The Health Equity Compact: Catalyzing Change In Massachusetts and Beyond

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Angel Bourgoin:
Welcome to this podcast from the Delta Center for a Thriving Safety Net. The Delta Center is a Robert Wood Johnson Foundation-funded initiative that brings together state primary care and behavioral health associations to advance policy and practice. I'm your host Angel Bourgoin, senior researcher at JSI, and part of the Delta Center Team.

Today, I'm speaking with Michael Curry, President and CEO of the Massachusetts League of Community Health Centers. He is also one of the co-founders of the Health Equity Compact. The Health Equity Compact is a coalition of over 70 leaders of color in Massachusetts from a diverse set of organizations who have come together on a shared mission to advance health equity in the state. I've had the pleasure of supporting the work of the Health Equity Compact as JSI project director, and this is a real treat for me to be able to talk with Michael today about the Compact and what other states can potentially learn from the Compact's journey so far.

Angel Bourgoin:
Hello Michael, it is so great to have the opportunity to talk with you today about this exciting work. Thank you so much for being here today.

Michael Curry:
Good morning. Glad to be here.

Angel Bourgoin:
I'd like to start with your perspective on health disparities and health inequities, and why these have captured the attention of so many people in the nation, and in Massachusetts, at this point in time.

Michael Curry:
It's unfortunate that it took a convergence of circumstances to make America focus on the health inequities, the deep and long-standing health disparities that exist in this country. And those circumstances, of course, were a series of racial tensions, most notably the murder of George Floyd, that captivated the world's attention. And our attention here, in the United States, watching that nine minutes and 29 seconds of George Floyd's life being taken away, over and over again, on television, in our social media feeds. And then, of course, that opened up our attention to a whole host of other cases across the country that almost seemed like they were happening, you know, weekly. Of new cases of new shoot shootings of new deaths of new injustices.

And then in the midst of all of that, we had a pandemic that forced us to stay at home. And what it did was it made us more conscious whether we want it to be or not to the broader inequities and justices, and quite frankly, through COVID, the health inequities that made some people more susceptible to this disease more likely to be hospitalized, to be infected, hospitalized and to die. I often like to say that I'm glad so many people are woke, and others are waking up, but some of us are insomniacs. That means way before these high-profile killings and way before COVID-19 hit, there were many people lifting up these issues across the country. They were the canaries in the coal mine telling us what was happening to socially vulnerable, to BIPOC, to communities across this country. And yet, we were not giving it the attention and the resources that it needed to solve these issues. So I think, you know, the reality is we're at that moment now, in the last three years, that we can't unsee what we've seen. And Jim Crow and racism are all now on the table for us to to understand to contemplate, and then hopefully to act on.

Angel Bourgoin (3:54):
Hmm, yes, let’s talk about what it means to act. Can we talk a little bit about what that action looks like? Can you please tell us about what the Health Equity Compact is and how it came to be? And if you could please - start with the work that was done through the Health Equity Task Force that was mandated by the Massachusetts Legislature?

Michael Curry:
Yeah so you know when you think about the the many insomniacs here in Massachusetts right the people that I've gotten to know and the Racial Justice, Civil Rights, social justice space across the state, they've been looking for an opportunity to address these issues. They've been on task forces and commissions over the years. Disparities Commission, they've been Disparity Solution Centers like Joe Dr. Joe Betancourt, they've been embedded in these large hospital and health systems, and health plans really championing, correct collecting race and ethnicity data and doing the real critical work of addressing systemic racism in our health system. That being said, COVID hit. It required all these new task forces and commissions, and many of us were called up to serve on them. And we got to work and do the critical work of framing what put us in a position as a country, as a state in

our cities that led to so many Black and Brown people being sick and hospitalized and dying of COVID.

We then turn that into a broader report in all those settings on what can be done going forward to prevent this from happening again, and no surprise to anyone, it included addressing the social determinants, it included getting people equal access to care, the affordability of care, the quality of care, equity in care, choice in care. All those things were discussed. It included how we marginalize and relegate some people to the shadows, like the undocumented communities. All these things came up, and the underfunding about public health infrastructure in this country. So they were documented in all these reports.

And a good friend of mine who was on those one of those task forces with me, former chair of House Ways and Means here in Massachusetts, called me he said, Mike, you know this, you know, *beep*, I won't say the word he said, but you know, this stuff will sit on a shelf and go nowhere, because we've been part of these task forces before, there have been other reports. He said, so how do we pull together people to now move an agenda in the Commonwealth? We are Massachusetts, we did chapter 58 that led to the Affordable Care Act that became a model for other states across the country to think about how to cover more people and how to switch our reimbursement model to provide care that's more value-based. We're leading in those conversations since 2005/2006. Why are we not leading on health equity? And then, you know, we made some phone calls, and there was some conversations with some key leaders. And most of them were not people of color in key influential positions. And we got some traction, but not a lot of momentum. And then a good friend and colleague of ours was appointed to the head of DEI for a major hospital system here, Beth Israel Lahey, Juan Lopera, made a phone call and said, Hey, what are we doing, we've been on these Commission's and task forces, he was equally as frustrated that it might not go anywhere. And that led to the three of us really starting to call around and pull together Black and Latinx leaders, particularly, who are leading health systems in business and organizations that were interested in health equity.

It didn't take long, Angel, for us to pull together some 50 plus leaders who immediately answered the call, and said, Let's do it. Let's figure it out. And I want to I want to underscore for this. I'm sure this is true in Massachusetts. I know this is true in Massachusetts, and I'm sure it's true across the country. We've never seen a moment in this country's history. And in this state's history, where the numbers of Black and Latinx and now people of color generally are serving in the most influential positions in this nation that can now bring those institutions, those organizations to the table to solve one of the longest-standing issues in this country pertain of this country's history with race and racism, which is this issue around health inequity. That meant that we had a table of leaders and our philanthropic community leaders in that space or business and finance, but particularly those in the health space that came together.

And we launched what we now call the Health Equity Compact, which means that we agreed to do a few things. One is to advance policy in the state, the next train leaving the station we're arguing should be a health equity reform bill. And we presented a bill after a year of deliberation and, quite frankly, negotiation really, around what should be in an omnibus health equity bill. And then we work together to think of and explore other ways we can work together. So we have some other very interesting and exciting parts of the Health Equity Compact. But to your question, right people, right place, right time has been what I would say describes the movement we call the Health Equity Compact.

Angel Bourgoin (9:02):
I'd like to ask you about the leaders who are brought to the table here. It's not just healthcare organizations. It's not just the Massachusetts League of Community Health Centers. It's not just hospital systems. You mentioned business, you mentioned philanthropy, but there are also other sectors that are represented like academia and labor and behavioral health and oral health, public health. Can you talk a little bit about the importance of bringing these different sectors all together?

Michael Curry:
Yeah, I mean, under COVID, we would often say that here and across the country that it was a war against the disease. And I used to always lift up in every room that I was in, virtual and in person, that if we saw war, why are we not getting all the generals in the same room, to come up with a strategy to attack this disease? Well, I think the same is true on health equity. And what we've pulled together is 70 generals and counting. And to your point, they are hospital executives like our children's hospital here, Kevin Churchwell, or one of our largest health plans, Point32, which is a combination of Tufts and Harvard Pilgrim. Cain Hayes is at the table, the Dean of the Harvard Chan School, the Harvard School of Public Health, and the Harvard Medical School, Dr. Joan Reed and exiting her position, Dr. Michelle Williams. I mean, you can't ask for a better lineup when you think about Filaine, who is one of the phenomenal leaders is SEIU 1199. Or Nancy Norman, a very prominent leader in the behavioral health space. And Myechia-Minter Jordan at CareQuest leading the oral health conversation.

So again, we think about health inequity, it's important that we get an expanded view of what that looks like. It's your teeth, it's your eyes, it's your mental health, your behavioral health, it's your substance use disorder, it's your overall physical health, it's trauma, it's social determinants of health. And now, when you have a conversation and includes academia, the Chancellor of the University of Massachusetts Boston, that includes philanthropy, like Lee Pelton, at the Boston Foundation, in business, like Mass Business Roundtable, with Associated Industries in Massachusetts, you now can move the needle on these issues in a way that you wouldn't be able to if you just had individuals and single organizations or one part of the sector, at the table. You want to do big things, you need big people with big ideas, and with big organizations. And also combined with that, Angel,

with the community perspective and voice, right. Because the two have to come hand in hand.

So while we have these movers and shakers in the business and health, and academic spaces to table and labor, we also are making sure we stay grounded and connected to communities so that we get their perspective. And we can inform the work that we're doing as a coalition, as a movement. I think that is the model. That's what I'm most proud of is that this is a “nothing about us, without us” movement, but it's also people with lived experiences driving the bus.

Angel Bourgoin (12:05):
Yes, so speaking of being connected to communities, community health centers are very much connected to people who experience health inequities every day. Why was it important for the Massachusetts League of Community Health Centers to be a part of the Health Equity Compact?

Michael Curry:
Yeah, you know, so funny. I think if I answer that question, I think immediately about Congresswoman Ayanna Presley here in Massachusetts has a phrase that she's become very known for. She says those closer to the pain should be closer to the power. And she uses that as her mantra lifting up that you need community voice and community perspective. I think about your question about why the league and why now, really is about those closer to the pain.

Community health centers were started in 1965 as a demonstration project. They were really intended to respond to this higher rates of disease, morbidity, and mortality, the health circumstances that too often were the experience of Black and Brown people in this country, and poor white people across the country. And it was folks like Dr. Jack Geiger, a civil rights activist who was a physician here in Massachusetts, or Count Gibson or Dr. John Hatch, or Dr. Smith in Mississippi and others, Elsie Dorsey. Names that people should know just like, you know, Dr. Martin Luther King and Diane Nash, they were activists who understood, if not us, then who if not now, then when. In the 1960s, they organized and created these entities called community health centers. And these organizations first born out of a community health center in Dorchester in Massachusetts in 1965. And then Mount Bayou Mississippi, just a few months later. Mount Bayou with abject poverty. And not too long after that, just a few years later, primary care associations were born.

We at the Massachusetts League of community health centers just turned 50 last year as a primary care association. **So not only are health centers on the front line of dealing with disease and and giving people access to primary care and serving as health safety net and being the backstop or the companion to public health infrastructure in cities and towns. We're also solving for the social determinants of health and being engaged in those conversations.** How do we help to solve for the circumstances,

the conditions, the challenges that our communities are facing here and across the country as a result? The reason why, if not us, then who? If not now, then when? I became CEO, I really said, you know, I come from a community health center, I'm a child of a community health center. I know what it's like to go get my teeth done, my, my eyes treated, to go there for trauma, when you're dealing with violence and circumstances in your community. **Why can't health centers be closer to the power? Why is it that primary care associations can't help to convene the parties to deal with these systemic issues that quite frankly, we get tired of treating people for their disease or their circumstances, and sending them back to the same conditions that made them sick in the first place?** We now know that 80% of what drives your health status has nothing to do with the care you receive. It's all upstream. It's access to healthy food. It's the violence and trauma in your communities. It's a job, a fair Wage. It's all those upstream issues, access to nutrition and a gym, and healthy living. So how do we now go upstream? I think that was the question I asked myself, Angel. And what I came to was, this is how we were founded.

We were founded in 1965. Not just to treat patients but to challenge and advocate for access to clean water, to advocate and be champions for economic development, we became an economic engine. So it made perfect sense, Angel, that we go back to our roots, as they say down south and get back to the critical work that we do. And that means massively wanted to be a part of convening the broader community of color and the health and business and academic space to say what can we do together to wipe out the terrain of race and inequities in our health system? And can we bring our lived experience together to do that? Now, I would say the Primary Care Association here, like the others across the country, have something very powerful, which is we have the credibility of our communities. That we work hand in hand with our hospital systems and with our academic partners and with our nursing homes and first responders and our policy makers in a way like no one else does. And they know we do God's work. So when you're when you come at the conversation in that position, you're in a great place to invite people to the table to have a conversation about solving big problems. And we were able to do that here in Massachusetts.

Angel Bourgoin (17:03):
Can you speak a little more about the importance of who is at the table? In particular, bringing leaders of color to the table?

Michael Curry:
I jokingly say, although it's not a joke, Angel, I jokingly say, if women ran stuff, we wouldn't have a maternal health crisis in this country. And whenever I say that in audiences, people laugh, but then I explain it. That when the women are in positions of power, like the the Speaker of the House, the Senate President, the governor, the head of Health and Human Services, the head of the foundations. At every level, and in all those positions, then we don't relegate maternal health and the priorities of addressing a crisis to number three or four on the list, they become number one, or number two, because they have the lived

experiences that make it a priority. Too often in this country, because we don't have the diversity in the C-suites, we don't have the diversity in the medical schools, we don't have the diversity in the policy halls that make these decisions. We don't get the attention to the critical issues that we're talking about.

Angel Bourgoin (18:08):
Do you think that you could see something like the Health Equity Compact happening outside of Massachusetts? Obviously there's a lot of variation in state environments and not everyone has as liberal of a reputation as Massachusetts has.

Michael Curry:
I just want to...I want to level set for a second here. Don't think this conversation is easy in Massachusetts. I want to make sure people have proper context, which is just because it's so-called liberal, blue Democrat leaning Massachusetts, don't think that our majority legislature or our majority C-suite of our companies still understand the urgency of prioritizing health equity, racial and ethnic disparities, because it's not their lived experience. Therefore, the challenge existed here and continue to exist here for us to lift up that priority, and to use our positions of influence and privilege to then moving agenda in Massachusetts.

So what does that look like in Texas or Alabama, or North Carolina, or Florida? What that looks like is you still convene people with lived experience, you still call people to the table who have leadership in key areas who have the ability to get the governors ear, the secretaries ear, or who may who may be the secretary or the governor, and you pull those people to the table and say, hey, what can we do together? Right, we're stronger together. What can we do to advance health equity in our city our state? And I think that that model exists can exist anywhere, Angel, but it takes you know, there's a line from the movie *The Help*, that my good friend Rosalind Brock, who used to be the chairman of the National NAACP, she used to always quote the line from the movie which says "courage will not skip this generation". And I think this is about courage. I think the model that could exist across the country, is having enough courage, resolve, commitment, to step up, to approach the powers that be in business and philanthropy and in government, in ourselves, quite frankly, Angel. Because I think we also have to challenge ourselves to do something different about how we provide care, and how we address the factors that impact our health outcomes.

That comes at great anxiety. And does even here in Massachusetts, when you get people who may have converging interests, may have profit margins and other things that you've got to consider. But yet, because of the lived experience of willing to take the risk to have the conversation, I think that's the model, Angel. Is is find, the allies, find the people who really want to show the courage haven't skipped this generation. And let's do big things like we've always done in this country. Let's do big things like you've done in your states, and

we've done in Massachusetts, and let's move the needle on health equity. I think it can be done.

Angel Bourgoin (21:07):
So, let's talk a little more about how this can be done – because as you say, it is going to take courage in the face of other interests like profit margins, and in some political environments, it can be contentious to even use words like health equity. So could you speak specifically to state contexts in which you can get a lot of pushback on trying to advance health equity?

Michael Curry:
Yeah, I mean, ultimately, I think everything is about messaging. It's about persuasion. And you know, you could be in a state where words like health equity could be triggering for some who feel like there's an over-focus on a particular population or sub-population. But the reality is this data matters, the truth matters. So if I can come to you and show you where the morbidity and mortality rate is, if I can bring data to you that shows that Black women are not benefiting from the tremendous advancement of women to survive breast cancer in the same way that white women are. If I can come to you and show the maternal morbidity, death rates of Black women and pregnancy. And it's not contrary to opinion, just because Black women have babies young, that is also about societal conditions, and disparate treatment. 21 years or so after the Institute of Medicine's report on equal treatment, **if I can come to you and show you the data, no matter whether you're red or blue, Northern or Southern, conservative or progressive, no matter what your political affiliation, data matters. So maybe a personal story about a particular patient may not move you. But maybe the data will, maybe the cost savings will. So as we have this conversation around health equity in Massachusetts, we're using every tool available to make the point right where we're giving you the anecdotal stories,** we're getting data from the field from the ground, from patients from communities, as we do a tour of the Commonwealth to listen to communities, about what they're experiencing health equity, we're doing a statewide poll to get a statewide perspective on How people of all backgrounds feel about health equity. But we're also gathering the data.

We're also looking at what the cost implications are the cost of inequity to the Commonwealth. As we think about lost productivity of Black and Brown folks who are living shorter 5, 10 year less lives and maybe incarcerated or are calling in sick because they're dealing with high rates of disease, not just now COVID, but cancer, diabetes, heart disease, hypertension. I think it's about making persuasive and compelling arguments no matter where you are, Angel. I think that's the work of the Compact. And that's the charge for the rest of us across the country, is how do we now make the business case, the moral case, the social case, the equity case, and do it in a way that will touch anyone and everyone, no matter what their perspective is. You may not want to believe that there's a need to have interventions for Black women in maternal health, but the data says otherwise. And if it is

about saving lives, which I believe most people want to do, then you make a compelling case. And you ask for the resources and the right policies that can drive us to making sure that people are living their best lives and are in equal standing with their fellow citizens, no matter what zip code they're in or what race they are.

Angel Bourgoin (24:32):
Thank you for that. So what we just talked about is a little bit of how we convince them to take action. But then there's a bit of a question too, about what is the action that we're trying to get them to take? Because this idea of advancing health equity, that is a broad concept, it can be really tricky to get shared agreement on what that particular definition is, and then also what needs to be done in order to advance health equity. So could you please speak to how the compact conceptualizes, and then operationalizes, the notion of health equity?

Michael Curry:
There has to be a concerted effort to mobilize and dispatch resources, and resources could be dollars, they could be community health workers, behavioral health coaches, they could be gym memberships, and healthy food options. All of those things are not new, Angel they've been discussed. They've been presented in reports for years. But I think that the conversation now needs to shift to a sense of urgency, and we need to connect the dots to the solutions that we know will change the health inequities that exist across this country.

So that being said, the Compact is intensely focused, laser focused on what we can do together. I think the Health Equity Compact is really thinking in a very visionary way about how we can make that a reality here in Massachusetts, or how do we collect race and ethnicity data? John Snow, as I talked to you, Angel, John Snow 101: If you want to target disease and deal with the impacts of disease, you got to have the data. So as we know, from John snow's example, how do you now figure out where the disease is? How do we have the collection of race and ethnicity data in a way that now can have us think differently about our public health strategies? And how we treat disease? How we message for coming in for care or taking a vaccine? All those things are now part of the conversation under the Health Equity Compact.

The other piece to this that I think is critical as well is governance, right? How do you put people in positions that now have the authority, the power, the lived experience, the passion, the commitment to do something about these issues? As I said, if women were in positions of power, we would have no maternal health crisis. How do you have a leader in equity within government, that across our children's services, our mental health departments, and agencies across the Department of Public Health and Health Departments writ large. Somebody is accountable for connecting all those dots on all those services, to make sure that equity is always a part of the conversation, because equity is often left out. And what I've often said is equity is always competing against something else. We can't afford it. It's going to make people uncomfortable. We don't know enough,

we don't have the right people in place. It's not efficient. When in fact, what we often find ourselves in, here and across the country, and COVID was a prime example of that, is **when you don't include equity on the front end, you struggle with it on the back end.** Because they don't come in for care, because they won't take a vaccine because of the high rates of disease and death within communities of color, and poor communities. So how do we now make equity, the start of the conversation, and I think this health reform movement around equity in Massachusetts presents that option.

And last but not least, at some point, we pivot from just pushing government and policy to move the needle in this stuff to how can we do it together. One of the things I love that I watched happen across the country both through my work on the many task forces, but my national work on a task force around public health, and modernizing the public health system, with some phenomenal leaders like Governor Kasich and others who served on those Commission's with me on that particular task force. One of the key things out of the COVID pandemic was, we did it together. So that means we public health was working with community health centers and with government and with faith based communities. We had pharmaceutical companies and hospitals, teaching and community engage with local community organizations, we had a really a collective of folks who don't often talk to each other, working collaboratively to put out COVID tests, to do contact tracing, to message why the vaccines are safe and to deliver vaccines and put them in parking lots in schools and in the pews and the churches at the alters across this country. How do you put that in a bottle and use that across the country to address health equity? And I think what we've created here in Massachusetts with Health Equity Compact, is just that, right? It's that genie in a bottle of bringing really strong, powerful entities and organizations and people together to do the unimaginable work of eliminating health inequity in this country. So that sounds grand, it sounds maybe like hyperbole, I guess, would be the best way to describe it. But eliminating health inequity in this country. That's the goal. Right? That's the ambitious goal.

Angel Bourgoin (29:53):
Yes, it is an ambitious goal because there is so much work to be done, but as you say, we have to have courage. Now, the particular example you cited about people coming together to address COVID-19, this urgent context in which a lot of different sectors came together to deliver vaccines – that is an effort specific to a particular disease. And the work of health equity is about more than just about any one disease or even the delivery of healthcare services. It goes beyond to the social determinants of health, and that goes beyond the walls of healthcare organizations, and we have to think about a lot of different kinds of organizations across both the public and private sectors. So, can you talk a little bit about how folks can really tackle health equity and where do you start?

Michael Curry:
Well, I mean, I think one is I use COVID, as an analogy to be like, we can start by coming together. It's not just about one disease, one disease just gave us the template, the blueprint for how to do it for other conditions for other societal challenges. So you start by

pulling people together, right, I go back to my original point about it's a war. And there are generals, and the war against disease, the war against bad outcomes, disparate outcomes requires that you get the generals to the table, that you get community voice involved, that you get community perspective, and I think that's where you start. That's the number one place to start. Nothing about us without us; lived experience is the core of all of this work. And if you can get people to the table, then what happens organically out of that is people start to get visionary. And they start to be very ambitious about what's possible. And then it's not like, hey, you know, three people coming together, these are people coming together with resources with influence with access, with power, with privilege. And they can use and marshal all of that, to move us in a direction.

So I think what number one is to get us together. And then once you get people in the same room, accountability then matters. How do you keep people together and locked in so that as you get in conflicting views about affordability, and cost, and what's driving cost, and co-pays and high-cost care entities and you get involved in redistribution or distribution of resources, you get involved with some of the sticky points. What can drive you is the fact that one people are there not because of a business imperative, they're there because of a moral imperative, a lived experience is driving them to stay at the table. And even if you end up and I think this is a critical point for us, in Massachusetts, across the country, you may not end up with the full loaf. Because a full loaf might not be possible through this particular effort, we may not be able to agree on these 20 things. But if we can agree on these 70 things that move the needle on health equity, then we've achieved the goal of doing something that's a seismic shift in how we address these issues in our state or in our city. That's really what I'm talking about.

That's really what we've done here in Massachusetts, is come together and say, Hey, let's agree on what we can agree on. And let's, let's keep it moving. Let's let's try to advance that. Let's stay together, let's work out the issues. And maybe it's iterative. So we'll work on this, and then we'll come back together to solve some things we couldn't agree on. At first, and we'll tackle those as we go along. But I will tell you, I've been around long enough to know in this policy space, that I've never seen it. I've never seen the movement that I think we're witnessing here in Massachusetts, that really could be a model for the rest of the country. And how you take right people, right place, right time, and turn that into a movement.

Angel Bourgoin (33:40):
And a movement is absolutely going to be needed if we're looking for system-level change. Let's talk about right people, right place, right time – you say we're witnessing that here in Massachusetts, but what about folks in other states who might be trying to build on this sort of model? How do they know it's the right people, right place, and right time, or what can they do in order to make sure that that happens?

Michael Curry:
As I mentioned earlier in this heightened consciousness around inequities and injustice, we can explain why people live in the conditions. And we talk about redlining. We can talk about just a historical minute ago, our hospitals, particularly in southern states were segregated. We're not talking in my parents lifetime, we're talking in my lifetime. In the 1960s really, as I was being born in 1968, was really the tale, the midst of the desegregation of our hospital systems in this country in 1960s. Through the passage of Medicaid and Medicare, we're talking about access to quality schools and segregation through the 1970s and some of the residual barriers that exist for kids getting academic rigor and opportunity, right. So I mentioned that to say this, that we know that there are systemic historical issues that we've been dealing with in this country. And now that heightened consciousness is coming with action.

People want to do something to reposition Americans, we've always repositioned Americans. We've invested in farmers, businesses to save their farms, we've done that for returning veterans through the GI Bill and reposition. We've done that through the New Deal. And giving opportunities we've gone back to the 1800s. We've done that through the Homestead Act and Southern Homestead Act to have people build land and build wealth and have home ownership. This is a version of that. **This is a conversation about how do you reposition America in terms of health? How do you reposition people who've been left behind and quite frankly, ignored and experimented on?** If I did say, as we now know who J Marion Sims is the father of gynecology and experimenting on Black women, Anarhca, Lucy, and Betsy I always say say their names, as we know about the four decades plus experimentation on Black men that weren't treated for their syphilis as we know that Black and Brown folks don't have the same experience in our medical system. Some 20 plus years after the Institute of Medicine validated what activists have been saying on street corners about doctors don't treat us the same, they don't prescribe us medicine in the same way as they do others. They amputate our limbs, they don't believe our pain, like we have that consciousness whether you know anyone listening to this hasn't gotten here or not. You just got your ears plugged, because we've come to the understanding that these things are real. And they've been as part of our history as American Pie.

But the reality is, now we have an opportunity to do something about it. Now we can, as Rebecca Lee Crumpler says, you know, there's a cost for every ailment. And we now have the charge is your responsibility. I always say again, you can't unsee something. Now that you see it, you have an obligation to try to figure it out. And it comes again, with some risk, you know, any change in his country, you know, major developments in this country, were done with people who took the risk to advance it. So whether you're in Massachusetts, or Florida, or Texas, or California, or Minneapolis, St. Paul, Minnesota, we have an obligation to take this moment and make sure that we're making use of it. And then hopefully, and I'm asking that you be the right person. To your question, Angel, you are the right person. And this is the right time.

Angel Bourgoin:
Yes, yes. And that is what I'm hearing loud and clear from you: the right people, right place, right time. That's that's us. That's now. That's everywhere in this country, that we need to be moving on this.

Michael Curry:
Absolutely.

Angel Bourgoin (37:47):
So let's talk a little bit about the compact and the work that you know, you and so many other leaders of color are pushing forward. Can you please give a sense about sort of what that work looks like and what the major successes has been to date?

Michael Curry:
Yeah, so one is, and I credit [JSI Research & Training] Institute and of course, having a technical partner like JSI, who came on board right away and didn't care much about whether there was a, you know, some vendor fee to even compensate JSI for the tremendous amount of technical assistance they provide. Because again, right people Right Place Right Time. Sometimes it's right people, right organizations, right place, right time. JSI and your work, Angel Bourgoin, was critical to this, because you kept us organized, right? You had a vision helped direct our vision around how to get stakeholder engagement. So those early meetings of having all of the members, the increasing membership, get on a call, and start to talk about what was possible together what we could do in terms of policy. You know, when you think about getting a [JSI Research & Training] Institute level leaders, who run organizations who have to make sure that they're answering to their boards, and then say, hey, we want you to get on a regular call you and your staff, your surrogates, get on a regular call, and start to hammer out what we can do together is pretty phenomenal in the middle of a pandemic. So, you know, JSI's role in convening us and facilitating that conversation was a game changer. But for JSI's role in that work, we would not be here.

So that's one, two is, it's great when you have a team that includes the former chair House Ways and Means who's now, you know, in private practice as a policy person, and was driving these conversations and giving us really his example of years of working on health disparities and advancing policy within the state legislature. So he brought that experience and those relationships to the table. It's also a game changer when you can start to develop the right team. So of course, over the course of time, JSI was then accompanied by the former Associate Commissioner for the Department of Public Health, who had just left administration and was really looking to take a break. And as we often do, Angel, we said, you don't have time to take a break, we need you. And we draft you in a service. Lindsey Tucker, who when she was at Department of Public Health here in Massachusetts, was the convener under the commissioner for what they call the health equity advisory group under COVID. So many of us work closely with Lindsey, on these exact issues when she was

in her government role. And we twisted her arm and she came on board to support the work that JSI was doing.

And then we just started pulling these dynamic, brilliant young people from policy and public health and from schools, into the work too. So you have a core group of star leaders who are in the health and business and labor space and academic space, then you surround them with a core team of workers who understand the issues, who have a passion. And that led us to developing a health equity bill, which is now sitting before the general court, the Massachusetts legislature, with some phenomenal sponsors who also bring lived experience and a passion to advocate among their 200 colleagues in the building and legislature to advance this within the two year sessions. That bill is in play. It'll have a hearing, at some point in the next few months. It'll be, I hope, a packed room with people with lived experience that we've said to them, Lindsey and I've talked in her role. And I said, Lindsay, as we go across the Commonwealth, I want us to have the #healthequityvoter. Because we want you, when we come to New Bedford or Western Mass or North Shore, South Shore. And we leave you with the health disparities numbers for your communities, and we give you a definition for health equity. And we give you some information that can build a passion for health equity in the Commonwealth, **we want you to now say to your elected officials, what are you doing around health equity? And are you voting on that bill? And are you supporting the movement? And I think that's starting to happen.**

So that's the other leg of the stool. As I mentioned earlier, polls matter, people's opinions matter. The Mass Inc organization has agreed to do a public opinion poll. We should have that data in the next several weeks that tells us what Massachusetts thinks about health equity with a, you know, statistic valid sampling of the Commonwealth. To answer that question and some really good targeted questions in this space. The work of the Health Equity Summit. We are preparing to do something groundbreaking in Massachusetts. Which is in Massachusetts, we already have what we call a health cost trends hearing, which our Health Policy Commission hosts annually brings all the parties to the table to talk about What's driving costs and what we can do to curb costs. Well, we're modeling what would be in the bill, what is in the bill of a health equity summit that we then can get in the room and talk about what's driving health inequities? And what are you doing from a community health center perspective or standpoint? What do you see as the barriers? What are you doing from a hospital, a business standpoint? We're going to convene all the parties to be in a room and make that the central focus for the hours of the summit.

And then last, but not least, and I mentioned it earlier, that which gets measured gets done. And business case is critical to this health equity conversation. And we were very fortunate, the former CEO of Blue Cross Blue Shield of Massachusetts, Andrew Dreyfus, when we met with him, he said, You need to make a business case. That's how we got health reform passed in Massachusetts, you know, you want to make a business case. So go down to the

foundation, talk to our leader, Audrey Shelton at the Blue Cross Foundation, and see what's possible. We now are on the brink of releasing a staggering report that really points out something that I love to say that says, pay now or pay greater later. Which is we have a situation in this country where we're allowing these health inequities to impact our growth, potential, our survival and stability of our businesses. And quite frankly, our overall productivity as a city, state and nation. How do we now address in a workforce crisis, this challenge of health inequity is going to be a key revelation out of this report, pay now or pay greater later is my way of describing this groundbreaking work by the Blue Cross Blue Shield foundation with an organization called Tau Altero and their phenomenal researching.

Angel Bourgoin:
Thank you so much for that overview, Michael. Clearly, we've been very busy.

Michael Curry:
Insomniacs, that's why we've been busy.

Angel Bourgoin (44:48):
That's exactly what it is. And you were too Michael, and thank you so much for your incredibly generous words. I think that reflects something about your leadership and elevating other people in this work within the Compact membership and the team that's supporting and thank you so much for that. I think it also honestly, I think this particular lack of ego from you is something that we see also within the broader compact membership, just how incredible that this group of folks who are that C-suite level with this level of power within the organizations make the time for this work and don't bring an ego to this work, which I think is really quite impressive. And because you could see it going in a very different direction.

Michael Curry:
Yeah. And you know, just to that point, I think ‘cause we all have egos, and we all have been in settings where people struggle with who gets the microphone, who gets the quote, who gets the credit. You know what I think is really the differentiator for this work is lived experience again, right? As I believe, strongly, if you get a whole bunch of women in a room, and they're going to tackle the maternal health crisis in this country. What you'll see as people will subvert their egos, they'll take a backseat, they'll work collaboratively in a way that's different. Because they also have the lived experience of dealing with adverse pregnancies or seeing loved ones lose a mother or baby to a pregnancy or having to get a C section and the implications of that, in their own lives. I think that that is the real differentiator Angel, which is I think people really check their egos at the door, because they know this work is life or death.

Angel Bourgoin (46:22):
Yes, yes. That makes a lot of sense and is such an important argument for why it is important to have people with lived experience at these tables, and helping to shape you know, what policy looks like, and moving this work forward.

So you have just talked a lot about the different kinds of work that the Compact is involved in, across, you know, building a particular team, on making sure that we have a sense of what community members really care about, through the public opinion poll and the talking with different communities about this. You've mentioned about the importance of making a business case. There's a lot of work that the Compact is doing. So can you say a little bit of something to the folks who are listening perhaps in other state associations who may be hesitant to take on you know, all these different activities? What advice would you have for them to assist them, perhaps, to help be able to guide them and doing this kind of work and in particular on the fundraising piece of this.

Michael Curry:
Yes, I think a few things. So one is know that every example of this is going to be different. You know, we often say in the health center movement, if you've seen one health center, you've seen one health center. Well, I would say if you've seen one health equity movement, you've seen one health equity movement. That it's going to look different in other parts of the country. And maybe the Primary Care Association plays a different role. But in cases where the primary care association can play a leading role, as I said earlier, because we are trusted allies in this work, we're trusted partners, in this work, health centers are, primary care associations are, because we work with so many parties that often don't talk to each other. It gives us a unique position, it does mean personal time, you know. I can't understate how much of my time I've spent, aside from making sure that I meet the needs of my members through data and clinical support and policy and advocacy and workforce and technical assistance to add this to the plate to say no, you know what, we're also going to do this broader work around health equity.

And I want to state this for the primary care associations who listen to this conversation. Some of my own community here in Massachusetts said, Well, why are you doing this work? This is not directly what you're expected to do as a primary care association. And one of the things that I say to people when they've said this, to me, even out of our own family is I say, All roads lead to Rome. Is that when you talk about health equity, when you talk about addressing disease and resourcing communities, you are talking community health centers. So maybe there's a little self serving in this, that it gets to solve for the conditions our patients face. It gets to address the systemic issues that happen in our communities. It gets to ultimately leads to more resourcing of community based organization and the health safety net, which we are. It means that economic engines get the resources, which we are. So I think, you know, sometimes there's direct advocacy, you know, I need X dollars to fund X program or Y program. And then there's that broader advocacy that will uplift and truly have a tide that lifts all boats. And I think this broader advocacy has direct benefits for

community health centers and the work of primary care associations. But you may have to make that connection for people.

So it does mean raising money, we in addition to raising money, for the work of the league and our members. The good thing is when you pull a lot of organizations together and leaders of color together now not just Black and Latinx. But now more broadly, leaders of color, and AAPI, and other leaders of color who are at the table and engage, then they also come with resources. And some of those resources can then become what you use to do the advocacy and to bring on the technical partners like [JSI Research & Training] Institute or hire a phenomenal leader like the ones we've hired. But then you can also start to spread your wings and apply to funders who are also turning their attention to health equity, and investing in this work. I am now getting calls from philanthropic organizations saying hey, I just want to meet up. I want to know what you're doing and how we can be helpful. You build it, they'll come. And I think primary care associations are uniquely situated to build it, and then understand that it ultimately will impact and improve the lives of our patients and the strength of our community health centers.

Angel Bourgoin (50:58):
That's great. Thanks so much. You know, I think that the fundraising piece, if you could talk just a little bit further on that piece knowing that PCAs they do a lot right, and some PCAs have greater capacity than others. And behavioral health associations often have less capacity than primary care associations do. Can you speak to a little bit about, you know, the concern about not being able to have the capacity to do the work that they are tasked with doing, because of, you know, their responsibility, their membership? How can you do both?

Michael Curry:
Well, I think you know, I don't have the, the fleet answer, because I think that looks different depending on where you are. But I think, you know, we all have systems, right? We have government, and government, whether it be, you know, tax revenue and how they deploy resources in a state or whether it's federal resources that come to states or direct federal resources, or philanthropic dollars. And of course, that looks different if you're in a rural community without a philanthropic organization within miles, or you're in a metropolitan urban area. There are business organizations with corporate entities that provide funding, foundations that provide funding. There are many sources of support for this work and health equity.

The challenge becomes, can you pull people to the table that then comes with the embedded resources, based on their involvement. So if you pull your major hospital system and they say, Hey, I need you involved in this work. Whether your primary is, you know, in our model is a person of color, with that lived experience or a secondary supporter, like we have in Massachusetts, we've created another and we're still refining another level of support. So you don't have a person of color leading your entity, but you

have a commitment to this work. So we want to make sure we keep you engaged, we get you on a phone call, we ask for your support financially, in terms of your time and your research. I think that's happening here. And it can happen anywhere in the country, where folks will give you the resources they have to help further this work. And it's more difficult in rural areas, in communities where there's not a wealth of business and philanthropy. But I think that still can be done.

There are national organizations that are doing phenomenal work, to resource community efforts. Robert Wood Johnson is just, you know, one of the shining stars of organizations that put their money where their mouth is, and invest in the critical work that many of us are doing across the country. So I think that the opportunity is there. Just think outside the box. As we say, in my Black community, that I grew up here in Roxbury, Massachusetts, in Boston, closed mouths don't get fed. So you got to open your mouth and say what you're looking for.

Angel Bourgoin (53:42):
Thank you so much for talking a little bit about you know, what other state associations can do in order to get started, and in particular fund this kind of work. I'm wondering if you have any other additional pieces of advice that you may share?

Michael Curry:
Well, I think there's a critical one. So know that this talk may make all of this sound easy. It's not. Nothing that is worth it is easy. I think one of the more critical things that anyone who wants to do this work needs to think about is that a person like myself, I constantly think about what could go wrong. It's probably what makes me good at the business work that I do. It makes me good at the civil rights work and social justice work I do. It's because I'm constantly anticipating how people will respond, what the challenges are, that are just around the corner, because if you think about that you can prepare for them. So there's a little of predictive work that has to go into this to say, hey, if we pull people together, what's likely to happen? What is likely to be their hesitation, their reservation, what's likely to be the things that drive us apart? And then if you can imagine them, and some of this just is historically based because it's happened many times before. And all of this work in some degree is repackaging the Tylenol as my predecessor at the PCA, Jim Hunt used to say, repackaging the Tylenol, We're doing something somebody else did before. We're just calling it something else. But the reality is anticipating what went wrong, then you can do things differently to make sure that they are sustainable.

So, you know, the conflicting interest of members, the backlash from organizations that feel like BIPOC led efforts are, you know, three Black folks sitting at a lunch counter. What does that mean? What is this is this disruptive it's not good. Instead of it being Hey, this is just another constituency like we have in society that's political, that's social, that's professional. Another constituency that's come together to make sure that they're advocating for what's in the best interests of their communities. And I think when you think

about BIPOC leaders coming together, it's a constituency that has an urgent message and the data to back it up as to what we can do to address these issues. So anticipating, navigating the issues is another major point, Angel, I would want people to think about expect some setbacks. Again, history tells us no major effort in this country has ever been successful that didn't have setbacks.

Angel Bourgoin (56:12):
Absolutely. So that's really helpful advice about just being able to anticipate what challenges are likely to come up and expect those setbacks. Any other closing words of wisdom here?

Michael Curry:
I would say maybe, maybe a closing word of wisdom is an African proverb that I quote, often, which is, **"Rivers are filled one drop at a time. Rivers are filled one drop at a time." So you know, what you do now, matters, who you call matters, who you invite to the table will matter, what you're willing to advance, even with some risk matters. And it'll matter for your kids and your grandkids. And I do believe this work is that significant that every drop matters.**

So I look at what we're doing here in Massachusetts as a drop, that hopefully will have a ripple effect across the nation. And there's some great work happening in all the cities and towns and states around this stuff. And I'm looking forward to learning what those are, and then trying to be part of adopting those here in the Commonwealth as well. But we're hoping that this Health Equity Compact model can have a ripple effect and be tailored to what you're experiencing where you are. And then we can finally say that in this country, that every man and woman, every citizen has the optimal ability to live out their life in a healthy way, raise their grandkids, build wealth. And I think that's the goal. And I think we're on the way.

Angel Bourgoin (57:43):
Michael, thank you so much for taking the time to talk with me today about the Health Equity Compact, thank you for your leadership, for your dedication and the spirit that you bring to the work of the compact and more broadly to advance health equity for everyone in Massachusetts and hopefully, hopefully the rest of the nation as well.

Michael Curry:
Thank you, Angel, pleasure. And a big shout out to JSI to you, Angel. We would not be here but for you. So thank you for having me. Thank you

That was my interview with Michael Curry, President and CEO of the Massachusetts League of Community Health Centers. You can find out more about the Health Equity Compact, its members, and the Compact's breakthrough health reform bill on the website www.healthequitycompact.org.