

Prioritizing Equity video series: Moving Upstream

In this July 2, 2020, installment of our Prioritizing Equity YouTube series, join physicians and health equity leaders as they illuminate the ways in which physicians are moving upstream to reimagine, redesign and reconstruct what a more equitable health care system can look like.

Panel

- **Sandra Hernández, MD**—President & CEO, California Health Care Foundation
- **Rishi Manchanda, MD, MPH**—President & CEO, Health Begins
- **Lauren R. Powell, MPA, PhD**—VP, head of healthcare industry, TIME'S UP
- **David Zuckerman, MPP**—Director of Healthcare Anchor Network, The Democracy Collaborative

Moderator

- **Aletha Maybank, MD, MPH**—Chief health equity officer, group vice president, Center for Health Equity, American Medical Association

Transcript

July 2, 2020

Dr. Maybank: Good afternoon, everyone. Welcome back to Prioritizing Equity Series here at the American Medical Association. I'm Dr. Aletha Maybank, chief health equity officer over the Center for Health Equity, and we're very happy to have you back and have another great conversation today. For those of you who don't know the Center for Health Equity is now a year old at the AMA and our role is really to help support the AMA embed equity in practice, culture, innovation, performance across the entire enterprise and work with others within this institution, membership and those external to the organization to do it and just really strengthen AMA's work and position as it relates to equity.

Just to let you all know, we have our Health Equity Resource Center on our website related to COVID-19, that's still up and running. We had a great last conversation with some leaders within the LGBTQ community, please check it out, it's posted and available to watch. Next week we're going to have a conversation with some leaders of an effort that we're actually doing in collaboration with Essence Magazine and brand called, Release the Pressure, but it's also in partnership with the American Medical Association Foundation, with the American Association—or the Association of Black Cardiologists, the National Medical Association and the Minority Institute of Health as well. We'll be speaking about heart health, but really what does that mean during the time of COVID and at the intersection of equity? Hopefully you all can join us next week as well.

Today, I have the honor and pleasure with being with these amazing folks. We have Dr. Rishi Manchanda, who is president and CEO of Health Begins. If you could just raise your hand a little bit so folks know who you are. Great, thank you. We have Dr. Sandra Hernandez, who is president and CEO of the California Health Care Foundation. Thank you. We have Dr. Lauren Powell, who is VP and head of Healthcare Industry at TIME'S UP and she raised her hand. Good. And we have David Zuckerman, he was director of Healthcare Anchor Network at the Democracy Collaborative. Just really thank you all for being able to take the time and spend it with me today, but also share your awesome expertise.

What I'm very clear about, and folks who know me, I come a very public health background. I've been in public health departments really the majority of my career, and I've trained in public health. The root and basis of how we're trained is really this totality of what creates health. The downstream opportunities as it relates to the health care system, morbidity, mortality, all the language around risk factors, all of that, that's the downstream. Public health really provides that larger frame of what we're terming as moving upstream. I'm going to have you all define what that means for you, but understanding that where we live, the conditions that we live in and that we have access to actually determine the choices and the behaviors in our health outcomes overall.

Those conditions can be social in nature, they can be structural in nature as well, as we all know. Then there is some fundamental root causes of which we've had conversations about in the past related to racism and White supremacy. Today, I wanted to really speak with you all to talk about there's this awareness in the public health side. Now, I'm in this health care space, and I'm learning a tremendous amount as a pediatrician, a preventive medicine doctor, but I am realizing sometimes that there are gaps in understanding this totality of what creates health and it shows up clearly in how our systems are structured, in the conversations we have and the education that's available. The question is, what do we do ultimately about this.

We're going to get to all of that in the conversation today, but before we start that, I want to have a sense of one, where are you all, literally, physically in this country and then two, how are you doing and how have you been doing? It's now, what, three and a half months, almost four months for most of us? I just want to have a sense of how you all are doing. Lauren, do you want to start?

Dr. Powell: Sure. Well, good afternoon. First of all, thanks for the opportunity to join you today in this conversation. I am joining you from Richmond, Virginia, which is where I live. At times, I'm at the offices in D.C, but I live in Richmond, Virginia. It is an interesting time to be here. Yesterday, we just removed two Confederate monuments, and there's more to come.

All those who are familiar with the history of Virginia, which is essentially ground zero slavery and ground zero of the Confederacy, cradle of the Confederacy, if you will, is an interesting time to be here. COVID is very difficult. This is a big state, not as big as California or Texas, but lots of implications. They are certainly seeing similar issues in the Black and Brown communities here with how COVID is impacting those and also Native communities that are here as well.

I am okay, I feel like it's a day to day thing. I'm glad to have the training that I have and happy to be able to contribute to equity in this moment.

Dr. Maybank: Absolutely. Thank you. David?

Zuckerman: Just want to echo what Lauren said. I really appreciate the invitation to be here and in conversation with all of you. I think the word that I've been using a lot is adjusting, and I think these last three and a half months I've been here in Washington D.C, I'm about two miles from the White House, and I live alone. It's been a process of adjusting in that environment, and yet at the same time, I have a tremendous amount of privileges and the ability to do this work remotely and not be out every day and exposed, but just dealing with family and friends who have come down with the virus, but also in that process of adjusting to this space that we are now finding ourselves in for this period of time.

Also, really just trying to find those silver linings, those things that are happening in this time and period that might not have. Whether that's getting to know a neighbor closely or finally have the opportunity to spend time with family and doing some stuff as a family that we probably wouldn't have found time for, if it wasn't for this moment. Appreciating both that as well.

Dr. Maybank: Thank you. Thank you. Sandra?

Dr. Hernández: Good morning. I'm happy to be part of the conversation as well and want to thank you Dr. Maybank for convening us today. I'm sitting in San Francisco, California, in my home. The California Health Care Foundation has been working virtually for over three months now, and in a state that is quite large and quite diverse, an organization that's really committed itself for more than 20 years to improve health care in California to make it work. In particular, to understand how the status quo perpetuates these disparities and what can be done to improve on those.

The foundation staff and their well-being of course, as the CEO, is always front and center, and so making sure that we have the mechanisms by which we can continue to do our work while we're supporting our employees, many of whom are moms and have young children or juggling working

from home and all of those considerations.

Personally, my partner and wife of 28 years is in the hospital recovering from an elective surgery. I've also had this unique window into our care system at a point of time of COVID-19, and really just talking with the nurses and CNAs and the clinicians and looking at hospitals or dealing with COVID. I have this very unique perch at the moment to really hear from frontline health care workers what their experiences are, what their concerns are and the like.

I would just add, my training, not unlike yours, was in primary care as an intern. I've worked in public health for about 15 years. What you can see clearly happening here is that the country is at a point in time when we're really looking, I think deeply at our public health infrastructure and our health care delivery systems are saying, what's wrong with this picture? How is it that we have 18% of our GDP in health care, and we don't have basic PPE or contact tracers that can speak the language and be trusted by the community?

We're at an inflection point. I feel like we're at inflection point, and I'm very honored to be working with an organization that's committed to really thinking about what kind of change we need going forward.

Dr. Maybank: Thank you. Thank you very much. Rishi? How are you doing and where are you?

Dr. Manchanda: Thanks, Aletha. I'll just add my thanks to you and to the AMA for the invitation and the privilege of joining David and Lauren and Sandra. I'm based in Los Angeles. My wife, our two kids and a dog are in a two bedroom apartment here in Sherman Oaks, for those who know LA. LA is now locking down again after easing restrictions over the past few weeks, and I think we're seeing, of course, that across California and in other states.

I think what's personally been challenging and stirring at the same time, is all the paradoxes. I feel at the same time, entirely disconnected from a lot of the people that we've talked with across the country, through our work at Health Begins, because of the virtual nature of things and at the same time, find bright spots and incredible opportunities for getting grounded despite not withstanding this distance. Bright spots finding through conversation, through work with colleagues across the country and through reading.

It's a remarkable moment, I think, because the pandemic is laying bare what my colleagues and I at Health Begins, and I think everybody here on this panel, has long been aware of and that is that moving upstream means looking at the things that we don't see, that we can't see. To look at the things we can't see is always a challenge. The structure is in the forces and the environment and the policies that shape people's lives. This pandemic has made it possible for more people to see what, or to look at what it's hard to see. That's stirring, but it's also sobering.

Dr. Maybank: Absolutely. I'm going to continue with you because I'm going to ask you to frame. I've learned a lot from Health Begins, and I think a lot of folks have in terms of just framing out these distinctions. Like moving upstream, my fear in some of these terms, and you've heard me say this, they become jargon, and not well understood. They become code words for things that we should be saying sometimes, in terms of root causes and the isms that we know exist. Can you just frame for people, you just talk about the invisibility of it, but just a little bit more about what is moving upstream, and why is it important?

Dr. Manchanda: Yeah, absolutely. I'll start with just the punch line, moving upstream for Health Begins and the allies and partners we have the privilege of working with means something very specific, very rigorous, and what it means is continuously improving the social drivers of health and equity at all levels: individual social needs, community level social determinants of health and structural determinants of health equity.

To unpack that, it means figuring out how to provide the highest standard of care when it comes to addressing health and social needs of individual patients. Those for example, with food insecurity. It means concrete, anti-racist strategies that require institutions of health care, the practices, the systems that work in, to support efforts to address community social determinants, like not food insecurity for individuals, but food deserts.

Then it also requires the ability to support and, again, rally institutional strategies that are concrete and transparent to address the structural determinants of health. For example, supermarket redlining or other historic redlining efforts that are manifestations of structural racism that explain why food deserts exist in certain communities and why there is a higher prevalence of food insecurity among Black and Brown communities or poor communities in the US.

Moving upstream requires action to all three levels. To your point, Aletha, pre-COVID, I think a lot of health care leaders, systems doctors were starting to use the term moving upstream and in many ways that's a sign of progress, that the term of moving upstream was going mainstream, so to speak. The challenge, though, is, of course, that because the underlying structures in the US that propagate inequity and that perpetuate health disparities, disease and death disproportionately, because those structures are unequal, when systems talk about moving upstream, and don't do it the right way, which is to make sure that it's addressing all three layers. It actually aids and abets in perpetuating the status quo.

In other words, just doing food insecurity screening is necessary but insufficient in our definition of what it means to move upstream. It's fundamentally, actually, as this last three and half months is demonstrating, what it means to move upstream by addressing social drivers at individual, community and structural levels with rigor means being explicitly anti-racist at each of those levels.

To just unpack it one final time, when I started doing this work in 2008, and coming across the upstream parable that unlocked a lot of the way of thinking about in framing this issue, the upstream parable that I heard and as many of you have heard was, there are three friends who come to a river. It's not an idyllic scene. There are people in the water who are drowning; children, adults, the elderly, the first friend jumps right in and starts to save those who are downstream, the rescuer. A second friend jumps in and swims a little further upstream and builds a raft to usher more people to safety. Then over time, they recognize that the same people sometimes that they just saved are back in the water again, or that the tide persists, that more and more people are in the water in dire straits.

They finally spot their third friend who's in the water and she's swimming much further upstream and they shout to her, "Where are you going?" She shouts back, "I'm going to find out who or what is throwing these people in the water." What it means to move upstream in this moment right now, and what it's always meant, is meant to provide not just an analysis that allows us to look at the things that we can't see. Not just to look at an individual person and say, "Are you food insecure or not? Which is itself, the higher standard of care. It's to recognize that to do anything less than providing a higher standard of care is actually aiding and abetting a system that is inherently been racist.

What I challenge a lot of my colleagues and my fellow physicians to do and what I've learned from a lot of my colleagues, both in medicine, in social service, et cetera, is that when it comes to moving upstream, it means addressing social needs for individual patients, because that's the right thing to do, is the best standard of care, the inherent value proposition in moving upstream to address food and hunger or housing insecurity for an individual patient is that it's anti-racist. It's the right thing to do, it's the best standard of care.

Then it doesn't stop there. It means asking your institution, what you can do at the community level, and of course, the structural level. It's three levels, and there's a right way of doing it, and there's a wrong way of doing it. It's time that many health care systems that have been using the term moving upstream, ask themselves, whether they're on the right side of what it means to do upstream work, or are using the term, but not really understanding the phrase.

Dr. Maybank: Thank you, that was, I think, extremely helpful and helpful as a grounding and helpful for the audience. David, I'm going to come back to you in a second to build off of what was just said, I'm going to go to Lauren first. Just talk about TIME'S UP and its evolution because I think that's a really important story and meaningful work. Then also, what's happening during COVID? But how is that really critical to this moving upstream work at this point in time?

Dr. Powell: Thank you, and Rishi, that was such a great layout. It was also an entire word. Thank you for laying out that whole framework. I'm with TIME'S UP and many viewing and certainly our other panelists may be familiar with TIME'S UP Foundation, which was created really in the wake of the Me Too Movement, being Golden Globes 2017-ish and the creation of an organization that was really about gender equity. But about gender equity, specifically in the workplace.

Within TIME'S UP Foundation, there's a legal defense fund, which is really an individual level intervention to create the opportunity for women who may not have the economic and financial means to necessarily separate from maybe an employer or system that is perpetuating gender inequities through sexual harassment and sexual assault. That provides a pathway, an individual intervention pathway to assist those women. But TIME'S UP also knew that this is a systems problem, and it's an industry problem per industry.

Industry specific initiatives and focuses have been created. There's a TIME'S UP Advertisement, TIME'S UP Entertainment. There is a TIME'S UP Healthcare, and that is where I'm situated. I work specifically to focus on eradicating gender inequities for women working in the health care workplace. We define that very broadly inclusive of hospitals and clinics, but also public health workplaces, and other areas that are considered within health care.

Where we're taking this approach to really work upstream is in the industry work, and that is that we're focused on systems change. That means changing companies, changing culture, changing policy. The other thing I thought about when I was refreshing, "how do we actually define upstream?" What I find myself always doing is reminding people that it's not downstream. Basically, it's constantly fighting against our knee jerk reaction to do the simplest thing right in front of us, which is really not always going to have generational impact.

It's literally fighting to get upstream. Even in the work that I do with our community at TIME'S UP Healthcare leaders, we have to constantly anchor ourselves and remember, we're fighting for systems change, and that is so much harder. Systems are very complex, they have been created over hundreds of years. They've been created to run exactly the way that they are running.

When you think about how do we put a cog in there to make it not run the same way or how do we dismantle it in some small part so that it eventually blows up all together? That's a bit more complex. Specifically, when thinking about COVID-19, we are focused—I so appreciate Sandra bringing up the frontline health care workers, we're very much focused on the frontline health care workers, who are overwhelmingly women, who are disproportionately women of color in the lowest wage paying positions.

Thinking about what does that mean, not only for COVID, and the spread of COVID, but what does that mean for those workers? What does that mean for the care that patients will receive as a result of how those workers are treated? Thinking about paid sick leave as a public health issue, a public health policy, but also what that does for the safety and well-being of health care workers? What that then does for the safety and well-being of patients that come in?

We've been focused on that. We've been thinking about childcare and the challenges that many women are facing trying to juggle so many different roles, not only in the frontlines, in society and in their careers, in the frontlines at home and having to manage multiple tasks and wear multiple hats.

Then further thinking about what is this doing to our health care system which is created to care for people? How is this crisis perhaps perpetuating other underlying inequities; racism and transphobia, homophobia, lots of other forms of oppression. In thinking about what is our role in interrupting that as well?

Dr. Maybank: Thank you, I have to get to my mute button. There's a lawnmower outside, so I'm trying to protect you all from hearing that. So, I apologize. Sandra, what Lauren highlighted is really, sometimes that's left out of the conversation is the need for investment, and the need for support some outside institution or from within the institution to actually be able to do this work.

I'm very clear, and I'm sure all of you are that to do equity work, and to do it meaningfully, you have to have resources, literal dollars to it, but also people in time that are doing it or else it's just not done well. Sometimes there's this narrative that, oh, we can figure it out. But it's like, it's a little harder to just figure it out. You really need to invest some capital and things in this. Can you speak to some of the work of the Health Care Foundation, the California Health Care Foundation, especially during this time with COVID, and how you've been supporting health care systems.

Dr. Hernández: Sure. I'm happy to do that. Maybe I'll start with a small anecdote from when I was director of health, not in the philanthropic sector yet, because I think this interplays with one that's really valuable to see from both sides. We had the time San Francisco General Hospital were really trying to figure out what to do with patients who were frequently in the emergency room, frequently in psychiatric emergency services, would get admitted three days, we give them a voucher for three more days to go out and do follow up and they would never follow up.

Right about that time, one of our national philanthropic organizations was really interested in doing supportive housing. Of course, as a primary care provider, you're really not educated in how do you finance supportive housing, and what are the service models that work? There are ways in which the philanthropic sector can work hand in hand with the public sector or the delivery system to take things that have been tested and tried and really to try to scale them and implement them.

With the help of a national funder at that time, San Francisco built, over a long period of time, more than 20,000 units of supportive housing. We did that through the health department. That's the public sector hand in hand. Having been in philanthropy now for well over 20 years, first running the San Francisco Foundation, Community Foundation really focused on everything from economic development, to education, to early childhood education, to housing, to environmental health, really just rounded out a bigger public health profile.

Fast forward to today, California Health Care Foundation sits in a state with three or four or five other large statewide health care funders. Really, what you see happening today in real time, is we are pulling together as a group of philanthropists and saying a couple of things. One, what is the appropriate role for us in this pandemic at this moment in time, given all the inadequacies and historic

underfunding of public health? What is the way that we should work together to really lean in at this very disruptive moment?

I think it's interesting, the combination of the pandemic, the significant economic crisis that's associated with it, and the protests that we're seeing at this moment. There's a lot of attention on police and police reform and defending police and even police behavior as a public health matter in and of itself. But I also think the health care system is also needing a significant reboot. We focus a great deal on that account because it is the public program that serves 13 million, 14 million people in the state of California. It was part of the ACA expansion, California did that in a very robust way.

Here we are today, with many, many people, millions of people being displaced from employer-based coverage. Once again have this opportunity to say, "how do we make sure these individuals easily and readily get access to Medicaid?" There are examples where the foundations came together to implement ACA, to put all the information together, the policies together. We have a very strong individual exchange in California, spending a lot of money to doing marketing to make sure that subsidies are used.

I think this is a moment in time, both to say, how do we learn from what we did in the early days of ACA, but also just thinking forward, how do we make this thing as seamless going forward so that people don't have to figure out how to bounce in and out of programs when they're eligible, when they're not? How does COVID work? Should I enroll in Medicaid? I made a little less money. I made too much money. We have a very complicated system that is not user friendly when it comes to universal access, and that's a goal the foundation's been engaged with and will continue to do.

The other big opportunity, if you will, is to really shift the paradigm from being a clinician, physician centered organization of delivery of health care, to really think about something that's more consumer driven. What we're seeing in telehealth today is that. It is really saying we as a delivery system need to figure out how to get care to you, not you getting care to us. And COVID, the notion of stay away because we're trying to do surge planning, and don't utilize ERs unless you absolutely have to, has really shifted the paradigm for thinking about where and how we do care.

We have delivery systems that have 300 fold the number of telehealth visits that they were doing just six months ago. We talk a lot about structures. Rishi referred to it, Lauren referred to it. I think it's important even to break that down. Structures are about what's funded, what do you pay for? Who does that? What is the face of that? How do we make that work for consumers? The workforce piece that you were referring to, Lauren. Then what are the behaviors and attitudes that are embedded in that, which really has to do with all the stuff that we're talking about now around racism and behaviors and beliefs.

The foundation made its largest investment in the history of the organization to provide telehealth capability to our safety net in the state that includes our federally qualified health centers in particular,

many of whom were not paid at all for doing telehealth in the past and suddenly, the regulations do as much telehealth as you possibly can do. That pivot is an opportunity and one that I don't think we'll turn back. If you think about people who live in rural areas and have very unique conditions or children that have special needs, the notion of having to drive two and a half hours and then parking and then figuring out childcare and then figuring out the waiting room, and then the provider's an hour and a half late, and maybe you see somebody at the end of the day, those days really need to end. We need to figure out how we create a delivery system that is really responsive at the point of care.

What this pandemic is allowing us to do is do that and do it at scale, and the foundation has leaned into that as of many others. You can't just—

Dr. Maybank: Because I want to make sure I get to David in a few more times, but that leads me to David actually as well and building off of what everyone said. David, I met you two years ago. I've heard about the work that you were doing and leading up from being in Chicago. You're learning about an effort called West Side United, of which it is a collaborative effort. Things that people who are in public health are pretty familiar with. But what is unique about the opportunity is that it has six health care institutions that are termed anchor, which you're going to help explain what that means, that have come together to do investments that are upstream.

Understanding, as Sandra, you were saying that we have to move beyond the home and the individual patient, but what are we doing as institutions and systems to move not only our thinking, our understanding, but our actual dollars to actually invest upstream within the neighborhoods in the context of where those hospitals sit? Can you talk about the work of the Healthcare Anchor Mission Network, and how that works to promote moving upstream, as a first question, then I have another question for you as well.

Zuckerman: Great, thank you for that, and I'll try to build on some of the comments of the other panelists and just say that I think even starting with the moving upstream comment is often about moving from the individual to the system on recognizing the root causes of poor health, the racial and economic inequities that drive unjust outcomes we see in our society and the health outcomes ultimately. But I also think of it as how do we move from the individual actions and the assets we individually have, to thinking about the collective assets and the system assets, and how those can be leveraged more powerfully to address those systemic needs that we see.

I say that within the context of the work of the democracy collaborative, broadly, which works to offer an alternative and just economic vision of our current political economy, and ultimately, the community wealth building pathways to build that democratic, small d, economy. I often think about the fact that, one word that we're very allergic to in the US is how do we design the system to move ourselves towards equity? But we forget that we designed the system to perpetuate the current inequities, both racial and economic, and that the only way we're going to address these inequities is to think intentionally about a new design.

Practically, for us that's thinking about this idea of community wealth building, which is really about reimagining traditional economic development strategies by prioritizing different drivers that really contrast with the inequities that I think traditional economic development has brought to so many communities across this country, both in terms of really negatively impacting communities of color, but also in generally really extracting wealth from many communities.

I think the four drivers of community wealth building that I'll just put on the table, and I think that will help inform why these anchor strategies are important, are an emphasis on equity, an emphasis on place because we know that these inequities concentrate down to the zip code level, understanding how ownership perpetuates these inequities and how we need to think differently about the design of new models of community ownership, then also understanding how resources move in communities, the local economic multiplier effect that can come from targeting resources in different ways.

That really influences the work of the democracy collaborative around articulating the role and building the field of anchor institutions. For us, anchor institutions are nonprofit and public institutions. They have this social, this embedded social mission that I would argue can be better activated. But they have also grown over the last 30, 40 years to become these powerful economic engines within their communities. There is an opportunity to really leverage these two factors, to think differently about the design of our local economies and how we can make them more equitable and more powerfully address these root causes of poor health.

For us, this act of a health system or university leaning into this idea of the role of an anchor institution is the anchor mission. Over the last decade, we've been working to elevate this idea within the health care sector. About three and a half years ago, we were able to form the Healthcare Anchor Network. I serve as the director for the Healthcare Anchor Network, which has grown to be a health system collaboration of now 50 member health systems working to build more inclusive and sustainable local economies to improve community health and well-being and really address these root causes of poor health, the racial and economic inequities we see.

The way that's at the heart of what we do, is thinking about the economic assets that these systems have differently. The everyday way they do business that perpetuates inequities, that with institutional racism that's embedded within these institutions, we need to think differently about how we hire, how we purchase and how we invest the endowments that are traditionally in stocks and bonds and how those dollars can be leveraged more powerfully.

That's where we started, and it's really expanded beyond that even beyond those that focus on the economic assets to other places such as, how do these systems use their voice differently to elevate these inequities, but also advocate for the additional public resources that need to go towards making these sustainable changes? Because they alone can't change the conditions, the health systems in the case of West Side United where these six health systems coming together, can't alone change the conditions in the communities.

But I would also suggest that without them being part of the solution, we can't change the conditions in these communities either, without these local and rooted economic engines being part of the conversation.

Dr. Maybank: Right. Exactly, and thank you for that. That's one of the challenges that I would say I've noticed. How do you break through this dominant narrative about what creates health, and it's shifting away from the health care system. How do you gain buy in from people? All of you are working to gain buy in to some level, you are working with folks that get it, I get it, and we're all working together collectively in that way. But the reality is, there's still such a tremendous gap in understanding what this all is about and how health care systems can work in the way that you just described, Dave, and the framework of what you laid out, Rishi, how are you all overcoming that barrier of getting buy in and explaining to people that this is what it is, and this is why you need to be on board? That's open to anyone to answer.

Dr. Manchanda: I can take a quick pass and pass the baton to anybody who wants to take it. I want to build on, just to answer that question, Aletha, the point that David just made and I think everybody's spoken to which is collective action. A lot of our work, what we found is the way to learn about how to change buy in and gender buy in is through talk, but mostly through action. We still learn by doing. It's consistent with what many physicians and health care professionals in general know. We are actors in terms of how to implement change, and we learn by doing as a profession, we have apprenticeship models that are deep. We're really familiar with learn by doing.

We also know that there are certain methodologies that we've learned from other industries in the past 50 years that have proven that when we don't know exactly how to do something, there's actually an approach, quality improvement, et cetera, that allows us to learn by doing in ways that can literally save lives.

What we've done is to look at collective action in helping to support and form teams across the country through learning collaboratives, physician groups of health care systems, teams to essentially come together, starting within health care, which is our main audience of stakeholders, and then letting those teams then include community partners. Those teams, and these learning collaboratives are very organized in goal directed ways to achieve, through an upstream quality improvement process that we've developed, to achieve demonstrable changes. Not just social needs, but to lay down concrete strategies for institutional and structural action.

It's collective action at the level of teams to address and improve individual social needs and health outcomes. But that same collective action is required among institutions. To David, your point, what I admire about the democracy collaborative, and other collective institutional efforts is okay, what can we do now as a collective there right now to address and invest in, to divest from certain resources and to invest in where we know the needs are at because that's the way to change the structures, it's to change how we pay for, and what we pay for.

Then it takes collective action at the societal level, as we're seeing evident clearly, in the past three and a half months, it requires protests, it requires policy changes, it requires dismantling structures that perpetuate America's caste system as Isabel Wilkerson just wrote about New York Times yesterday. It requires us to be able to work at each level in a collective way. That's how we learn how to get buy in, by showing what it looks like to work together in new ways.

We can't imagine ourselves into a new future, we have to work at it. That practice, that ability to work in practice is something that we do a lot in our work in Health Begins. If I can put something provocative to the team, I think about democracy and democracy collaborative triggered that thought for me, and I think about institutional roles, and I think about the 50 institutions and the Healthcare Network or institutions that are grantees of the California Health Care Foundation, or the membership that AMA has or the works that Health Begins or TIME'S UP. All of the institutions that are part of our networks right now represent, in this moment, civic institutions, economic institutions. We have an election coming up, and we know that one of the strongest upstream determinants of health is the distribution of power and resources.

There is a 1983 motor voter law that was passed that made it such that this place called the DMV became a bastion of voter registration. There's nothing more inherently democratic about the DMV than about it, an agency that receives federal funds to provide care, meaning hospitals and health care systems. I wonder, we've proved this 12 years ago, and every year, there are opportunities for our institutions of health care to be what they are, which is civic and economic institutions and to provide voter registration, at the very least. Nonpartisan voter registration so that people that we serve are also able to have more and more access now than ever to vote.

There are opportunities to, right in our own home, to stop medical debt. There's so many opportunities to start with reframing the house that we live in, the house of organized medicine right now and then leverage our civic and economic responsibilities in ways that are more probable and possible and evident now than perhaps we saw before. I want to put that out there and see what our other friends think.

Dr. Hernández: I'd love to jump into that if—

Dr. Maybank: Sure, please.

Dr. Hernández: Thank you, Rishi, for that. I do think that many of our affinity groups, if you will, in this case, we're on an AMA call and thinking about the vast number of physicians all across the country. It is an enormous political force. It is an enormous economic force. We're at a moment in time, we're really thinking about what kind of delivery system is going to provide for the equity that we're all talking about, and everybody says we want. Yet, now, like many other entities, we tend to operate as a protectionist organization as opposed to an activist organization.

I think what we're seeing in the social unrest and the discourse that we're having in this country about class and about race, and about these vast disparities, really is a moment in time where you'd like to see the voice of organized medicine really be bold, and be inspirational and look at itself and say, "What hasn't worked here?"

I'll just name two very specific things as Rishi did, we are upcoming on election and there are clinics in Rishi's front yard that are actively doing voter registration. But to name two things, look at graduate medical education, look at how it's funded. Look at who runs it. Look at who determines who gets in. Look at the mechanisms by which we screen people out. Look at the disparities that we have in our population demographic.

In California, single digit Latino physicians in a population that's 35% Latino. Where half children under the age of five are Latinx families. The same is not any better in our African American community. Why is that? There have been efforts funded by philanthropy to reorganize how we fund graduate education. Why do we train people in acute care hospitals and then wonder why everybody ends up as a subspecialist? How do we think about how we finance medical education? Who can afford to go to medical school?

Those are issues that are in our practice. We sustain those status quos. We're talking about structures in some abstract way. Who's on admissions committees? When there was a recommendation that the IOM promoted for how to restructure graduate medical education was organized medicine that killed that. There's been major efforts at universal coverage of Medicare for all, where has the voice of organized medicine been then?

I don't think we can talk about structures and racism and classism without looking at our own profession and saying, what is it that we need to do different? Look at birth equity among Black women. This has been true since I went to medical school, vast disparities, vast disparities. To me, we're not going to close that gap until we as a medical profession say, what is it that we are contributing to the way this delivery system functions in such a racist way?

I think we're going to name the structures, and name the opportunities and think about how we use our power to change these systems, and we need to think about the pathways that we have for STEM, and for our pathways to medicine. California had some as valid in November, affirmative action. In 29 years, we've banned the notion of affirmative action, and yet we have legacy admissions to all of our private medical schools. Where your parents went there, you'll get a second read, get a third read, you get in, and affirmative action is somehow rigging the system against people who are meritorious. We have some enormous opportunities at this moment in time, and I would just urge our medical profession to do—

Dr. Maybank: Absolutely. Thank you, Sandra.

For some reason I'm cutting. I don't know if it's cutting off on your end or my end. That's one thing that's hard to tell, I don't know, which is choppy. But I want to get to, because we don't have much time left in the call, I want to make sure we give folks an opportunity to speak. Lauren, coming to you. One, do you have anything that you want to say based on all that you've heard? I did want to also ask you, just related to I was talking earlier about the buy in, there was the collective action. I was very impressed. I was in New York City when the launch of Time's Up Healthcare happened. I wasn't there because I was part of TIME'S UP Healthcare, I was invited by Monique Hedmann, Dr. Monique Hedmann now, who just graduated from med school.

I remember walking into the room and seeing all these women in black. I was like, "Where did this come from?" The ability of TIME'S UP, and I think the strategy that was used by Esther and other folks who were at the helm at that time, was really quite brilliant. Can you speak to that, and then its usefulness at this point in time to talk about the political determinants of how to address the political determinants of health that Rishi mentioned earlier? Because I think that kind of strategy of which Dave is doing too, that's a collective strategy, in order to advocate, in order to use that voice in order to impact politics and the political determinants of health?

Dr. Powell: Yeah, that's great. One, yes, I do have something to add to what I was just listening to. I agree with everything. I think that we also have to name what's fueling these structural inequities and to the core, for sure, that's also systems of oppression, racism to be specific. When I think about—Rishi laid out the parable of the upstreamist and what upstream, middle stream and downstream really looks like. I think it's so imperative and we recognize this as well at TIME'S UP. We can't dismantle sexism without dismantling racism. You can't fully work upstream without acknowledging, understanding and tackling racism. Otherwise, you stand to perpetuate the downstreamist approach, which is to maintain the status quo. I was thinking about this as all of you were talking, that there are several levels, if we think about racism, a White supremacist would say, leave them to all drown maybe. Someone who is not in touch with White privilege might say, those people with the strongest swimming ability will be able to make it out of the river. Then perhaps someone with a White savior complex perspective might say I've saved a couple of people, and I should pat myself on the back for that, and that's great.

I think it's so important that we really recognize the way that racism without fully tackling it, without fully understanding it and fully addressing it has the ability to fully perpetuate all of the downstream approaches and to fully perpetuate inequities. I think that's super important. We certainly recognize that and take that into our work at times of recognizing again, we can't dismantle sexism, we can't dismantle gender inequities without one, an intersectional approach. But two, dismantling racism at the same time.

TIME'S UP Healthcare was created. Esther Choo, Dara Kass, Jessi Gold and Jane van Dis all came together to really start to spearhead the work of TIME'S UP Healthcare. These are women who have

an army of a network of other women, as you said, who are very committed to really creating more equitable opportunities for women in medicine, but broadly in health care.

One of the ways we've gone about really being intentional about systems change is a signatory program we have with lots of health care institutions around the country. That is large organizations with a lot of power, a lot of clout, quite frankly, and a lot of resources to be able to make significant change within their organizations that have a really great trickle down effect and impact on their employees, and on those working in the workforce.

By joining our signatory program, those organizations have to take a pledge to admit and to acknowledge that sexual harassment, sexual assault has no place in the workplace. That you will be proactive about actually intervening should cases arise, and that there will be actual consequences. We're working in this moment to ensure that we're trying to incorporate similar measures around racism, that there is zero tolerance for either one of these activities, for either one of these types of behavior. That there will be grave consequences should they occur.

That's kind of a—we're moving, we're making progress, but we understand that's also a slow moving tide, because again, this is systems change we're going after, not trying to make it better for one person at a time, but trying to change the whole system. That requires us to really push on leaders, push on culture, push on policies, and really make the business case in fact, for the need to fully incorporate equity.

This not only impacts your workforce, but it impacts how your workforce does their job, which in this case means keeping people alive and taking care of them. In that we all need health care. We really have to make this an imperative.

Zuckerman: If I could just build on that? Dr. Maybank. You're on mute—

Dr. Maybank: Yeah. Go ahead, Dave.

Zuckerman: Great. I think just two thoughts to end on, to build on what the other panelists have said, including Lauren's comment there. I think that we have this systemic vision or this vision of where we'd like to go and where many people understand the depth of the racial and economic inequities, the systemic racism that we see in our country. Others are waking up to it. Then there's this gulf between how do we get from where we are to where we need to go?

I think that what really helps move people on that is then those steps that they can take. When I think of the anchor strategies, thinking about leveraging resources differently, I don't think on their own, they're going to transform the system, but I think they're a necessary component in order to reach the change we want to see.

I think that that has been something that's been really powerful and help those who participate in the Healthcare Anchor Network move a new framework of how we can organize the good things we've been doing into a much more intentional, strategic way to address inequities and community conditions.

Then I think the other thing I would just share is that, bringing it down to each of us individually and the human dimension of this work. I think we all know this, it's deeply difficult, and it's even more difficult for that one or two people within an institution who feel like they're alone in voicing the challenges. I think that the Healthcare Anchor Network and other spaces like it, really create a support network. Some have described it as group therapy in order to help recharge people and allow them to go back and advocate for these important changes that we need to see.

I think it's hard and it's lonely, and that work constantly needs recharging. Up until recently, there haven't really been the spaces to help people do that. Then I think on the flip side, at the end of the day though, some of this is that there also needs to be ways to give more folks cover to jump, and that I have found that oftentimes, people want to say yes, they just want 10 other people to say yes with them before they say yes.

I think there's this balancing act. That's both I think that in terms of the individual, the hard work, the empathy for those individuals, but also, my cynicism is that sometimes we're there, we just need people to feel like they can jump and say yes.

Then the last thing, just in terms of what I'm reminded that Dr. David Williams at Harvard has said about the issues about really how do we begin to address issues of racism in our country? That the two biggest gaps are understanding among White people, that it's a problem and then beginning to develop empathy in order to make the decisions needed, the choices needed to move forward. I think within all of this work, there is that how do we continue to deepen the understanding and building the empathy to move us forward with our goals around equity?

Dr. Maybank: Yes, thank you. There's empathy, but I think also there's a challenge of values too, and not being in alignment with values. Camara Jones talks a lot about that at the root in terms of American exceptionalism are the myths. There are these myths that exist as well, the exceptionalism, the meritocracy, the myth of hierarchy amongst really racial identification and skin color.

I think values are really going to be tremendous and challenging and elevating them, as they move forward to do this work. Even what Sandra was speaking about, the accountability, and Lauren, you've talked about this as well, that needs to happen at the institutional level to name and claim their potential and their history of causing historical harms, and AMA is definitely a part of that. Ours is most obvious, and people tend to point their finger to the AMA, and that's fine, and it is understood. But understand the majority of institutions across this country that have been historically White, which is the majority of institutions, have that history and all need to be accountable in order to move this work

forward, and realign, I feel, their values and understanding about just human beings, what you were mentioning, David as well.

We're at the end of this, and these things always usually go pretty quickly. Everybody has really brilliant things to say. I want to always continue it just a little bit longer because I really wanted to ask a really simple question and maybe this is possible, I don't know. You can only really say one word was about divest. All of you hinted to this, that something—Sandra, you talked about how folks are talking about police, abolishing police and divesting. Rishi, you mentioned divesting as well.

We don't have those conversations in health care. I think you're absolutely right. What does that look like to divest in health care? What needs to be reinvested in certain areas? David, you've mentioned some of it, but I just think it would be great to have more meaningful conversations about divesting. Anybody have two words that they want to say about divesting and where we would start with that? Really, two words, go ahead.

Dr. Manchanda: Two words, invest in public health, divest from health care. Divest from policing and invest in public health. More than two thirds of counties in the US, as we know right now spend more than twice on policing than they do on public health. Our job in health care is to see ourselves as part of the public health agenda. COVID has made that apparent that doctors on the front lines are only as good as the public health infrastructure that's around us. We need to divest and take the money from value based payment forms and all the upstream investments that upstream investments are making to improve outcomes for patients and take a tithe, take a percentage of those investments and divest it from health care, to invest in public health.

Dr. Maybank: Thank you. Anybody else, real quick?

Dr. Powell: Yeah, I would only add to that second, invest in public health times three and invest in women in leadership and diversity in leadership.

Dr. Hernández: I would say, we really need to shift dollars that don't give us better outcomes into our education system. Every dollar that we waste in health care is a dollar that we are taking out of our social services and our education programs to our generational impact.

Zuckerman: I would say, invest in community wealth building and community and economic development and rethinking how our local economies work and the outcomes they produce.

Dr. Maybank: All right, well, we did it then. One o'clock. Well, if you were in central time, it's one o'clock. It's two o'clock on the east. I thank you all for your information, and your expertise and your time today. For all of those who are listening in, this will be available usually within the next couple of hours or so, so you're able to share it. There'll be an annotated version as well.

But I definitely just recommend that folks, share it around, because I think moving upstream is still a pretty new idea in one sense. It's not a new idea, but in terms of its embracing among the health care community, it's still very new and still not well understood. The more information we get out there, the better. Thanks a lot, again, and have a wonderful weekend. A wonderful holiday weekend.

Zuckerman: Thank you.

Dr. Manchanda: Thank you.

Dr. Hernández: Thank you.

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