

**STRATEGIES TO ENSURE EQUITY AND INCLUSION IN THE COALITION FOR A
HEALTHY GREATER WORCESTER'S 2021 - 2026 COMMUNITY HEALTH
IMPROVEMENT PLAN (CHIP)**

PRESENTED TO THE COALITION FOR A HEALTHY GREATER WORCESTER

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METROBRIDGE



Boston University Initiative on Cities

About this Report

This report is a product of student work in Boston University's *SAR HS 349 Cultural Humility, Racial Justice, and Health* taught by Kaytlin Eldred in Spring 2022.

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About BU MetroBridge

MetroBridge empowers students across Boston University to tackle urban issues, and at the same time, helps city leaders confront key challenges. MetroBridge connects with local governments to understand their priorities, and then collaborates with Boston University faculty to translate each city's unique needs into course projects. Students in undergraduate and graduate classes engage in city projects as class assignments while working directly with local government leaders during the semester. The goal of MetroBridge is to mutually benefit both the Boston University community and local governments by expanding access to experiential learning and by providing tailored support to under-resourced cities.



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SUMMARY MEMO

PROJECT BACKGROUND

The Coalition for a Healthy Greater Worcester (“Coalition”) brings people and organizations together around health issues that affect quality of life in the region. They raise awareness, create opportunities for networking, and support finding solutions. They develop, implement, and evaluate initiatives, events, projects, and policies that address areas of common interest to members. Their objective is to mobilize the community to advocate for health in all policies and ensure implementation through effective program models and best practices.

The Community Health Improvement Plan (CHIP) is a regional strategic plan for addressing health disparities and improving community health. The CHIP is used as a roadmap for health improvement over a five period and guides the investment of resources. This plan informs the use of these resources for the Worcester Department of Public Health, hospitals, and health plans, and all organizations that have a stake in improving health for the residents of Worcester and the surrounding communities.

The Coalition requested that Professor Eldred and her students perform best practices research to inform four of CHIP’s Action Agenda interventions, while paying particular attention to consideration for Worcester’s priority populations.

METHODOLOGY

During the Spring 2022 semester, Professor Kaytlin Eldred and her undergraduate students in SAR HS 349: Cultural Humility, Racial Justice, and Health provided social justice research support to the Coalition to better address public health challenges in Worcester. We identified successful implementation strategies within cities of similar size and demographics to inform the following 2021 – 2026 CHIP Action Agenda items:

- Mobilize community mental health, nutrition security, and primary care services
- Implement trainings on principles of anti-racism, LGBTQUI+ acceptance, cultural humility, and empathetic communication
- Broaden and scale resource navigation systems
- Develop recruitment, retainment, and advance strategies to diversify workforce

Our recommendations also provide key considerations for Worcester’s priority populations, which were identified by the 2018 Community Health Assessment. These groups include:

- Vulnerable children and their families
- Immigrants and non-English speakers
- Unhoused and unstably housed individuals
- Older adults
- Youth and adolescents
- Racial and ethnic minorities and others facing discrimination

MOBILIZING MENTAL HEALTH RESOURCES TO COMMUNITIES

Worcester community members were asked to complete an optional survey to collect anonymized demographic data for the development of The Community Health Improvement Plan (CHIP). When it comes to mental health, 51.9% of respondents had experience with mental health issues and/or mental health services. 50.9% reported having experienced bias or discrimination. 27.3% of respondents shared that they, a family member, or a friend had experience with substance use disorder and/or addiction (CHIP).

OBJECTIVE 1 - CRISIS INTERVENTION

There is an established need for a specialized crisis response system to be put in place for crises involving mental health issues or substance use disorder issues, as an alternative to traditional public safety systems.

Mobile Crisis Services

Multiple communities have found success implementing mobile crisis services. In Phoenix, AZ, their first Crisis Recovery Center was established in 1996 with the intention to offer an alternative to acute inpatient, jail, and emergency departments (EDs), a place where a mental health crisis could be handled by professionals as immediately as possible. [Akron, Ohio](#) was one of the first cities to implement the Memphis [Crisis Intervention Team \(CIT\) Model](#) and also developed a supplemental intervention program for at-risk populations. The Akron "CIT Outreach Program," links law enforcement officers with outreach workers from "Community Supports Services" who travel in a marked cruiser to contact referrals and attempt to engage people with behavioral health issues before a crisis escalates. The team refers individuals to mental health and other services, such as elder care and drug addiction services. When the team transports an individual in a cruiser, the person normally rides without handcuffs next to a mental health case manager, in order to emphasize that the person is not under arrest, and people are only restrained if the person is determined to be at risk of harming him or herself. In [Miami-Dade County, FL](#), their Eleventh Judicial Circuit Criminal Mental Health Project (CMHP), was established in 2000 to divert individuals with serious mental illnesses or co-occurring SMI and substance use disorders away from the criminal justice system and into comprehensive community-based treatment and support services by pre-booking jail diversion consisting of Crisis Intervention Team (CIT) training for law enforcement officers and post-booking jail diversion serving individuals booked into the county jail and awaiting adjudication. The behavioral health crisis calls are directed to trained Crisis Intervention Team (CIT) police officers that have diverted over 9,000 calls to crisis units and responded to over 40,000 without arrest or hospitalization over the last 5 years of the program. While their website did not address in-depth how they handle mental health cases with undocumented immigrants, in their publication [Jail diversion: the Miami model](#) they state, "The facility will also include a courtroom and space for social service agencies, such as housing providers, legal services, and immigration services that will address the comprehensive needs of individuals served." Here in Massachusetts, [emergency crisis services](#) are offered without healthcare coverage at no cost but little is known further about the successes/outreach of this program.

There is room for improvement in this sector however – In Phoenix, for example, their program was an improvement on current avenues for care but still had some issues relevant to crisis care overall in emergency departments. It focused too much on procedures and diagnoses and too little on engagement and collaboration, which are vitally important for the individual in a mental health crisis.

As a consequence of implementing mobile crisis services, however, In Phoenix, it was shown that there was reduced cost of care per case when diverting to mobile crisis services as opposed to calling the police.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided an overview of services and their funding sources here. Additionally, according to the [American Rescue Plan Act \(ARP\) of 2021: Section 9813](#), “CMS, through the Center for Medicaid and CHIP Services (CMCS), awarded \$15 million in planning grants to 20 State Medicaid Agencies for the purpose of developing a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services.” Guidance on how to provide mobile crisis services can be found here.

Opioioid Crisis - New York & The National Harm Reduction Coalition

In April 2006, New York passed a law making it legal for non-medical individuals to administer Naloxone, more commonly known as Narcan, to another individual in order to prevent an opioid overdose from escalating and becoming fatal. This provides the basis on which opioid overdose prevention programs can be established. Subsequently, the New York State Department of Health AIDS Institute implemented the [Naloxone Co-payment Assistance Program \(N-CAP\)](#). This is offered for New Yorkers who have prescription coverage through their health insurance plans that allow co-payments for naloxone for up to \$40 for each prescription. This amount will be billed to N-CAP and not the individual getting the prescription. Therefore, there are no or lower out of pocket expenses when getting it, which is one of the benefits of the program. In addition, individuals do not need to enroll in this program. Instead, any individual who is at risk themselves for an overdose or their family members may acquire naloxone through a patient at one of the participating pharmacies. A precipitation is not necessary to receive naloxone as pharmacies can get authorized to dispense naloxone. Pharmacies that participate in the New York State AIDS Drug Assistance Program are eligible to participate in N-CAP. If pharmacies are not enrolled in the AIDS Drug Assistance Program (ADAP), they can become enrolled by calling the ADAP office. This program was not intended to replace naloxone kits that existing opioid prevention programs offer, but as an additional resource that could provide more accessibility to obtain naloxone but also maximize state resources. One naloxone kit provided by opioid prevention programs cost New York State about \$70, but N-CAP co-payments paid by the New York State cost between \$1-40. If an individual or family member participates in using N-CAP, their personal identifying information will not be collected.

One of the main limitations of the N-CAP is that it is intended for those who are insured to receive naloxone at no or lower out of pocket cost. If someone is uninsured, then they are recommended to access naloxone at a registered opioid overdose prevention program.

The [National Harm Reduction Coalition](#) is aimed at creating evidence-based harm reduction strategies and building leadership among people who use drugs. The organization highlights that they want to meet and involve communities where they are at and work to build it into a supportive environment for people who use drugs. Some communities they work with include people who use drugs, policymakers and advocates, shelter and supportive housing agencies, substance use treatment, local community leaders. This coalition works with places across the country and currently there is one program in Worcester – the AIDs Project Worcester which offers Syringe Services Program Narcan training enrollment and distribution, and more.

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The National Harm Reduction Coalition was awarded \$5.3 million dollars in grants to 42 projects in 5 states (IN, KY, WV, TN, and NC) for their HepConnect initiative. This initiative launched at targeting the Greater Appalachia focusing on the intersection of drug use and hepatitis C infection as this population saw a 300% increase in Hepatitis C (HCV) infections. The [HepConnect Initiative](#) is focusing on using the awarded grants to expand services like mobile vans, testing materials for those who use drugs, increasing staff, training and support groups, and promoting community education, to create environments that are receptive to these programs. The work in Appalachia serves as an example for the potential that the AIDS Project in Worcester holds if it partners more with the initiative.

OBJECTIVE 2 - EARLY CHILDHOOD MENTAL HEALTH AND FAMILY SUPPORT

Offenders who have mental illnesses are at high risk of being incarcerated for a longer period or of being placed into solitary confinement which only exacerbates the symptoms of their mental illness. This leaves many of these individuals vulnerable to homelessness and rearrests because they are jailed instead of treated, along with the fact that emergency departments are not properly equipped to deal with patients who have mental illnesses. Now more than ever, there is a need for resources that are specifically centered around mental health and family support.

[Connected Care Pilot Program](#)

The Connected Care Pilot Program is a federally funded tele-mental health service that will provide funding for up to 85% of the cost of eligible services, which fall under the following categories: (1) Patient broadband internet access services; (2) health care provider broadband data connections; (3) connected care information services; and (4) certain network equipment. The Pilot Program will support connected care services across the country, with the focus being on low-income and veteran patients. One drawback listed on their website is that: "The Pilot Program participant must wait at least 28 days from the date on which the Form 461 is posted on USAC's website before selecting a service provider." This delay may not be helpful for critical need patients. [eligibility](#), a patient is considered low-income by determining whether (1) the patient is eligible for Medicaid or (2) the patient's household income is at or below 135% of the U.S. Department of Health and Human Services Federal Poverty Guidelines, and a patient is considered a veteran if they qualify for health care through the U.S. Department of Veterans Affairs' Veterans Health Administration.

[Living Room Model in RI international Crisis Response Center](#)

RI International is a global organization with around 50 programs throughout the United States that has a mission centered on peer-centered care. RI international's Crisis Response Center has utilized a Living Room Model that focuses on being in good contact with the person in distress while creating a welcoming environment that yields active engagement and collaboration throughout their stay. Within this model, participants are immediately paired with a full team of "Peer Support Specialists" in recovery and work directly with this team and are even encouraged to create their own recovery team.

With issuing this new model to support those battling mental health issues, specifically targeting those who have been a victim of substance use disorder and have been wrongfully arrested. Implementing this model, none of the issues are delegated to law enforcement, which means they are reducing the amount of time spent in Emergency Department and can the officers be released back to duty. Essentially, people with mental health illnesses are spending less time being imprisoned for their illness, and instead actually getting the support they need. Since the program has begun, the program has not

refused a single police referral in the past five years, despite over half being involuntary. Law enforcement engages in zero “wall time,” by-passing the Emergency Department completely.

The implementation of these programs eases law enforcement burden and improves the experience for the person in crisis. Those who are battling with mental health illness spend less contact time with the police, which decreases the likelihood of an arrest. Instead of the police needing to arrest them and wait for them until they are admitted to the Emergency Department, there is now a designated place or center where the police could bring these people that are more properly equipped to give them assistance. Furthermore, “this model demonstrates the importance of peer support in crisis and recovery systems and their ability to serve individuals more effectively than in emergency or police departments.”

Living Room Model in Skokie, Illinois

The Living Room Model is also making its mark in Skokie, Illinois as it focuses on tackling common issues that individuals in a psychiatric crisis might face when being brought to an Emergency Department. In addition, it operates in a way that creates solutions to combat those targeted issues by providing “immediate, client-centered, and recovery-oriented services.” Looking further into the common [issues](#) individuals with a mental health crisis face at the Emergency Department consist of long wait times before an evaluation, shortage of beds in the Emergency Department, and difficulties getting insurance coverage for mental health related issues, or just the issue of not having insurance at all. Though the goals for the Living Room Model are still centered around creating support for those going through mental health issues, the set-up is flexible enough to be presented in different ways. In Skokie, the Living Room Model is more patient centered, recovery-oriented services, with a home-like community setting that emphasizes autonomy, hope and respect.

Since implementing the model, it has yielded approximately \$550,000 of savings for the State of Illinois”. Within this model, they try to refer to the participants as “guests” it has been found that “Guests of The Living Room are overwhelmingly individuals with Medicaid or no insurance of any kind. Each ED deflection represents a savings of approximately \$2,631”. Not only is it helping individuals receive proper care without all the hassle of law enforcement, but it is also proving to be cost effective because the State no longer must spend large amounts of money on these individuals who wait all night in the ER and still don’t receive proper care. Not only has it an impact in terms of funding, but these types of programs have left lasting impacts on the individuals themselves. An individual who has first-hand experience of the living room model made it clear about his being sent to the ER, by saying “I’m sick of going to the ER. At the ER, it’s very frantic, there are no choices. Meanwhile his experience at the crisis produced a much different attitude as he says, “Here I was able to talk and calm down. I might have even ended up in the hospital for a week”. Being able to hear the gratitude from people who are battling mental health issues, demonstrates the direct impact and success these programs are producing.

Programs with “Living Room Models” are producing a “[93% deflection rate](#),” which means that a visit does not result in a trip to the Emergency Department and instead with the guest returning to the community when sufficient relief from distress has been achieved. As with any new program that is up and coming, there is still a lot of room for improvement to really solidify what is proven to be effective and beneficial to the parties involved. While the initial outcomes of The Living Room have been positive

thus far, “research is needed to more systematically understand and evaluate this alternative treatment environment.”

The Living Room was originally [funded](#) by a special project grant from the State of Illinois’ Division of Mental Health (DMH). Unlike services delivered in Emergency Departments, there are never any out-of-pocket costs for guests of The Living Room. The special project grant was renewed for a second year in 2012, but in order to ensure adequate long-term funding, additional revenue was required. Now, for a subset of clients, The Living Room bills Medicaid or Illinois’ DMH for crisis intervention services. Specifically, Medicaid provides reimbursement for Medicaid-eligible clients of the community mental health center in which The Living Room resides. Illinois’ DMH provides reimbursement for clients of the agency with no insurance of any kind.

OBJECTIVE 3 - ACCESSIBLE, CULTURALLY RELEVANT SERVICES AND TRANSLATION

The third and final objective of the mental health committee is to help make accessible, and culturally relevant services and translation. While existing research has suggested that mental health disorders do not vary significantly between different racial, groups, the [effects of mental illness do vary](#). Even if these individuals seek mental help, they do not remain engaged in outpatient services or use as many of the service units. [Factors](#) that contribute to these poor mental health outcomes include inaccessibility, cultural stigma around mental health, and lack of linguistic support.

Think Cultural Health

Sponsored by the Office of Minority Health, [Think Cultural Health](#) is an online resource created in 2004 with the purpose to provide continuing education resources regarding culturally and linguistically appropriate services (CLAS). Some of the programs that Think Cultural Health offers include, but are not limited to: Behavioral Health, Disaster, Deployment Refresher, Nurses, Maternal Health Care. These e-learning programs are free and can be completed remotely. Upon special requests, there can be in-person training. Depending on the states listed on their website, the courses can be counted towards educational credit. While Massachusetts may not be one of the states that offers the courses to also be used as educational credit, courses can still be completed for participation merit and to spread awareness overall.

Liberty Language Service

Another online resource is Liberty Language Service, an agency that offers training and certification testing of interpreters in the healthcare setting. They offer both individual and organization training with prices ranging from \$400-\$600 depending on the program. Exact prices are not listed as the interested party would have to contact the company via email to get a quote. Payment plans are offered through monthly installments if paying the total price upfront is not feasible. Once individuals are trained and certified they may go on to work in healthcare settings such as hospitals and rehabilitation centers for example. Those who are already trained and certified as interpreters can take other courses they offer as mini sessions, such as “Avoiding Common Mistakes in Medical Interpreting” at a more affordable price of \$35. It is recognized that paying \$400 to get certified as an interpreter may not be financially realistic for certain individuals in the Worcester area, therefore perhaps it is possible that grants could be used to sponsor interested and eligible members of the community for this. Currently, there is a reduced program cost of \$360, rather than of \$400, but it is not listed how long this will last. This Professional Medical Interpreter training offered is a self-paced online, where individuals will complete

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40 hours of training over the course of 2 months. Liberty’s interpreter training meets any job or certification that asks for a minimum of 40 hours of training.

[Bridging the Gap](#) is also a course offered by Liberty Language Services. It differs from the above course in that this is taught in person by a live instructor with set dates and times individuals are expected to come. The cost for this course is \$600. Trainings are taught in English, and the [syllabus](#) can be found on their website as well. Upon certain requests or instructors, resources can be provided to help an individual translate the medical interpretation into their native language.

In order to enroll, a short [Enrollment & Information Request Form](#) must be completed, and then a member from Liberty will reach out afterwards. Regardless of the self-paced course or the live instructor on zoom, completion of either courses can be applied for certification through National Board of Certification for Medical Interpreters (NBCMI) or the Certification Commission for Healthcare Interpreters (CCHI).

Action Items

We recommend applying for the Connected Care Pilot program or examining how recipients of the most recent grant - Boston Medical center & Boston Community medical group are using it. Collaboration with the recipients of this program could also be fruitful. Implementation of cultural humility to those in the community and to groups working with the CHIP could be done by hosting an event in Worcester to encourage participation and spread awareness. “The U.S. Bureau of Labor Statistics estimates that, between 2019 to 2029, the employment of interpreters and translators is going to grow much faster than average. As society becomes more diverse and the economy more globalized, multilingual people with strong communication skills are becoming increasingly in-demand” ([Liberty 2022](#)). Sponsoring individuals from Worcester to get certified could have broader long-term effects than just helping the CHIP itself. The priority populations intended for these action items and implementation strategies include minorities, Limited English Proficiency (LEP), individuals facing substance abuse, children (indirect and direct impacts they face), and low-income families.

<https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out>
https://www.mhanational.org/issues/position-statement-59-responding-behavioral-health-crises#_edn7

MOBILIZING NUTRITION SERVICES TO COMMUNITIES

Worcester residents experience limited access to community health services due to barriers. Focusing on nutrition, residents identified a need for better access to food, nutrition information, and SNAP, HIP, and WIC enrollment.

OBJECTIVE 1: MOBILIZED UNITS AND SYSTEMS FOR FOOD ACCESS

Improving accessibility to food for vulnerable populations in Worcester is essential. Existing programs that have been successful in the greater Boston area could be utilized similarly in Worcester. Increasing federally funded meal programs for summers, after school programs, and in school programs will increase the availability of nutritious meals for children and adolescents.

About Fresh: Fresh Truck and Fresh Connect

[About Fresh](#) is a non-profit organization that operates two programs: Fresh Truck and Fresh Connect. Fresh Truck uses school buses as mobile fruit and vegetable markets. Their mission is to mobilize and provide fresh, healthy, and affordable foods to low socioeconomic households and communities. Fresh Truck stops at the same places in Roxbury, Dorchester, Mattapan, and other communities at the same time every week; some of the stops allow online pre-ordering for pickup.

In 2018, Fresh Truck served 13,436 households, with \$630,431 worth of food being delivered to the targeted families ([2018 Annual Report](#)). Moreover, in 2020 there were 29,013 healthy food transactions with Fresh Truck, which included \$904,921 worth of fruits and vegetables ([2020 Annual Report](#)). Fresh Truck shoppers have stated that Fresh Truck is convenient and helpful, and that they are eating healthier ([2018 Annual Report](#)). Fresh Truck has been able to continue with their mission by receiving funding from donors such as the American Heart Association, Blue Cross Blue Shield MA, Brigham and Women's Faulkner Hospital, and Massachusetts General Hospital ([2018 Annual Report](#)).

[Fresh Connect](#) is About Fresh's second program and it works with healthcare providers and organizations invested in health to provide Fresh Connect debit cards to food-insecure patients. These debit cards can be used at select grocery stores, mobile markets, farmers' markets, and online to purchase eligible healthy foods. Fresh Connect debit cards are funded by healthcare institutions, such as Boston Medical Center, Brigham, and Women's Faulkner Hospital, and Brigham Medicaid ACO. In 2020, Fresh Connect reported that \$219,709 was spent on healthy food by recipients of Fresh Connect debit cards ([2020 Annual Report](#)).

Although Fresh Truck and Fresh Connect have been successful, they are still somewhat limited in the communities that they serve. Fresh Truck is only accessible in Boston neighborhoods and Fresh Connect is only accessible at select locations, but there may be room for expansion into Worcester.

Improving Child and Adolescent Food Access

Although federal nutrition programs are currently available to Worcester, improvement of their utilization could largely increase food access for children and adolescents, specifically. After school programs which operate outside of school hours and are operated by a school district are eligible for federal reimbursement to provide meals to the children involved in these activities through the [After School Snack Program](#). Additionally, the [Child and Adult Care Food Program](#) provides similar reimbursements to care facilities which provide nutritious foods to those utilizing them. The [Special Milk](#)

[Program](#) provides those facilities that are not already utilizing federal meal service with additional milk. Finally, the [Summer Food Service Program](#) provides free healthy meals to children and adolescents of low-income communities during the summer, when school meals are not accessible.

Each of these programs are already accessible to the Worcester community; however, increased utilization could substantially decrease gaps in food access for youth and adolescents. It is important to remember that specifications can change for each program. For example, the qualifications for facilities to receive reimbursement from the After School Snack Program include the age of children being served, the time of day that the program takes place, location of the school, and distinction of extracurriculars. Additionally, Child and Adult Food Program funding is only possible for facilities that are nonprofit, whether public or private, outside school hours, and are licensed. The Special Milk Program only serves facilities that are not already receiving federal funding for meals. Finally, the Summer Food Service Program requires meals to be distributed in specific locations, recorded properly, and ultimately operated from a site which keeps excellent track of its meals.

Although these requirements may seem tedious, once each program’s expectations are met, schools and other facilities will be able to provide meals to those in need during vulnerable times of the day and year. Because these programs are already accessible to Worcester, there is little work that would need to be done to utilize them.

The goal of utilizing these youth and adolescent meal programs would be to receive full reimbursement for meals provided; however, some caveats in funding may leave certain care centers and extracurricular groups with a partial cost of providing meals. In these instances, programs could be reevaluated and altered to better meet the criteria of their respective government program, or funds may be raised on a donation basis.

OBJECTIVE 2: MOBILIZED UNITS AND SYSTEMS FOR NUTRITION INFORMATION

Making nutrition information accessible is important for improving the health of underrepresented populations in Worcester. Key components of increased accessibility include making information available online, in multiple languages, in safe spaces, and mobilized.

CitySprouts

[CitySprouts](#) is based in Cambridge, MA and is funded through generous donations and grants and focuses on educating elementary age children on healthy dietary patterns and building school gardens. This program serves more than 4,000 school children, aged 11-14, more than half are of low-socioeconomic status. CitySprouts is a hands-on program, they offer courses over the summer. Children can partake care for the school garden, earn income, and learn valuable nutritional information. CitySprouts hands-on program limits the reachability of its benefits to only individuals physically attending. The program can implement strategies that increase the reach of their interventions.

Cambridge in Motion

Cambridge in Motion is based in Cambridge, MA and is funded by the Massachusetts Department of Public Health, focuses on promoting healthy eating to residents in Cambridge by offering nutritional information guides and recipes in a variety of languages on the Cambridge Public Health website. They also promote healthy eating through their [Health Markets Program](#) which partners with convenience stores in the area to offer healthy and affordable food and drink options to customers.

Cambridge in Motion is not very well advertised and only those specifically looking for the program will have an easy time finding the website. Advertising the program in different ways such as through social media and at schools would help expand the program’s reach. Additionally, possibly putting up the nutritional information guides and recipes in the convenience stores the program partners with would be a beneficial way to educate the public while they are buying food.

Community Servings

[Community Servings](#) is a 501c3 nonprofit organization providing nutrition information and education, as well as specialized meals. They serve individuals and families living with illness, with about 4000 clients in Massachusetts. Community Servings is still a relatively new program; they are currently involved in two NIH-funded studies studying the effectiveness of their programming.

There are two main forms of nutrition information provided by Community Servings, online nutrition resources and nutrition education. The resources are tailored to fit different dietary needs, including specific medical conditions, vegetarian-friendly, and for older adults. In terms of more direct nutrition education, Community Serving holds classes, presentations, and workshops as well as individual assessment and counseling. However, it was not clear how exactly to access some of their more involved programs, like the counseling sessions and workshops, which may cause potential clients to not fully utilize the program.

This is a relatively narrow program, as it is aimed to be a community-based program, so it is also working at a relatively small scale. They do focus on specific vulnerable populations, skewing towards the elderly, with their focus on people living with illnesses such as HIV/AIDS, diabetes, kidney disease, etc.

OBJECTIVE 3: MOBILIZED UNITS AND SYSTEMS FOR SNAP, HIP, AND WIC ENROLLMENT

The Supplemental Nutrition Assistance Program (SNAP) provides low-income people with financial support on an EBT card to purchase nutritious food. The Healthy Incentives Program (HIP) is a Massachusetts-specific program that incentivizes people to use their SNAP benefits to purchase healthy food from farm vendors (that accept HIP) by putting money back onto their EBT card. WIC provides low-income Women, Infants and Children up to age 5 with nutritious food supplements. Making enrollment for these programs more accessible, such as by offering information in multiple languages, allowing applicants to apply in a variety of ways and at different times and locations, and explaining the information in a way that is understandable to anyone who reads it, is important for improving health in Worcester. Three main barriers were found in a [2005 study](#): time, confusion around eligibility, and perceived stigma. Especially for working parents, attending mandatory meetings can be a huge barrier given the restrictions of hours of operation. Suggested actions therefore include adding evening appointments and appointments on Sunday. Another recommendation was wider outreach and advertising of WIC.

City of Cambridge

On the City of Cambridge website, residents can find lots of information about SNAP, HIP and WIC, and how to apply to these programs. The City of Cambridge website also hyperlinks to the Department of Transitional Assistance website where people can take a survey to find out if they are eligible to take part in the program. People can apply for SNAP, a federally funded program that serves around 8,000 Cambridge residents, on the City of Cambridge website, in-person (multiple locations around Cambridge), through the mail, or by fax. The website also provides a few programs that help people

apply for SNAP. The Margaret Fuller Neighborhood House hosts sessions online or over the phone, and the Cambridge Economic Opportunity committee provides help in-person at Cambridge City Hall, over email, and through an online questionnaire on their website.

People who live in Massachusetts and receive SNAP benefits are automatically signed up for HIP, which is a program that relies on donations from organizations to fund it. About [91,000](#) households in Massachusetts use HIP. The Cambridge, MA website has a list of farmers markets in Cambridge where people can use HIP benefits. For WIC, also a federally funded program, the Cambridge Public Health website lists stores where WIC benefits can be used. The Cambridge Health Alliance website provides information on WIC including how to apply.

While it's great that there is so much information about these three programs, it would be easier for people to access the information if it were all available on a single website. Also, a lot of the information, such as which vendors people can use HIP benefits or the surveys that help people determine if they are eligible, are only offered in English and Spanish.

Nearly [660,000](#) residents in Massachusetts are eligible for SNAP but are not enrolled, and only about 54.9% of WIC-eligible residents in Cambridge are on the program, so making it easy to find out about these programs and how to apply to them is important. Also, places that offer in-person or over-the-phone help for applying to SNAP are only available on the weekdays during limited hours.

Streamlining WIC

[Streamlining WIC Certification Practices](#) was a project conducted in 10 different states across the country by the Center on Budget and Policy Priorities in conjunction with the Altarum Institute. They implemented multiple programs across the country with different specific goals aimed at improving WIC.

In California, video conferencing alternatives to in-person visits for recertification were implemented through one of their 83 local agencies. Data showed a 4.5% increase per month in WIC benefit issuance among participants offered videoconferencing versus those who were not. Surveys of participants related increased convenience and high ease of use of the service. The program's cost was \$10 per webcam and \$1,500 per quarter for a video conferencing platform. Minnesota's Fillmore County WIC office implemented a smaller-scale video conferencing option into their program, with 91% of survey respondents indicating it would make participation easier.

Vermont offered telephone calls as opposed to in-person visits for WIC mid-certifications through three local agencies. These telephone appointments were kept, versus no show, 80% of the time, compared to in person visits which were attended 49% of the time during the same year. Additionally, phone calls save travel time and costs, with about 40% of families saving 45 minutes or more.

Idaho aimed to shorten time needed for WIC certification by enabling WIC offices to check Medicaid status (conferring income eligibility for WIC) in an online portal before or during appointment. 80% WIC participants also have Medicaid, which could be checked via a <1 minute phone call prior to the appointment to save time. WIC staff were given access to and trained on usage of the Medicaid portal in order to complete these checks. Additionally, WIC applicants did not need to have their Medicaid card on them or even know their status.

Multiple other agencies in other states implemented a similar streamlining process using electronic documentation to check for WIC eligibility. Colorado authorized WIC staff access to immunization records, leading to WIC temporary to permanent certification rising from 43 to 65% after staff training. Minnesota also used immunization records in addition to allowing participants to email in eligibility documents. Greater Baden in Maryland purchased a platform that allowed participants to submit documentation prior to certification appointments. These various methods save time as well as make it easier on families and staff.

Action Items

1. To improve food access in Worcester, working with About Fresh to launch Fresh Truck stops in Worcester could prove beneficial. If that is not possible, creating a similar mobile fruit and vegetable market would improve food access. Lastly, increasing awareness of Fresh Connect and the number of locations in Worcester that accept Fresh Connect debit cards would improve food access.
2. Increasing utilization of existing federally funded programs such as After School Meals, Child and Adult Care Food Program, Special Milk Program, and Summer Food Service Program is a manageable and effective way to provide children and adolescents with increased access to meals throughout times of the day and year that are particularly vulnerable.
3. Expanding nutritional education programs to reach a broader audience and improving the way information is communicated will increase the usage of these programs. Also increasing the accessibility to nutritional information through online videos and guides will benefit those who can't attend in-person.
4. Utilizing technology for government programs such as WIC, SNAP, and HIP will increase certification and usage. For example, authorizing WIC staffs' usage of databases such as Medicaid and immunization records, and implementing phone calls and video conferencing options for applicable points in the [re]certification process.

MOBILIZING PHYSICALS AND SCREENING SERVICES TO COMMUNITIES

Based on survey data the City of Worcester through the Greater Worcester Community Health Improvement Plan, is working on mobilizing healthcare by using different modes of healthcare. The objectives are to mobilize units and systems for access to obtaining low-barrier physicals, access to obtaining quick preventative screenings, and assistance with telehealth set up to increase access to primary and preventive care.

OBJECTIVE 1: ACCESS TO OBTAINING LOW-BARRIER PHYSICALS

Mobile Health Clinics (MHCs) deliver care directly to neighborhoods by providing a range of primary care interventions out of a van, including physicals, immunizations, imaging, and screenings. MHCs allow providers to be adaptable to the specific needs of the target community at little to no cost to the patient while improving health outcomes in underserved groups and decreasing emergency and urgent care costs for hospitals and clinics. MHCs are a great intervention for Worcester to implement in order to meet goals regarding target groups and guiding principles.

MHCs also bring providers who share a culture and language with the residents of that community, optimizing reception and utilization of the service. Furthermore, by making primary and preventive care more easily accessible, we can increase the quality of life of patients, increase their lifespan, and prevent or effectively manage chronic disease. We can promote health and the importance of regular screening amongst children, adolescents, and adults alike, as well as providing care for those who are unstably housed. There are countless examples across the country of MHCs which increased adherence to regular care, the closest example being Boston University's MHC, the [Outreach Van](#), which provides health services and basic necessities to East Boston residents through the Boston University Schools of Medicine and Public Health.

From a financial perspective, it may seem that mobile health clinics are very costly to begin and maintain. However, research has been done by several organizations to evaluate the effectiveness of MHCs. According to the [Mobile Health Map Impact Report](#), MHCs significantly decrease costs associated with urgent and emergency room care—each MHC that exists results in 600 fewer emergency room visits per year. That means all the costs associated with those 600 visits are also eliminated. Furthermore, the report found that every \$1 invested into MHCs results in a \$12 return. A [peer-reviewed literature review](#) on the effectiveness of MHCs cited two programs with great ROI: [HABITS for Life](#), a 3-year mobile retinal screening program, had an [ROI of \\$15 dollars per dollar invested](#), while another, [Southern California Breathmobiles](#), a mobile pediatric asthma management clinic, had an [ROI of \\$6.73 per dollar invested](#). Both programs resulted in statistically significant health status improvement. While implementation of MHCs may require some financial investment, it is clear from this data that in the long term, MHCs will save money.

MHCs are not without their limitations. Along with associated costs, staff recruitment and retention, lack of continuity of care, and suitable location are all challenges that can make MHCs a difficult project to consider. However, there are a few solutions to effectively address these issues. The first is a partnership with UMass Memorial and UMass Chan Medical School. These partnerships will provide necessary funding, as well as the network that MHC staff will need when making referrals. Having a partnership with UMass Memorial also means that patient records can be stored, so they can be contacted to ensure continuity of care. These organizations can also incentivize physicians, medical

students, faculty and attending physicians, and allied health professionals to participate in staffing the MHCs. Lastly, partnering with community leaders and organizations, engaging the community in town halls and conversations, as well as community mapping can be done to ensure community buy-in and cooperation to help solve logistical issues.

OBJECTIVE 2: ACCESS TO OBTAINING QUICK PREVENTATIVE SCREENINGS

Rosie's Place:

Success: You can still be covered without insurance, and income-based assessments are done. Rosie's place provides services such as blood pressure check, blood sugar checks, HIV testing, physical exams for disability passes for MBTA are offered. This health center covers check-ups, pregnancy care, immunizations, prescriptions, and mental/substance abuse help. This center strives to meet needs for women struggling with poverty and homelessness.

Improvements: The overnight shelter provides a bed to 20 women for up to 21 days at a time. As this is a relatively short period of time, women seem to struggle to figure out a long-term solution after this period is up. Since this is a lottery-based system, sometimes enough beds are unavailable.

Consequences: Would positively impact Worcester by providing a safe environment where advocacy, ESOL classes, legal services, housing stabilization, food, essential hygiene services, shelter, and medical care can be given to vulnerable women. Help can be offered in person or online.

Funding: Rosie's Place relies solely on support of individuals, foundations and corporations and does not accept any city, state or federal funding. 86 cents of every dollar raised goes directly to services for women in need.

Physically Active Residential Communities and Schools (PARCS):

Success: It provided low-cost fitness and wellness services to the neighborhoods. The centers are staffed with students from IUPUI like from the kinesiology department. Members with low physical fitness will make use of an accessible fitness resource despite financial constraints.

Improvements: There is a need for affordable fitness options.

Consequences: It provides safe, accessible and affordable exercise opportunities. It addresses disparities in physical fitness and health.

Funding: PARCS is a partnership between the Indianapolis Public School (IPS) System and Indiana University (IUPUI).

Can Community Health:

Success: Private non-profit that offers medical, dental, psychological care as well as free rapid HIV and HEP C testing, regardless of financial situation, insurance status, or ability to pay.

Improvements: One possible improvement to this project would be expanding the doctors and clinics that are in the areas that this non-profit services. Many of the locations only have one location within a larger city which limits the number of people that can be seen within the clinic.

Consequences: If implemented in Worcester, this would expand access to care to individuals no matter their financial status. It would also provide access to free HIV/HCV testing to individuals as well as provide financial assistance for treatment for these viruses for individuals to test positive.

Funding: Federal Funding (Ryan White, HOPWA, and prevention programs), State Funding (Medicaid programs), Local Funding (donations and grants), HIP (High Impact Prevention) Funding, and HPC (Health Planning Council) Funding

CHOICES: Connecticut's State Health Insurance Assistance Program (SHIP):

Success: SHIP agencies empower, educate, and assist Medicare-eligible individuals, their families, and caregivers through objective outreach, counseling, and training to make informed health insurance decisions that optimize access to care and benefits. Free services are provided to Medicare-eligible individuals, families, and caregivers of all ages and income levels. CHOICES strives to provide outreach and education to all individuals in need of assistance, with particular attention to reaching individuals with disabilities, individuals who have low incomes, individuals who live in rural areas, and individuals whose primary language is not English. Eligibility Screening and application assistance with cost-assistance programs including Medicaid, the Medicare Savings Program, the Low-Income Subsidy/Extra Help Program. It is staffed by counselors who have received extensive training in health insurance issues. They can provide written and verbal information and can refer interested persons to trained counselors in local communities for one-on-one, in-person assistance as needed. CHOICES counselors are able to meet with seniors, persons with a disability and other Medicare beneficiaries or their families at various community sites.

Improvements: While affording coverage and care is a challenge for many residents, the group most likely to lack coverage are those whose incomes fall just above the threshold for Medicaid.

Consequences: An assistance program in Worcester could provide information and assistance necessary for residents to understand their rights, receive benefits that they are entitled to regarding health insurance and what kind of care it covers.

Funding: CHOICES is a partnership between the state's 5 Area Agencies on Aging (AAAs) and the Center for Medicare Advocacy, Inc. It is administered by the Department of Aging and Disability Services. The CHOICES Program (Connecticut's programs for Health insurance, Outreach, Information and Eligibility Screening) is designated as the official State Health Insurance Program (SHIP) for Connecticut. It is funded in large part by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Dept. of Health and Human Services.

OBJECTIVE 3: ASSISTANCE WITH TELEHEALTH SET UP

Successes:

Existing formats of telehealth exist that can help a variety of people remotely. Different successful transitions from in-person care to telehealth. [Chronic care management](#) to provide integrated primary care as well as improvements of various pitfalls including medication reconciliation and dialogue about effective home care of chronic diseases. [Provider-to-Provider models](#) that allow rural PCPs and specialist providers to work together to share knowledge. E-consults are asynchronous provider-to-provider models that allow for greater access between providers. [A program](#) was implemented utilizing telehealth that allowed specialists located in urban areas to connect with patients in rural long-term care facilities to provide improved care to patients with chronic conditions. [Home monitoring](#) can engage patients in their homes between medical visits for effective home management. Emory university utilized this and found improved readmission rates and decreased ER evaluations. [A study shows based in California](#), telehealth utilization increases in the Hispanic and low-income group due to low cost and time flexibility during Covid.

Improvements:

Currently in Worcester, Telehealth is not easily accessible for patients due to various reasons. [Worcester Free Care Collaborative](#) (WFCC) has ended telehealth clinics due to a low demand beginning September 1, 2021, however in-person visits are available at multiple clinics. Increased Telehealth access by promoting Telemedicine set-up in local primary care offices or increasing awareness to residents can improve primary care and chronic condition care for the people of Worcester.

Consequences:

Reintroducing Telehealth can improve primary care and long-term care for patients, as well as increase access to care for patients with difficulties with transportation or need care from providers at a long distance.

Funding:

Government programs exist to help fund set-up and implementation of telehealth. A program that could be a good fit for Worcester is [Family Planning Telehealth Infrastructure Enhancement and Expansion Grants](#), which provides one-time funding to expand and enhance the telehealth infrastructure and capacity of their service delivery networks. Various funding opportunities exist for various goals regarding telehealth. [Massachusetts FQHC Telehealth Consortium](#) has funding opportunities to enact telehealth infrastructure in various communities, especially to address racial, healthcare, and digital inequalities.

Action Items:

To increase access to low-barrier physicals and primary care, we recommend:

1. Collecting data through community mapping to determine the neighborhoods that would benefit the most from a mobile health clinic
2. Identify the budget that will be required to start and maintain MHCs.
3. It could be helpful to contact organizations who have effective MHC projects already for guidance, such as BUSM's Outreach Van Project

Boston University Initiative on Cities

4. Creating and/or continuing partnerships and generating buy-in from UMass Memorial, UMass Chan Medical School, and local community leadership will help to eliminate many problems that are associated with starting and maintaining MHC service.
5. We also recommend that UMass Chan's current WFCC program, as well as CHIP's mobile COVID-19 vaccine distribution program gather data on their return on investment (ROI) and effectiveness, especially analyzing the extent to which emergency room visits and critical care needs were decreased, and the savings from this.
6. Use existing models to implement chronic care services such as blood pressure checks, blood sugar checks, and physical exams.
7. Apply for existing funding opportunities for implementation of telehealth infrastructure
8. Inform local healthcare providers about the impact of telehealth applications on patient care

IMPLEMENT TRAININGS ON PRINCIPLES OF ANTI-RACISM, LGBTQIA+ ACCEPTANCE, CULTURAL HUMILITY, AND EMPATHETIC COMMUNICATION

When surveyed, many of the participants in the Community Conversation on Health Education and Literacy expressed experiencing explicit bias and racism from service providers. As a result, the CHIP plans to implement training on principles of anti-racism, LGBTQIA+ acceptance, cultural humility, and empathetic communication. The objective is that organizational funders, leaders, and employees will participate in routine anti-racism and trauma-informed care training led by a facilitator most suited for their current needs. These trainings can help service providers learn cultural humility and empathetic communication and apply these skills to their work. We looked at various trainings and analyzed them for efficacy, improvements, and successes. Some definitions to know are:

- **Cultural Humility:** Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.
- **Empathetic Communication:** In the context of a clinical encounter, empathetic communication refers to cognitive empathy and involves several discrete steps, including: sensitively recognizing a patient's verbal and non-verbal cues of distress or difficulty, mindfully imagining this unique experience, and offering a verbal as well as non-verbal expression of this understanding

OBJECTIVE 1: DIVERSITY, EQUITY, AND INCLUSION TRAINING

Culture Change Initiative, Albuquerque, NM

In 2019, employees of the city of Albuquerque participated in racial equity workshops and other training that included working with the LGBTQ community, and disability communities. The mayor appointed a Culture Change Leader to develop a training program for city employees. A Culture Change Initiative was launched, and they contracted with local organizations and the People's Institute for Survival and Beyond to develop and deliver the training. Monthly sessions were open to all city employees, and overall, 1,500 city employees received training.

The Culture Change Initiative (CCI) delivered training to 1,500 city employees from 2018-2020, with 82% of those participants saying they would recommend the training to a colleague. The CCI was able to use both local resources, and a larger organization to develop and inform the trainings they used, which allowed them to address a wide range of topics. Using community members and employees who have valuable lived experiences or education to facilitate discussions was also important to the CCI's success in this initiative. The CCI came out with a progress report, and the post-workshop survey results showed that 87% of participants felt that they learned something new, 97% said the training was applicable to their lives personally and professionally, and 96% of participants reported that the trainer's knowledge was above average/excellent. The trainings were also a way for different city departments to interact with each other and build connections between departments. Participants especially responded to small group dialogues and requested that there be more of these in future training.

The CCI report identified some areas for improvement in their report, such as surveying participants on what topics they want included in the future, developing some sort of acknowledgement of their

participation, and inviting community members to participate in workshops and training. The CCI also recognized that larger changes need to be made in order to accommodate making DEI training a regular part of how the city government functions. This includes getting city departments to regularly budget for DEI training opportunities and resources and assisting departments in creating equity teams that can help continue DEI work in their respective departments. Ideally, DEI work becomes a core part of every department, and part of this would also be making this training mandatory. It was suggested that special sessions based on affinity groups be added as well. Small group dialogues were positively received by most participants, so using this format for discussion seems best.

The CCI had a positive impact on the city employees of Albuquerque and was able to develop and implement a training initiative successfully. Using community resources and an experienced outside organization to help develop training seems to have been an effective strategy for the CCI. This allowed for them to invite community members to be facilitators and speakers at their training, which can draw people into participation.

OBJECTIVE 2: IMPLEMENT ANTI-RACISM TRAINING FOR COUNSELORS (EMPHASIS ON TRAUMA OF RACISM)

The American School Counselor Association has many resources for counselors to address racism in their community for students and their families. The trauma of racism is a highlighted point in the CHIP and it is very important to acknowledge the mental impact of the trauma of racism on individuals. There is a shift from trauma-informed care to [healing-centered engagement](#). This is because the focus on an individual's trauma can make them feel like that is all a counselor sees in the individual, while healing-centered engagement is geared towards the person has been through trauma.

This program focused on the practice of healing centered engagement (HCE). HCE is strength based, advances a collective view of healing, and re-centers culture as a central feature in well-being. Researchers have pointed out the ways in which patients have redefined the terms used to describe their illnesses in ways that affirmed, humanized and dignified their condition. What is different about this technique and why it works is because healing centered engagement is explicitly political, rather than clinical. Researchers have found that well-being is a function of the control and power young people have in their schools and communities. When people advocate for policies and opportunities that address causes of trauma, such as lack of access to mental health, these activities contribute to a sense of purpose, power and control over life situations.

The first part of this training is focusing on being culturally grounded and viewing healing as the restoration of identity. Healing is experienced collectively, and is shaped by shared identity such as race, gender, or sexual orientation. Healing centered engagement is the result of building a healthy identity, and a sense of belonging. Step number two is being asset driven and focus on the well-being we want, rather than symptoms we want to suppress. This is because while it is important to acknowledge trauma and its influence on young people's mental health, healing centered strategies move one step beyond by focusing on what we want to achieve, rather than merely treating emotional and behavioral symptoms of trauma. Step three is to build empathy because fostering empathy allows for young people to feel safe sharing their experiences and emotions. The process ultimately restores their sense of well-being because they have the power name and respond to their emotional states. The last step in HCE is to build critical reflection and take loving action. Without an analysis of these issues, young people often

internalize, and blame themselves for lack of confidence. Critical reflection provides a lens by which to filter, examine, and consider analytical and spiritual responses to trauma.

To improve this program, we suggest having multiple facilitators that represent those they are counseling. Cost was the primary reason this wasn't done initially and may not always something schools and communities can afford, but only having one facilitator may not create the desired connection.

The ASCA has many free resources including several webinars and training videos. Implementing HCE may involve increasing the diversity of a space's counseling team where another person may have to be hired. While this may seem costly the impacts show a more holistic approach to healing from trauma and emphasizes to the counseled individual that healing is a journey not an end goal

OBJECTIVE 3: HOSPITAL ADMINISTRATION TRAINING

Explicit and implicit racism does not stop in medical practices. Many providers and administrators hold racial biases that will impact an individual's health outcomes. Physicians usually have these biases due to the fast-paced environment that is most health facilities. This results in providers making quick assumptions about a patient to get them care as quickly as possible. Unfortunately, these assumptions can cause the patient to receive impersonalized care that is not the right course of action for them. This causes Black patients to mistrust medical institutions due to the worse and sometimes harmful care they receive due to the implicit and explicit biases they face when dealing with a health provider. This can result in minority people not seeking medical attention when they need it, further expanding the gap of health disparities between white, Latinx, and Black Americans.

A program that directly addressed training in medical practices was [Alina Health in Minneapolis, MN and Health Catalyst](#). After seeing the data that doctors were disproportionately not referring African American patients to hospice the team who found the data started raising awareness to the hospital's providers. This prompted discussion with the providers about the disparity and what the causes of it were. After some push back from the providers about the bias and implementations that could be taken to minimize it Alina Health decided to create a mandatory implicit bias training for their employees. This then inspired Health Catalyst, a healthcare data analytics company, to address their implicit biases with training despite not interacting with patients.

They had several points of action that helped them successively give anti-racist training.

1. Their first step is to identify data of health disparities to begin addressing implicit bias.
2. They made sure that the classes were mandatory at the health center and those who took the class were given a certification. In order to be accessible, they held 3 separate sessions.
3. They involved all members of the team, not just physicians, as the patients' perspective can provide places and contact points where implicit biases can impact their care.
4. They made sure leadership was involved and trained.
5. They made sure to provide clear takeaways from the training that is tailored to the group so they could easily implement strategies to fight their implicit biases.
6. They encouraged discussion after the training to debrief what had been eye opening and how they wanted to implement what they learned in their daily practice.

The impacts of the training were evident by how after the mandatory teaching providers who were hesitant connected with the material and realized they have to change how they interact with their

patients. However, the program did need improvements after being done at Health Catalyst; they want to expand the program to be more inclusive to other minority groups, not just African Americans. Like most of our research funding was not provided but after some personal research it was found that the program has a health equity manager who works for the company. If a full time position is not something plausible it seems that diversity consultants are often hired at an hourly rate from \$100-\$300+ (SHRM.org). There also is an organization called Re-envision consulting for Worcester Chamber of Commerce. Their website did not provide what they charge but it could be a good local resource.

Implementation Strategies

Implementation strategies that seemed to work for the trainings we looked at were:

1. Ensuring that the team leading diversity training is diverse and demographically reflective of the population of their trainees and the communities they are serving
2. Teaching both explicit and implicit racism as well as how they both manifest
3. Not only lecturing trainees on racism but having a conversation about their experiences and how they as individuals can apply anti bias training
4. Surveying participants for what training they might like to see in the future is valuable for making participants feel like they are being trained in skills that they want
5. Encouraging regular budgeting for training can transition these trainings to a normalized, regular, and frequent process

BROADEN AND SCALE RESOURCE NAVIGATION AND DEVELOP RECRUITMENT, RETAINMENT, AND ADVANCEMENT STRATEGIES TO DIVERSIFY THE WORKFORCE

The Coalition for a Healthy Greater Worcester conducted a survey in which 50.9% of the participants reported having experienced bias or discrimination (CHIP Document). [Studies](#) have shown that racial-based bias and discrimination can be minimized when there are racial similarities between patients and their providers. For this reason, it is important to work towards diversifying the healthcare workforce. As stated by a participant of Community Conversation on Health Education & Literacy, a big area of concern is focused on the advocacy of immigrants and English learners in healthcare settings. Therefore, it is a goal to prioritize these communities and ensure their access to a healthcare staff understanding of their diverse backgrounds and needs. We have outlined and analyzed various employment diversification models built to tackle goals like ours. Additionally, another area of focus for our committee involves developing multi-resource navigation and assistance tools to better serve the diverse community of Worcester. Two navigation systems we found frequently mentioned in literature are the Guided Care Model and the Sooke Navigator project. [The Guided Care Model](#) places an emphasis on providing team-based care to patients while the [Sooke Navigator Project](#) emphasizes community-building between providers and their patients. Both systems aim to provide patients with the appropriate tools to navigate their healthcare needs in order to eliminate any barriers to care. In the following section we outline how different organizations are already tackling these goals.

OBJECTIVE 1: DEVELOP A CENTRAL HUB FOR ACCESSIBLE RESOURCES AND NAVIGATION OF CARE

[*VA hospitals \(Minneapolis, MN researchers\)*](#)

This program found success in measuring specific risk factors for health outcomes and targeting care based on that. There was also the implementation of coaching patients for better communication with their provider, where patients could role-play appointments or have someone attend the visit with them to better ensure appropriate care and understanding between the provider and patient. The success of using home visits was identified through the use of high intensity care models. Overall, there were improvements in health outcomes and a decrease in hospitalizations when the care models were used. There could be a more standardized measurement for patient communications with their provider, as well as more methods of evaluation of success of the model, specifically using patient centered surveying.

There was a lack of patient identified experience so it is not clear whether patients would have reported their care to be improved, or what aspects of the model were more impactful to them. It was also found that the care coordination interventions were most effective for patients who had less severe conditions. There was also a lack in standardization specifically related to the tools used for communication.

Because this model was implemented in a VA hospital the funding came from the Department of Veteran's Affairs.

[*John Hopkins Community Health Partnership - East Baltimore, Maryland*](#)

Patients identified a feeling of receiving a higher level of care throughout the program as opposed to the previous model which was more distanced. Specifically, the use of health behavior specialists who implemented at home visits for care in order to combat barriers to care patients may have had. These

specialists created a more personalized connection to patients and their care enabling better perception of care received. Program also used a risk care model which identified patients who were most likely at risk for rehospitalization. This leads to improved health outcomes and a decrease in spending. The “care coordination model” highlighted the importance of connecting communities with their physicians through a mediator. Overall, the project impact found that the implementation of the care model allowed for a decrease in Medicaid groups re-hospitalization, medical costs, as well as lower spending and improved health outcomes.

Other measures aside from rehospitalization rates and overall spending costs should be evaluated for a success level. There is a possibility for measuring levels of testing, community care, and physician visits. It should also be noted that this model may not be generalizable to larger populations because the group specifically used was specific to Medicaid and Medicare participants.

The largest drawback in this intervention was the loss of funding for some community care components which were some of the most important aspects in the model. The importance of community connections within individual care is what was the most impactful part for the patient's personal feeling of having a better level of care. Without home visits there are larger barriers to care access reintroduced towards the patient population.

The main source of funding was the Health Care Innovation awards which is given by the US Department of Health and Human Services. The project received a governmental grant for \$19.9M and the patient population was those on Medicare and Medicaid, so the cost of procedures and reimbursement differed from private insurance.

OBJECTIVE 2: DEVELOP RECRUITMENT, RETAINMENT, AND ADVANCEMENT STRATEGIES TO DIVERSIFY THE WORKFORCE

With this objective in mind, we have investigated Pipeline Project Human Services Career Support Programs. This is so we can create a career pathway with skill building, wraparound support and mentoring for immigrants, refugees, and others wishing to launch a career in the Human Services field.

[San Diego Workforce Partnership's Bridge to Employment in the Healthcare Industry Program Success](#)

In the study of the San Diego Workforce Partnership's Bridge to Employment in the Healthcare Industry Program. This program is aimed to help low-income adults, including Temporary Assistance for Needy Families (TANF) recipients, enroll in and complete occupational healthcare training and find healthcare employment. In order to measure the effectiveness of this study, the program used an experimental design with 507 members in the treatment group who had access to this program and 500 members in the control group who did not have access for the span of 3 years.

One finding from this program is that it increased healthcare credentials by 16 percentage points and increased exam-based certifications by 24 percentage points between the two groups. Another success is that this program also increased employment in healthcare by 10 percentage points but did not change the overall employment rate.

Due to the imprecision in the earnings and educational costs, the program was not able to determine whether the benefits of the Bridge program outweigh the costs. This program was good in theory but did not have much impact on the vulnerable population of low-income adults. This Bridge program developed recruitment strategies to be aimed towards a vulnerable population to diversify the workforce. There may not have been sufficient resources provided for this group in order to thrive in this program such as providing monthly stipends to assist with their personal needs outside of this program. The case management services should serve the participant holistically rather than just employment. In terms of retention strategies, the employment services for post-training is a good idea but for better retention the program should be with the participant until employment is found. Cost/funding - This Bridge to Employment program is part of the Pathways for Advancing Careers and Education (PACE) which is funded by the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services.

Seattle Parks and Recreation Program

This program provides employment for homeless people. This includes training and learning how to work in a structured program that provides job skills that benefit their environment. It's a group of five people with one experienced staff supervisor.

Each corps member signs a contract to one year of employment, education, and life skills development. The groups work five days per week and study after hours at the Conservation Corps Learning Center. Each corps member is provided case management and other services necessary such as mental health counseling or drug and alcohol recovery services. At the end of their enrollment, Conservation corps help each member move into permanent employment.

Within a year of the program, more than half of its members were able to complete it and better their living environments. Over 80 percent walk away with stable shelter, and over 90 percent walk away with long-term employment with an average pay of \$15.00 per hour. Since the start of the program in 1986, the Corps has introduced over 800 people to be a part of the community. The program has a yearly cost of \$4 million and doesn't depend on public funding. It covers 75 percent of its cost by completing work for the City and seeking grants.

Implementation suggestions about care models and hiring practices/advancements strategy:

Some advancement strategies are a better behavioral health workforce that best serve their employers for recruitment and retention rates but also to diversify the workforce. Virginia Department of Behavioral Health and Developmental services provides leadership training to applicants from both state agency and local clinical behavioral health staff. In a behavioral workforce retention survey by the University of Michigan Behavioral Health Workforce that the challenges of recruitment and retention are from discrimination in the workplace to BIPOC folks therefore, reducing discriminatory practices can provide opportunities for advancement.

Another strategy is to tailor educational pipeline programs to support underrepresented communities. Alaska offers remote learning opportunities for a bachelor's program in social work to best support students who live in rural Native Alaskan communities.

Furthermore, providing financial incentives to recruit and retain BIPOC folks in the workforce is another strategy to add. Oregon Health Authority aided in a law, American Rescue Plan Act Funds, to include

retention bonuses, tuition assistance, childcare subsidies, and more to obtain licensure and stipends for supervising clinicians.

The implementation strategies that the Seattle Parks and Recreation program established includes listening sessions, online open houses, park ambassador surveys, community engagement ambassador surveys, line of business engagement activities, and a central email address. Listening sessions are more geared towards BIPOC to give them a chance to voice out any concerns or issues they may have. Online open houses provide all necessary information about the implementation process. Park ambassador surveys ensure the success and efficacy of the online open houses. Community engagement ambassador surveys help give a voice to any underrepresented Seattle residents. Line of business engagement activities are conducted to show the finer details that need to be paid attention to. A central email address provides one point of contact for anyone who has any suggestions or questions they want to ask.