Podcast Interview Transcript

James Sanders and Mary Jo Baisch

In each volume of *Progress in Community Health Partnerships: Research, Education, and Action,* the editors select one article for our Beyond the Manuscript podcast interview with the authors. Beyond the Manuscript provides authors with the opportunity to tell listeners what they would want to know about the project beyond what went into the final manuscript. Beyond the Manuscript podcasts are available for download on the journal's website (www.press.jhu.edu/journals/ progress_in_community_health_partnerships/multimedia.html). This Beyond the Manuscript podcast is with James Sanders of the Medical College of Wisconsin, Department of Family and Community Medicine, and Mary Jo Baisch of the University of Wisconsin–Milwaukee, Institute for Urban Health Partnerships authors of "Community-based Participatory Action: Impact on a Neighborhood Level Community Health Improvement Process. Associate Editor Patricia Tracey conducted the interview. The following is an edited transcript of the Beyond the Manuscript podcast.

Pat Tracey: I'm going to give a brief description of your manuscript, *Community-Based Participatory Action: Impact on a Neighborhood-Level Community Health Improvement Process.*

The Riverview Health Initiative is a community-based participatory action (CPBA)-driven coalition that used several action models to create a community health improvement process, which incorporated resident input in developing a health assessment survey to augment epidemiologic data. The survey that was created allowed neighborhood residents to describe their health status, behaviors, and health care utilization. It also included perceptions about neighborhood support and safety, mental and emotional health, and other issues not usually captured in invaluable epidemiologic data.

The community health improvement process provided local data that helped practitioners better target scarce resources to specific health concerns of the community, linking the processes of CHP and CBPA allowed the Riverwest Health Initiative to be informed in an ongoing manner about the neighborhood's strengths and challenges.

Pat Tracey: You established the Coalition in 2003. Can you tell me what was happening in the Riverwest community that caused your partners to want to come together to form the Riverwest Health Initiative, and who were your partners?

Jim Sanders: In early spring of 2003, my health clinic physically opened its center in the Riverwest neighborhood, so by default I became a neighborhood member. And as any good community-minded physician, I promptly put on my overcoat and went out and started meeting my neighbors. Some of the first people I met were from the social service agencies and some of the folks from the local public schools, and we started talking about what our ideas of health are and what our ideas of a healthy community that we'd like to live and practice in.

© 2008 The Johns Hopkins University Press

Well, it became apparent very quickly that we all had the same ideas, even though I was using a stethoscope and they were using other means to achieve these ends. We thought pragmatically the best way is to join forces so that we wouldn't be at cross ends with each other, but rather, better for coming together. Thus, very quietly and almost innocently, this initiative is born. From the get-go, we designed it to be a disorganized, nonlinear model of association, where any private citizen or agency group can come together or join up at any time and drop off at any time. So there's no lead agency per se and no minor agency; we all have equal voices and we all bring our talents that we can share for the health of the community.

Initially, because the neighborhood had such a great history of activism, there were a number of immediate partners who wanted to be part of this. As I said, we had a large local service agency, we had a couple of the public schools, we had a minority health organization, we had my local medical clinic, and we had a large health system that's in the area. We had the University of Wisconsin–Milwaukee's School of Nursing, and we had private residents. We actually had the local newspaper represented too, and it's grown from there.

Pat Tracey: Were there any issues that the community was concerned about, that wanted to pull this all together and make this initiative work?

Jim Sanders: The neighborhood as a whole does have significant health issues. You can measure those epidemiologically from the health department statistics, or you could measure those just socially from the anecdotal stories of the folks that were accessing services at the agencies or at the local health facilities. They were entrenched in poverty, single-parent households, kids dropping out of school, a lot of teenage pregnancies, high levels of chronic disease that were being untreated or poorly treated, and high levels of uninsurance.

Nothing that was different from a lot of other inner-city cores, but this neighborhood, as I said, is unique to Milwaukee because it's somewhat demographically integrated and mixed, as well as economically stratified, so that we have different income levels. We also had a rich history of activism, so there were a number of groups that have institutional memory of being active around community development, harkening back to the 1930s, when the unions were organized for labor purposes.

Mary Jo Baisch: I'd like to add to that. We all came in with ideas of what the issues were with the community, but it was pretty clear from the beginning that those were our ideas, and we wanted to make sure that we were getting the ideas of the community, of community members, and that's what led to the community assessment. So we were a coalition for probably a year or a year and a half before we really started looking at what would we do if we did a community health assessment for this neighborhood. And because we didn't want to come in with preconceived ideas of what the health issues were in the community, we decided that the community assessment would be one of the first things that we would do as a coalition.

Pat Tracey: I have another question I'd like to talk about. Is what you talked about—how you blended four community-based action models to create a health improvement process that was uniquely suited for the neighborhood, and you talked about four different models. Taking what you needed from the four models, you created a position for a community health liaison which was patterned after Safe and Sound Neighborhood community partner position. And by using that health as a motif in

lieu of safety and security, can you talk more about that position and what that health liaison person did and importance?

Mary Jo Baisch: When you look at those four models, the community-oriented primary care; the community partner model of crime prevention, that was the Safe and Sound community partner; a district public health nursing from the Settlement Houses with Lillian Wald; and community capacity development, the underlying theory behind all of that is that you would do a neighborhood assessment, that you'd build on the strengths of the community, and that you would do it door to door.

So that's the premise behind the community health liaison position. We hired a nurse with public health experience, and she actually did go and does go door to door to meet with people. And if you look at what she's done over time, she started out with a huge amount of community outreach, going door to door and meeting with individuals and families in the community, and then out of that, building on what we learned from the community assessment and from her own experience with the individuals she has seen, working more in the area of health education, social marketing, some consulting with different groups and agencies, and building, and a lot of advocacy, which is what she's found to be the biggest issue.

Pat Tracey: Great. Okay. Jim, do you have anything to add to that?

Jim Sanders: Well, we are also fortunate in that the health liaison came out of the neighborhood, so that's good for two reasons. One, personally she has innate knowledge of the neighborhood. And most people who work at the neighborhood level realize that even though it's a small geographic zone per se, or definition, there's a lot of differences, even going block to block within any of these neighborhoods. So she was right up to speed from day 1 on what blocks perhaps needed more attention and what blocks were hanging together pretty tightly already.

Second, on the other side of the coin, she had immediate credibility. She wasn't an outsider coming in peddling something. On the contrary, she was one of their own, and so when she knocked on doors people opened the doors and started to speak to her in a way that only comes with shared experience and trust, and she had that from the get-go. So we were really lucky on those two fronts.

Mary Jo Baisch: Because she was a nurse, she had some credibility from the health standpoint, so people were willing to tell her what their issues were, and she was able to make referrals for the services that people needed.

Pat Tracey: You say that over 300 surveys were returned to you after they were developed. Now what were the top concerns of the Riverwest community and what did you find unique or surprising about the results of those data?

Jim Sanders: The interesting thing from the survey results was that they all fit somewhat categorically into what the city or the states have also laid out in their general health plans for the next few years or the rest of this decade. What was interesting is when you get down to the very local level, the neighborhood level, it's how these health priorities actually play out or what the nuances are.

For example, in Riverwest they told us, the neighborhood says that they have nutritional concerns. Okay. Well, the state says that's an issue for them too, but they relate it more toward obesity or poor-quality foods, lack of choice of foods, poor food education, that sort of thing. In our community

the nutrition is that, plus it's hunger. We have a full 20% of our survey respondents telling us that they have to skip meals because they don't have the food budget, and we know from other evidence that urban Africa-American female obesity is linked to food scarcity and food insecurity.

So here we have an obesity problem, but as a physician particularly I can speak, I'd never considered it to be a hunger problem. And so that is sort of an example how rich these community data are when they start informing on what the city and the state are emphasizing.

Second, they told us they have mental health issues. Well, again, so do the city and the state, but in our case, the neighborhood, it's not diagnosable, it's not DSM-IV-R kind of criteria, where they're in need of psychiatric care; rather, they're stressed out, they're irritable, they're sullen, they're not really on the full rose petal of life, you know. They're working two jobs, their kids are getting more underfoot, they're arguing with their spouse or their partner. They're stressed, and that goes, again, to the health of the community. When your population isn't happy about their situation, they're not going to be happy or expressing themselves in full civic manner.

And then they've talked about safety, perceived safety, and security issues, and that goes right hand in hand with their mental health. You know, if you're not feeling good about where you're living, you're not feeling good about yourself either.

And last, the issue of access, and access to care, and we know we have a—I don't even know the word—a scandal in this country around uninsurance, lack of insurance.

And Milwaukee is no exception to that and our neighborhood is no exception. So it wasn't surprising that we found people that weren't insured. But they told us not only were they not insured, but that costs, out-of-pocket expenses like deductibles and medicines were keeping them from seeking care.

And then it was also transportation issues, a full 20% saying they've got it all together, they've got the insurance card, they may be able to pay for their meds, but they can't get to where they need to go because of transportation.

Pat Tracey: Right.

Jim Sanders: Well again, that's a subtle nuance in our neighborhood, which the state and city data could never tell us. So now as an initiative we can start reacting to that, you see. So it's very informative.

Pat Tracey: Mary Jo, do you have anything?

Mary Jo Baisch: I think what it's done is it's changed the way we've developed the strategic plan for the neighborhood. So when we think about—first of all, we're based on the premise that those 300 people who filled out the surveys are generally people that have the resources to read, write, fill out a survey, and return it. We gave them, it was, we had postage-paid envelopes so they returned them, but they had to have the time to fill it out, the time and the expertise to fill it out. So we figured that the data that we received back on the survey were probably the tip of the iceberg. So if 20% of the people in the community are saying that they're skipping meals because they can't afford them, then it's probably a much larger population that we're dealing with.

This is a community of about 7,000 households. We've really directed our nutrition program to how we work with the food pantries to support what we can do with them. So we're doing health education right at the food pantry and showing people what they can do to use that food in a different way.

We're also doing more advocacy for general, just general nutrition across the city. We lost 17 grocery stores in the city over the last 5 years, and so access to fruits, vegetables, and affordable food is just not there like it used to be. And so the advocacy that we do on a broader level is really important to helping people in this local neighborhood.

What we're seeing happen is that when you look at the community health liaison, she's working with individuals and families and directing that toward our larger community, but as the coalition continues we end up doing larger things on the system level that's informed by what's happening in this neighborhood.

The city had never done a comprehensive community assessment before, and now the city assessment, after they read our report, has seen the importance of doing a citywide community health assessment, and they're starting to do it. So we feel really excited that what we've done in the neighborhood and community level is impacting the larger system.

Pat Tracey: It sounds like a great initiative. Do you have anything else that either of you would like to let your listeners hear about?

Mary Jo Baisch: One of the things that we were talking about was how the community was informed and how we played out the principles of CBPA, and I think what's really important about that is that there's a group of professionals in the coalition and community members in the coalition, and they have to work in partnership.

The community, the professionals have to understand that they have as much to learn from the community as the community does from the professionals. Too often you get this paternalistic or maternalistic view of the professionals coming in to do something to the community, and that's not the way this one works. The community assessment, for example, was informed by community members from the very beginning, how should we do it, what questions should be asked, how do you analyze the data, what does it mean. After the data were collected and we started looking at the frequencies and the information, we kept taking it back to different community groups, saying, "What do you think? Does this look right?" and it was validated by what community members, different groups of community members felt.