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Proem

As a student of leadership, I relish experiencing, hearing about and from good, no great, leaders. I worked for several. Sometimes I was one. What makes a good/great leader? They strategize with their team and customers, encourage, and appreciate their staff, hire for diversity of lived experience and ways of thinking about the world, and get stuff out of the way of good people doing their good work.

Introducing Dr. Kiame Mahaniah 01:40

My friend, Dr. Kiame Mahaniah, a good/great leader is CEO of the Lynn Community Health Center, a Federally Qualified Health Centers (FQHC) near me. Kiame and I meet monthly in a book club and often discuss health care, health care advocacy, and issues of health equity

FQHCs sit on the sharp point of health equity and community-centered care. Need a barometer of the health of our healthcare system? Check out your local FQHC. According to the Health Resources and Services Administration (HSRA), FQHCs are *community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and veterans.*

Health centers integrate access to pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care. By emphasizing coordinated care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology, health centers reduce health disparities.

Let's meet Dr. Kiame.

Health Hats, the Podcast process and status 02:40

Please note that I started publishing a bit less frequently as I explore adding video to my menu of media options. I've gone from written blogs to audio podcasts, to, now, videos. The technology and workflow are more complex and I'm a novice. Please bear with me. My written edition is the transcript in the show notes. I transcribe video first for video captions, then for the printed word. I use music throughout my audio and video productions. I'm still figuring out the correct mix of apps to use for video production. You'd think I'd have audio production down by now, my audio quality has been uneven recently. Unfortunately, it took recording two interviews poorly before I realized the problem. Read the transcript or check out the video on YouTube if that helps. My apologies and my appreciation for you hanging in there with me.

Podcast intro 03:57

Welcome to Health Hats, the Podcast I'm Danny van Leeuwen a two-legged cisgender old white man of privilege who knows a little bit about a lot of healthcare and a lot of our very little. We will listen and learn about what it takes to adjust to life's realities in the awesome circus of healthcare. Let's make some sense of all of this.

Health is fragile. Falling through the cracks. 04:34

Health Hats: Kiame. How are you? So glad you joined us.

Kiame Mahaniah: Thank you. I'm honored to be on Health Hats.

Health Hats: Thank you. I've been looking forward to talking to you for some time. Thank you.

Health Hats: So why don't we start by telling a little about when you first realized health was fragile?

Kiame Mahaniah: I grew up in Congo. I can't remember a single time since I've had a conscious self where I didn't think that life was extremely fragile. I think growing up in a country where infectious disease is still. Infectious diseases are probably the top five reasons that people die. I had relatives who had polio. It was evident that life itself was very fragile. Still, it also was very clear from having spent my childhood in the Congo. Then my teenage years in Switzerland also showed that a lot of that fragility and vulnerability is related to the circumstances and systems surrounding you because I moved from a place where kids die of dehydration from cholera. And to a place in Switzerland where essentially nobody dies from infectious disease under 75. And so, I've always been very aware of how fragile humans are. Still, it underlies my interest in working in the health center movement because I've always been interested in okay.

Given that we're humans, whatever system we design will have cracks. And so, I'd like to have. I'd like to dedicate my life to working in those cracks, right? Like how do I reduce the size of those cracks? How do we address the depth of those cracks, and how many people are falling in those cracks? So obviously, doing it the US is way easier than doing it. In the Congo, where I grew up, it doesn't matter what society you're in. There will be cracks.

The health system. Not random. 06:47

Kiame Mahaniah: So, I've always known that life is fragile. I think it's only recently, in the last, I'd say 10 or 15 years, that I've realized just that the system isn't random. Yeah. Like that, a system punishes certain people, certain types of people, more than others. So, I think. If you're not sighted, it's a complicated system to use. If you don't read, it's tough to navigate the system. And I would say that if you don't have an infinite amount of patience, it's challenging to navigate the system as well. So, I think certain personalities are just not suited for it, and that's not that without getting into ableism, race, ethnicity, and right. It's just so like, on the face of it, we were a complicated system. And so the health center in Lynn and health centers everywhere, we specialize in selecting which groups we want to work with to make their life easier.

Performance improvement - opportunities in the cracks 07:56

Health Hats: There's so much in what you just said. My career, I spent a lot of my career in performance improvement. And when I went from being a student of individual health as a nurse and then as an administrator to a student of organizational health, I built my career around cracks because the opportunities are in the cracks. And I felt So some days I thought of them as cracks. And if I were a little more positive, I would think of them as thresholds. And it depends on my frame but still. And the other piece you said is interesting is that the metaphor works in flow. And that I know I looked. I looked at this

on your website for the Lynn Community Health Center. And I saw that who's on the first blog, which Abbott and Costello's Who's on First is probably to me and my grandsons, the some of the funniest works ever. I've seen it a thousand times, and still, just, it's a gut splitter. But I noticed that what you discussed in it was the seven healthcare flows. And if I recall them, patient, family, staff medicine, supply equipment, and information. And I was we could spend hours on any of those, but I was wondering about information because you started with if you are sighted and you can if you're sighted, and you can't read, so you're blind, or you can't read, you're screwed. So, then information is. Then it's oral. But anyway, how does the information flow in your work as CEO of a health center? So, this is a federally qualified health center, right?

Kiame Mahaniah: That is correct.

CEO: care that meets people where they are 10:33

Health Hats: Okay. So, we could talk about what that means in a minute. What does a CEO have to do with that?

Kiame Mahaniah: I think that, as I mentioned before, systems determine so much of what happens, right? What surrounds you determines, right? As the research shows like you don't even decide how much food you eat, that's decided, but the size of the plate and color. And it's so amazing. These things that we think we control, but it. If you're in a setting, you'll just do something because that setting primes you. And so I think the CEO's job is to figure out what settings would allow teams to engage patients better and have patients experience more convenience and more sort of empowerment. And as an example, how do you make it? What the patient cares about at that moment when they come to the office? How do you make it so that the care team focuses on what the patient cares about? And that's information flow, right? And so, if, for instance, your systems are so bad that it makes the patient late. Or your systems are frustrated enough that the patient comes in and they're mad about something. And so they forget half of what they wanted to talk about because they're just concentrating on how rude X person was. Or they don't necessarily have the, or let's say they just came off from a hospitalization. And what they want to talk about is how confusing that hospitalization was. So, is that information available to the team? Do they know that the patient was hospitalized? Are they able to? Did somebody talk to the patient ahead of time? So, they would be like, oh yeah, I bet Danny was confused by this. And that's what I call the information flow. And those are the things that, as a CEO, can impact, right? What kind of data systems do we have? How much time is allocated to the patient? What type of support happens before the patient even shows up? What are we investing in? And like you mentioned that the concept of the opportunity, right? You could either think of it as a crack, or you could think of it as this opportunity to improve things.

CEO: setting priorities 13:08

Kiame Mahaniah: So, there's a considerable number of opportunities. And really, I would say that as CEO, my biggest job is deciding for the institution. Okay. Of the 17 things we could be working on that are essential to patients this year, we're going to work on these three, right? And so, by default, it means not ignoring the other 14, but you will go towards those three priorities you've chosen whenever

you have limited resources, like time or money. So, I think my biggest job is determining the institution's priorities.

CEO: cheerleader 13:46

Kiame Mahaniah: And then I would say B is a cheerleader. As human beings, we're often primed to devalue what we do. We don't think of all the fantastic things we accomplish daily in our one-on-one context, particularly for those who work in healthcare and an institution where you're taking care of very challenging situations. We get inured to the magic of what we do, right? Like people show up desperate or think they have something terrible, or they know they have something terrible or their kid has something terrible. And your job is to either reassure them or provide them with the tools by which they can grasp what's happening to them. And I think we, so I would say that 20, at least 20% of my job is cheerleading is just like telling people you're doing great. You're amazing. You do great work. What do you need to do more amazing work? Let's keep going.

CEO data and safety 14:47

Kiame Mahaniah: So, I spent much of my time negotiating contracts. I spend a lot of my time looking at our safety event system right. I spent a lot of my time looking at data. There's now a pattern in the reports to figure out, right?

If you see in the space of three months that you get seven reports of the nurses saying that when they're giving the injections, the needle breaks or whatever, you're like, okay, we must have changed. If you want to change manufacturers in the needles, it's time to go back to buying the old ones. So yeah, I would say that I see my job as trying to eliminate barriers for the people that do the frontline work.

Getting stuff out of staff's way 15:29

Health Hats: Yeah, yeah. You're speaking my language. My first clinical supervision job was as an ICU manager. And I had never been a manager before, and I'd never worked in an ICU and had taught a great job. I had. I had set up an ACLS program and advanced cardiac life support that the ICU nurses had taken. So, this was quite a while ago, and the ICU manager left, and they came to me and said, we want you to be our manager. And I said that's crazy because I've never been a manager, and I don't know the ICU. And they were like. I'll teach you about the ICU. And you'll be a fine manager. And I got the job and realized quickly that they didn't take breaks. The staff didn't take breaks. They would work all day without breaks and lunch. And so, it was like my first staff meeting: Hey, we're intelligent people. We can take breaks. How are we going to do it? And it was just setting up systems so they could have a healthy over many hours. They were where there were eight or 12 hours in the unit. And I was surprised. And then I discovered they had many bladder infections, which you. It was so. I wasn't expecting it, but the point is getting stuff out of people's way so they can do their jobs. Yeah, that's big. Now you went from, you were a staff physician, and then you became CEO?

Progression to CEO 17:31

Kiame Mahaniah: That's a short version. Yes. Yeah. Yes. I was a staff physician, and I was in Lawrence at the time. Oh, okay. When we first moved to New England and then I became, and then I became an attending physician who taught residents and students as part of my job. Then I became involved in quality improvement. Like you, that was my path to leadership. And then, I became the medical director of a small site of a small team. Then eventually, I became the associate chief medical officer. And then, I left Lawrence and became CMO. And then, four years later, I became CEO. So, it's been this progression. Yeah. And I would say it wasn't a planned progression. My passion clinically was substance use disorder treatment. Okay. And I quickly realized that there's so much stigma in that arena that, to quote Al Capone, you do, you can do more with a smile and a gun than just a smile. And so I realized that having authority meant that I could get my substance use disorder treatment programs up and running faster. So that's really what attracted me to leadership. If I'm the boss, I can do more things I think should be done. And then that led me, and I really, the reason I jumped to the CEO, and this might be interesting for your podcast listeners, is that MassHealth, which is the organization in Massachusetts that runs Medicaid was on the verge of moving from a fee for service program for institutions like ours to capitated value-based payment program. And that had been the holy grail of primary care. And particularly for those of us who work in disenfranchised communities that had been the holy grail for the last 50 years. And so, I felt, oh, I'd love to be in a high enough leadership position when this happens that I can impact the system.

Integration of behavioral and physical health 19:51

Health Hats: Okay. So, I'm interested in the substance abuse angle. I spent a bunch of my career in behavioral health, whether it was an integrated substance abuse program or behavioral health managed care, and in a performance improvement, like director or VP of performance improvement, but so it part of being a federally qualified health system is that, and do you have to correct me if I don't have this right? Is there more of a focus on integrating behavioral health, substance abuse, mental health, and physical health? Is that true?

Kiame Mahaniah: Yes. Our federal overlords, who are in HRSA, this is something that has been pushing within the patient-centered medical home. Okay. Which is the big thing, like 20 years ago. And so they evolved into yes. How do you integrate? How do you integrate a holistic approach to the patient? Yes. So behavioral health and injecting substance use disorder treatment to make that part of your routine care is a big was a big emphasis of HRSA. So yes, you're correct that you'll see federally qualified health.

Health Hats: What's HRSA?

Kiame Mahaniah: I don't know what it stands for, but health resource service administration or something like that. They're part of CMS, which is Medicare. But yeah. And they're the federal branch that makes all the rules for us in the health center world? Yes. And so you'll if you sort of sample ambulatory care facilities across the US, you'd realize, oh, that's weird. Why are, so why is so much behavioral health based in a federally qualified health center? Why is so much substance use disorder treatment based in a community health center? So, it's partially because of that influence, but the other

part is that from being in healthcare, you have to spend about 23 minutes in a medical office before you realize that, oh, Wow. Everything's about mental health. It gets like after the densest person realizes that very quickly. Yeah. And then I love substance use disorder because it's neither mental health nor medical, right? You'll miss the other if you just take one side of it. Like there's no, this sort of division we've inherited from the Greeks of the mind on one side and the body on the other falls apart when you're talking about substance use disorder. And because we have that dichotomy in our model, we don't understand substance use disorder, but we don't understand something so intertwined that it's both and more. And so it's one of the reasons we have a tough time treating it in our current system: it challenges the basics of how we view healthcare. I don't think it's partially why I enjoy it so much. It's such a, yeah. It's such an exciting field. I love the existential conversations I have with my patients.

Succeeding 60% of the time 23:16

Kiame Mahaniah: Now, it is hard because we succeed only about 60% of the time, which means that 60% of our patients are sober. They build their lives, they reconquer their demons, and they're able to achieve. They can be closer to the person they always want, but 40% of our patients don't make it. And a considerable proportion of those has those patients die. And so, it is also a high stake. It's like a high-stakes endeavor.

Health Hats: Can you say the same thing about diabetes and high blood pressure that yeah. Percent or makes is some number that's not a hundred percent.

Kiame Mahaniah: Yeah, you're correct. You know your numbers, right? Like an excellent at an excellent ambulatory care facility. They have a 65, and 70% success rate with their patients who have diabetes or patients who have high blood pressure. And that's like a top-notch health system. So that means that it is just less dramatic in diabetes, right? Because it takes 20 years to develop blindness. It takes 25 years to develop kidney damage and another 30 years to have an amputation as opposed to substance use disorder, which happens in 2, 3, or 4 years. But yes, it's the same issue.

One-on-one visits - why? 24:40

Kiame Mahaniah: Healthcare, as an example, Danny, I think it's so weird that we have one-on-one visits. If I'm having one on one visits with my patients with diabetes, and I think they probably are not even the one who shops for the food, they're not the one who cooks. Like, why am I talking to them? I should be bringing it in. Whoever is in their family and circle decides what to buy, what to cook, and everything. But it's, intriguing to me that even our EMRs. Like we have a top-of-the-line EMR here at the health center. And yet I wouldn't be able to go into my EMR and say, who's in Danny's family and have Ann and your son show up? It wouldn't happen even if they were patients of the health center. And yes I would say that one of the reasons

Impact of snow removal or not 25:30

Kiame Mahaniah: I love substance use disordered so much that it's a distillation of the problems we have in chronic disease management in general. We know that if we damage people as kids, there's

much more likely to use drugs, but do we take steps to undamage kids? Not really. We're like yeah, that's how it is. And that's how it is in healthcare in general. For instance, we know that not clearing snow from sidewalks in poor communities in the winter means that nobody's going to walk, which means all these other side effects happen when you don't exercise. However, we still routinely run out of money in poor communities to clear snow. And yeah. You're correct that all chronic disease is mental health and medical combined, but we choose to separate them. And then further we isolate, right? We say, oh, diabetes is different from hypertension. It's different from lupus. It's different from the right. To try to get a hold of it, as opposed to thinking, what does this patient need?

Sponsor 26:43

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Staff retention. Pay, fatigue, epidemic 27:24

Health Hats: I noticed on your website that you have a temporary closure on Sunday visits because you're having staffing issues. And it seems like everything you're talking about. So, it depends on your staff that you, as a are you, have to have people to cheer.

Kiame Mahaniah: Yes. And so that, yeah, that's why I do so much cheerleading because we need people to stay.

Health Hats: Yeah. What's that about? Could you talk a little bit about that?

Kiame Mahaniah: I would say it's several different things. So, this is where I'm putting my what my coach calls MSU hat, where it's making stuff up, except she doesn't say stuff. She says a word that ends with H I T., But I think that number one, because we're traditionally under-resourced, we generally pay people between 15 and 25% less than the private world. So essentially, people work here because they believe in the mission. And if you're in that 10 to 15% range, you can keep people. But when the market changes, we're talking about a 30% difference. Then it's hard. So far, COVID surprised us that suddenly boom, nurse prices, and behavioral health salaries just zoomed out there. And it caught us by surprise, and we lost a lot of people that were just like so 30, 40% difference. I must go. Sorry. Which is understandable. Second, I think that the pandemic-tired healthcare. It made people tired. So even if we have the people as staff employees, we have about five times more people on leave now than we used to pre-COVID, like on long-term leave. The long-term leave. And something that's a significant number, right? That's a considerable number, five times as many people. And so, that's an issue. Then the other thing I would say is when we think of healthcare, we think of nurses and physicians, right? We think of it because that's who we see on TV. But healthcare is 80% not people like that, right? Yes. It's 80% facilities

guys, community health workers, receptionists, medical assistants, and recovery coaches like enrollment navigators like it's right. And many of those people worked at the health center because we're in their community. It was an excellent job in the community. They didn't sign up to put their patient and their families at risk during a pandemic. They love our mission and feel proud, but they're here because it's a good job. They're not here to be frontline cannon fodder. So, part of it is that we sent many people recalibrated, and they're like, if I want to make $20 an hour, I might as well be an assistant manager at Market Basket. I'm not dealing with pandemics and sick people. And so, I think that the pay differentials, the fatigue, and general anxiety about the next epidemic have made it difficult to maintain staffing.

Long queues for services 31:00

Kiame Mahaniah: And so we have, but our first time in our history at the health center here, we have several hundred people waiting for every single one of our services. Whether it's vision, dental, therapy, psychopharmacology, substance use disorder, or medical enrollment, like helping people get insurance, all of those services have, and some are terrible. Like our waitlist for a therapist is, Unbelievable. So, some societies also changed during the pandemic, and we cannot keep up.

The stress you can manage 31:53

Health Hats: Wow. That sounds like a lot of stress.

Kiame Mahaniah: Yes. I've also learned not to take on the stress of things. I can't control it like I can increase people, I can increase people's salaries to hope to keep them more. I can cheerlead them. We can give people breaks. So like last summer, we did Fridays in the summer. So three Fridays, everybody had off as extra, and we arranged for it to be in front of the Monday holidays. So, everybody in the health center three times during the summer last summer had four-day weekends, right? We try to do things like that, but I can't control whether some private startup is paying almost twice as much as we do. And I can't control that people must take care of their families and be on leave. So, we adjust. And I think we have such a supportive community that they understand that if we're closed on Sundays, it's just because we can't be open, right? It's not like we are making more money or our community trust that we have no malicious intent. They know we're doing the best we can.

Staff morale - can't help everyone who needs help 33:05

Kiame Mahaniah: And yes, I would say that a significant negative morale factor in our staff right now is knowing no matter how much you do. You will not be able to help everybody who needs your help. And particularly for people in behavioral health. It's a killer. Like it's just terrible because you know how many people are suffering from mental illness. And just like we don't have the space to help you. You might be suicidal. You might be psychotic, but we don't have the space to help you. And you're asking for help. Paradoxically enough, it makes people leave, even though they know it will worsen if they leave. But it's, they just can't handle that disappointment. Yeah.

Investing in training, like cops and soldiers 33:56

Health Hats: What should we have talked about that we haven't

Kiame Mahaniah: I think system-wise, and I've been saying that to whoever has power that I can, we pay for our police officers to become police officers. We pay our soldiers to become soldiers because we think of it as a service. And I believe that social workers, particularly social workers who are therapists, should be in the same category. I think teachers should be in the same category. Like it should just be that. I think it's incredible that we make therapists pay for their training. It should be part of the service, right? Like you want to be a social worker. It's like being a police officer or a soldier. We pay for it. So, we have to start looking at what it means to invest in the foundations of healthcare in daycare providers. What does it mean?

Free market? 34:57

Kiame Mahaniah: So, I think that we have, because people always, we're free market capitalism in the US, but people often forget that when Adam Smith was talking about the invisible hand of the market, he was always preceding it by saying, assuming that your people are working in a moral framework, right? Like if you have an ethical, moral framework that people are working out of. You can trust the free market to have the invisible hand. And I think we have to relook at those values because having a free market doesn't guarantee good, efficient, or convenient care, particularly for disenfranchised people. And that's not my field, but it's out there like it's an education field, a workforce issue, but I feel it's hard to go to graduate school and then come out and make $50,000. And you borrowed, I don't know how much money to make. So I think that in the future, healthcare is going to hurt. Not necessarily the top of the license because I get many statuses as a physician. Like I'm well paid, I'm well respected. So I think there'll always be people interested in being physicians, but all the other jobs that make healthcare happen. We need to figure out how we'll support it because paying people $16 an hour to be a receptionist in a doctor's office is just not tenable.

And so, I think that the workforce issue is something the market will not solve.

Miss being a frontline clinician? 36:29

Health Hats: Anything you want to ask me?

Kiame Mahaniah: Yeah. I'm curious. Do you miss not being like frontline and getting your hands dirty in the ICU or something like that?

Health Hats: That's an excellent question. Yes, I enjoyed direct care, whether I was a nurse or a paramedic, or I enjoyed it. I loved being part of people's lives for a few minutes. I've said before it's a license to be nosy. I also like that it was. I only had so much I could handle, but I enjoyed it and was good at it. But then I discovered organizations, and I felt my ability and impact were more significant as I got into leadership, and now with disabilities, I just couldn't do it. Like when COVID started, I was like, I should volunteer. I should go back to work. I'm a nurse, and my wife is like, yeah, she's holding me up as I'm turning quickly and look like I'm going to fall over, and she said, yeah, you're going to put your pack on, use your two canes and you're, how are you going to do this?

Staying in touch with the front lines 38:24

Health Hats: I think the challenge now is to stay in touch with the frontline. Like, I think that's what's hard. The higher you get for me, the more work it is to stay relevant and listen to what the patients feel. What are people thinking? What are the caregivers thinking? What are community services? What are they dealing with? And so, the bad thing about not being on the frontline myself is I get out of touch and am full of myself. I'm such a smart guy. But I'm not. No, I am. But what do I know about the life of somebody who just came from the Congo? What do I know about the life of a 13-year-old? So it's there's so much, I don't know. And so, I felt direct care. Then you're in it. You're in it up to your eyeballs. I was given yourself giving a half a chance. You're in it up to your eye. You must pay attention, all right. Thank you. I appreciate you taking the time

Kiame Mahaniah: Thank you, Danny. All right. Take care. Bye.

Reflection 40:02

Wouldn't you want to be on Kiame's team? He profoundly appreciates his staff from top to bottom, from side to side. He loves the Center's patients and feels for their life challenges. He takes his own, non-American healthcare experience in the Congo and Switzerland for a non-native experience of healthcare – something like Trevor Noah on the Daily Show looking at politics from his South African orientation. He understands what he can control and what he can't and focuses appropriately. He values the integrative framework and mission of FQHCs and weeps with its underrealized potential. Where have you seen great leadership in integrated health? Please share.

Outro 41:10

I host write, edit, engineer, and produce Health Hats, the Podcast. Kayla Nelson provides website and social media consultation and creates video trailers. Joey van Leeuwen supplies musical support, especially for the podcast intro and out. I play bari sax on some episodes alone or with the Lechuga Fresca Latin Band.

I'm grateful to you who have the most critical roles as listeners, readers, and watchers. See the show notes, previous podcasts, and other resources through my website, www.health-hats.com and my YouTube channel. Please subscribe and contribute. If you like it, share it. See around the block.