FINISHED FILE

BOSTON UNIVERISTY
SPH Reads: Ripples of Hope in the Mississippi Delta
Tuesday, September 30, 2025
1:00 p.m. EDT

Services provided by:
Caption First, Inc.
P.O. Box 3066
Monument, CO 80132
www.captionfirst.com

***

>> ADNAN HYDER: Greetings, everyone. Welcome. My name is Adnan Hyder. I'm honored to serve as the Dean of the Boston University School of Public Health. And I am really privileged to welcome you all to this conversation.

This is actually our first public health conversation of this semester. And I want to really thank all our staff and offices that make this possible, both at the Dean's Office, Marketing and Communications team, and our Office of Diversity, Equity, Inclusion and Justice.

This webinar is focused around something we call SPH Reads. SPH Reads is an annual program where we select an important and interesting book, usually a very thought-provoking book that has elements or that are critical to public health. And so this time we have selected the book Ripples of Hope in the Mississippi Delta, charting the health equity agenda. And this book is really important not just because of the content and the importance of health equity and its policy implications, but also because of the author.

The author, David Jones, the late professor, was our colleague here at Boston University School of Public Health, and we are grateful for the work that he did here at the school, but also around the country, and particularly in the Mississippi Delta.

We look forward to discussing how this book and its important findings have sparked conversations already around the country on implementing recommendations that promote health equity.

I am also delighted that we have three amazing panelists to help us chart that conversation. First, I want to recognize Professor Jones' mother, Dr. Debra Bingham, who is going to be part of this conversation; and then two of my own colleagues who are critical to a discussion of this work, Professor Nicole Huberfeld and Professor Sarah Gordon. Thank you to all of you for being here, and particularly to Debra for continuing the important legacy of her late son.

I am now going to hand over the proceedings to my dear colleague, the Associate Dean for Diversity, Equity, Inclusion and Justice here at the Boston University School of Public Health, Professor Yvette Cozier. She will introduce the conversation and moderate it. Over to you, Dean Cozier.

>> YVETTE COZIER: Thank you, Dean Hyder, for that introduction.

It is my pleasure to be moderating today's discussion. Now I have the privilege of introducing today's speakers.

First, we will hear from Nicole Huberfeld. Professor Huberfeld is Edward R. Utley Professor of Health Law at BU School of Law and School of Public Health, where she is faculty in the Health Law Program and Co-Director of the BU Program on Reproductive Justice. Her Research studies the intersection of health law and constitutional law, often focusing on federalism, while studying the needs of vulnerable populations in health reform, Medicaid, and reproductive rights.

Then, we will turn to Sarah Gordon. Dr. Gordon is an Assistant Professor in the Department of Health Law, Policy, and Management at the Policy, and Management at the BU. She co-directs the BU Medicaid Policy Lab. She is a health services researcher with expertise in health insurance, access to care, and Medicaid policy. She applies econometric and causal inference-based methods to assess the impacts of state-level health care policies on low-income populations.

Finally, we will turn to Debra Bingham. Dr. Bingham is the Founder and Chief Executive Officer for the Institute for Perinatal Quality Improvement, Perinatal consultant, and an Associate Professor at Curry College School of Nursing and Health Sciences. Dr. Bingham is working to expand the utilization of implementation science and improvement science theories, frameworks, methods and tools in an effort to eliminate preventable perinatal morbidity and mortality and eliminate perinatal racial disparities.

We are delighted to have all of you here with us today. As a reminder to our audience, following today's presentation, we will turn to a moderated group discussion. When we have about 10 to 15 Minutes left in the program, I will turn to audience questions. Please submit questions using Zoom's Q&A function button located in the bottom middle of your screen. I will now turn things over for our presentation.

>> NICOLE HUBERFELD: Thank you, Dean Hyder, and thank you, Dean Cozier. It's such a pleasure to be here with everybody today, and it is my privilege to get us going on really what this book is about and why we are involved in it and why everybody should care.

As you can see, you have the three co-editors of the book with you. And what we want to make sure everybody understands is that even though The Delta consistently ranks as having some of the worst health outcomes in the United States, Dr. David Jones wanted to use his deep study of implementing the Affordable Care Act and its potential to flatten long-standing inequities and racial disparities on health to try to figure out how to improve the lives of people who needed it the most.

He was also inspired by RFK's 1967 visit to The Delta, which ultimately resulted in a book called Ripples of Hope, so it's quite clear that he draws his inspiration from that visit and the discovery of the deep disparities in health that existed there.

David understood that the voices of the residents of the Delta were key to his investigation and also to his learning. He wanted to understand how he could contribute to the policy conversation, but he also wanted to show and not tell the impact of health disparities and why place matters to health.

It helped, in many ways, that David was a political scientist in a School of Public Health. It made it so that the impacts on real people were always front of mind to him and not just political science theory but the real implications of politics on health.

So, David turned to local leaders, residents in The Delta, and also others to learn firsthand the complex intricate connections between race and place and health in the region.

He wanted others to see The Delta not as an outlier, not as an exception, but as an example. He always meant for this book to be not just for academic audiences, but, rather, accessible to everyone. And importantly, he started this work before COVID, before the words health equity were on everyone's lips.

Slide 2, please.

So, I think it's important to see David's own words as to why this is the research that he did and why this is the book that he wrote.

Others have written about the effects of social structures on health, but I do not know of any work that brings together statistics and stories to comprehensively examine how these factors intersect and interact in a single place.

Now let me just say a couple of words about why Sarah Gordon and I were involved in this project. Sarah and I coauthored pretty extensively with David, and we were lucky to engage in nerding out over an entire set of healthcare and federalism writings focused on first the Affordable Care Act turning 10 and then on the role of federalism in the response to COVID.

I also wrote with David and another co-author, Eddie Miller about block grants for Medicaid and other issues. And in fact, just to give you an example of the impact of this work, which I can firmly state I attribute to David and his broad thinking, we had a piece in JAMA health forum called what federalism means for the U.S. response to coronavirus disease in 2019 which is what waives we were calling COVID-19 at the end of the pandemic and as up today is 667,000 views. So, obviously, our impact is meaningful. But more importantly David wanted others to understand not what we were up to, but what public health and politics mean for everybody.

Next slide, please.

So, our co-editor work was on a complete but rough manuscript, which what the goal of quite critically preserving David's voice. His voice was uniquely pragmatic and hopeful. He wasn't a Pollyanna, but always optimistic and had the biggest heart. So, he was trying to forward his thinking on long-standing questions and problems and used this place-based research to do so.

We didn't want to add to the research he did, and we felt we should not. But, rather, what we did is that we brought internal consistencies to the book, a parallel structure for each chapter. We made sure that each chapter has an introduction, history, a cite to RFK's work, gaps and root causes, a preview of a policy agenda, ripples of hope with examples and equity policy agendas with goals for every level of government and nonprofits.

And to me, I just have to say, if you don't have time to read the whole book, though it's very readable, I deeply recommend the prolog. To me this demonstrates exactly how complicated the task and the research were.

David made it look deceptively easy to bring together the things that he did, to make connections between disciplines, between theories, between applications of history, politics and law. He made it easy for all readers to see, for example, how the Mississippi constitution has entrenched racial disparities

and the politics of the state and therefore the health of the state. It's a complex long history, and he does it with an economy that is really remarkable.

So, we see here that there are five topical chapters. Each exploring a major determinant of health. Always with an eye toward Mississippi not as an outlier but as a microcosm of what we see throughout the United States.

Now I will turn it over to Sarah Gordon.

>> SARAH GORDON: Thank you, Nicole. So, the methods that David used in this book are a very unique combination of qualitative data collection and analysis with a synthesis of policy and social science research.

So, David gathered and analyzed insights through focus group interviews with Delta residents, advocates, leaders and officials. And he employed a method called photo voice, which is a type of community-based participatory research in which community members provide photographs that they take themselves, a nod to their own narratives, which adds a novel visual richness to the qualitative data collection. He then situates this deep ethnographic research with a compendium of very convincing research to enrich and contextualize these new ideas.

The book also emphasizes translational policy research, asking how can these findings and what we are learning from these individual narratives affect real change.

And he answers that question through including in each chapter these ripples of hope to highlight how local groups and individuals are working to overcome barriers to health in The Delta region.

By offering health equity policies and goals and examples for national, state, and local governments and communities, he helps highlight how organizations on the ground are coming up with novel approaches to address health equity right in their own communities.

I'm going now to allude a bit to some of the eloquent remarks of Dr. Rocco who has presented on this work with us before because I think he summarized it so well.

These ripples of hope highlight how human beings can and do take action to solve the problems that they face, even when they are very local, even when they are under-resourced. And he shows that these ripples are worth paying attention to, that we can learn from them. And in this way the book is very generative. It shows how the people who have been affected by our system's problems can be partners in a dialogue between research and practice.

So, these policy goals show us how to translate these ripples of hope into a tide and it's our job to honor David's legacy by carrying them forward.

Next slide, please.

David was always emphatic that blaming individuals for health choices is not the solution. He used evidence to show again and again how environments can shape health. This book describes how a community-led goal oriented approach to creating health equity is needed and that everyone benefits when we ensure that all people can pursue a safe, healthy and fulfilling life.

In his own words, the key to having the largest effect on health is not only to make changes that help clinicians more effectively treat individual patients, or even to educate people on the benefits of eating vegetables and exercising, but also to understand the underlying structural factors that shape the distribution of health and disease to identify the policies that drive these differences, and to work to change them.

The goal of health reform should be health.

David's untimely and tragic death due to unsafe infrastructure underscores a central message of his life's work. Individuals, especially those who are marginalized, suffer tragic consequences when leaders of our institutions fail to provide safe and healthy environments.

Debra I'm going to pass it to you.

>> DEBRA BINGHAM: Thank you so much. So, David's book is both compassionate and practical. It provides a roadmap for anyone who would like to make a difference wherever they live. Causing leaders to act for change and provides examples from The Delta to show how.

He reminds us that small steps, ripples of hope, can save lives and improve health.

I really am so appreciative to Boston University School of Public Health, Dr. Cozier and Dr. Hyder and my co-editors, particularly excited that this book was chosen for the community read this year.

And before we go to discussion, I just want to read this quote from David's book, because often we think the problem is outside of each of us. We don't think we are part of the problem. And I think this quote speaks to David's sense of understanding that he was still part of the problem. And so I will just read it.

The more time I spent in Mississippi, the more I came to appreciate that The Delta is not an outlier in the American landscape, but that the dynamics of race and class here epitomize what is happening in the rest of the country. I came to better understand that racism is more than bad people intentionally harming someone else they view as inferior.

It can take that form, but it is also people, sometimes including me, who believe they are not racist, but who are

unable to acknowledge or unwilling to change the systems that structurally benefit them while disadvantaging others. The more time I spent in Mississippi, the more I was able to see the same inequities and racism in my own community.

So, I hope that as you spend time with David's book, that you will also be able to see how the inequities in your own communities where you live, wherever you spend your time. And I just hope that we all are able to reflect more on how what we do or not doing in order to ensure everyone has the opportunity to be healthy in the fullest sense of the word.

So, now turn it over to you, Dr. Cozier, for the discussion.

>> YVETTE COZIER: Great. Thank you all. Thank you all for your thoughtful words.

We will now move to our moderated discussion. As a reminder to the audience, we will turn to audience questions when there are about 10 to Fitch minutes left of the program. So, please submit your questions using the Q&A function at the bottom of the screen.

So, my first question to all of you, and, again, from the very beginning of the book, it's about empowering people or really elevating their voices. So, how do we do this best to the people experiencing the public health issues and problems?

Again, I want to buffer that by saying, in the communities that we live in. Some people may not be able to go and embed in another place. Where we are now, how do we elevate those voices of those who are closest to the public health problems?

And anyone can take that.

>> DEBRA BINGHAM: I will say a couple of things. One is to notice who is in the room and not in the room, is something very simply we can do, all of us. And making sure that we are diverse and having more input from everyone's voices, because that makes us stronger as a community and helps us do things.

And I think the other thing that David showed us so beautifully and has been, we mentioned before, is to not use a deficit-only viewpoint. It's not like I have all the answers. It's a collective, you know, we have pulled together, we are supporting each other, and we learn from each other, and not be thinking about deficits only, but thinking about assets and what are the assets that everyone brings to the table.

>> YVETTE COZIER: Anyone else like to add to that as well?

>> SARAH GORDON: I will just say, I came to this book with the perspective of a health economist, which is my background and training. And it was really through writing with David and working on this book that my steadfast belief in the religion of numbers and quantitative results has, I want to say, evolved. And I just feel like David's book is a great example of how

important it is to include community perspective and narrative alongside more empirical quantitative work. And now I have really taken that into my own research, where a lot of my work is on Medicaid, and I do a lot of quantitative analysis, but I now do a lot of qualitative data collection as well.

Because one thing I think David shows in his book and emphasizes is that policy intention is really different than policy impact. So, people who are recipients, who experience the effects of a given policy, it may not have the effects on them that was originally intended. And understanding how policies actually affect everyday people, there's really no way to do that, except for to talk to them and to listen.

And I think in public health right now, I think one of the most important things we can do is listen, especially in this moment where public health is having a hard moment, PR moment, for sure. And I think being able to listen and get feedback and understand how policies, interventions and programs actually affect people is so critical. And I think that's something that David would really want us to carry forward in all of our work.

>> NICOLE HUBERFELD: I think I would just add also, and I agree with what Sarah and Debra said. Those were beautiful comments. One thing that really stuck out to me in our work editing the book was how hard it was not just to read the narratives that people shared with him, because some of them were deeply personal and, obviously, painful experiences, stories of malnutrition and also stories of internal stigma, not just external stigma.

So, the reason I raise that for this question is that listening is important for everybody. We face our own, you know, prejudices in thinking about not just other places, but the place where we are. And David raised that in his preface, right, that he was forced to confront his own biases in work that he was doing in his hometown.

So, when we talk about the idea of elevating the voices of people who are experiencing public health issues and problems, that doesn't just mean, you know, being an outsider coming in and listening. That means listening to your own community, listening to the people in the schools where you are, the people in the government where you are, and making sure, too, that the people in your own community know that they can participate.

I think that's important as well. So, I would just elevate that people really did open up and share with him in unusual ways and I think that's part of what made his methodology so powerful. And it's part of what made editing the book such a challenge, because we didn't want to lose those stories, even though sometimes they were hard to read.

>> YVETTE COZIER: I will just add that one of the things along the lines that you are talking about in the book was when David was weighing out Robert F. Kennedy Sr.'s trip to the Delta and how he saw the ravages of poverty there. And when he brought that back to the agricultural secretary, his initial response is, "There can't be people who have no income. How would they exist?" But yet, they existed.

So, to your point, Debra, who is in the room, who is not, whose voice is being represented and understanding how policies actually impact people. That really drove something home to me in reading those words of the book.

Another question that stems from what we have just talked about is individual versus collective responsibility. How do we shift from exclusively talking about what individuals do and how individuals, you know, believe they are solely responsible for their health, versus to a larger collective, recognize we build the world in which we all live and which the world impacts individuals. If you would like to say anything about that. And anyone. Anyone can.

>> DEBRA BINGHAM: I will start out again. Yeah, this is a very troubling narrative and as a healthcare professional, I often hear, I will just say it, we call it patient blame. Like we are blaming the patient for their poor health, right?

How do we shift from blaming individuals for their health versus recognizing that we are all part of this system, and as a quality improvement leader, it's like, our systems are designed to get the results they get. And we have clear demonstration of communities that are healthier and other communities that aren't in our country.

So, and it's not hard -- and that's one of the main things that David really is trying to illustrate by using the voices of people in the Delta, as well as data from the country, to pull that together to really show how it's not either/or. Now of course, but David's death, unfortunately, underscores this not even/or message. Because he was training for an ultramarathon. He was a white male with a lot of privilege. And he dies because of an infrastructure failure and from people not doing their job. The stairs he fell through had been known to be a hazard for over a year, and they weren't properly secured. And within hours of his death, they are properly secured, thank heavens. But still, if they had been secured earlier, then nothing would have happened.

And then within a week, the stairs were removed. Why do we need tragedies, why do we need deaths in order to act? But at least at a minimum, when those tragedies do occur, we do need to act collectively. We do need to stand up against that kind of

injustice. And those things that also are harming each one of us in our communities.

We are not alone in these outcomes. They affect all of us.

>> NICOLE HUBERFELD: I think, too, it's important to recognize, we are living in a moment where there is a return to the individual responsibility narrative that's exactly what we are seeing with the example of work requirements in the budget reconciliation bill that was passed on July 4th. That is a narrative of individual responsibility that has haunted Medicaid since its beginning. And it is actually, in reality, a structural barrier to health insurance enrollment. Work requirements are designed to disenroll people. While there's a narrative of individual responsibility, the reality is that the law there creates a collective action problem because collectively state administrators are not going to be able to manage this law in a way that makes it anything other than a disenrollment tool.

And so I think it is important for us to recognize what we are seeing in front of us and not just hear the words, but absorb and think about them. Because that individual responsibility narrative is pernicious and persistent. It is this myth of self-reliance that has existed since the beginning of the United States, and it is a myth. And this myth cuts across all kinds of communities.

So, if you think about something like food insecurity, food insecurity is an issue for people in all rural areas, regardless of their other demographics. And food insecurity is a national problem. Food insecurity does not respect state lines or city lines. This is a collective action problem that people live in places where they don't have access to quality food or if they do, it's not affordable.

So, that requires all of us to think about the nature of food insecurity. And the unique modern problem of being both obese and malnourished, because our food supply chain relies on foods that must be processed in order to be cheap.

We have mega problems that must be addressed. And blaming the individual for poor nutritional habits can only get you so far. So, when people talk about things like soda taxes to address obesity, that's such a problematic downstream solution to a very upstream issue.

So, we can talk about individual versus collective, and that's certainly what David wants us to think about in this book. But I think another way to think about is it upstream versus downstream. The more upstream we can go, the more we are changing the environment and the less we are blaming the individual.

>> SARAH GORDON: Many of my comments were really almost exactly the same as what Nicole just said so I will just agree with her that I also feel like right now, there is a push to return to this narrative. And what's happening with research is particularly concerning. There's this push not to show that there are systematic differences across demographics, like race or ethnicity or socioeconomic status to essentially obscure the fact that there are large systematic differences across groups of people, rather than just as a result of individual circumstance or choice.

And, again, this narrative is intertwined with this really deeply-held core American belief, this idea of pulling yourself up by your boot straps, which in case if anyone doesn't know, the origin of which is that that's impossible to do, right? No one can actually do that. And now it's sort of become a colloquialism that it is something we should strive for but it is impossible and that is exactly what we are seeing here where there is no path to a full, a person achieving the full potential of their health if they are living in an environment that does not also support that.

So, how do we counter this? What do we do? And I think, actually, the type of interweaving of narrative and linking that to structural policy levers that David does in this book, is actually one way that we push back against that, that we again and again show how these upstream factors shape people's lives.

Because I think it's very concerning, you know, this idea of people internalizing this futility and engaging in self-blame and it leads to a lot of issues in society when people aren't able to realize that, you know, there are a lot of choices being made by powerful people that are affecting their circumstances and that it is not an individual-level issue.

So, yeah, it is a bit worrisome and scary at this time and it's everyone in public health our responsibility to keep trying to draw these links.

>> YVETTE COZIER: Thank you all for that. And this goes into my next question. And it stems from that inherent discomfort with power and politics in public health. In the book David talks about power and politics are central to determining who has access to resources. And it has been said that even in public health, our approach towards -- you know, our discomfort with that is something that we are going to have to embrace.

So, how do we overcome that in public health? How do we approach this and recognizing that we try to be apolitical, but we are talking about political systems. We are talking about political policies and processes that are trickling down to whole communities. How do we overcome that?

>> SARAH GORDON: I am happy to go first. I have some thoughts on this, because it's been a moving target for me personally in my own work and research and something that I used to talk about with David.

I mean, my approach as a health economist or it used to be that I provide data and evidence and that's it. That's my job. That's what makes me trustworthy, and that's my contribution. I can demonstrate how different policies and interventions affect the population health.

I think we are at a point where that is not enough and it is naive to think that that alone is going to sway decisionmakers at this time. I am also teaching an advocacy course in the online MPH program right now and we are talking a lot about this. I mean, I think failing to understand how politics influence this population health is a blind spot for public health and it has been for a long time. And it is part of the reason that we are in the pickle that we are in right now.

So, I am very, very honored that in our department at BU we have several political scientists, not a lot of health policy departments do. David was a trailblazer in that regard. When I applied for this position at BU he was one of the first people I spoke to, and I thought that's funny, why is a political scientist in a health policy department? That gives you an example of how my thinking has changed over time.

And so, understanding public opinion, political influence, all of these things is part -- has to be part of what we do in public health. But I think we are not quite ready for that. It's not where the field actually is. I think we need to move in that direction. Even in disciplines that we don't think necessarily are intertwined with policy the way health policy is. Like things like biostatistics, everything we do in public health is influenced by our political environment.

So, I think that this moment in time is teaching public health that in a very real way.

>> NICOLE HUBERFELD: That was great, Sarah. Thank you.

I think I would like to add that if you recognize that law is a determinant of health and that politicians make laws, then you understand why you must engage, right? You don't have to become a lawyer. You don't have to become a political scientist. But one way that David tried to make this real for his students was that he made it part of his class that they had to go to the Capitol and engage with legislators and understand how the sandwich is made. Like, he wanted them to see and demystify for themselves how politics actually work. He didn't want it to just be a theory. That was always his approach.

And I think we should also acknowledge, it represents what a great teacher he was, because that's a time-consuming exercise for him to shepherd students to the Capitol. But it was a fantastic exercise because it was so eye-opening.

And I think it is unfortunate that a lot of students make it to graduate school and have never had a civics class. And that is a problem that is occurring in elementary, middle school levels, right, that they don't know how government works. And that makes government more mystifying for everybody.

So, I think part of the goal is to make it so that -- and I like to say government rather than politics, because, yes we could talk about political determinants of health and Sarah made excellent points just now. But it's a bigger-picture in my view that because the government itself is mysterious, it is hard to see how our choices at the ballot box and how our choices and our policymakers impact even the people who are the civil servants who do the regular work of implementing the laws that shape how we are healthy and how we get access to care.

So, we have to not be uncomfortable with government and not be uncomfortable. And this is not a political statement. It's not about whether you lean left, right, or center. But, rather, the fact that without government, there are things we just really can't do, regardless of how much government you think there should be.

So, if we can help people who are learning about public health to understand how to engage with the government in all the different ways that that is possible, whether it is observing the legislative process, whether it's going to court and seeing how something is every day as family court works, what it looks like to separate a family during a divorce, right? What it looks like to try to comment on regulations that are coming up through state or federal government, which anybody can do. It's one of the most democratic processes that we have, right?

There are so many ways to engage. And that was one of the things that David wanted people to understand. There isn't one path. You don't have to become a politician, but you do need to understand that if you don't engage with these paths, it is much harder for all of us to figure out how to be healthy.

>> DEBRA BINGHAM: I will just add, you know, he lived this in his own life. He felt very strongly about local government, and getting involved in what's happening in your local community. So, he, as busy as he was, he actually did volunteer in our town.

He also wrote a paper where it's titled "More Public Health Leaders Should Run for Office." He really wanted people with public health backgrounds to run for office and him and some

students actually went and counted during the 2018 legislative session, how many of those people within these positions across the country had a public health background. And the answer is only 21 out of 7383 public officials had a public health background of any kind. And that was 0.3%.

Now, of all of that, that's where that comes from. Of all of the people who graduate with a public health degree, that's kind of -- that seems like a really low percentage point for us not to be more connected in the political process.

And I met people at the State House, actually. After he died, I went and I was advocating for some work around for the safety for the MBTA, and I had people introduce themselves to me. They had been in his class and had chosen to become -- work in the state -- in our state government here in this state. He had actively influenced people to do just for that. So, running for office.

I will also say one of the things that I realized is that conversation is where change begins and we all have the power to change the conversation. Sometimes we feel powerless or we feel like we are not doing enough. We all have the power to change the conversation. So speaking up and doing things in that way.

But, yeah, and just being -- yeah, those are the things I would add to this conversation.

>> YVETTE COZIER: Yes, in voting, right?

>> DEBRA BINGHAM: Of course. Yes, of course, of course, yes. Thank you. I'm so glad you said that.

>> YVETTE COZIER: It's also, it's in the book, voting rights, as one of those ways to move this forward. So, yes.

So, a final question I have for each of you, before we turn over to audience questions, and we do have a few, is what do you want students who didn't know David to know about David and his work?

>> DEBRA BINGHAM: That's hard. I wish you could know him. So, yeah. But you could know him by reading his book. Yeah.

>> NICOLE HUBERFELD: I have done a lot of co-authoring in my time as a scholar and someone who works in academia. And co-authoring with David was always awesome (chuckles). I never knew someone to use the comment function and track changes as positively as David did. And, in fact, Sarah and David and I called ourselves the dream team, referring to our work together, because we were crossing disciplines and also keeping each other company.

So, I think that's important because to understand who David really was and what drove this book, you have to see that, yes, of course, he was brilliant and his work was serious and important. And, yes, he was an incredible teacher. But he also did everything with love. His heart was so big and that's I

think the hardest thing to convey. That's what I want people to know.

>> YVETTE COZIER: Sarah.

>> SARAH GORDON: I have to say David was the person who taught me how to teach. When I came to this school, I hadn't taught my own courses yet. I was fresh out of a Ph.D. program, and I took over a class that David taught. And he was so generous sharing all of his materials with me.

But I think the biggest thing that I took away and I think that he would want everyone to know is just how much he believes in our public health students. How much potential he saw in each and every student that entered his classroom.

And even when he was teaching three classes and grading and teaching at night, even though he had three children, you know, he always was excited by the students and their ideas and their discussion.

I think that's just a wonderful force to have permeate our halls at BU SPH and is something that I hope all of our students feel when they are in our courses. And just something really beautiful that David left me with in my own teaching.

>> DEBRA BINGHAM: Yeah. Can I add one more thing?

>> YVETTE COZIER: Absolutely.

>> DEBRA BINGHAM: He also loved to have fun. And he loved to talk with people and enjoy their ideas and share with them. But I bring up the fun part because he figured out how to connect his love of music and with his love of people, with his love of research and the work he did. So, he would plan his research studies to be where Fish concerts are. We haven't brought this out, but I don't think there's any doubt in my mind that the fact that there's a lot of great music down in Mississippi did draw him down to Mississippi as part of the reason he wanted to do the book in Mississippi. Because he loved, he loved, loved Mississippi on many levels, but he loved the music that he got to share down in Mississippi.

>> YVETTE COZIER: Thank you all for sharing those images of David. And I love the music part myself. So, that's wonderful.

We do have a few audience questions. And the first is from Elizabeth Sommers. Her question says I imagine some of the folks Dr. Jones interviewed were U.S. military veterans. As veterans they would be eligible for GI Bill benefits, that include access to education and housing. But because of racism, we know that historically these benefits have not been available to all veterans. Could you comment?

>> NICOLE HUBERFELD: I don't have a recollection of specific veteran stories in our work with the book. But what I will say is it's important to note that the GI Bill is, basically, about money. So you can't pay for something that

doesn't exist. And the access to education and healthcare and all of that, you have to be near a VA to use a VA hospital. You have to be near a source of education to take advantage of education.

And one of the points that David makes about the Delta is it's an under-resourced area in a number of wades including that it is very hard to travel from point A to point B, let alone walk from point A to point B. So the walkability area is fairly slow in the areas he was studying. But beyond that, it's hard for people to get to the things that they need.

So, while I can't speak specifically to veterans, and I love the question, because it's a really great and important question, I think it speaks to the broader set of issues that David was studying, which is that it can only do you so much to throw money at the issue because you have to have the resources to use the money and get access to those things.

>> SARAH GORDON: Yeah. And I will just add, I agree, I don't think there was anything specific about veterans that came up in David's qualitative data collection. And one challenge for us as co-editors, we got the book, finished, completed, but it hadn't been peer reviewed or edited yet. So we made the decision at the beginning in order to preserve, prioritize preserving David's voice and what he intended for the book, not to do any additional data collection. So, not to expand on what he had already collected. Because we just didn't want to put too much of our own imprint on his work.

So, there are a lot of things that have come up since then that I think it would have been really great to have probed more deeply.

But this is such a unique circumstance. And so we are left with some important directions for future research.

>> YVETTE COZIER: And Debra, did you want to add anything?

>> DEBRA BINGHAM: No. I think they covered it very well. So, we can go to the next question.

>> YVETTE COZIER: This one is from Nicole Stringfellow, somebody that --

>> DEBRA BINGHAM: Hi, Nicole.

>> YVETTE COZIER: And I had the pleasure of meeting her myself. And her question is, how can researchers move the needle for better public health after their research is complete?

>> DEBRA BINGHAM: Nicole, I feel like you should answer that question. Yeah, because you have lived this so much. People coming down and researching the Delta to death is one of the things you have talked about and helped me understand that.

But you also told me that it was pretty rare for you to have people come back, researchers to come back. And he knew

that he would have and that was one reason that I went back to the Delta and that's how I got to know Nicole. Linda Nicole Stringfellow, I just reached out to her because he had named her in the book, but I didn't have -- I had never met her and she was so generous to welcome me to the Delta, as well as to help bring stories of David and her working together that I would never have had otherwise.

And we did a film. We have a little 15-minute film we did where Linda is in that film. So if anyone wants to watch that film, it's called "Create Ripples of Hope."

But mostly coming back, make sure people know the book comes out. And also connecting with people. It's not just trying to get from people, but also sharing what came out of their time with you.

I don't know. Nicole, you want to add anything else into that? Or anyone else on the panel?

>> SARAH GORDON: Yeah. So I think about this a lot. So, I am a quantitative researcher, as I said. But I care deeply about translation. I think, you know, a peer reviewed journal is not really the end point of where our work should be going.

So, I can give a few examples of things that I think can be particularly effective. So, get involved in government. I spent a long time working in federal government on the policies that I was studying. So, being able to actually use the results of my work to shape how policies were implemented. And going back to our prior conversation, politics has a lot of influence there. But it can still be very valuable to be on the inside and to be working in government.

Short of that, I think people should always be thinking about a research product and then a corresponding white paper or policy brief that can be shared and disseminated with people who don't want to go read a long research article behind a paywall, right? Something that can be used to be shared with policymakers, with advocacy organizations, something that's going to make the work useful.

And this is more work, but I have noticed that a lot of funders of research are really focused on this, so they will often require a translation or impact section and want to support. And sometimes even provide in-house support to help disseminate research findings to people who can actually use them.

And in the context of David's focus on state health policy and Medicaid, I think this is more are not than ever. There's going to be a lot of policymakers who are going to trying to make hard trade-offs in the face of massive budget cuts and having information at their fingertips to be able to do that and not having to dig to find research articles is a key step that

we as public health researchers haven't always been great at. But I think we are moving more in that direction.

And then lastly, if your research is focused on a specific population, if it's involved community-based participatory research, being sure to share findings with the communities affected, right, so that they can also advocate for themselves based on a better understanding of how these structures work and their influence.

>> NICOLE HUBERFELD: Great answers, both of you. And thank you for this really important question.

I have to say that I have done more translational work since I came to BU than I did in my prior academic job. So I think it's a really value of our institution. And it does take more time to do it. It doesn't necessarily have direct quantifiable benefits. But there's nothing more important than making our research available to people who need it. And most people don't understand or know what we know.

I think that's one of the most important things that we can realize about ourselves and how we do these deep dives. We are driven by something that we feel is true and good. We want to research something to help populations. We want to research something to make a policy change.

I think one of the best things we can do is talk to people across disciplines, right, so that we are ensuring that what we know in our own discipline, what we study in our own discipline is useful to people in other disciplines who think about the same issues. That unto itself is a form of translation.

But then if you can't understand how they do or don't understand what you are working on in your research, that helps you to see what you need to do to make that work valuable to people who are not in your discipline at all or in your field at all or in your subject matter domain at all.

In other words, we can all be good researchers, but we become great at our jobs when we make this information available to other people. And I think that's a real value BU SPH, our department, which is interdisciplinary because we have people that are economists and political scientists and because at SPH we talk to each other, and guest lecture for each other and also just like each other, which is helpful.

I think translation is probably the best, most important thing that I do in my job even though it isn't something that's immediately quantifiably rewarded in my work. It is what we do because we need to. It's an imperative.

>> YVETTE COZIER: Thank you all for your comments and your insights. And as we are getting close to the top of the hour, I want to read something from the book, and this is literally the last page of the book. And just to say the book begins with

David being very optimistic. We believe that health equity is possible. Here at the end he says, this is a hopeful book, even if did not always feel like it. But hope for hope's sake is empty.

Goes on to say, when asked at the end of a focus group to write a short statement about what he wished policymakers and others knew about his life, a teenager in Clarksdale wrote the following: I want you to know that we are affected. We are the future that sees no future, due to past mistakes. We seek change but change is so high up, and no one is willing to build that ladder of success. We know about hope. But we can't keep putting hope in your hands and you just washing it away before you eat up our goals and success, because you are well-paid. Our meals don't consist of money greens and sweet salary tea, but hope. Hope that one day it will be another day. Hope that one day those bites are full of chance, full of change, full of reasons to wake up again. We want to be full because this hunger of oppression is eating us all up, whether you know it or not. One day you will know and one day you will say that we were the future that made it a better day.

And with that, I want to thank our panelists, Nicole Huberfeld, Sarah Gordon, Debra Bingham, thank you for bringing David's book to us so that we can learn from this for years to come.

And at this time I would like to turn this over to Dean Hyder.

>> ADNAN HYDER: First of all, thank you very much, Yvette. I really appreciated your moderation of this important event. I also want to thank Nicole, Sarah, and particularly Debra for bringing in the perspective that David enunciated in his book but also, of course, to the people who made that book, to the people who are living in the Delta every day and whose lives you all care about and David cared about. And I think that is fundamental and foundational to everything that you said.

It was an excellent conversation. Thanks to all of you, thanks to all our participants and their contributions.

I do want to remind everyone that this series will continue. We have our next public health conversation, vaccine hesitancy, a critical topic right now, and that will be on October the 8th. But this is an amazing start to those conversations. And thank you again for joining us today. It was a pleasure hosting this from Boston University's School of Public Health. Thank you all.

>> Recording stopped.

(Session was concluded at 1:59 p.m. ET)