

Yvette Cozier: Hello, everyone. My name is Yvette Cozier, Associate Dean for Diversity, Equity, Inclusion and Justice at Boston University's School of Public Health. Thank you for joining us for this public health conversation starter.

Today's conversation is part of our SPH Reads series. SPH Reads is a school-wide reading program which aims to encourage critical thought and discussion among all members of the BUSPH community and is centered on a carefully chosen thought-provoking book. The selection for the 2025-2026 academic year is Ripples of Hope in the Mississippi Delta: charting the Health Equity Policy Agenda, written by David K. Jones and edited by Deborah Bingham, Nicole Huberfeld, and Sarah H. Gordon.

Today, I have the privilege of speaking with Dr. Thea James, who serves as Vice President of Mission and Associate Chief Medical Officer at Boston Medical Center, and co-founder for the BMC Health Equity Accelerator. As VP of Mission, Dr. James works with caregivers throughout BMC. Additionally, she has primary responsibility for coordinating and maximizing BMC's relationships and strategic alliances with a wide range of local, state, and national multi-sector organizations, including community agencies, housing advocates, and others that partner with BMC.

Dr. James, thank you so much for being with us today.

Dr. Thea L. Jam...: Thank you for the honor to be with you today. I'm really excited. Thank you so much.

Yvette Cozier: Great, great. So why don't we start out? Can you start out by sharing a bit more about your background and how you came to be doing the work you are involved in today?

Dr. Thea L. Jam...: Sure. I am an emergency medicine physician by training, and I did my emergency medicine residency at Boston City Hospital, so I'm sort of dating myself. But some of the things, probably everything that I know from the perspective of healthcare, how healthcare is delivered, what the issues are in healthcare, particularly in healthcare education, I think it all came to me being an emergency medicine physician. And so in the emergency department, you see everything. And if you are curious, I mean really curious and intending to understand what the root cause is, if you really want to have impact on your patients, you will pay attention and you will start with the patient.

And one of the things I noticed early on is that patients would come in, we would treat them, we'd diagnose them, treat them, either discharge them or admit them, but in a few weeks, they'd be back with the exact same problem. And at some point I started asking them, "What would it take for these things not to happen?" And honestly, no matter what story they told me, it was always rooted in economics. So it was very clear to me right away what the number

one, I would say, barrier was. And obviously when you start putting things together as I did, because I was learning as well, these are structural barriers.

And so I would say that medical education does not teach people. It's primary educational strategy, it seems, is to teach people to diagnose and treat disease, but it doesn't start there. I would say it doesn't end there. I mean, we are not taught to listen. And listening goes so far, both in terms of how the patient interacts with you, how they're willing to open to you and tell you things that aren't obvious. And you just learn so much more about what is going to work and what is not going to work.

But so what I've found and still find about healthcare professionals is they make up their own minds about why they're seeing what they're seeing without asking the patients themselves. Even in Dr. David Jones' book, he talks about starting with talking to individuals, and that's key. That is such a key element of being able to be impactful and effective as a healthcare professional.

And so I think everything should begin with the person, the people, the community, they know what they need. We don't. Even when you're looking at things like data, we generally look at data across sectors and we decide what the data mean. And then we use what we think we know to create solutions. But it's so much easier to ask the people who make up the data, the people the data represent, they know what these things mean, and you can partner with them to create solutions.

And so I'm getting ahead of myself because that's really what's a bit of the magic sauce of the Accelerator. But getting back to how I started, that's how I started by listening to patients, asking patients and trying to help my colleagues understand. Because when people would decide we're dealing with populations that have limited resources and when they decide to not use their limited resources to pay for copays or pick up prescriptions or get on three buses to go to another neighborhood to buy more healthy, more expensive food, when they decide not to do that or not come to chemotherapy even for a very similar reason, it's not because they are poor decision-makers or not because they don't care. They're making rational decisions for them and their families.

And so those are the kind of things that I learned early on, but I also understood that it wasn't this thing you hear people talk about all the time that you can't boil the ocean. Well, if you accept that, then you don't understand how it happened to begin with, because it's not natural that it's happening that way. It's happening by design. And so people who are not thriving in these predictable ways, they're not thriving because things were designed for them not to thrive. So I learned all of that.

I also learned that you can indeed do something about it. It often you have to, number one, begin with them. And then you have to, I mean, hospitals can't do everything, so you have to step outside the walls of the hospital. You have to create partnerships in neighborhoods with people who they can be across

sectors because living and thriving in life, you are interacting and engaging with all types of sectors, be it things that enable economic opportunities, economic mobility. I mean, the operative word is access. Access is the operative word. So that's where it all begins.

So we began to have some success. And when I say we, I've never done anything on my own. It's a team sport from me from start to finish. And so we had some opportunities to engage in some opportunities to alter people's life course trajectories through providing access. One of the earlier ones was the Violence Intervention Advocacy Program, and then the Accelerator followed.

But I'm going to stop so that you can ask another question.

Yvette Cozier: Sure, sure. So just following up on that, for those who are not familiar with the BMC Health Accelerator, can you share a little bit more about the history and the work, the day-to-day work of that organization?

Dr. Thea L. Jam...: Right. Yeah. So it's not really an organization, it's actually just an internal entity, if you will.

I would say that the Accelerator began around 2020 or so, 2020, 2022, when everyone was talking about equity and inequities, poor health outcomes, but mainly equity. And people were coming up, everybody was coming up with a commitment to equity statement. And BMC has always been an organization that has been innovative and creative and has had created programs that have been disseminated across the country. In some cases, once you name the organization like the Medical-Legal Partnership, you now have to say the city behind it because although it started here, it's in other cities and stuff, is now. But when this equity word and commitments to it were coming out, our executive leadership, CEO, COO at the time, they were saying, "We're not going to do that. We're not going to do that because we understand a lot of this. We've been doing this work for a while."

But I think the one thing that really hit the nail on the head for them was when the Boston Public Health Commission health outcomes data was published, it's published regularly, every few years or so. And I think what got to them really was looking at the fact that these outcomes had not changed over decades, like prostate cancer deaths and infant mortality, diabetes, all these things, all these things that are always highly predictable. You already know pretty much no matter what you measure, if you look at it from a demographic perspective, you already know who's going to do worse. And so in this case, I think that really, really, really did nudge them a bit.

And so we decided that instead of coming out with commitment to equity statements, we decided to do an internal look. We would look inside our own house to see where we might find inequities and outcomes data. And of course

we found things, and then we identified some clinical areas that had the highest rates of disparate outcomes, and we just went to work with that.

And it started out with organizing more than 80 leaders across our organization and exploring more than a hundred different analyses of baseline data to understand where the greatest inequities existed and to initiate, and I call it an interrogation to uncover drivers that we would address. And we also prioritized a list of initial bodies of work that would be embedded across the system. And it was across various different entities like clinical operations, education, research, advocacy, determinants of health, everything, even public safety.

And so we organized into six work groups. All of those things being in what would be infused in all of the clinical areas would be all those areas I just named. So there would be policy and advocacy, for example, there would be research and education across each of these clinical areas. There would be looking at it from the perspective of determinants of health.

It was very, very intense, very rigorous, I would say, in terms of the data, the meetings, the approach that we used. It was pretty hard. And there was a really high level of accountability where there was really deep, lots of meetings and people had to report out on their progress over time. And so it was pretty tough.

And then we wrote about it. We wrote a piece in New England Journal of Medicine, in the Catalyst Publication and talked about what we were doing. I mean, we just let it all out publicly.

And I would say the most important piece to all of that as well is, again, the people. We interviewed many, many, many patients to talk about and understand what their experience was in the healthcare system, our healthcare system. And some people were kind of surprised at some of the statements that people expressed, and we would have these large Zoom meetings and patients' comments would be on slides and people could see it right there.

And so we started with the patients and we wanted to close gaps. Our goal was to close gaps. And I would say the magic sauce for all of it was starting with the patients instead of us thinking, interpreting the data, having the patients interpret the data, and also having them to partner with us in creating solutions. And I think what that resulted in was hitting the nail on the head the first time. So we had dramatic closures and in rapid time. So I think it was the most efficient process I've ever seen in terms of identifying disparity gaps or inequities and creating solutions and having the outcomes from that approach be so dramatic and so rapid.

Yvette Cozier: Wow, that's amazing. So again, just sort of following on that, seeing the closure of some of these gaps, going to the book, Ripples of Hope, the first chapter

begins with the statement, more or less, that health equity is possible. Do you agree from what you've seen?

Dr. Thea L. Jam...: I do. I do think it's possible, but you definitely have to understand where it's rooted and you have to incorporate to ... I mean, to have the most efficient and accurate outcomes, I think you have to address some things that, you have to challenge convention, first of all, because most people don't begin with the people, historically at least. And so that there are fits and starts. And I just feel like you're not really able to achieve the maximal outcome and impact that you could, but a lot of people don't recognize that. They can have deep commitments to equity, to the work, but they may not recognize what they need in order to get there. And it's just too simple to just ask the people. I feel like even if medical education taught that, outcomes in medical education would be a lot better than they are. But yeah, I do think it's possible, but you really have to understand also historically, I mean, you have to understand how these inequities were created to begin with.

And I mean, sometimes I feel, I haven't said this in a long time, but I mean, I feel like one of the greatest modern teachers of that would be during the pandemic when predictably we already knew where the worst outcomes would occur geographically and which populations would do worse and would die at greater rates. And there were maps of this, people were keeping maps across the country and their cities and stuff. Those maps match the redlining maps. So the redlining was quite intentional and quite successful in terms of the impact it's had throughout the decades. But if people don't recognize how when you prevent people from having access to economic mobility and economic stability and all the things we need to thrive, how it self-perpetuates over time.

Yvette Cozier: And so you were just talking about one of the challenges is, or that we need to challenge ourself and think outside of the box, right?

Dr. Thea L. Jam...: Yes.

Yvette Cozier: I guess this is a question of what keeps us from doing that within public health, within medicine? What keeps us from thinking outside of the box?

Dr. Thea L. Jam...: I think because the people who are teaching it may not understand, maybe. Nobody needs to be saved. This is not a savior mentality kind of a thing. I mean, everybody just wants ... I mean, people just want to thrive. They just want access like everyone. And sometimes you may not recognize, this was mentioned in the book too, I think, by Dr. Jones, recognizing how you may unintentionally be perpetuating these things and these inequities.

And I remember reading during the pandemic and someone was talking about ... I forget the name of the book now, I apologize. But a woman wrote a book and she was talking about how when she was a child, her parents were very leftward leaning. But if a kid of color came home and talked about something that

happened to the kid or the family or whatever, the parents would say, and they were Black, parents would say, "They're very nice people, they're very nice people, but they don't work hard enough or they're not smart enough and they make poor decisions." And I kind of think, I don't know. And I think people can believe those things without recognizing how, A, that they believe in them, and, B, how it impacts how you interact with those people or how you interact in your life, or how when you have opportunities to shift and change things, you can't do it when you have that mindset.

But I'm going to tell you something, I always say it's not complicated. It's not hard. It just isn't. It's just shifting your mindset and not thinking you know what is best for other people. They know what's best for them. And here's the other thing about, I think when we have a mindset like that where we may not be able to think through the benefit of access and equity, I can't help but think about so much about economics. I just can't because I just keep seeing it over and over again. I've also, by the way, we've also seen data that can prove that too, a bit.

But I just feel like ... So when people have access to financial stability and financial security, they also become contributors to the aggregate economy and health outcomes improve, cost of care goes down and because they also become contributors to the aggregate economy, everybody wins because subsidies that are included in budgets don't have to be there. The GDP is impacted in a positive way. The government benefits. You don't have to include these carve-outs and things in your budget. In fact, you have somebody who's now contributing in a positive way. But I don't think that people always think through these situations, these opportunities all the way through. And I think mindset and just not being aware of how these things happen to begin with prevents people from being able to think in that way.

And so the Accelerator in and of itself, its goal is to challenge things like this and to challenge and redesign systems and to get to that point by, again, starting with patients and communities using really rigorous data and evaluation and addressing access, like removing the barriers to that and building solutions.

And I feel like what we're planning to do is just to test these solutions and programs to disrupt these inequitable systems. And ultimately, what we intend to do is to improve the data that I was talking about in the beginning to increase life expectancy and contribute to others who are doing the exact same thing. In many ways, we're all collaborating with others across the city, the Boston Public Health Commission, the state, other programs, other organizations that are in the city that are working on all these types of things, even from a policy perspective, like the Health Equity Compact and people like that, and the other hospitals. We're actually now doing a lot of collaborative things together as well.

Yvette Cozier:

Great. That's great. So what advice do you have for current students of public health? We're about to graduate a new flock of students, and we have many

alums certainly who are interested in health equity. What advice would you give them?

Dr. Thea L. Jam...: Start with a clean slate in your mind. Just start with the slate of just wanting to learn and interrogate everything back to the root cause and begin with the people. No matter what it is you're doing, if it involves humans, begin with them, because they know better than anyway. And if you want success, I mean, that's where the diamonds are. That's where the solutions are, that's where the knowledge is, that's where the opportunity is.

And if I were you, I would challenge convention. I'm telling you, if it's out there, I mean, if it's not out there, if what you think is necessary and what the patients and the people and the communities tell you is necessary, if you don't see it, if you don't see something that hasn't been done, it's waiting for you. It's waiting for you to do it. And it doesn't mean that it shouldn't be done. You hear people talk about things like ... I vowed never to say this again because I don't want to repeat things that shouldn't be out there. Things like, "You can't boil the ocean." Well, then should people drown in it? I mean, really challenge convention, and that's how innovation happens, that's how creativity happens, that's how change happens, that's how transformation happens.

And I am the type of person who only wants to engage in transformative acts. I only want to engage in work that will be transformative because otherwise it's hard for me to find a reason to be doing it and it's really hard to engage in it if I can't see a transformation on the other side. And so the opportunity is there. Just do it. Just do it. Life is short. I should know, because I'm well on my way. So I'm just saying, don't wait, just go for it, do it, do the thing people said can't be done and be joyful and grateful about the outcome you will see.

Yvette Cozier: Those are lofty words to live by, but I think very inspiring for those who are dedicated to this work, want to be involved in this work. And those are strong marching orders there.

Dr. Thea L. Jam...: But I'm telling you, it's through lived experience. This is not just something I'm dreaming up or ... And I am speaking from lived experience. I'm telling you, it's been my experience. So it is completely doable.

Yvette Cozier: So yeah, I endorse that and I endorse what, the words of Dr. Jones, health equity is possible. We have evidence here that it is possible. And through the Accelerator we're getting there. So thank you so very much for your insights.

Dr. Thea L. Jam...: Thank you.

Yvette Cozier: I do have one last question for you.

Dr. Thea L. Jam...: Sure.

Yvette Cozier: And you can swat it away if you want. You began with sharing your background and your experience as an ER doctor. Are you a fan of, ever watched The Pitt?

Dr. Thea L. Jam...: Oh my gosh, yes.

Yvette Cozier: Okay.

Dr. Thea L. Jam...: Oh my gosh, yes. That is the most accurate depiction of emergency medicine that I've ever seen.

Yvette Cozier: Okay.

Dr. Thea L. Jam...: All of it, start to finish for the most part, and including, and especially the characters. I mean, those personalities are alive and well in the emergency department every day, all day. I mean, the physicians, the staff, and even the patients.

Yvette Cozier: The patients.

Dr. Thea L. Jam...: All of that is alive and well, for sure.

I wanted to say one more thing, Yvette, about this.

Yvette Cozier: Yeah, absolutely.

Dr. Thea L. Jam...: And particularly when we're talking about as students are graduating and going out, when I went to business school, I went to business school not to learn healthcare management or anything like that, because in my mind it already wasn't working. And I didn't want to learn something that I couldn't apply because it just doesn't work. And I learned that obviously because I learned that from ... Well, I came to that conclusion because I learned early that United States spends more money in healthcare than any country in the world, right, and the health outcomes are the inverse. So something about that business model does not work. There's no return. Okay?

And so I went to business school to try to find a way to make the case for economic mobility and economic access as an approach, an additional approach to successful healthcare and being able to have a return on the investment. Because I don't know of another business that invests that much in something with no return.

And so I learned it in the first module and that module was called Creating and Capturing Value. And it made so much sense to me because ... And my gosh, the thought came to my mind immediately because I was thinking when we are dealing in healthcare, and particularly in an essential hospital or a safety net hospital, which is a microcosm of the populations we serve, because we have the exact same challenges and lack of access and all these other things. But

when we are asking people, as I mentioned earlier, who have limited resources to go out and use their limited resources on things over survival it is of no value to them and of none to us because the cycle continues, poor health outcomes, increased costs. But when you provide them with an opportunity to alter their life course trajectory in a major way and become stable, and one of the ways we found this in data that's been done here by the housing department, I'll call it, when you actually provide people with something that is of value to them, they latch right onto it and those data like housing data, for example.

So when Medicaid changed its reimbursement model, we really, from fee-for-service to accountable to value-based care, accountable care, we had to understand what was driving everything and the cost. And we realized that 2% of the population was responsible for 40% of the cost. But when those people were housed and with services, because before they were housed, their utilization looked like fire on a Y-axis. But once they were housed, I mean, readmissions for mental health, by the way, those 2% were characterized by mental health substance use disorder and housing insecurity. But once they were housed, those mental health readmissions, for example, decreased by 78%, cost of care by 50%, these kinds of things. So we are creating a value proposition, offering them a value proposition, and we reap and benefit from the value of that, which is decreased admissions, improved healthcare outcomes, and lower healthcare costs.

And so it's really not that complicated. Everybody just wants to thrive. And if we focus on that versus all these models and approaches that have been taught for so many decades and things, if we actually, again, listen to the people, we are more than likely to solve the problem and more than likely to create a situation that is a win-win for everybody.

So sorry I didn't say that earlier. I meant to, but ...

Yvette Cozier: No, no, no. Thank you for sharing that. That is so true. And I like that I wrote this down, creating and capturing value is something that we have to put in our focus there. So thank you again for another kernel of knowledge and wisdom and that we can shift our actions towards. So thank you, Dr. James.

Dr. Thea L. Jam...: Thank you. Thank you. And I'm proud of BU School of Public Health. I also have an MPH from there, so thank you.

Yvette Cozier: Another alum. Another alum doing amazing things. Thank you so much for joining us today.

Dr. Thea L. Jam...: All right. Thank you as well. Thank you.

Yvette Cozier: Appreciate you. Thanks.