Sustained Community Engagement: Mind-Bending, Moving, Nimble, Complex #155

01/16/2022

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Proem

Welcome to the eleventh episode in Health Hats' community engagement series. I'm fascinated with communities that gather to solve a problem, their problem. I tune my ears to such communities and grab guests to join us and share. Less often, I discover institutions actively and sustainably (over years or decades) engaged with the communities they serve. What's the difference – one time and sustained? One time is meaningful, significant, fulfilling, amazing. And hard to learn from and time-consuming to start. No rapid zero to 60 mph when you need it. Sustained engagement takes time to build an investment upfront and ongoing, but it's available on demand. They're different, with different results. One such institution sustaining community engagement is the Cambridge Health Alliance (CHA). Several episodes ago, we met Dr. Kirstin Meisinger, who recommended inviting Janice John and Jamila Xible to be our guests.

Introducing Jamila Xible and Janice John 01:28

Health Hats: Jamila Xible, Director of Health Education and Access Programs at the Cambridge Health Alliance, is responsible for the oversight of several programs, including the Volunteer Health Advisors, Aging Wisely Everett, Senior Suicide Prevention, Women's Health Network, and the Community Health Improvement Learning Institute, which regularly offers Community Health Worker training. Jamila holds a Master of Arts in Law and Diplomacy from Tufts University.

Janice John, PA, is a Medical Director at Cambridge Health Alliance, an experienced Community Health Clinician, Leader, and Educator with a passion for shaping our health care delivery system to improve the health of our communities. She's a transformational leader, alliance builder, strategic thinker, creative problem solver, and collaborator.

Health Hats: Jamila and Janice, thank you for joining us today. I'm delighted. Could you guys introduce yourselves to our listeners and readers and tell us a bit of yourself and how you got to this place of investing in community engagement? Janice, you want to start.

Janice John: Sure. I'm Janice John. I am a PA at the Cambridge Health Alliance. PA physician assistant and I work in primary care at CHA and have been with the organization for about a decade. And worked in homeless health care for nearly a decade before that. Working really in community medicine has been the entire arc of my career but often really from the perspective of a clinical provider.

Health Hats: Okay. Jamila, tell us about yourself. Thank you.

Jamila Xible: My name is Jamila Xible. I work as a Director of Health Education and Access at the Cambridge Health Alliance. It's my road to where I am is not straight. I had a lot of detours, but my undergrad in social work in Brazil in a time when Brazil was opening from a military dictatorship, and there was a lot of community work being done. And I was deeply involved, and that stopped a little bit when I came here. But as I aged and matured, I came back to this work.

Communities served by CHA 04:57

Health Hats: *I asked Janice and Jamila about the relationships with the communities CHA serves.*

Janice John: I started leading our COVID outpatient clinic in March 2020. Our clinic took care of patients upstream from the emergency room and evaluated patients through the first couple of weeks. Early in the pandemic, it was apparent that the communities hit the hardest were immigrant communities. And that there were some significant differences in who came into our clinic, our outpatient clinic, who called in with symptoms, wanting a test, et cetera, et cetera, and who ended up in the ER and needed hospitalization. So, people most likely to come in for upstream care had differences within sub-

communities. It wasn't something that we could figure out with a clinical lens. We needed to understand from the perspective of the communities. And because of that, I reached out to our community health improvement team. Jamila is our rock star for community engagement. And we brainstormed to try to think of ways to figure this out. And, but it was really seeing the discrepancies and disparities really in our communities that made us try to figure out what we were not doing, not seeing, not understanding.

Most healthcare occurs upstream from hospitals and clinics 06:47

Health Hats: Real quick, say something briefly about upstream. What does that mean?

Janice John: The way I think about care is that most health doesn't happen in the health system. Most of health happens far before anyone walks in the doors. What influences health is a series of things that happen in life in built community, et cetera, et cetera. And when COVID was emerging, we had a playbook from China that focused on hospitalization. A lot of the national conversation influenced by what was happening in Italy was around ventilators. There were entire working groups trying to figure out who would get ventilators. And our system said we are an outpatient and community care delivery system. This is not necessarily the proper roadmap. This is not where we need to focus all of our energy. And we need to be thinking about what we do before the hospital. We anticipated that the ERs would get filled, that the hospitals would get filled, and we wanted to build something upstream.

Serving communities of immigrants 08:05

Jamila Xible: I feel like I'm part of a community of immigrants. And when I look at what happened at CHA, those are the folks that are suffering right now. I'm so grateful that I can be involved in this work with people like Janice. Like our clinical team, we work in an organization where folks have that sense of mission. I talk to people from other hospitals, they ask, what the physicians, the what? The PCP is the what? They come with you to the community. Yes, they do research. Yeah, they do. So, it's an environment. Everybody seems to be in the same boat. This is our mission. We're going to try to improve what is going on out there. So, my role has evolved. Basically, we do a lot of community health worker training, and then we work with the community health workers that we trained in the community to improve the health, where they live and work. It evolved under COVID. Health education became all about COVID, and again, really lucky that I could involve our clinical teams, bring them out, and have their full support trying to engage people in discussions on things that would make them safer. And many times, that discussion was just about mask-wearing, about social distancing, and handwashing, but then it evolved into the vaccine work that we're doing right now. And this equity work that a robust team of people all around Massachusetts is very invested in doing this equity work, which is tedious at times because we are the folks in between people who need and resources. And many times, those resources don't come in the package that we want them to come. And many times, people that need those resources have a hard time accessing that. And part of my job is knocking down those barriers to access, understanding what they are, and knocking them down.

Investing in community health workers 10:16

Health Hats: Wow. There's a lot in what you're saying there. Let me pick on something. So you were talking about community health workers. Are the community health workers employed by community organizations, by CHA? Do they work pro bono? What's the array of arrangements that there are with community health workers?

Jamila Xible: Right now, community health workers are an important, significant part of any health system around Massachusetts, perhaps about in the whole United States and in the world. You see them everywhere. We have employees that qualify under that umbrella of community health workers within the hospital walls and without and outside the hospital walls. So, for example, inside, we have patient navigators and patient resource coordinators. We have care partners. We have them tackling mental health. We have them connecting people to resources in many different, over 50 roles within a hospital wall. Pay them.

Health Hats: Oh goodness, many different roles. Wow.

Jamila Xible: Outside the hospital walls, we also have a number of community health workers. Our community health improvement department has about 70 people. Many of them in that role of health educators, patient navigators, you name it, but working outside, as Janice said, tackling social determinants of health. It's not something that it's there, and we can't affect, but social determinants of health is the term commonly used. I don't like that word determinants. I like to say social influencers because we can change them.

Health Hats: So, CHA has made an investment in this that's impressive.

Jamila Xible: And Danny, just one thing, not CHA, the state, and it's in the accountable care act. The role of community health workers is solid as part of the care team. This role of community health worker. So, it's not only us, but it's happening everywhere. Sorry.

Health Hats: No, I appreciate that. But in my limited experience, I would say there's what's required, and then there's what is done and what's the spirit behind all that.

Janice John: In our Instagram feed this morning. It was announced that CHA was named the number one hospital in Massachusetts for health equity and value by the Lown Institute.

Health Hats: Congratulations.

Behavioral health community workers 13:09

Janice John: To your point, I think that there is what is required. But that's a different thing for figuring out how to make a system work more effectively, leverage resources, and utilize resources to bring the most value to the population. And Jamila talked about all the various roles or types of community health workers in Cambridge Health Alliance. One good example just to pivot away from COVID for just a second is within our behavior integrated behavioral health. So, our system lost a really large number of psychiatrists and needed to pivot some resources to inpatient services because of the mental health crisis. And we. Yeah, we're struggling as a system to provide care to all who need it right now, like every other system pertaining to behavioral health. But one of the things that we've been working on for several years now is this primary care behavioral health integrated mental health care. And one of the critical parts of that is our behavioral health care partners. So, these are unlicensed mental health team members who can provide a great number of services in conjunction with the rest of the behavioral health team overseen by the rest of the behavioral health team. Still, allowing for the prescribers, allowing for the therapist to take care of the patients most in need and not every, not necessarily every single patient, some patients do well with a care partner and brief interventions and that kind of thing. And when you think about it from a community perspective, in a population health perspective, mental health care behavioral health care can feel intimidating. And there are lots of different perspectives within our immigrant communities about accessing care, mental health care, behavioral health care. And so, having this role doesn't just allow for a different allocation of resources, but it also can be much more accessible to patients who may feel a little bit intimidated by doing therapy or seeking psychiatric care.

Hiring from within communities 15:31

Health Hats: I have two questions. Pick one. And one of them is that it sounds like you hire for within, meaning you hire from the communities you serve so that commute so that the health workers are coming from those communities. I'd be interested in that. And the other thing, just to get it out there, is that you're talking about the differing approaches that communities have to Mental health, behavioral health care. And I'd be interested in hearing about the range. So why don't you pick one of those, Janice, and then we'll let Jamila talk about the other. Sure.

Janice John: So, as far as hiring from within our communities, I think that this is something that CHA for many years now has taken an institutional approach and has sought to hire from within the community, promote people from within our communities into leadership roles, and having more advanced roles. Take something like our medical assistants. Most of our medical assistants are bilingual, trilingual, are from our communities, and just have so much insight into the unique challenges that our communities, our teams, our patients face. But then, allowing them to potentially enter something like a care partner role or a leadership role or something like that. And with a lot of intentionality. And I think our HR department has done a pretty good job of this for quite some time.

Overload of information accessing care 17:18

Health Hats: Oh, that's great. So, Jamila, what about the range of approaches? The approach is probably not the right word, but the range of how different communities will be ready for access, stigma, w what is the range that you feel like your communities offer in terms of opportunity and challenges in accessing mental health and behavioral health care?

Jamila Xible: Why don't we talk about accessing anything at all? Many of the folks that we serve came to this country recently, and some came here like 30 years ago, but up to today, they still don't speak English. So, understanding, like for you, Danny, to understand the healthcare system, it's confusing. For me, I work in healthcare. When I look at my health insurance, what it covers, what it doesn't, it's very confusing. So now, imagine arriving in this land and having to learn everything. Language, places where you go shopping, what kind of products you buy, school, where your kids will go, vaccines you need for school or work, or whatever. So, all this stuff, it's like an overload of information in folks' minds. They don't have time to think and do what it takes to access care and other resources. And what that means is understanding health insurance, especially for those that don't have documentation of their immigration status in this country. So how what is accessible to them? For example, for folks that are coming from Brazil. In Brazil, if you get sick, you get the phone and call a doctor. And most likely, if you feel like my heart is aching, you will call a cardiologist. If you have stomach pain, you're going to call a gastro person. Here we need to say no. There is a place you have to stop first, and that's a primary care provider. You have to start there. That's what opens the doors to everything, including mental health, cardiology. Then people usually ask me, but Jamila, how much does it cost if I just want to pay for a cardiologist? And it's hard to explain that people won't tell you that. People won't tell you how much it costs until after you have that exam because they don't know what they're going to be, what your symptoms are, what kind of tests you'll need. And so it's tough for folks to understand that and plan. So, part of what we do as community health workers are explained and help folks navigate the system. And guess what, the emergency room is open for you. That's not the optimal case if you don't have a true emergency. So then making that distinction between what is urgent, what is an emergency, and what is just the regular maintenance. And then it comes that conversation on why it is so important to do that regular maintenance, but sometimes what I feel like across all the communities that we serve, people have so much more to deal with that they are functioning, they're addressing emergencies. And if they don't have an emergency medical situation, they will not go there. So, reaching out and bringing people in it's it is what our goal is, our mission and our challenge,

Health Hats: Yes. Yes. Yes. I'm just I'm processing.

Volunteer Health Advisors 21:03

Jamila Xible: The cool thing is, Danny, we have this awesome program at community health. It's called the Volunteer Health Advisors Program. So, every year we recruit about 25 to 30 people from the communities we serve that reflect that community. And we train them as community health workers. And after we teach them, they volunteer with us for 48 hours. Then what they do is they help us

connect with communities. Some work with churches, some work with municipalities or CB community-based organizations, and they help us do the work we do for a year. And then after that, that also works as a connection for them to find jobs as community health workers. It's an awesome little program.

Janice John: And just to speak to that as a primary care clinician. I remember when this was pre-COVID, but I had a patient come into the office who was a new patient to CHA. She was new to the US and didn't speak English yet. And was accompanied by someone, a VHA who I didn't see the same language as her. So, it wasn't acting as a translator at all. But there was enough cultural similarity that the patient could overcome her fears, partly just by having another woman there and having someone who could share some of her deepest fears with me as the provider. So, it also helped me as the provider to step back for a second and the kind of clinical space and think about the most important thing to this person at this moment in time. And that VHA was just so helpful in helping me prioritize and understanding, from the patient's perspective, what was the most important? It was a beautiful moment. It's a great program.

Nuances of culture 23:01

Jamila Xible: And then you, let me just say, so when we go out there, and we tell folks you are safe here, you can come to CHA we'll serve you. You come; you will find great doctors. You'll find primary care providers. For me, it's awesome to have Janice and her team, a lot of folks from different languages. So, I was talking about that idea of people coming into the hospital and meeting what we promise, which is a good provider. What Janice described right now was listening and trying to understand the culture and figure out how that affects treatment and that relationship.

Health Hats: Yeah. Yeah. Those nuances of culture are so huge.

Jamila Xible: And I feel like, in most traditional healthcare systems, you go to the doctor, and he has the power to tell you what to do. And many times, if the doctor comes from the same culture you come from, there'll be more success even though you come from the same culture. The same culture doesn't mean sameness. Many cultures, different individuals are multi-layered. But at CHA our doctors every day, our primary care providers every day, they see people very different from what they know. And I feel as an organization, that's what separates us from many other healthcare systems in our area, in the country. I feel that our clinical team can do what Janice was saying right now, sit back and understand the needs and cultural factors that impact that care?

Health Hats: You're doing a lot. It's impressive. What do you think to take it to another level? What do you mean?

Closing the gap for equitable care – a bit 25:04

Janice John: I can speak to this a little bit, and I have a degree in healthcare delivery science. I think that our systems are, when we think about this from a change management perspective and the incentives involved in the system culture involved in the system, all these different pieces we are nationally in the US far from where we need to be, to provide equitable quality affordable health care to communities. So, we're just we're pretty far. And I think at CHA, we've closed the gap a little bit. Maybe a little bit more than a little bit. But I think to continue moving in the right direction. We need to think about how we are paying for health nationally. What we define as value and through whose lens and even in thinking about how we train healthcare providers teams, et cetera, right? We teach people in a pretty traumatizing system. And so that trauma can impact trust and connection with patients, especially from vulnerable communities. And I think that certainly thinking about incentives and how healthcare is paid for and who's part of that design of healthcare whose voices get heard and how care gets delivered. And also, how are we training people at a very basic level because we have to change the culture, and the culture of health care is pretty, pretty deep.

Health Hats: Oh yeah. Yeah. That would be an understatement. Wow.

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Outreach versus engagement 27:55

Health Hats: So, what should we be talking about that? We haven't we talked about? Jamila, do you want to start?

Jamila Xible: I think maybe not explicitly. I don't think we talked about the importance for healthcare institutions to engage communities in the process of care. And by engage, I don't mean outreach. Reach out. There's this idea that we do outreach, and outreach is a one-way thing. You tell people what to do. Engaging is bringing the community into what you're doing and helping them design the services that we are providing. I think it's a very powerful thing. And Janice and I took this participatory research collaboration as a powerful example of how we can continue doing that. The other thing that. When I say again what Janice was talking about the training.

Cultural humility 29:14

Jamila Xible: We, the medical profession, are very hierarchical, which is the importance of training. I'm a trainer in cultural humility. And I feel like that can be applied in many ways to improve.

Health Hats: A trainer in cultural humility. I love that.

Jamila Xible: Yes. So cultural humility. Yeah. It's a whole thing. It's a concept developed by a couple of doctors in California. And I was very lucky that I was trained by one of those doctors that developed the concept.

Health Hats: *I'll include something about cultural humility in the show notes. Next, Janice and I spoke about hierarchy in health delivery systems and the role of PAs, Physician Assistant, soon to be Physician Associate. What do PAs do?*

Physician Assistant, Physician Associate 30:23

Janice John: We deliver care. And, in a context so I, in addition to leading a clinical team, I also within the context of Cambridge Health Alliance, have been the chief PA for several years for primary care. And so, I've hired a team now of about 40 PAs. And many of them were born and raised in our communities, and the PA education was a much more accessible model to deliver care and not just culturally humble care, but culturally concordant care. And so, we have several Haitian PAs, and most of the greatest gaps in chronic disease management exist in our Haitian community. Several complex factors contribute to this. But the amount of trust between our community members and several of these Haitian Creole-speaking. But born and raised PAs from our communities, they're able to bridge trust in a way that many of the rest of us may have a harder time doing. And so, I think that our profession, the profession of PA physician associates. What we have is our professional identity is as a team member. Teaming is 100% kind of our core identity. And I think that makes us ready to partner with patients, partner with communities. Partly because our training isn't necessary to lead our training, it's to partner with. And so, yes, hierarchy is prevalent in medicine. Unfortunately, it can be toxic and harmful at times and contribute to some of the traumatization and re-traumatization that exists both within teams and as it pertains to patient care. And it is also true that shifting our orientation to how we engage with patients moving from that hero model and to helper mode can be an incredible bridge.

Barometer for inclusion and engagement 32:59

Health Hats: *As I've said before, my barometer for community engagement considers severely marginalized communities - whatever that means - like those without brick-and-mortar homes, those living in jails and prisons, those with rare diseases, and children with disabilities. How do lessons learned, principles, and initiatives apply to these communities? In episode #150, Kirsten Meisinger, also from Cambridge Health Alliance, spoke about the public health foundation of CHA. I took the opportunity to ask Janice about CHA's engagement with the homeless community.*

Janice John: I am not as connected to homeless care within Cambridge Health Alliance as I was when I was in Boston. Boston Healthcare for the Homeless is another incredible organization. And you should talk to team members from over there. They're doing incredible work. And I think that the way they have approached care for, really quite a few decades at this point, is to design for the margins. And so,

what they very much do, and they really have a lot figured out, right? So, they have consumer advisory boards. One of their consumer advisory board members is on their board. They do a lot within their delivery service delivery model to go to where the patients are. So, whether that is on a street and street medicine or to shelters drop-ins et cetera, their main hub is on Albany Street and Mass Ave in Boston, where just the greatest number of homeless patients at homeless people stay. There's a shelter right behind. And then people, unfortunately, staying on the streets because that's where we're at right now with the closure of one of the biggest shelters in Boston. I think that the model of really going to where patients are and working to deliver care. I think that we talked about this a little bit before. What would we need to do? What we're doing at CHA is if we could figure out how to transition more of our care to communities where community health workers are inviting clinical teams in that. I think that the payment model doesn't align with that right now. And we're a public system trying to stay afloat and continue to provide care. But I think that would be a total paradigm shift.

The complexities of community engagement 35:32

Health Hats: Thank you. Jamila, I'll give you the last word. If there were two things that you wanted listeners or readers to leave with from this conversation, what are those two?

Jamila Xible: The work that we do is complex. We're working with people; we're working with care; we are working with the healthcare industry. I feel like we've put a lot of thought into it, and unfortunately, we still don't see the ideal situation, right? Ideally, everybody would be as healthy as possible in resources would not be a problem. And I feel like many people think that there'll be one answer to what we do. But it's not. It's complex. It involves a lot of professionals. It involves teams, and it's difficult because you include teams from different areas. It's complicated not only time personalities. It's complicated. I think that's what I feel like for us in the field, and I talk about me. Some days, I feel like it's one step forward and two behind, but yeah, I feel lucky that we in Massachusetts. I feel lucky that the communities we serve have had very progressive voices, not only within our house health healthcare system but also in the community itself. And that interaction is precious. And that's what keeps bringing us to innovation and to change, to keep putting us in the right direction.

Health Hats: Thank you. Thank you both. This has been great. I appreciate it. Thank you so much. I have a feeling this is not the last time we'll chat. Thank you for taking the time and sharing with us.

Jamila Xible: Yeah. Thank you, Danny.

Reflection 38:02

I learned much today about the fabric of community engagement. I'm impressed with how Cambridge Health Alliance weaves the threads of community engagement with the warp of its public health mission. (Woven fabric lingo -warp and weave). I'd never heard of cultural humility. I love the two-way street of education and hiring for the diversity of community health workers and leaders. I'd expect a

return on investment if the goal is community health and rapid response to crises. Do you know of other examples of sustained community engagement in healthcare research, delivery, entrepreneurship, or funding like CHA or PCORI? If you do, let me know and introduce me to someone who might be a guest on Health Hats, the Podcast. My next guest will be Talya Myron Schatz, a consultant, and researcher at the intersection of medicine and behavioral economics. We'll speak about medical decision-making. Thanks for joining us. Onward.