CLEAR VISION AND BOLD ACTION: FUNDING HEALTH EQUITY IN A CHANGING AMERICA

Akilah Johnson 00:37

There we are. Hello. How is everybody? Clearly, I shouldn't have left my cold brew backstage. My name is Akilah Johnson. I am a national health reporter at The Washington Post, and today I will be your guide through our conversation about how institutions, funders, and communities can sustain and advance health equity amid a changing political and financial landscape. I'm pleased to be joined by Dr. Joel Bervell, a physician, podcast host, and medical myth buster. Next to him is Dr. Uché Blackstock, the founder and CEO of Advancing Health Equity. Then, we have Silas Buchanan, founder and CEO of Our Healthy Community. And last, but certainly not least, Dr. Avenel Joseph, who is the vice president for policy at the Robert Wood Johnson Foundation. Welcome!

Joel Bervell 01:29

Thank you!

Uché Blackstock 01:30

Thank you!

Akilah Johnson 01:31

And so, before we dive in, I have asked each of our panelists to share to introduce themselves by sharing one fact that is not in the bio that you all have read in all of the various program books and online information. And so I'm going to start with you. Dr. Bervell, what is one fun fact about you that we think this crowd needs to know?

Joel Bervell 01:53

I love that. I think, for me, one fun fact is I love to travel, and this relates to a lot of how I see the world, but I've been to over 60 countries, and my goal is to hit every country in the world one day.

Akilah Johnson 02:03

Ooh, love that. That is going to be good. That broadens the perspective of how we have this conversation. Dr. Blackstock?

Uché Blackstock 02:10

What's not in my bio is that I'm a second-generation Black woman physician, very, very proudly, and that experience of observing my mother care for our community has informed everything I do today.

Silas Buchanan 02:26

Yes. So what's not in the bio? Recently, I've taken over board chair position for CLX, The Civic Learning Exchange. The full name is Civic Learning, Exchange for Action and Research. And this is a 501(c)(3) designed to drive community-engaged research. The executive director happens to be sitting right there, Sharon Ricks. You guys will meet her at some point, I'm sure. But that is a fact that is not in the bio.

Akilah Johnson 02:55

Wonderful. Silas. And Dr. Joseph?

Avenel Joseph 03:00

What's not in my bio is that I am a first-generation American. I'm the child of immigrants, and the first person in my family to obtain a doctorate, and I'm very proud of being a product of immigrants.

Akilah Johnson 03:16

Wonderful! Thank you all for those fascinating tidbits. Okay, I will share. I was not going to share, but I will take a moderator point of privilege and say one fun fact about me that is not in my bio is my mother is the best source I can never quote because she is an internist and a pediatrician who has an independent practice in suburban Chicago. So she gives me all the deeds, but I can never quote her, because she's my mom. So before we dive in, I would really like to ground our conversation today in a moment that I think continues to frame so much of the national conversation around health equity, and that would be the pandemic. You know, COVID-19 didn't create health inequities, but it made them impossible to ignore. The pandemic exposed how structural racism, economic inequality, and gaps in the health system shape who gets sick, who gets care, and who recovers. And so with that in mind, I want to start our first bucket of questions are going to be about from the reckoning to retrenchment. And so Dr. Joseph, the pandemic and the so-called racial reckoning of 2020 brought unprecedented attention and resources to health equity. Just a few years later, many of those same initiatives are facing political and financial backlash. How has this pendulum swing from reckoning to retrenchment changed the way your organization approaches health equity?

Avenel Joseph 04:44

Oh, that's a great question. So first, I'll say it hasn't, which is a beautiful thing. It hasn't changed our approach to centering health equity, centering, addressing structural racism and other intersectional factors in the programming and work that we do. It has changed the context in which we work, and much of the Robert Wood Johnson Foundation's organizational credo is that we are based in evidence. We are an evidence-generating, data-generating organization, among other things, and in an environment where we are really in an anti-facts movement, where you have the elimination of data of all sorts from government websites, where you have anti-history movements even that are in place in our museums and in schools across the country. Where you have defunding of the source of the research and the evidence and the data that helps to fuel health equity work happening, it has caused us to step into spaces that we didn't think we'd have to step into. There are some things that you take for granted, that there will always be a vaccine recommendation panel that is stocked with scientists and data experts and medical experts who are following the data and not being proliferators of misinformation and disinformation and anti-facts. So it has caused us to fund health equity research even more than we did before, to try to step into some of the gaps that are existing as a result of the retrenchment of NIH dollars, of CDC research dollars, and other dollars that have come from the federal government. But we also know that even in collaboration that we're doing with other funders who are very committed to data and evidence to drive equity, that we're no match to the loss of the federal government. And that's a perspective that we're always analyzing and trying to figure out where our resources, where our dollars, are most helpful to stem the flow of bleeding that's happening. One thing that I'll say is that you can't address what you can't see, and we can't see data that's not being collected. Much of the investments—we've for many, many years supported a fair census, we've had to increase our resourcing to census data collection much earlier, because the sort of data that's produced from the census that helps to distribute resources, that helps to decide health interventions will not exist under this current—

Akilah Johnson 07:38

I feel like I was introduced to you, as I think a lot of people were, on social media, right, doing the medical myth busting. And I think during the pandemic, right, there was such a hunger and there was so much attention focused on that. How have you seen the pendulum swing, and how have you tried to tackle that and handle that?

Joel Bervell 07:54

Yeah, I think that's a great question, especially since I sit at the intersection of social media, which thankfully isn't beholden to a lot of things that are happening in the federal government right now. What I think the beauty of social media is, is we get to decide the stories we tell, and as communities, we decide what are the stories that we're going to amplify there. I think what I've noticed is I really started creating content online about health equity and trying to showcase how health equity impacted people on the ground, through specific examples. Talking—still doesn't work well on darker skin tones, trying to tell those narratives to figure out, how do we make health equity actually tangible to people? What I've noticed since 2020, is in 2020 thankfully, there was a lot of news attention. There was articles being written about it, but unfortunately, there wasn't a lot of kind of general understanding of what to do next. Right? Now, when there's no funding, people are now ready to kind of take this next step, but we're not having the news out there to actually understand, what are the changes being made? What I've seen on social media is actually an increased hunger for that. If anything, my videos have gotten more views now, and there's more comments from people saying, what can I be doing in this space? And I think what I'm always trying to do is figure out, how can we show the moral imperative that health equity has for everyone? And so social media is a beautiful way to do that, because I can look at the comments and see what people are saying. I can look at the views of how people are wanting to learn about AI. How is AI impacting health care, especially when the president, in July, put an executive order that's saying, "Keep wokeness out of AI." What does that mean for the health-care field? And, so really trying to connect these different dots for people on the ground so that when they want—when they're actually wanting to step forward and use untraditional new media in order to tackle these problems, they have the ability to do so.

Akilah Johnson 09:37

Now, Dr. Blackstock, I know that you have used different various forms of communication to advance health equity, stepping outside of academic medicine. What lessons has this moment taught you, and what lessons are you bringing into this moment?

Uché Blackstock 09:53

Yeah, thank you, Akilah. So for those who know me, you know this work is deeply, deeply personal, and you know, I know, when we had our pre-call, we talked about, for a lot of us, the pandemic was really a turning point. Even though I had founded my organization Advancing Health Equity in 2019 and not knowing that we were going to be, you know— there was going to be a worldwide crisis, I knew that I

wanted to be able to operationalize what equity looked like in health care in a way that was authentic and not performative. And I felt like for people who know my story, sometimes working within institutions, you are not able to do the work as fully and as authentically as you would like. And so it was interesting that when March of 2020 happened, I was working both clinically in urgent care and in Brooklyn, New York, in my neighborhood, and seeing the browning of my patients. And so I just started writing about it. I started writing op-eds. And I said, "We have to call the attention, even though we don't have the demographic data." And so, as you said, you know, for in that year, I had to actually turn away business from Advancing Health Equity, because it was almost like everyone else had caught up, although I knew in January, once I had seen what the risk factors were for COVID-19, I knew it was our communities that were going to be impacted the most. And, I remember sending my sister a text saying, "Do you see this" because our communities carry the highest burden of chronic disease, right? Our communities are living in multigenerational housing, and so to see the pendulum swing from organizations and people being very committed to health equity to now backing, backtracking from it has been, has been demoralizing. I'll be honest, because, like Dr. Bervell said, I've always thought there was a moral imperative to it, but I also think this is a moment for us to think about how we are reframing—how we can reframe health equity. And I see that, because when you look at a lot of the work that, like the Commonwealth Fund, has done, you see that our country is an outlier in so many ways, in terms of health—right—life expectancy, maternal mortality, and that's for every racial demographic group. So I think this is a moment for us to reimagine and rethink about, you know, how are we talking about health equity in a way that everyone understands that it's a benefit for everybody—right? When we have systems that are less inequitable, everyone benefits—right? We spend less on health care, right? So there's both the moral and business argument for it. So that's what I really see. You know, I want to take advantage of this moment that feels very chaotic and very distressing, and I'm reassured because I'm seeing organizations still do the work, right, still committed to the work. The name may be different, but for us, the name never mattered, right? It's the work that always mattered in the communities.

Akilah Johnson 12:48

Silas, so we're talking—Dr. Bervell and Dr. Blackstock have touched on the moral imperative of health equity, but let's talk about the dollars and cents of it a little bit. And so, are you finding that in this environment, or is this environment and forcing philanthropy and other funders to play a more active role in helping community-based organizations step into where government no longer will or can't invest?

Silas Buchanan 13:13

Yeah—So another good question, and I think the answer is yes, but as Avenel said, you know, philanthropy, philanthropy can only do so much, right? They can't step into the breach fully. It's impossible to do. You know what we do at Our Healthy Community, we build ecosystems, platforms that are designed to consistently put the leaders of underserved, under-resourced, faith- and community-based organizations together with consistency. What's happening today doesn't necessarily catch us by surprise, and we're not necessarily unprepared for it, right? It is from whence we come. You know, everywhere I go, like my grandmother, my grandfather with me, right? Who ran soup kitchen, who drove the bus after school, who took people to their doctor's appointment. You know, we—we grew up having to figure out how to

operate in inequitable places and spaces. And philanthropic organizations weren't rushing in headlong either at that time, right? So none of this is really taking us by surprise, but to answer your question, the importance of having philanthropic organizations raise their hand to support the work that my organization does, and now the 501(c)(3) that I'm proud to chair the board of, it's critically important. Our community-facing organizations need their own spaces that are not owned by health-care, payer, provider, government, academic, life science, and pharmaceutical stakeholders, right?

Akilah Johnson 14:51

So, how do they sustain right? So as you're talking about kind of this grassroots "robbing Peter to pay Paul," kind of effort that so many community-based organizations have to do to take care of their own, how in this moment, where there's funding is being rolled back and the funding that exists, there's increased competitiveness for it, like, how are folks sustaining the work that they have been doing before philanthropy was holding up their hand and after, philanthropy has held up their hand and is now kind of some folks are putting it down—are putting it down a little bit?

Silas Buchanan 15:24

Yeah, you know, when you go into most communities, probably what, 99 percent of those 501(c)(3)s are not funded by philanthropic organizations anyway, right? Philanthropic organizations will throw small bits of money into communities, and they're almost like scrapping at each other to get at it. And so the importance of the platforms that we build, again, it's, you know, we were little kids, right? And the very first thing we learned from our parents when we went to the zoo was, you know, stay with the group. There's safety in numbers. And so our platforms are designed to build sustaining, sticky, culturally appropriate platforms where community-based organizations, regardless of their geography, can kind of come together and can stick together, while at the same time, we give each organization their own private, password-protected space to do their own community engagement work, right? And so it just, I think, gives them a little bit more of a competitive advantage and getting more of that later—But maybe that answers your question a bit.

Akilah Johnson 16:11

No, it does, and it actually raises another question for me. Surprise, surprise—the journalist has another question. And that has to do with you know, are you witnessing the creation of new collaborative models? Are you seeing new partnerships emerge as this work continues despite constraints? And you touched on that a little bit, but I want to hear what Dr. Joseph has to say on that issue.

Dr. Avenel Joseph 16:47

Yes, I think it is. I mean, if one of the things that we can learn from total destruction is that you're able to build back something that's more creative, that's more responsive, that's actually answering the questions that have been raised by community and trying to propose solutions with community, one of the things that we're seeing in the absence of a data ecosystem supported by the federal government and readily available datasets, we've partnered with some private entities to invest in a platform called Pop Hive, which essentially uses electronic medical records to give you public health trend data in communities based on these electronic medical records that have been de-identified. That kind of a collaboration between private foundation and private companies hasn't really happened to create a public platform that's completely free to be used in order to replicate sort of some of the gaps that have existed from the federal government, because it's localized data, because it's very community-based data. It's much more relevant to the communities who are looking for answers to the questions that they may have about what's popping up, where the resources need to be distributed, etc. So I do think that in this in deprivation, comes the opportunity for imagination— there—this is one example in ways that it's happening. I think we're challenging ourselves at RWJF, and I know many in philanthropy are challenging ourselves to not just do things the way that things have always been done, but to think about new collaborative methods that can get us to the future that we want.

Akilah Johnson 18:22

You know, I want to talk about the workforce and future doctors, right? So we've been talking about kind of retrenchment and the rollback of DEI efforts also threatens workplace diversity, and we know how crucial that is in advancing health equity. And so, you know, especially in medicine and science. And so after decades of work to diversify medical schools, to get students of color that I have spoken to, and I'm interested in kind of what you all's perspectives are, really fear that they, you know, they say the last, but they fear that they may that the already narrow door is narrowing even more, and the implications of that, and so like what that means for patient care, innovation, trust, and also this kind of collaborative new coalitions that are building. So Dr. Blackstock, what do you think is at stake —when we—in the medical workforce in this moment?

Uché Blackstock 19:17

So some people have heard me speak before or read my book, you may be familiar with this story. But, in April of 2020 I remember walking into an exam room with a patient, EMR had said she was a 20-something year old woman there for shortness of breath after been diagnosed with COVID a few weeks earlier, and so I walked into the room and she's sitting on the exam table with her head in her hands, and she looks up at me, and she kind of squints. I say, "Hi, I'm Dr. Blackstock," and she kind of she looks at me and says, "Are you Black?" And I recognize it is because I had PPE—PPE on head to toe, like those are the early days. I literally, my hair was covered—I was double masked, eye goggles. I even had shoe covers on, so I was covered head to toe. And I said, "Yes, I am." And she let out this deep breath, this sigh of relief. And I have to say, in that moment, I felt so proud to be the doctor that she needed, but also it was very clear to me that she had been—she had had interactions with health professionals where she had not felt heard, listened to, and appreciated right? So that's just an anecdote, but we know from the data. We know that racial concordance, especially for people of color, especially for Black people, in terms of patient-

clinician relationship, it actually makes a difference in terms of outcomes. It makes—people are more likely to want to, you know, follow the physician's recommendations, they leave the encounter with a more positive outlook, right? They feel listened to and heard. There's even a study that the Journal of American Medical Association published, I think, two or three years ago that showed that even having one Black primary care physician in a US county improved life expectancy for Black patients living in that county and actually overall life expectancy. The sad part is that only a fraction of US counties actually have even one Black primary care physician, right? So we make such a difference. And, you know, I talk about, you know, in my book, the Flexner Report, which I know some of you are familiar with, and I'll just give a quick, a quick overview of it, but it's a report in 1910 that was commissioned by the Carnegie Foundation and the American Medical Association, which has its own storied past with discrimination. But essentially that report performed by Abraham Flexner, an education specialist who had his own—held his own racist views, essentially closed five out of seven of the historically Black medical schools that were open at that time. Okay. By 1910, those schools had trained about 1,500 Black doctors. Black students were not being accepted to White—predominantly White—medical schools. And so what happened is actually the Journal of American Medical Association, they came up with an article in 2020 that estimated, if those medical schools had remained open, they would have trained between 25,000 and 35,000 Black doctors, 25,000 and 35,000 Black doctors. Like, can we just sit with the impact of that. Just imagine the research that could have been done, the mentoring that could have happened, just everything, the loss of brain potential, right? And so I think about that. I think about that's the domino effect we're seeing today. I think about the SCOTUS decision in higher education from a few years ago, and we already are seeing a decrease in the percentage of Black students and students of color being accepted to college and medical school, right? And sorry, go ahead.

Akilah Johnson 22:49

Absolutely, and so I've had some conversation with folks along these same lines. And so one of the arguments that people say is that—that it is, it's just not practical to have a workforce that is representative of our nation. That's just not practical. That's not how businesses run, and that in these hiring decisions and acceptance and school acceptance decisions, these things should be based off of merit. And so, like, what is the big deal? And so I'm gonna throw that out there?

Uché Blackstock 23:20

Yeah. Right.

Akilah Johnson 23:21

I see you sitting up, then I'm gonna go to Dr. Bervell because you were shaking your head in agreement with Dr. Blackstock.

Uché Blackstock 23:21

What is the big deal? Is, like, you know, one, as I mentioned, we know that it makes, it makes a difference to have a workforce that represents what our patient population looks like. But also, the other part is, when we're thinking about what is the obligation of medical schools, academic institutions, literally, they have, they have an obligation to train a workforce that reflects the patient population. This is, this is not the communities that they serve. This is, this is not like radical idea. This is, they have an obligation to do that, and when they don't do that, we see, we see what happens in terms of of health outcomes. And I also think that, you know, obviously have to think these traditional notions of what makes a successful doctor, right? But the fact is, is that people of color, when we go to medical school, we're more likely to work in underserved areas, like we're more likely to go back to our communities to care for our communities, right? For many of us, this is just, this is more than just being a doctor, right? This is like, how can we be in service to our communities? And so I think that there are, like, multiple ways to look at that, the answer to that question, but overall, it just, it brings it brings value, right? It brings value in terms of the learning spaces. It brings value in terms of how our patients fair. You know, I think about my—as I mentioned—my mother in the '80s and '90s, she and her colleagues were doing what we call health equity work in our communities, right? They were—they were organizing community health fairs. They were making sure that patients had wraparound services, right? So that really what is important is that we're training clinicians who understand the obstacles and barriers that their patients face that impact their health, right? And while they don't have to solve every problem, they do have an obligation to understand where their patients are coming from.

Akilah Johnson 25:13

So Dr. Bervell, I see you shaking your head, and I want to ask you, because Dr. Blackstock said, you know the obligation of medical schools to train a workforce and clinician class, for lack of a better term, that is going to be able to take care of the population in their area, the population they serve. And so what makes a good doctor?

Joel Bervell 25:34

Yeah, I think that's a great question. And I think what makes a good doctor really depends on the communities that you serve. For me, what makes a good doctor is someone that's empathetic, that listens, that obviously knows and understands medicine. But the end of the day, if you can't get your patient to talk to you and give you the details that you need, you won't be able to actually be able to diagnose them accurately. And I've seen this with my own patients that I see in the clinic, where they'll come in to me and say, "Hey, I never wanted to actually mention this one thing, because I didn't trust my doctor or my doctor"—There's actually someone I saw just last month, and he came in to me, and he had this whole record of having prostate cancer, and he was kind of not going in for treatments. And so I turned to him, I said, "Why aren't you going into your treatments for prostate cancer?" And he said, I have prostate cancer? And it shook me, because I realized that no one had explained it to him in a way that he actually understood, sure it was documented in the charts, sure he was—he had all the right treatments, but he was being labeled as non-adherent to his medication regimen because he had no idea that he actually had

prostate cancer. He was an immigrant from Sudan, came over here as a refugee, had been living in the United States, had no idea what it was. I ended up saying that the next patient I had, I told my staff, like, "Hey, can you actually put it off? I'm going to try and spend some extra time." I spent an hour, walked him through not just what he had, but what the pathophysiology was, why the medications mattered, how he should have support in his community, what his supports looked like at home, whether he had transportation. That shouldn't be the job of just one person as a doctor, but in that moment, I recognized that he needed more than just the care of medicine. He needed support from a human that cared about him. And so I think you can have the smartest doctor who knows all the details, but if they aren't actually putting that to practice and actually making sure that their patients hear that information, it doesn't matter. And I have had colleagues in my classes in medical school. I only graduated last year, so I'm still a new doctor in residency, still, but I've had colleagues in my classes who—literally—I kid you not—I would not have them be my doctor. And I say that wholeheartedly. Where I saw—I was on student government, so I saw the things that there was kind of going on behind the scenes when I sit on that Academic Council and the ways that they were either treating patients or the things that their attendees were saying about them, I would not want them to treat me or my family. And so I think what makes a doctor has to be broadened out, as Dr. Blackstock was saying, to beyond what we think about it right now, and to connect to what you were saying about the importance of having physicians who look differently in medicine. It changes the way health care is delivered. And it's already happened since 2020 on. And so one thing I know that you often say too is that in 1978 there were more Black men in medicine than there are today. Think about that. In 1978, there were more Black men in medicine than there are today.

Akilah Johnson 28:19

And since we're talking about funding. No, no sorry, go ahead!

Uché Blackstock 28:24

I just feel like so much of what you said resonated. But, so what happens when people also don't want to go to the doctor? Like communities have a high degree of unmet needs, people do not go. They don't want to go when they get other symptoms, and so all of those issues end up accumulating, right? And people end up getting, being sicker when they present for care, right? And then they have poorer outcomes, right? So we actually do want a system where people trust their health professionals, and I think that is a whole trust piece, is an earned piece, right? We have, there's a lot of damage and trauma that's been done, and so I think the focus, especially now, in this age of misinformation and mistrust, is really not to put the burden on our patients, but to put the burden on organizations and institutions to engender that trust.

Dr. Avenel Joseph 29:17

I just want to draw on two things that were said by these great clinic clinical examples that came through. The first is that when you have a diverse workforce, diverse clinician and medical care providers, it improves care for everybody. We have data that shows us the entire system, the entire hospital system in which these clinicians are presenting themselves, all of the patients in that system will benefit. So that's

number one. Then number two, just sort of referencing back to the 25 to 35,000 doctors that would have been produced to this time. What we're seeing now in the reduction of some of these, the inputs into our medical schools are whole generations of lost doctors. So that 20—we're talking now that in another 10 years, it's not like, okay, 10 years everything is going to turn on "We're going to have some great, very caring, very listening doctors on the bedside." That's not going to happen, because right now, today, those doctors, those emergent doctors, aren't getting into the programs in the first place. And so the longevity, the tail that exists as a result of the changes that are happening today are really important for us to focus in on and to try to figure out where we can have interventions along the way.

Akilah Johnson 30:24

Can I just mention one other wait—I lost my train of thought, one sec.

Silas Buchanan 30:29

I'm gonna chime in here. Having brilliant doctors is absolutely needed, and the diversity matters, but while we're waiting for diversity to catch up, having cultural competent doctors, right? Doctors that exhibit some cultural humility, that have taken time to get to know the patients that they're serving becomes really, really important, because health care is very intimidating for all of us, right? For all of us. But you know, when you walk into a hospital, what's the first thing you see, typically, right? It's the picture of the current leadership, right, and all the past leadership, right? President—and they're all White men, typically, right? And then right underneath that, you see the current board of directors and all the past boards of directors, and typically, they're all White, right? And so kind of right from the very beginning, right from when you walk in the door, you're intimidated, and you can't wait to leave. And so when my mom was in hospital, we got on the elevator. This is the Cleveland Clinic, right? And—and I got to tell you, you know, and I shouldn't have said the name—but I'll just say this, it's on the record now. Okay, it's on the record now, but look a one-square mile radius around some of our world-class care hospital, right, have some of the worst health outcomes. We got on the elevator, and it was a cafeteria worker and—and she said, which is my mom in a wheelchair, I'm pushing her, right, and me. And she said, "Everything okay?" Said, yeah. She said, "Everybody treating you okay?" Here, she's a cafeteria worker, right? And we said, yeah, yeah, we're good, we're good, we're good. And I told my mom, I said, so this is why I have had to go get an MD almost in small cell lung cancer, right? Just so I can roll with you to assure that we are okay. Because if you don't come into health care with some education, trying to meet the physicians where they are, what we're finding is they are not always trying to meet patient, consumers, and us where, where we are, and that is a tricky thing to navigate.

Akilah Johnson 32:46

Let's stay on that thread for just one second, right? Let's, let's pull this thread in terms of historically marginalized communities really having a voice and being central to not just funding but program designs, right? Like, how hospitals operate, what does community, what does cultural competency even mean in 2025, right? Like, what would have made, aside from the cafeteria worker, Silas, what would have been

cultural—what would have been kind of, I want to say competent—cultural competency. But like, what, what would have made you feel as though, like, this is it?

Silas Buchanan 33:22

So I've said it right in this conversation, right? There's safety in numbers. You stay together. What am I doing? I am building platforms and spaces and ecosystems designed to put and keep people together with consistency who look like each other, right? Because if I'm in a if I have a diagnosis and I'm intimidated by health care, I want to know what are the top three questions I should ask. I mean, I walk into the room with my doctor, my mind goes blank. I don't know what that, and I'm intimidated. And so you look down and you don't ask the question because you don't know what to ask, and you don't want to be made sound made to be sound stupid. And I've seen patients in a posture where they're mistreated by physicians. What do they call it, Stockholm Syndrome, where they're almost begging the physician not to leave them, who has been mistreating them? You're not getting what you need, but you're afraid to let go, and you'd rather be treated poorly by this particular—so if you can put folks together where they're in spaces, where they're comfortable, and they get to learn.

Akilah Johnson 34:24

How do you do that? How do you put those folks in that space together?

Silas Buchanan 34:28

Okay, so let's see. We've got on my platform in Louisiana, LACHON. LACHON is Louisiana Community Health Outreach Network. That's, they say, 300 community health workers, I say about 150 but we've got, we've got 100 of them on our platform and a private password-protected space just for them, right? Because they're caregivers, and they need their own space to communicate with each other, and they're that layer between physicians many times and community. That is one way. This is my contribution as an entrepreneur and someone who really cares about improving health outcomes, reducing health disparities, improving health equity, to put folks—recognizing that we speak differently when researchers and physicians are not in the room. And when we're asked to show up into places and spaces as community leaders, typically, we don't own the space, right? The hospital system will say we're having a community meeting, and everybody come to the boardroom. We're like, okay, we're going to the big house, and we all go, and we run there, and there's donuts, and then after six months, your five words, right? Our funding priorities have changed. Wait, what? So you're throwing us back out on the street? Yeah, our funding priorities changed. We're going to go do something different. So it's about building things intentionally for the community that they own and control, right? Best, in brief, technology, and then you invite the researchers and the payers and the providers and sponsors and firms to that table. That's equity.

Akilah Johnson 36:10

Dr. Joseph, what sort of accountability mechanisms and partnerships help ensure that that type of equity that Silas just outlined remains more than a talking point, especially now.

Avenel Joseph 36:22

Yeah, I mean, it's going to look different for every system and every organization. I will say some of the ways that Robert Wood Johnson Foundation has done that is that we work with community leaders directly through a what we call a Wisdom Council. And this exists in different places, where, in different sort of bodies of work that we do, where we fully compensate our council people, or people for their lived experience, for with an understanding that those who are closest to the disparities that are closest to the harm are often those that have the best solutions to present, and we combine them with, with leaders that are all from all different walks of life. We have leaders who are from Indigenous populations, leaders who lead immigrant populations, leaders that lead various Black communities, faith communities, etc., for sort of some of that collective learning and accountability that we have to what we have stated is, are those communities that have been least, least invested in over time, I think those that is one of the ways that it can work. It's not, not always a way that, particularly with the hospital systems that Silas was sort of giving an example, doesn't really pay out that way. Many times, those people who are on community councils for hospitals aren't resourced for their time, aren't resourced for the extra work that they have to do, for the travel, aren't actually listened to. So to me, accountability is about trust. Accountability is about being willing to change direction as a result of the input that you get, and that doesn't always exist in different contexts.

Akilah Johnson 38:12

Let's keep talking about trust for a minute. Dr. Bervell, how do we rebuild public trust when information itself has become so politicized right now?

Joel Bervell 38:21

Absolutely, I think one thing about trust is you need to at least recognize. You have to tell people when trust has been lost and how it's been lost. And so the example I gave before with the man who had prostate cancer, I apologized. I think, funny enough, medical school, they tell you a lot of times, don't apologize, that just you have to look like the doctor to be the one that has to know everything. And I found the most powerful thing is recognizing that you don't know everything, and telling people and being very upfront about that. And I think institutions need to do the same thing. One of the ways that I think trust was lost during the COVID pandemic is we weren't totally transparently, radically transparent about things that we didn't know. We made it seem as if we knew everything off the bat, when, in fact, science is something that's always developing and we're learning from it. That should have been the message that we were telling people, that this is something that we don't totally know, and we are trying to figure it out. I think the us like that were within these fields felt like that. When I would talk to my friends that were not in the medical field, they felt like it was a top-down approach of you have to do this. This is you have to do this six, six feet of distancing, because we know that's the exact number, when, in fact, we don't know it's

exactly that, but what we know from the data is that is the best thing that can happen, or that is the best kind of spacing that can help us minimize the spread of COVID. And so I think one thing that we need to do more of in trust is to really be transparent. What I love about social media is it allows you to be transparent with people on the ground. I tell a lot of stories. I have a whole series of videos called Hidden Medical History, and I tell some of the most outrageous and tragic things that have happened through history, whether it's things like the Mississippi appendectomy, poor Black and White woman being given hysterectomies without their consent, or whether it's about people like Vertus Hardiman, the man who was subject to government experimentation with radiation because he had a tinea fungal infection, who was given radiation instead of giving the proper treatment or about things that we may know about more, like Henrietta Lacks or Tuskegee syphilis experiments. I tell these stories because I want people to understand that we've learned from them and that we're not hiding the past, but we're addressing it so we can move on. I think that's one way we build trust. The more you talk about it, the more that we're able to get people to understand the imperative of why we what's necessary to fund this type of information so we can continue to actually have research that allows us to better health-care systems.

Akilah Johnson 40:35

So I'm going to remix an audience question, because that is my moderator privilege here, but they touch on some really good points that has to do with trust. It has to do with, to me, I think it has to do with data, and it has to do with accountability. And it's the question is essentially, if we are supposed—if we're relegated, in this moment, to rebuilding health equity platforms, how can you do that in an environment where you know there are these unprecedented attacks against health-care workers, where CDC is being shot at and police officers are being killed in protection of that. But there has been little kind of public reckoning about these, about these moments. So how do you really engender and rebuild trust? Dr. Blackstock?

Uché Blackstock 41:18

Yeah, I also say, I actually don't even say, rebuild trust, build trust, because I feel like the trust was never there. And I also often will say, instead of medical mistrust, institutional untrustworthiness, because institutions have historically and even contemporarily proven themselves untrustworthy. But I do think that a lot of the work, and I'm sure Silas will agree, has to happen on a community level, like I think that, well, we know, first of all, most community members and groups, they have the answers already. And really it's about investing in the relationship, funding those relationships and power sharing. So that's I feel like that's a piece that you talked about, and we don't talk about enough, is power sharing, in terms of making key decisions, but also recognizing that this cannot happen overnight. People don't develop trust like overnight. And I think that's one of the things that we saw out of the pandemic, is that we wanted people to, for example, take a vaccine, right? And they're like, whoa, what can you explain to me exactly how it was developed and why and why I should take it? And we didn't do a great job of doing that. And so I really think it's about what's happening locally and hyper locally, and then it expands from there.

Joel Bervell 41:19

Sorry, I was just gonna add one thing that I think you one thing you're one thing you're pointing out is just humanizing the entire process. And I think one thing that we can do is to is find unlikely sources to engage people when they're not expecting it. That's how you actually reach people, not when they're vulnerable, but when they're most open to learning about new things. So whether that's going to barber shops, and this was done a lot during COVID, go to barber shops and have those conversations. Right? If you're doing your nails, have those conversations about health care there in ways that actually talk about these things. If it's on TV, like put it in an episode, not just of Grey's Anatomy, but maybe of an episode of your favorite reality TV show, whether that might be—like ways that you can actually have these conversations and broach it easily, because I think the other thing we're missing is just people willing to talk about it. So often, people will say, I don't know anything about medicine, or I don't know anything about health care. But the thing is, we do. We live in our bodies every single day. You may not have the words for it, but if we're able to teach more people about how to address and have these conversations, that can start to not rebuild but build trust by allowing us to have an easier way to access people.

Uché Blackstock 43:38

Yeah. And I also think, and Silas mentioned this community health workers, like community health workers, are so incredibly underutilized. You know, they are used globally. We use them in United States, but underutilized here. They are lay professionals that are either like from the community, or familiar with the community, that can do a lot of really wonderful prevention work, education work, and we know from studies they make a difference. Like New York City actually just came out with this really wonderful study about just also the financial impact of having community health workers. So we don't need to reinvent the wheel. There are a lot of wonderful, wonderful solutions out there that we need to really to lift up and amplify.

Silas Buchanan 44:16

The messenger matters, right? The messenger matters, and you just can't fall out of bed and say, we're going to partner with the churches. Oh, are you now? You've got to understand culture. There's a faith-based culture, and doesn't— regardless of race, ethnicity, there's a faith-based culture. You're just going to go partner with barbers, right? There's a barber beauty shop culture. And if you don't understand that, you're not partnering with anybody, right? So, you know, back in the day, my mom, I said to my mother once, she's no longer with us, but I said, you know, we should, it's nice to eat so much red meat, you know? She took a bite of her burger. She's like, Yeah, okay, you know. And then six weeks later, right? She said, you know, she said the church and the pastor talked about cutting back on red meat. I think I said, Mom, we talked about this, no? So these are the messengers right here. Joel Bervell is a messenger that matters, Uché Blackstock, is a messenger that matters, Avenel funds messengers that matter. That's the key.

Akilah Johnson 45:20

So we are talking about trusted messengers, and you're absolutely right. And so you know, an audience question talks has mentioned that public health has not always had the best marketing or public trust to this point that we're talking about, but it goes on to talk about who is the audience? So we've talked about the messenger, but who was the audience for this conversation that we're having right now about where health equity is in this moment and who needs to fund it, like when you all are talking, who are you all talking to right now? Dr. Joseph?

Avenel Joseph 45:50

Okay, so we're talking to other funders. We're talking a lot about the need for data in order to have a democracy, and why health equity, health data, the availability of these things are important for all sorts of funders, whether you're in the arts or the climate world or science world, all of these things, all of these sort of funders need to come together towards a common goal. I think the other—we have, we have a platform where we're able to talk to sort of the researchers and academics of the world, talk to them about the importance and where the gaps in research happen. Those are our primary audiences. We certainly do media where lay public, you know, consume our messages, and our CEO was that during COVID, considered America's doctor because he was on the news so much talking about prevention and the spread of the disease at the time. So we have sort of the general public as a secondary audience, I suppose, but primarily we're focused on talking with other funders and others who are in the space of trying to work together to address the problem.

Akilah Johnson 46:57

Silas, who is your target audience right now? When you're talking, who are you talking to today?

Silas Buchanan 46:58

You know who I'm talking to.

Akilah Johnson 47:00

I don't. I'm asking.

Silas Buchanan 47:01

I talk to community, you know, but I do, I talk to all sides frankly, right? We work intimately with community, but our relationships are, are also with with health-care stakeholders. And by that, I do mean payers, providers, government, i.e., public health, academic, life science, and pharmaceutical stakeholders. It's important that all side, that we shorten the distance between, between all stakeholders. It's just that

when, when one side is my kids were here right now, and I said to them, "options are," they would finish the sentence and say, "better than money, dad," and that's exactly right, right? You have got to have as many options as you possibly can. You have to be educated around what those options are. So community needs to be trained, prepared, understand what their options are. You don't need to run from the health-care stakeholder side. You just need to be prepared to equitably partner with them. So I speak to community.

Akilah Johnson 48:06

I'm asking everybody—Dr. Blackstock, who's your target audience right now?

Uché Blackstock 48:09

No , same as Silas, but I will say, you know, in 2021, and 2020 people would stop me and tell me, Dr. Blackstock, I got vaccinated because of you or I decided to send my children back to school because you sent your children back to school. And so that was communication that I was doing via social media. That was communication that I was doing with our communities via my job, my role as MSNBC medical contributor. It really was about making sure that our communities had the information that they needed to make informed decisions for themselves. Now I still, I still use my social media, and I still do on-air work, and I speak nationally, making sure that we don't forget about these issues. But of course, also with my firm Advancing Health Equity, we are here to help support stakeholders in the health-care ecosystem. Across the health-care ecosystem—support them in the in this moment. And what we're seeing a lot of is, you know, leadership of these organizations want to have, want to know, what is the ROI on this investment I made in health equity over the last few years, or what—how do we adjust our comms and messaging to this moment, but still stay committed to the work? So we are here. Our audience is wide, but ultimately it's always going to be what's the impact on our community.

Akilah Johnson 49:27

Dr. Bervell?

Joel Bervell 49:29

I think for me, my audience is the individual. I know that sounds so broad, but it's the individual person. I see myself as the brother, the son, the loved one that is a doctor that can tell people about their health in a way that makes them understand it better. I think I really began to realize that after, it was a specific video, I made about this equation, called the GFR equation, and some people may have heard about this. GFR stands for Glomerular Filtration Rate. It's essentially a measure of how well your kidneys work. If you have a high GFR number, your kidneys work well. If you have a low GFR number, your kidneys don't work very well. For decades, there'd been this racial correction that actually overestimated someone's GFR number if

you were Black and only if you were Black. What that did is that it made it harder for people to be able to get access to kidney specialist, to be diagnosed with chronic kidney disease or to get a life-saving kidney transplant. I remember I started making videos about that in 2020 because I learned about these equations in my medical school classes, and so I talked about it on TikTok, of all places, as if I was telling my mom about it. Just here's what this is. There is out there. To me, this doesn't make sense. I don't think race should be used. But who knows? In 2021, that equation was changed to no longer have race within it. And in 2023, the organ procurement and transplantation network said that if you've had this equation used, we're going to retrospectively go back and possibly adjust your kidney transplant wait times. To date, 15,000, about 15,000 people have actually moved up on the kidney transplant list because of that equation being changed In Black patients. And I think it's important to say also the people that were behind there that were actually making this happen were Black physicians, people like Dr. Eneanya. And I had someone reach out to me on social media, and she said, "I've been following you since 2019 when you posted your first video. I've been following all specifically your GFR kidney equation ones, because my sister has chronic kidney disease, I sent her a video to my sister. She took it to her doctor, and now she got moved up five years on the kidney transplant list." I think that's the power—I think that's the power of speaking to the individual person, of seeing them, not as another number or another patient, but as a loved one that you want to have the best for them. But then doing more than just that, and using the systems around us, reminding people why we need to fund systems like this, making sure that we have diversity within these fields, so that when we see problems, we recognize it, and make sure that we say, hey, this isn't my lived experience. Doesn't make sense to me, and actually go out and solve it and potentially save thousands of lives.

Akilah Johnson 52:04

You know? And so I don't even know what to say after that. I feel like that could have been a mic drop moment, but we have seven minutes. I keep asking some questions Dr. Bervell. But we're talking about, like, systems change, right? Like, that's what you're touching on, and then long-term vision, essentially. And so I guess I am interested in knowing, what does meaningful system change for health equity, like, what does that look like in this moment of political polarization, particularly when so much of the information that comes out about, I mean—some people may call it eugenics, right? Like the difference in terms of how certain medications interact or don't interact with people of color versus their counterparts. In this moment, what does meaningful systems level change actually look like? I was looking at you Dr. Bervell, but I will go to Dr Blackstock if you—

Uché Blackstock 53:04

Oh, no, we can go down the line—no, I think it looks like creating metrics that matter with communities. I think that often hospital systems, they have an idea of what they think matters in terms of health equity, but is that the same as what communities think? I think about just that on a very basic level, that when we have health inequities, we have people dying prematurely. What does that look like? That's missed birthday parties, missed graduations, retirement parties, right? So how can we also make sure that we humanize what those metrics are, but also then hold systems accountable. So if they're not reaching those metrics right, what needs to be done, and make sure that we have checks and balances in place to make

sure that happens. But I think also, ultimately, it's how does the community thrive as a result of any health equity initiative?

Akilah Johnson 54:01

And so because we are almost out of time, but I do want to get to this question. I'm going to ask that, if we can have this question kind of be your concluding like, include your concluding thoughts, and it would be what's one bold step that you think funders or institutions must take within this next year to keep health equity not only alive but advancing. I'm going to start with Dr. Bervell, and I'm just going to go—we're going to go down the line.

Joel Bervell 54:26

Yeah, I think it's changing the way—stepping into the world of new media, and so figuring out, how do you speak, kind of to what I said before, to individuals. I think so often we have this, like, one-size-fits-all metric, but it's finding those trusted messengers, amplifying your mission through those trusted messengers, so that you reach an entirely new audience, and you build everything that we've been talking about today, trust understanding of what the actual issues from the community level are, a reciprocal relationship, where it's not just giving information, but getting information back, and then kind of working through that. I think we've tried to do that a lot, but it's been difficult, and especially in this world misinformation and disinformation. I think it's even more important that we make sure that if in this to survive in this new age of new media, we need to really explain to people why this mission matters, educate them, and give them the tools to be able to parse out themselves.

Akilah Johnson 55:17

Absolutely. Dr. Blackstock?

Uché Blackstock 55:19

I think it is lifting up Black-led and people of color-led community-based organizations that have been doing the work for decades, right, and know the communities well and need to have their work funded and amplified. I always go back to the Black Panthers, 1960s, they were doing health equity work. They were—they had free clinics. They were giving away free breakfast giveaways, providing transportation for people to visit their loved ones who are incarcerated, doing sickle cell testing. Listen, we don't need to reinvent the hospital systems, companies don't need to reinvent the wheel. We already have organizations out there that are committed, but don't have the support we need to support them.

Akilah Johnson 55:59

Silas?

Silas Buchanan 56:03

So what's the title of our session here? Clear Vision and Bold Action, Funding Health Equity. I don't know that you can fund health equity, right? I think we should be thinking about how we are funding the processes that drive more equitable health and improve health outcomes. Because if you think you're going to fund health equity, you're not buying something. It's got to be a process that's got to be funded.

Avenel Joseph 56:35

Agree with everything that the panelists have said. I mean, I think—I think a few things. One is our health-care system is way too complicated. You don't need, you shouldn't need to have a PhD or MD in order to get care that you need. We need to keep it simple. I think we need to have a recognition that our health-care system has never been equitable to begin with. It is built on a foundation that is inequitable, and recognizing that allows us to create something that's different. I think that many laws and processes independent of what system that you're talking about has disenfranchised and disenabled some communities, largely based on race, but also based on gender, from achieving health and well-being that they want. It's not like anybody wakes up in the morning and says, "I want to be the sickest version of myself today." You know, we all want to achieve health and well-being, but there are barriers in the way for some, largely based on skin color and race, sometimes also on sexual orientation, that enables that to happen. And so one of the things that I think I'd want to leave this audience with is that all of those laws and processes and procedures that are in place, that have been built inequitably were built by people, and therefore they can be rebuilt by people. We do not have to consider anything as being the way that it needs to continue to be. We can do it differently. And that takes collective wisdom, that takes working together across sectors, that takes relational work, which takes time and trust, but it is all doable and all very possible.

Akilah Johnson 58:09

This have been—yeah—To say this has been fascinating and a timely conversation, I think, is a bit of an understatement. And so I just want to thank you all so much for being here, and I want to thank you all for joining us this afternoon. That concludes our conversation today. Again, I'm Akilah Johnson, and I want to thank everybody for joining us.