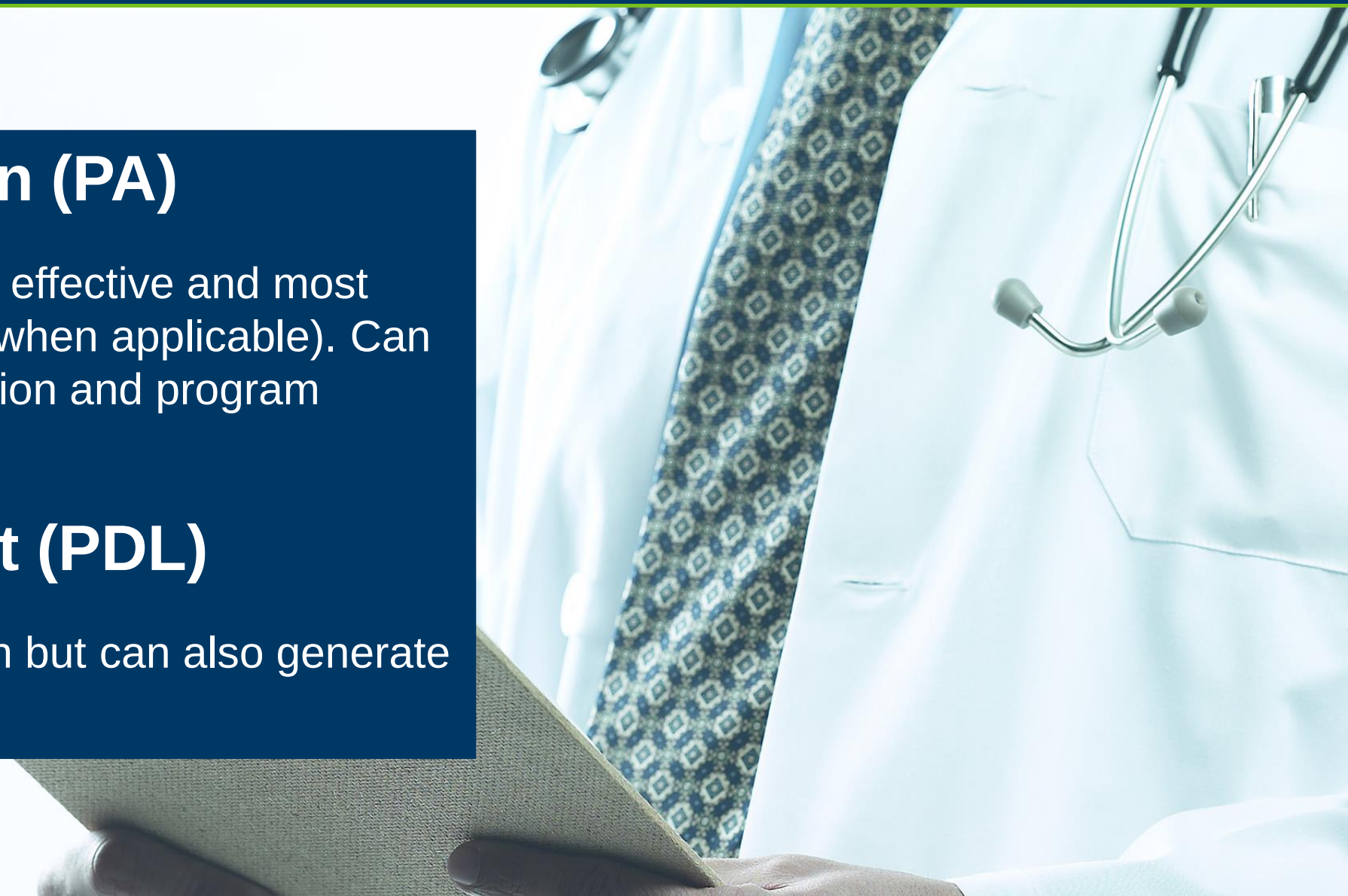
Medicaid Policy Levers: Managing the Pharmacy Benefit

Prior authorization (PA)

Can ensure drugs are safe, effective and most cost advantageous option (when applicable). Can promote appropriate utilization and program integrity

Preferred drug list (PDL)

Similar to prior authorization but can also generate supplemental drug rebates



Medicaid Policy Levers: Federal law establishes standards for PA

Requires a response within 24 hours

Requires a 72-hour supply in emergency situations

Allows limitations to discourage fraud, waste, abuse

Allows satisfaction of components of a drug use review program to ensure appropriate, medically necessary medications unlikely to produce adverse medical results

Medicaid Policy Lever: PA vendor

- MN DHS contracts with Kepro - a CMS-approved Quality Improvement Organization.
- Operationalizes the criteria that the DFC recommends, and DHS implements.
  - Receives requests primarily by phone or fax, though a few are received by mail.
  - Reviews requests with clinical staff (technicians, pharmacists, nurses or physicians) as appropriate.

Medicaid Policy Levers: Uniform PDL

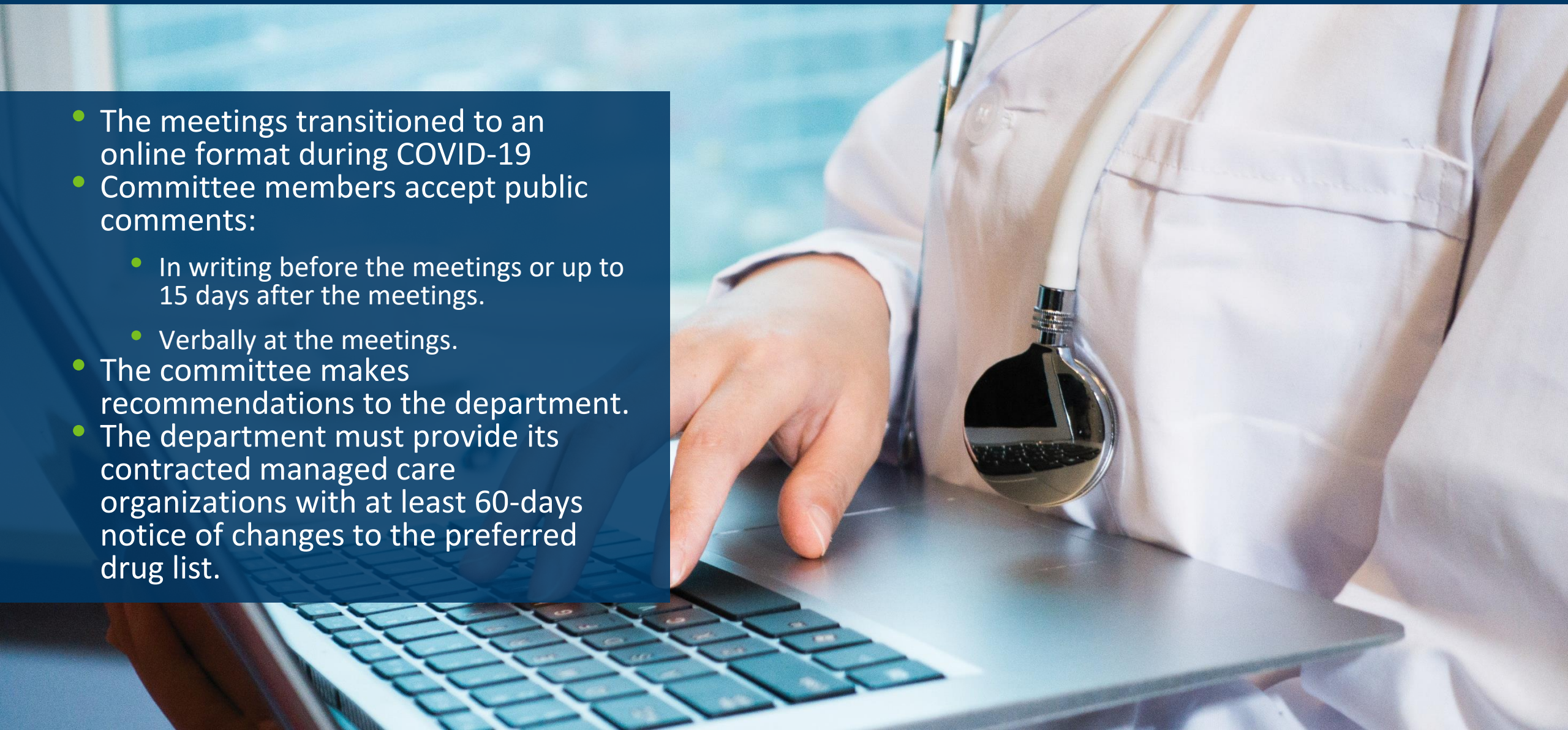
Nine different preferred drug lists

One uniform preferred drug list

Medicaid Policy Levers: Managing MN's PDL

- The Drug Formulary Committee manages the preferred drug list through its open, public process.
- Volunteer members include health care professionals and a member of the public.
- The committee reviews drug classes and recommendations for safety and efficacy.
  - Cost information cannot be discussed at the meetings or shared with the members due to the federal restriction.

Medicaid Policy Levers: Drug Formulary Committee public meetings



- The meetings transitioned to an online format during COVID-19
- Committee members accept public comments:
  - In writing before the meetings or up to 15 days after the meetings.
  - Verbally at the meetings.
- The committee makes recommendations to the department.
- The department must provide its contracted managed care organizations with at least 60-days notice of changes to the preferred drug list.

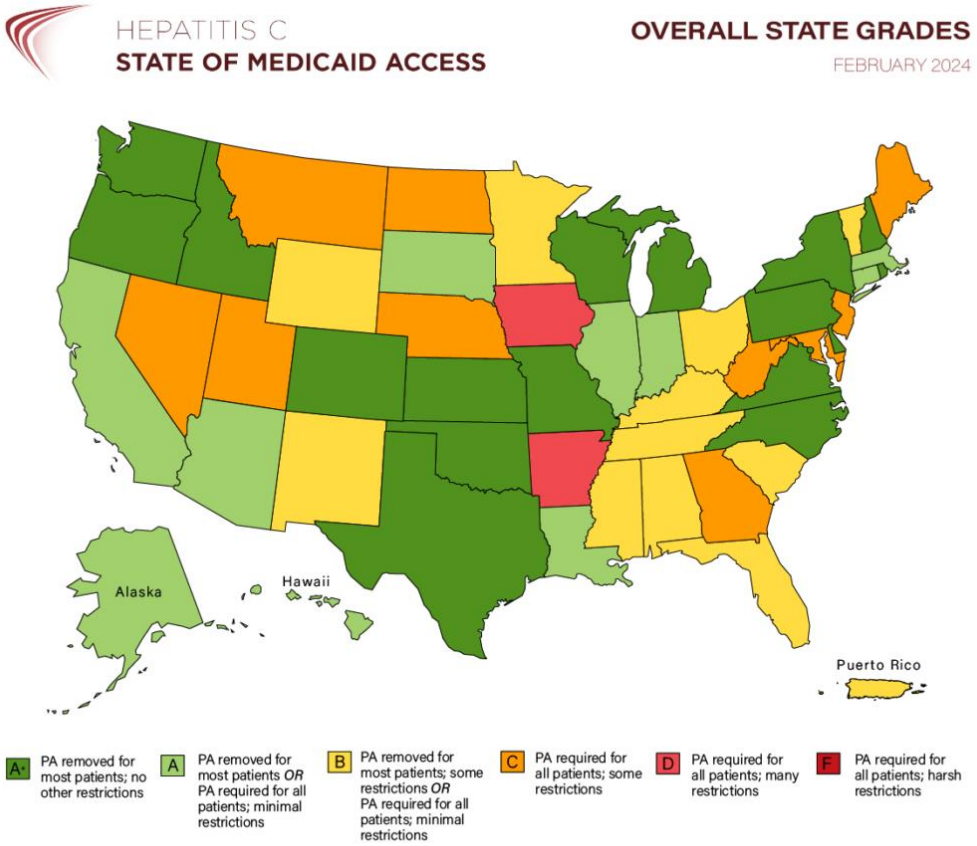
Medicaid Policy Levers: Department considerations in bringing topics to DFC

The department works with our vendor to assess a number of considerations, such as:

- Member impact (anticipated shifts in utilization vs. impacts on new regimens).
- Current utilization and trends.
- Clinical appropriateness and choice among preferred drugs.
- Availability and access to preferred drugs.
- Financial impacts (e.g., rebates and copayments)**

Hep C drug coverage in MN Medicaid

- In 2014 initial costs for a course of all oral treatments exceeded $90,000
- MN DHS last significantly updated the Medicaid Hep C drug policy in 2019
  - Allowing Hep C drugs to be prescribed by a primary care physician
  - Removal of the alcohol and the IV drug use abstinence requirements**
- Concerns about barriers faced by Medicaid members have continued to be a common theme among clinicians and community members
- Minnesota is [one of 24 states](#) that still require prior authorization for Hepatitis C treatment



Todd, J. (2024, February 29). *It's official: more than half of state Medicaid programs no longer require prior authorization for first-time hepatitis C treatment*. Hepatitis C: State of Medicaid Access. https://stateofhepc.org/its-official-more-than-half-of-state-medicaid-programs-no-longer-require-prior-authorization-for-first-time-hepatitis-c-treatment/?emci=17134fc7-8dd6-ee11-85f9-002248223794&emdi=ed54f924-28d7-ee11-85f9-002248223794&ceid=3861740

Hep C drug coverage: Evolving Literature (1/2)

	Sources	Evidence
Prior Authorization	Do et al. (2015); Vu et al. (2018); Javanbakht et al. (2020)	PA contributes to **longer time to treatment intervals**
	Kapadia et al. (2018); Thompson et al. (2022); CDC (2022)	Eligibility requirements **lower odds of seeking treatment**
	StateOfHepC.Org (2024)	The **majority** of US states have successfully removed PA requirements
Comorbid Substance Use Disorder	Rosenthal et al. (2020) ASAM (2022)	Concurrent OUD treatment has a potential positive influence on SVR **SUD testing/treatment requirement is a barrier to care**
Antiviral Drug Resistance Development	Llerena et al. (2017); Zhang et al. (2023)	Genotyping becomes increasingly important after initial SVR failure to account for mutations
Genotyping	Yasin et al. (2011); Nouroz et al. (2015); Wyles et al. (2017); Keikha et al. (2020)	**Genotyping is beneficial** when selecting medication

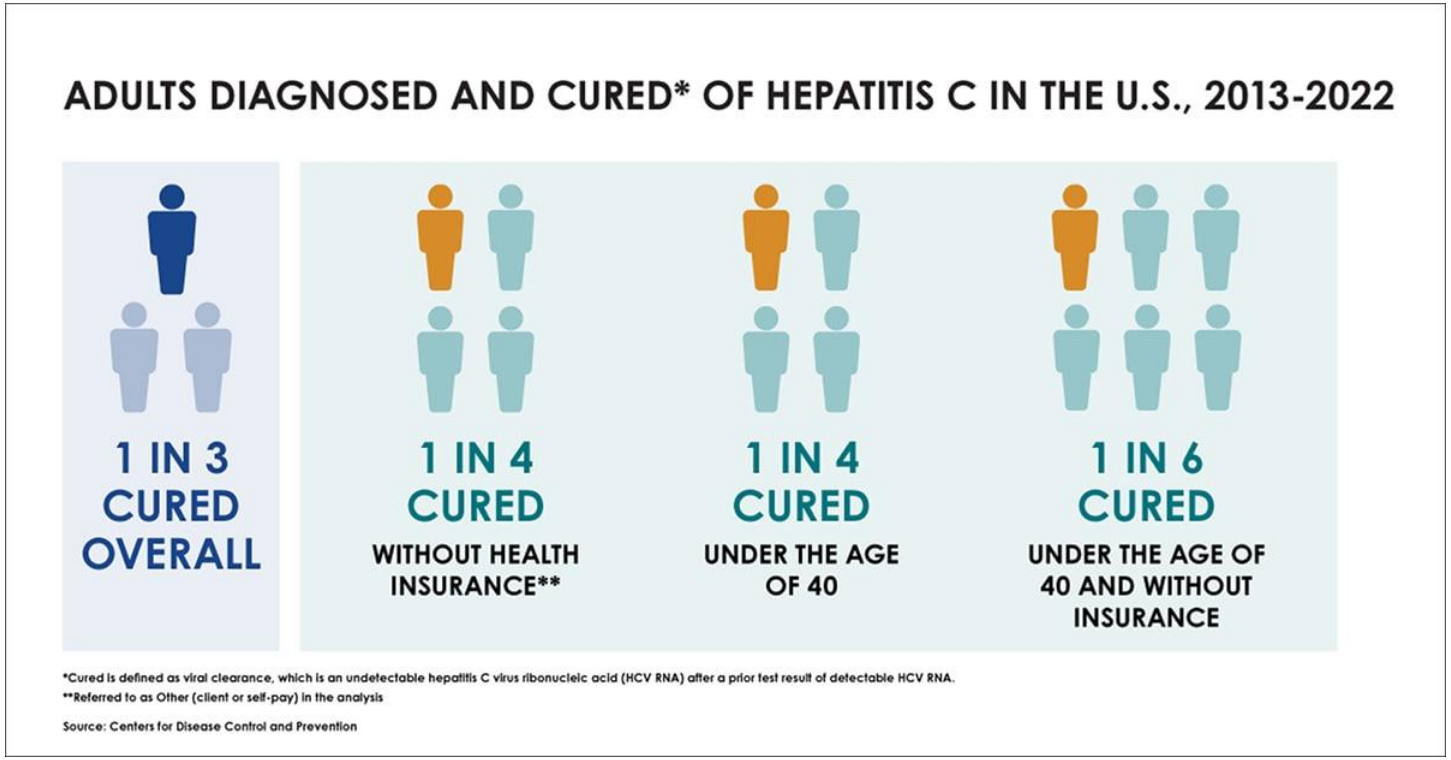
Hep C drug coverage: Evolving Literature (2/2)

- Before PA requirements were put in place in many states (January 2015) uptake of Hep C treatment was comparable between private and public insured patients (1)
- The PA has been shown to be a barrier to timely care. A single appeal can add ~36 days to the approval process (2)
- Medicaid recipients are less likely than private insurance to initiate treatment within 1 year of diagnosis. Among Medicaid recipients DAA treatment initiation lowest among : (3)
  - adults aged 18–29 years (48% less likely) & 30-49 years (32% less likely)
  - Black (7% less likely) or “other” race (27% less likely)
  - Individuals living in restrictive states (23% less likely to receive timely care compared to those living in states with no restrictions)

1. Do, A., et al. (2015). Drug authorization for Sofosbuvir/Ledipasvir (Harvoni) for chronic HCV infection in a Real-World cohort: A new barrier in the HCV care cascade. *PLOS ONE*, *10*(8), e0135645. https://doi.org/10.1371/journal.pone.0135645
2. Vu, T., et al. (2018). Increasing access to Hepatitis C virus medications: A program model using patient navigators and specialty pharmacy to obtain prior authorization approval. Journal of Managed Care & Specialty Pharmacy, 24(4), 329–333. https://doi.org/10.18553/jmcp.2018.24.4.329
3. Thompson, et al. (2022). Vital signs: Hepatitis C treatment among insured adults — United States, 2019–2020. Morbidity and Mortality Weekly Report, 71(32), 1011–1017. https://doi.org/10.15585/mmwr.mm7132e1

Proposed National Hepatitis C Elimination Program

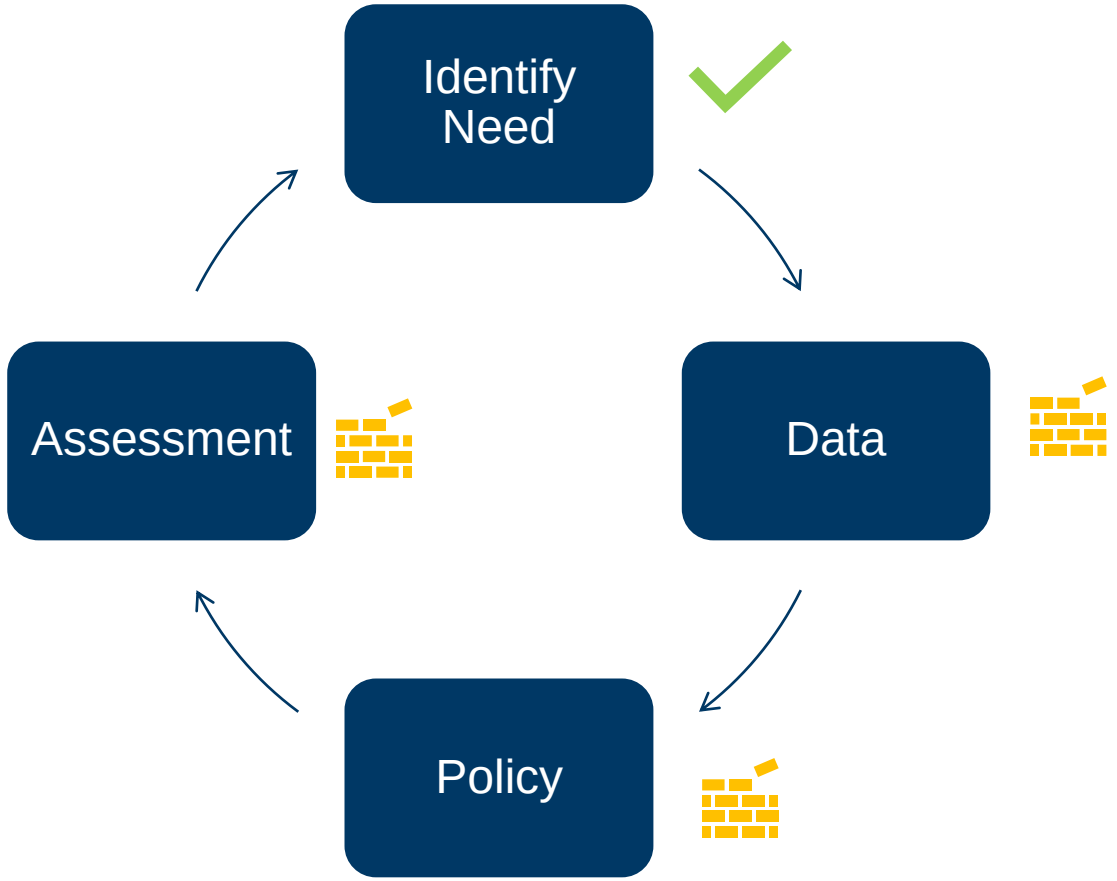
- Aims to significantly expand screening, testing, treatment, prevention, & monitoring of hepatitis C infections in the United States,
  - with a specific focus on populations at the greatest risk for infection
- Accelerating the availability of point-of-care (POC) diagnostic tests
- Provide broad access to curative hepatitis C medications
- A comprehensive public health effort to engage, inform, identify, and treat people with hepatitis C including workforce training, vaccine development, community outreach



Fleurence RL, Collins FS. A National Hepatitis C Elimination Program in the United States: A Historic Opportunity. *JAMA.* 2023;329(15):1251–1252. doi:10.1001/jama.2023.3692

Hep C drug coverage in MN Medicaid: Next Steps

- Data on Hep C treatment → What is important to know?
- Upcoming DFC meetings: April & July
- Non-pharmacy policies?
  - Hep C screening
- Future assessment of policy changes



Driving Overall Health Care Racial and Health Equity through State Government: *Make the Equitable decision the Easy decision*

- **How are we specifically addressing not just health equity but racial equity?**
- **Do we have the infrastructure (data, community engagement) to identify where the gaps are? To allocate resources, track progress and hold ourselves and our partners accountable?**
- **Are we being community-led?**

"Rarely, if ever, are any of us healed in isolation. Healing is an act of communion" – bell hooks

Recommended Reading & Tools

Policy Reports & Tools

- **Government Alliance on Race and Equity (GARE): Racial Equity Tools and Resources** - https://www.racialequityalliance.org/tools-resources/
- **International Association for Public Participation** - www.iap2.org
- **Presidential COVID-19 Health Equity Task Force Final Report and Recommendations October 2021**
- **Building Racial Equity Into the Walls of Health Policy** – *by Nathan Chomilo, Health Affairs Forefront, December 2020*
- **Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans (state.mn.us)**

"Structural Racism & Health Care 101"

- **The 1619 Project: New York Times Magazine -** by *Nikole Hannah Jones, et al*
- **Fatal Invention –** by *Dorothy Roberts*
- **Medical Apartheid –** by *Harriet Washington*

Thank YOU

You can find the 2022 report here: **Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans (state.mn.us)**

Questions? Feedback?

Reach out here: **Nathan.Chomilo@state.mn.us**