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Female: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping the health care of the future. This week, Mark and Margaret speak with Dr. Uche Blackstock, Founder and CEO of Advancing Health Equity. An organization spawned out of her own experience as an emergency physician, med school professor and a member of the first legacy family of African American women to graduate from Harvard Medical School. She talks about our mission to address racial inequity as an American health care issue, as well as the medical profession and the need to elevate people of color into leadership in health care.

Lori Robertson also checks in Managing Editor of FactCheck.org looks at statements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well-being in everyday lives. If you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. You can also ask Alexa to play the program. Now stay tuned for our interview with Dr. Uche Blackstock here on Conversations on Health Care.

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Mark Masselli: We're speaking today with Dr. Uche Blackstock, founder and CEO of Advancing Health Equity, which she created to address racial health disparities in the American healthcare system. Dr. Blackstock is an emergency medicine physician who until recently was the Faculty Director for Recruitment, Retention and Inclusion at the Office of Diversity Affairs at the NYU School of Medicine.

Margaret Flinter: Dr. Blackstock previously served as chief resident in emergency medicine at SUNY Downstate Medical Center. She earned her undergraduate and her medical degrees from Harvard, her frequent media appearances addressing health inequities during the COVID-19 pandemic have led to a new position as medical contributor for Yahoo News. Dr. Blackstock, we welcome you to Conversations on Health Care.

Dr. Uche Blackstock: Thank you so much for having me.

Mark Masselli: Yeah, Dr. Blackstock I think one of the great injustices being amplified by COVID-19 is that black indigenous people of color in this country have experienced far worse impacting

outcomes from the Coronavirus, something you predicted would happen. You're based in New York, the original hotspot in the United States. You've been chronicling what you have seen in clinics across the city. I wonder if you could paint for our listeners a picture for us of what racial health disparities look like in a pandemic.

Dr. Uche Blackstock: Sure, yeah, and I will just say that there are many people who have come before me, researchers like Dr. Kumar Jones, Dr. David Williams at Harvard, who have just been doing this work for decades and who, who's whose on who's work has been foundational in this movement to address health inequities, and I'm so deeply grateful to them. I have my organization, Advancing Health Equity and obviously health equity is something that I'm always thinking about.

When I was seeing patients back in March here at different urgent care sites in Brooklyn, I noticed with my very own eyes that my demographic of our patient population literally shifted within weeks. It was actually quite profound, because you know, Brooklyn is evolving as the parts of it that are gentrifying, and so I take care of a very diverse racial, socio economically group of patients. But what became very clear was that I was mostly seeing black and brown patients, mostly the essential workers and service workers. Those are the patients who were coming in predominantly with COVID-19 symptoms, the patients who didn't really have the luxury of being able to work from home. That was very apparent to me in the beginning. Even before New York City released some of its own data on which communities are being impacted, my own anecdotal observations have left me very concerned.

Margaret Flinter: Well, Dr. Blackstock, I think that comports very much with what we've seen across the country, but certainly starting in New York. The testing wasn't widely available in the early phases of the pandemic to anybody, maybe especially to communities of color. We certainly watched from not far away what was going on in New York as the ICUs were overwhelmed and you had to be deeply moved by the way the essential workers still showed up for their jobs every day at the grocery store, in the nursing home, in the hospitals. You've addressed it, but maybe you'd like to talk a little more about the impact of racial disparity not just within the healthcare system, but really in the economic system and how that's now played out over these last several months.

Dr. Uche Blackstock: No, yeah, absolutely. I have to say that seeing it with my own eyes, and then being someone who studies in these inequities

just -- it was moving, it was incredibly powerful and led me to write about it and want to amplify these messages. But what we've seen is that through this pandemic, it's not just a health impact, we've also seen a huge economic impact on black communities and other communities of color. I don't think that's a surprise, right, I think that the factors that have caused black communities to be disproportionately impacted are the same factors that have caused these communities to be vulnerable. They're all related to systemic racism.

But what I think is interesting is that we've seen, while black people just proportionately represented among essential workers, we're also represented among people who don't have job security, who were more likely to lose jobs during the pandemic, who were more likely to have to leave health insurance as a result of that job loss. We've also seen similar trends with black owned businesses that they were less likely to have cash on hand to get them through that pandemic. We've seen many black owned business, small businesses have to close. We say we're not just seeing a health impact, but a really significant economic impact. I think that any strategies, any policy that is going to address on supporting these communities in this moment, have to not only address the health care system, but also have to address jobs and housing and other areas as well.

Mark Masselli: Well, that's such a great point of how we're going to get people through the pandemic. We're coming up in October, seven months into the pandemic, and you know a lot more about how the virus spreads. New York continues to take, I think, stringent public health precautions, but many other states have been lacks in their public health protocols. We're seeing case numbers rising in various parts of the country. Share with us your concerns about the --around the pandemic, as we headed into the colder months with, I think, mixed messages from the federal government and your concerned for vulnerable populations, again, who will most likely be hardest hit?

Dr. Uche Blackstock: Yeah, I have to agree the messaging has been incredibly mixed. The way it's been done, it's been incredibly concerning as well. I think what we've seen in terms of political interference in terms of the FDA's work and the CDC's work has really has undermined any remaining trusts that black indigenous and other communities of color have had, excuse me, for our health care system. I actually worry that once we do have a safe and effective vaccine, whether these communities will want to take it, whether they will believe

that this is a vaccine that would be helpful to them. I think as we're going into the winter, as you mentioned, we're seeing states that are not really enforcing any of these basic public health measures that we know actually work. I think that even here in New York City, we can't let our guard down, which is why I think that -- and although we haven't seen any significant effort, we really need to target the most vulnerable communities. What does that look like? It's not just about getting PPE, but it's about messaging and outreach.

I've always advocated for state and local entities to really collaborate with community based organizations, organizations that are already on the ground, doing this work, and whose leaders are considered trusted by these communities, church based organizations. Really forming those alliances, I think, will be crucial as we head into the winter.

Margaret Flinter: Well, you are right on, we're certainly thinking about this as we anticipate the flu season and plan for and look beyond that to COVID. I guess, I would ask you -- totally agree with your strategic sense of both the messaging and the messenger as being incredibly important. But as you think about a COVID vaccine being available, hopefully, in the not too distant future, kind of what are your hopes and fears for how this is going to go, both in terms of making sure that we engage everybody in the trials that are going on, but also that we are straightforward and honest about risks and opportunities, but that we don't miss this opportunity to protect everybody, and particularly the people who are most vulnerable. It’s a huge challenge. What are you thinking about that?

Dr. Uche Blackstock: That's such a challenge. I think what we saw actually, I think, in the last one, two weeks, one to two weeks is the National Medical Association, which is the oldest and largest group of black doctors have actually taken upon itself to develop a task force that's going to bet FDC and CDC recommendations around vaccines and therapeutic. This is where we are, we're at this point where I don't think this is -- there’s ever been precedent for this before. The National Medical Association has never done this before, but obviously felt that there was a profound need to do this because black communities are being disproportionately impacted.

When I think about what needs to be done, a lot of it is in terms of policy. There's the Jobs and Justice Act that the Congressional Black Caucus is currently working on, and a lot of the policies are addressing jobs, housing, and also

specifically COVID-19. But we really need to get those pushed through so that we can get funding to our most vulnerable communities.

Mark Masselli: We're speaking today with Dr. Uche Blackstock, Founder and CEO of Advancing Health Equity to address racial health inequities in the American health care system. She is also the medical contributor at Yahoo News. Dr. Blackstock you've really been speaking truth to power in terms of the needs that and responsibilities that local, federal and state organizations have to deal with these health inequities. You were just talking a moment ago about the social determinants of health and you noted in your own experience, as a frontline provider in emergency room, that you would see patients regularly who didn't have adequate health insurance, lacked adequate housing, were facing food insecurity, working in low wage jobs, oftentimes without the proper protection or PPE. I wonder if you could talk about your quest to address social determinants as one of the most effective ways to improve health outcomes for the black indigenous and people of color populations beyond the pandemic. What's your thinking about the steps that we need to take to improve these disparities?

Dr. Uche Blackstock: I think that, in June, I testified in front of the Flex Subcommittee on the coronavirus. Some of my recommendations for them, they weren't necessarily specific to the pandemic. They were specific to what are the needs of our most vulnerable communities. But a lot of the policies I mentioned to them were around housing around opportunities for home ownership, and opportunities for building wealth and using policy to support those ideas.

Even thinking about investing more into public housing, investing more into mortgage programs that can provide a low interest loans to first time homebuyers. I'm thinking about how often credit is used to help people get mortgages, but then at the same time we know that black and brown communities are more likely to have lower credit scores and how that influences the ability to gain mortgages, and so working on programs that can address that financial literacy.

I think that when I think about what it's going to get us out of this, this is going to be a long term committed effort. I think on the part, it has to be on the part of this -- our federal government, also at the state and local levels, but we really need to be funneling resources. I think that's what -- because we've seen how federal policies like redlining, right, like other aspects of the new deal, like the GI Bill have essentially left

these communities disinvested in for four decades. We're seeing the combination of that and so we need to get us out of that is policies that will help to empower community members to help them to build wealth, because we know that is directly linked to health outcomes.

Margaret Flinter: Dr. Blackstock, we read your compelling piece in the publication stat, why black doctors like me are leaving faculty positions in academic medical centers. Here you are member of Harvard's first legacy families of African-American women to graduate from Harvard Medical School, your mother then later you, your sister, very impressive, very impressive milestones.

But the overall numbers tell a different story, right, very low representation across really all the health professions of people of color. You've made some efforts previously at NYU as Faculty Director of Minority Recruitment, but now at Advancing Health Equity to really change this picture to improve, I mean the early recruitment and gaining the interest of people and coaching them through the training pipeline and then retention when people are in practice. Tell us about that work that you're doing. It's very exciting work and so needed.

Dr. Uche Blackstock: No, thank you so much for asking about that, because no, as you mentioned, the numbers are still incredibly small for black physicians, but also other health care professionals as well. I also want to emphasize that, I know not everyone wants to be a physician and that there are other opportunities within health care such as nursing, physician assistant, physical therapy, occupational therapy. But what I think has become incredibly clear is that waiting until students get to college, and are premed that it's too late. It's much too late. It had to start -- it's so interesting.

I had tweeted about this last week, but it has to start at maybe even before kindergarten, right, it has to start -- not just in terms of exposure, mentoring and sponsoring these children, but also thinking about the educational system in our communities, right. Often the schools are underfunded, right? What are we going to do policy wise about that? Well, what our health care institutions going to do about forming public private alliances and programming so that we can work with kids starting from when they're little to expose them to these health care professions, because I think about my own mother who was fortunate enough to have someone in college. She was the first person in her family to go to college, but it was her chemistry professor who suggested that she apply to

medical school. She had no role models before that.

How can we just how can we start that much, much earlier in the pipeline, because, as we've seen, since the 70s, since diversity initiatives have been enacted by medical schools, we really haven't seen a change in the percentage of black physicians. I always tell people, the same reason that we're seeing racial health inequities is the same reason that why we see the very low number of black health care professionals, it's all connected, it's all related. We can't band-aid program starting in college, it's simply not going to work. We also need healthcare institutions to realize their part and their role in investing in the communities they serve, but also in the next generation of health care professionals, that it's up to them as well, it's their part as well.

Mark Masselli: I want to pick up on that theme of messaging early. Often, while we have some advances that are happening on the vaccine, you've recently said in Yahoo News that we also need to plan for the year ahead and beyond, and that we just need to remind people that they're going to need to be wearing masks, social distancing, and taking other precautions. But there is a question about the vaccine and who will access it first. I know you're concerned, I think we all are concerned about communities of color, we'll have a perhaps difficulty in accessing them. I'm wondering how you're thinking about it, how you're trying to advise decision makers about their responsibility to make sure targeted populations are early on, but also that were very clear early on about our communication, about the science, and also the responsibilities that individuals have. Could you share with us a little of your thinking?

Dr. Uche Blackstock: Sure, absolutely as I mentioned a little bit earlier, I think that what we've seen is an undermining of public health messaging by this administration, right, which is led to further distrust by the public. But what I am seeing that is reassuring is that there are organizations like the National Medical Association, but also their advisory groups that are out there advising on who should be -- on what the process should be that we should be waiting for adequate data from our phase three clinical trials, that we should not be rushing this, so to make sure that we do have a safe and effective vaccine. But then also, the other part of it is ensuring that we are putting -- and I think that the pharmaceutical companies and vaccine manufacturers are a little bit -- we're a little bit late to this. But I see that some of them are picking up on it that they really should have been focusing on how are we going to recruit community members

from black indigenous and other people color communities is so important.

I think that -- actually, what some data shows is that communities of color are actually more likely to engage in clinical trials, if you tell them, these are the risks and benefits to the individual, to the community, to the greater good. They actually are more likely to want to enroll in studies. I've been seeing over the last few weeks more effort being put into that, because I think because of we've been amplifying that message, that message is getting out there.

Then ultimately, I think, along the way we're going to have to make sure that once there is a safe and effective vaccine that that distribution process, as you mentioned, is a fair one, because I think we're seeing some of the data coming out from some -- or the recommendations from several advisory committees are saying that we can't explicitly say race, but we'll say if you are a health care worker or an essential or you have risk factors for being at -- if you're at increased risk for being infected with coronavirus. I think that we need to have, actually more nuanced conversation about that, because I can sense that some are difficult or some have difficulty saying we're going use race, right? But what we've seen what racism, right, not race has done in terms of health outcomes, right.

Margaret Flinter: We've been speaking today with Dr. Uche Blackstock, the Founder and the CEO of Advancing Health Equity and medical contributor at Yahoo News. Learn more about her work by going to advancinghealthequity.com. You can follow her coverage of the coronavirus at Yahoo news.com. Dr. Blackstock, we want to thank you for the work you've done and the work that you will do to advance the cause of health equity, and for joining us today on Conversations on Health Care.

Dr. Uche Blackstock: Thank you so much for having me and for this thoughtful discussion.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: President Donald Trump has touted an 85% decline in the nation's COVID-19 case fatality rates since April, and has attributed the drop to improvements in treatment. But better treatment is only part of the story. Experts say part if not most of the decline can be explained by expanded testing and a shift toward younger people rather than higher risk older folks catching the coronavirus. Since the end of July, Trump has included the impressive sounding statistic in press briefings and rallies. On July 27 briefing in North Carolina, Trump said, "Due to the medical advances we've already achieved and our increased knowledge and how to treat the virus. The mortality rate for patients over the age of 18 is 85% lower than it was in April." The case fatality rate is the percentage of deaths from the coronavirus among the confirmed cases.

The President is correct that the case fatality rate has fallen substantially since April. We calculated a crude case fatality rate of 7.7% for all ages for April that dropped 83% to 1.3% in the month of July, and further dropped to 0.9% for the month of August for a total decline of 88% since April. But Trump is wrong to attribute the steep decline only to treatment improvements when other factors are also at play.

In the beginning of the pandemic when testing was still extremely limited. U.S. was not capturing many of the lists of your COVID-19 cases, which led to an artificially high case fatality rate. During the month of April, only about 5.3 million tests were performed. But in July and August 23 million tests were performed in each month according to the COVID tracking project. It also matters who is getting sick, and that has also changed over time.

One expert told us that early on many outbreaks occurred in nursing homes where COVID-19 mortality is very high. But now more younger people are becoming infected and they are at lower risk of death. The Centers for Disease Control and Prevention said people ages 20 to 29 accounted for more than 20% of coronavirus cases from June to August. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at www.chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. People living in Sub-Saharan Africa have tougher odds at overcoming diseases. The problem is not just the lack of access to health care providers. But once someone is diagnosed with an illness, access to vital life saving medicine is out of reach for many who are sick simply because they can't afford them.

Gregory Rockson: Africa has some of the highest drug prices in the world, simply because it's a free pricing market. You can take a single medicine and two pharmacies next to each other will sell that same drug at wildly different prices.

Margaret Flinter: Gregory Rockson is the founder of mPharma, a nonprofit organization that seeking to address inequities in drug prices in Africa and the supply chain that often puts these life saving drugs out of reach of the people who need them. mPharma operates in four African countries, it decided to tackle the problem by redirecting the supply chain that forces small independent pharmacies and clinics to source their own drugs, and help offers these entities the chance to outsource their procurement for pharmaceuticals.

Gregory Rockson: We realized that if we could begin to bring together all these independent pharmacies and remove the pressure that they have to face in sourcing their own drugs, we can begin to address the issue of medicine availability and affordability.

Margaret Flinter: Rockson says they help improve the drug procurement supply chain by collecting data on actual drug sales, which allows health care entities to avoid over or under stocking, and it reduces their vulnerability to fraud and corruption, which sadly is rampant in drug supply chains in parts of the world.

Gregory Rockson: The beautiful thing about the service that we offer them is that not only are we taking ownership of the supply chain, we are also providing the financing to purchase the inventory. We offer them a simple value proposition, pay only when you dispense the drug to the patient. Beyond having the parts available, we actively help them manage their inventory.

Margaret Flinter: Rockson says another important benefit more affordable drug supplies help clinicians better manage patient outcomes. mPharma was a 2019 recipient of the School Foundation's Entrepreneurship Award.

Gregory Rockson: With our focus on bringing down the cost of drugs that there will be a systemic change that even other actors will be forced

to reduce their prices.

Margaret Flinter: mPharma, a nonprofit entity that utilizes reliable data on drug usage, eliminates fraud and waste in the drug supply chains, makes life saving medications more readily available to some of the world's most vulnerable people, improves outcomes and saves money. Now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcast. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.