TuftsMedicine

Center for Diversity, Equity and Inclusion

Respect. Justice. Belonging.

Diversity, Inclusion, and Health Equity Highlights Report 2023


EXIT

Table of contents

Executive Summary

This report, the first of its kind, is an introduction to and compilation of Tufts Medicine's (TM) commitment, strategies, and programs to advance health equity. It highlights many current initiatives that are helping TM create equitable healthcare experiences by addressing health disparities impacting the communities we are honored to serve.

The report frames health equity as part of TM's Diversity, Equity, and Inclusion (DEI) five-year strategy, with the Center for DEI responsible for leadership and coordination. It also frames health equity as part of TM's Mission, Vision, and Values. The report is structured using system-wide priorities to guide entity and department-level efforts and recognize the work of internal/external experts. This structure consists of six overarching themes, three for DEI and three for Health Equity: (DEI) Build culture of inclusion to foster belonging among our workforce and an anti-racist work environment, Develop capacity in leaders and staff to demonstrate new behaviors, create internal and external partnerships to execute our strategy, (Health Equity) Access to Quality and Equitable Care, Wellbeing, and Social Determinants of Health.

Entity-level efforts are centered around findings and recommendations from Community Health Needs Assessments (CHNAs), which provide the basis for each entity's community health improvement plan. Geography and department-level projects that have been compiled in a health equity initiative inventory. They include pilot programs, research education, outreach and grant-funded initiatives that demonstrate TM's commitment to partner with our communities to support their priorities, innovate, advance knowledge and providing frictionless, equitable care.

In partnership with our communities TM co-leads projects to address health disparities making an impact to those we serve. Thanks to our diversity and health equity internal experts that constantly seek to learn from one another to create programs and solutions to serve our mission and vision with an equity lens.

Acknowledgments

This report is the collective work of many contributors from across our system. Rosa Colón-Kolacko, PhD, Chief Diversity, Equity and Inclusion Officer, SVP; Rodrigo Monterrey, MPA, Sr. Director, Center for DEI; Morgan Payne, Center for DEI and LGH Pathology; Eileen Dern, Community Benefits Director, MWH; Barbara Kaufman, Community Benefits Manager, MWH; Sherry Dong, Community Benefits Director, Tufts MC; Lisa Taylor-Montminy, Community Benefits Director, LGH; Hannah Tello, Greater Lowell Health Alliance; Bethany Riportella, VP of Government Affairs, TM; Dr. Sucharita Kher, Attending Physician, Tufts MC; Lori Uzdarwin, Sr. Director of Care Management, TMIN; Michael Nickey, VP of Public Payer Strategy; Megan McManaman, Communication Coordinator, TM.

About Tufts Medicine:

Tufts Medicine is a not-for-profit health system leveraging the strengths of academic and community medicine. Our integrated system includes three Massachusetts-based hospitals (Tufts Medical Center, Lowell General Hospital and MelroseWakefield Hospital), Care at Home, which provides home health and hospice care, and our patient-centered Integrated Network of physicians. While each entity serves diverse communities with unique needs, we share a mission, vision, and deep commitment to health equity.

Mission

Why we exist

Empower people to live their best lives by reimagining healthcare, advancing knowledge and pioneering discovery

Vision

Where we are headed

Create the most equitable and frictionless healthcare experience in the world

Values

How we serve and deliver care

One Team
We make each other great

Respect
We put people first

Inclusion
We listen and learn from diverse thought

Heart
We bring compassion to healthcare

Courage
We boldly challenge the status quo

Excellence
We deliver exceptional results

Team Member Value Proposition

There is only one Tufts Medicine — where a compassionate culture empowers your personal and professional growth as we collaborate to humanize care for all

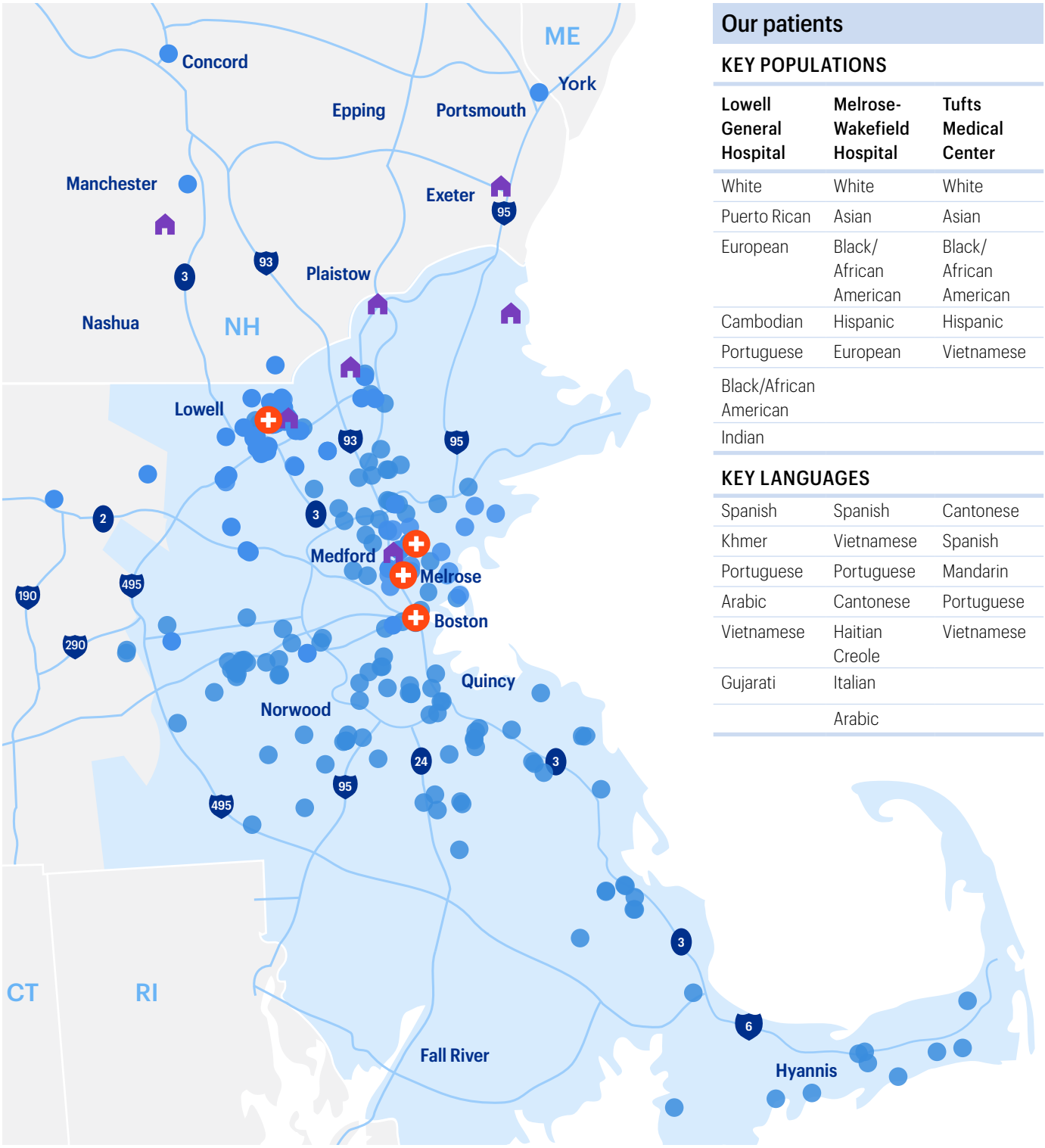
To empower and improve lives

We're the gamechangers

Healthcare with heart

Everyone is included

Tufts Medicine system



Our patients

KEY POPULATIONS

Lowell General Hospital	Melrose-Wakefield Hospital	Tufts Medical Center
White	White	White
Puerto Rican	Asian	Asian
European	Black/ African American	Black/ African American
Cambodian	Hispanic	Hispanic
Portuguese	European	Vietnamese
Black/African American		
Indian		

KEY LANGUAGES

Spanish	Spanish	Cantonese
Khmer	Vietnamese	Spanish
Portuguese	Portuguese	Mandarin
Arabic	Cantonese	Portuguese
Vietnamese	Haitian Creole	Vietnamese
Gujarati	Italian	
	Arabic	

Lowell General Hospital
Lawrence Memorial Hospital
Care at Home
MelroseWakefield Hospital
Tufts Medical Center
Integrated Network

Our commitment to diversity, equity and inclusion

Tufts Medicine is on a journey to re-imagine healthcare, and it starts by looking at ourselves. We are committed to ensuring an inclusive workplace and providing frictionless, equitable care experiences. This means nurturing a culture of inclusion and embedding DEI into policies, tools, and practices to address inequities that contribute to health disparities, including structural racism and other forms of discrimination. We engage our colleagues, patients, and com-munities as experts in their own lived experience and personal identity. We prioritize diversity in hiring, promotion, contracting, and leadership because represen-tation matters, and our data show gaps in these areas. We see this as ongoing work and rely on the commitment of everyone across our system to inform and execute this vision.

In 2020, Tufts Medicine created the Center for Diversity, Equity, and Inclusion (CDEI). Its mission is to build an inclusive culture where all people can thrive by advancing diversity, cultural competence, and eliminating structural racism to achieve health equity. To achieve this mission, the Center provides education, training, and solutions to build an inclusive culture to deliver equitable care experiences for our patients. In addition, through the DEI Academy, we are providing developmental experiences and programs to equip colleagues from across the system with the skills to advance inclusion, behaviors to transform our culture, and knowledge to achieve equity.

Center for Diversity, Equity and Inclusion systemic strategy

Equity-driven policies & practices

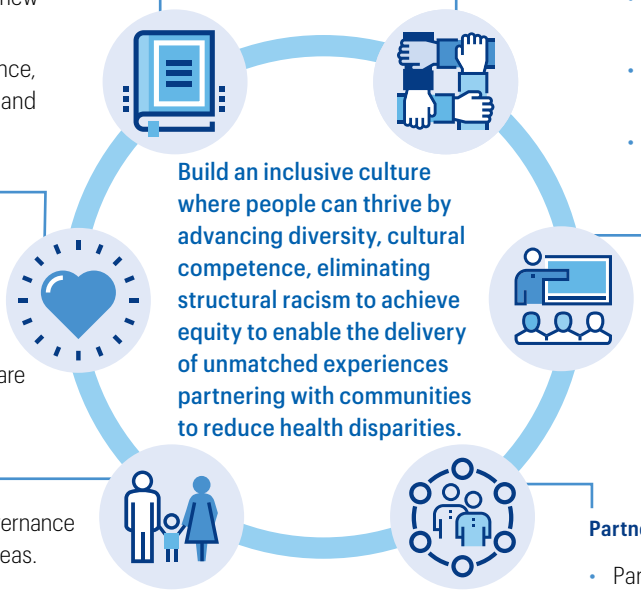
- Assess policies and practices for staff, patients and consumers and build new policies
- Embed diversity, cultural competence, equity and anti-racism into people and patient policies

Frictionless equitable experiences

- Optimize EPIC to deliver culturally competent care and implement Chinese version.
- Integrate cultural competence work in patient experience, healthcare provider practices and Workday

Health equity

- Establish health equity strategy, governance and prioritize system level focus areas.
- Implement new HE standards and waiver requirements
- Improve cultural and linguistic services
- Align community strategies with health equity programming
- Advocate for policy changes to enable equity through Health Equity Compact



Culture of inclusion and belonging

- Implement diversity recruitment strategy to represent the communities we serve
- Measure diversity and Inclusion as part of Engagement Survey
- Implement DEI interventions to address racism

Leadership & workforce development

- Build leadership and employee capacity implementing the DEI Academy and Pipeline Programs
- Provide self-assessments tools for leaders

Partnerships, governance & structure

- Partner with Tufts University and Medical School to leverage education and tools
- Strengthen DEI structure, councils and launch Employee Resource Groups to increase staff inclusion and transform culture
- Partner with the Community to attract talent and develop pipeline programs

The DEI strategy follows a four-year strategy road map:

Grow diverse talent and awareness → DEI building blocks Learning experiences → Unmatched equitable care and culture of belonging

2021: Infrastructure and strategy

- DEI in action pledge
- Awareness education
- Expand diversity celebrations
- Appoint CDEIO and DEI councils
- HR policy review
- Diversity recruitment goal
- Establish Center for DEI
- Health equity SDOH summary
- Embed cultural competence in EPIC
- Diversity index/inclusion theme survey
- Minority leaders pipeline programs

2022: Assessments, policies, processes

- Baseline assessments
- Equity and inclusion leadership
- Health equity inventory and dashboard
- Launch DEI Academy
- Equity and inclusion leaders assessment
- EPIC MyTuftsMed and language services integration
- Workday DEI alignment
- DEI integrated HE policies
- Diversity recruitment processes, metrics
- DEI commitment statement

2023: Embed DEI

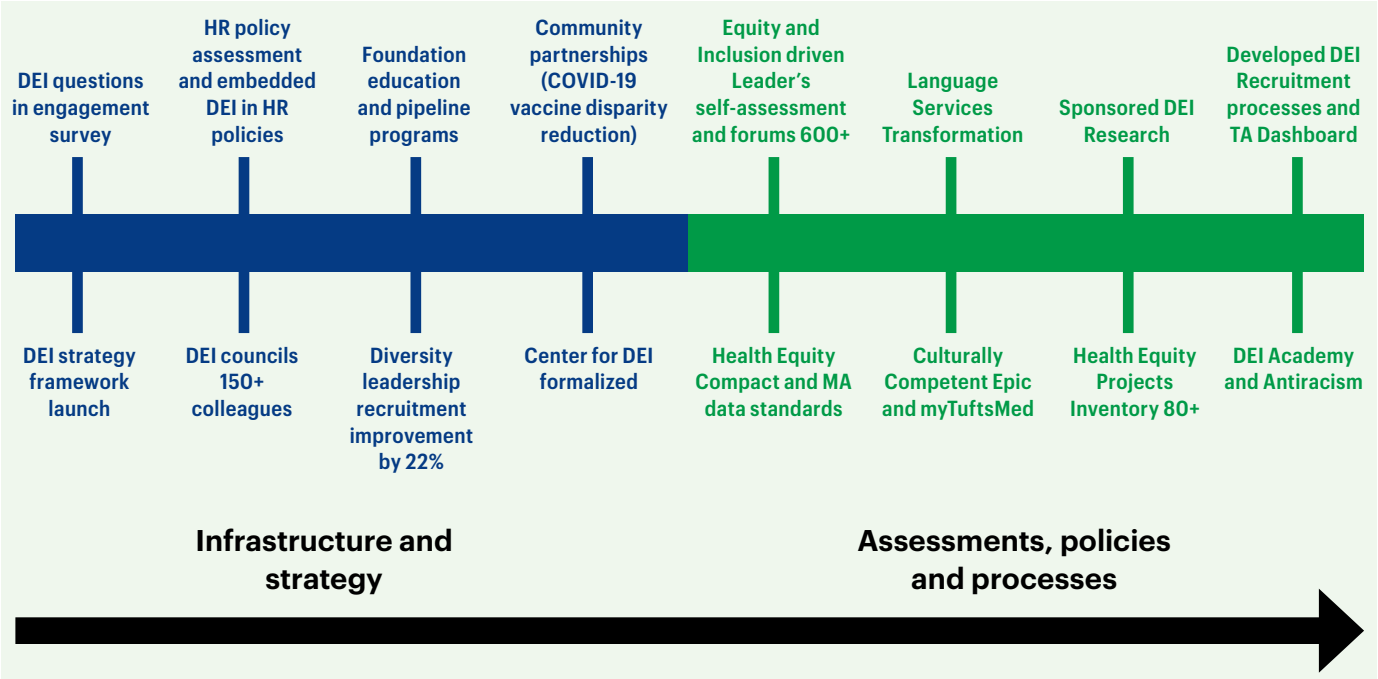
- Build DEI workforce capacity
- DEI as part of values and vision
- Embed DEI into management and HE system
- Diverse talent in pipeline programs and succession planning
- Health equity strategy and standards
- Equity and culturally competent practices driving patient and employee engagement
- Supplier diversity
- DEI and health equity annual report

2024: DEI, strategy, sustainability

- DEI integrated in strategy, healthcare and HR practices
- Workforce and patients represent communities
- Become a talent destination
- Reduce health disparities and improve social determinants in communities we serve
- National DEI best practice recognition

Leadership commitment, DEI metrics and education

TM Diversity, Equity and Inclusion Accomplishments



Health equity strategy

Using the Institute for Healthcare Improvement (IHI) framework and CMS 1115 Waiver requirements as milestones, Tufts Medicine has set the following health equity goals:

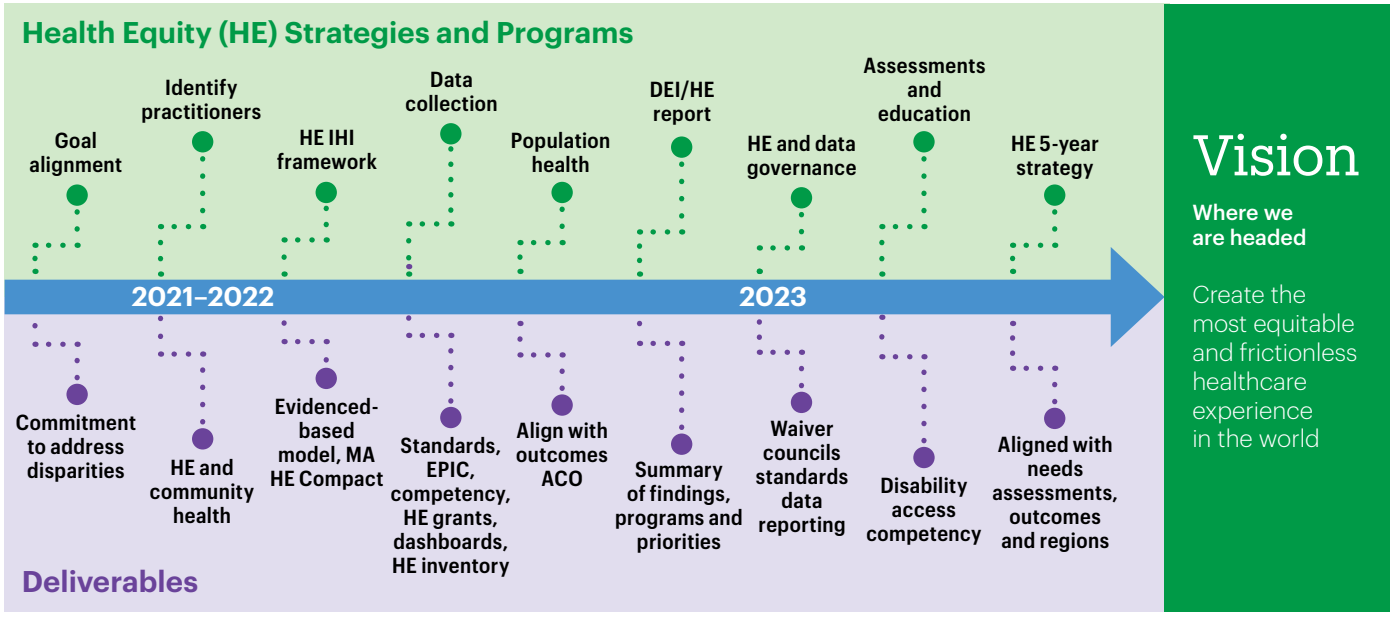
1. Commit accountable staff with authority to lead health equity efforts
2. Assess and improve access to and quality of care by screening for health-related social needs and tracking outcomes by race and other demographics
3. Streamline efforts across entities to share learning and resources, prioritize health disparities for bigger impact
4. Partner with communities to implement and track long-term strategies aligned with Community Health Needs Assessments (CHNAs) and Tufts Medicine's needs and opportunities.

Health Equity Priorities:

While we recognize that it is difficult to neatly categorize health care needs and barriers to care, we have identified through comprehensive Community Health Needs Assessments, four overarching themes that serve as a framework for addressing health equity needs as a system:

- **Access to Quality and Equitable Care:** Tufts Medicine's Vision is to create the most equitable and frictionless healthcare experience in the world. This means making sure all people, regardless of social factors, can get timely, affordable, high-quality, equitable health services from culturally competent providers.
- **Health and Wellbeing:** Tufts Medicine's mission is to empower people to live their best lives. This means playing a critical role in supporting behavioral health services and health behaviors that contribute to physical, mental, and social well-being, not just the absence of disease, or infirmity.
- **Social Determinants of Health:** Tufts Medicine has a role in identifying and addressing community-level barriers to health, influencing policy that impacts health equity through advocacy efforts, and making investments to ensure equitable access to living conditions that affect a wide range of health, functioning, and quality-of-life outcomes. These living conditions include food access, stable housing, transportation, education, employment, and violence/trauma services.
- **Address Bias in Medicine:** it is our goal to represent the communities we serve and build workforce capacity to eliminate biases historically entrenched in medical research, education, and practice.

A four-year strategy road map



Delivering the most equitable experiences requires creating a community of Health Equity experts across the system to build a strategy to change how we work.

Discrimination and Structural Violence
Tufts Medicine is committed to continue to learn from the communities it serves about their social needs and risk factors that impact health outcomes. Research over the past ten years suggests that discrimination impacts health primarily through three major path-ways: psychosocial stress, access to health and social resources, and violence and bodily harm. These pathways interact with, exacerbate and perpetuate one another, resulting in a disproportionate burden on marginalized communities in barriers to health.

The communities engaged in our Community Health Needs Assessments discussed discrimination as a social determinant of health, revealing concerns about Anti-Black, Anti-Immigrant, and Anti-Asian racism. Respondents who reported higher percentages of feelings of discrimination were also more likely to be at higher risk for complications of COVID-19, worry about meeting their basic needs, and were 75% less likely to have access to healthcare. This is consistent with national polls by Harvard, National Public Radio, and the Robert Wood Johnson Foundation, which found that more people of color report experiencing individual and institutional discrimination against their group compared to Whites.

Similarly, more individuals identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ) and women report experiencing discrimination toward their respective groups compared to non-LGBTQ men.

- **In Melrose,** 23% of Asian respondents, 24% of Black respondents, and 12% of Hispanic/Latinx respondents reported feeling discriminated against because of their race or ethnicity during the pandemic. Twenty-five percent of Asian respondents experienced discrimination by being wrongly accused of carrying COVID-19 infection.
- **In Boston,** according to the Behavioral Risk Survey (BRFS), even before COVID-19 and Black Lives Matter, nearly one third (30%) of Black adults reported that they had been stopped by police because of their race, compared to 12% of all Bostonians and only 2% of White Boston residents. According to the COVID-19 Community Impact Survey (CCIS), during the pandemic, 23% of Asians, 24% of Blacks, and 12% of Hispanics/Latinx reported feeling discriminated against because of their race or ethnicity, while 25% of Asian respondents reported being wrongly accused of carrying COVID-19 infection.
- **In Greater Lowell,** racial discrimination was ranked the top safety concern across all participants, including White non-Hispanics, in the 2022 Community Health Survey.

The following are the findings (%) of LGH participants perceptions based on safety items in their top three priorities:

	2019	2020	Change
Discrimination based on Race	14.9	27.9	+13.0
Discrimination based on Sex/Gender	3.9	11.5	+ 7.6
Discrimination based on Immigration status	9.2	10.2	+ 1.0
Discrimination based on Class/Income	8.8	6.8	– 2.0
Discrimination based on Sexuality	4.4	7.3	+ 2.9

System-wide initiatives

Tufts Medicine's efforts to improve health equity include investments, research, collaborations with community partners, advocacy, and the development and implementation of community-based health equity initiatives. Tufts Medicine is leading and coordinating efforts to meet health equity requirements and standards on many fronts. These include collecting, stratifying, and reporting patient demographic and social determinants data to identify and address health disparities, and implementing workflows to connect patients with services and resources to address their health-related social needs. These system-wide initiatives include:

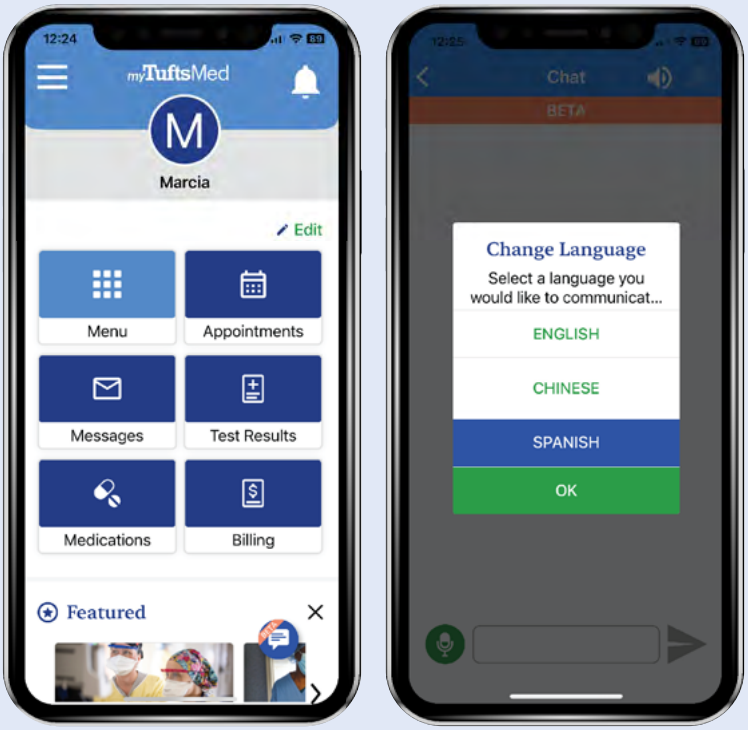
1. **Meeting CMS 115 Waiver Requirements:** We are engaged in a five-year initiative that includes reporting on our current patient data collection practices in year one, and implementing needed changes in each Hospital and across our ACO to demonstrate improvements in outcomes and reductions in disparities in subsequent years.
2. **Policy and Advocacy:** Tufts Medicine has prioritized advancing health equity in its advocacy efforts by engaging with stakeholders at the national, state, and municipal levels. The Government Affairs team tracks and weighs in on social determinants of health, including environ-ment and climate, substance use disorder, behavioral health, maternal health, food as medicine, and many other topics. The team provides patients and employees with tools to amplify their voices, including a resources page on the Tufts Medicine intranet where staff and clinicians can learn about advocacy efforts, share ideas, and ask questions.
3. **Health Equity Compact:** Tufts Medicine is part of the executive committee that launched the Health Equity Compact, a coalition of 50+ Black and Latinx leaders, representing healthcare, business, and non-profit organizations from across Massachusetts who have come together to advocate for and advance health equity in the Commonwealth launching the Bill Act to Advance Health Equity. This omnibus bill is a meaningful vehicle for advancing policy that will support the fair and just opportunity for all residents of the Commonwealth to live healthy lives. This legislation will advance health equity in the following ways: prioritize health equity in Massachusetts state govern-ment, standardize and report on health equity data to improve access and quality of care, develop a wide-ranging plan to address capacity and diversity in the healthcare workforce, and issue a report on the cost of racial inequities in health in Massachusetts. To learn more, visit **healthequitycompact.org.**
4. **Electronic Medical Record platform connects communities to resources:** In 2022, Tufts Medicine completed the system-wide implementation of a new Electronic Medical Record (EMR) system, called Epic, to facilitate equitable, frictionless, culturally-competent care and improve patient access to information and community resources.
    a. **MyTuftsMed,** a patient-facing portal that allows users to schedule, confirm or cancel their appointments, also enables patients to complete and update their personal information, including demographics, send messages to their providers in any language, and use voice to text chat bots to ask questions and get answers, all in their preferred language.
    b. The **FindHelp** (formerly Aunt Bertha) platform is integrated with MyTuftsMed and with EPIC, and allows patients and non-patients to access Tufts Medicine health and social services partners in local communities to support their care and meet needs including food, housing, and transportation, or other Social Determinants of Health.
5. **Advocating for changes in data-collection standards:** The Center for DEI was appointed to the Technical Advisory Group, led by the MA Center for Health Information and Analytics (CHIA), to improve health equity by standardizing best practices in demographic data collection and utilization in all payers claims data (APCD)

systems, including race, ethnicity, language, sexual orientation, gender identity, disability, and housing status. This group is chartered to develop this year's recommendations that will impact state level practices and will influence national standards to improve data collection and enable health disparities analysis, reporting and programming.

6. **Food as Medicine:** A $6.6 million grant from the National Institutes of Health (NIH) to the Friedman School of Nutrition Science and Policy at Tufts University funds a collaborative development of community-based programs to increase local production and consumption of fruits and vegetables in the Mississippi Delta. The project focuses on three counties where over 65 percent of residents identify as Black or African American, about 30 percent live at or below the poverty level, more than 50 percent of women and 40 percent of men have obesity, and diabetes is almost double the national average. The intervention will assess body mass index, hemoglobin A1C dietary intake, and other measures taken at regular intervals. To develop the program, the team from Tufts University School of Medicine and Tufts Medical Center engaged a variety of local stakeholders, including growers, health and agriculture educators, food retailers and community-based organizations. The study is an outgrowth of the Food is Medicine (FIM) movement, which recognizes the link between nutrition and chronic diseases. FIM programs include health clinic mobile food markets, patient prescriptions for healthier food, and produce delivery that make healthier foods easier to access for those in food deserts.

7. **Transforming and improving access to Language Services**: In 2022, Tufts Medicine worked to standardize the way we identify needs, requests, schedule and deliver language services to improve access and satisfaction. As part of the patient medical record, we have integrated patient needs, provider requests and automated the scheduling of interpreter services. We partnered with Language Line Solutions to create a virtual Interpreter Call Center, allowing Tufts Medicine interpreters to receive calls for language services first, before the request rolls over to an agency reducing cost. Benefits include on-demand access to professional interpreters 24/7/365 via phone and video.

myTuftsMed patient experience



Features

The app is available in five different language options that users can choose: English, Spanish, Chinese, Portuguese, Haitian Creole, Vietnamese and Khmer

1. Ability for patients to send messages in their preferred language
2. Patients interact via speech enabled chatbot
3. Ability to transfer to a live agent when needed. Multi-language support including Spanish and Chinese.

8. **Maternal Equity Bundle:** The Tufts Medical Center Maternal Fetal Medicine Department is part of the MA Perinatal Qualitative Collaborative, which began implementation of the Alliance fr Innovation on Moeternal Health (AIM) Maternity Equity Bundle in September 2022. This includes creation of an OB Equity team to address severe maternal morbidity (SMM) in minoritized populations, initiating quality improvement projects for the collection of Race, Ethnicity and Language data in our obstetric population, and reporting on SMM by race and ethnicity.

Interpreter Encounters by Entity, January 1 through December 31, 2022

Lowell General Hospital

DPH Language	In person: agency	staff	Phone	Video	Total
Spanish	0	642	22,288	7,689	**30,619**
Portuguese	0	816	15,153	4,169	**20,138**
Khmer/Cambodian	0	294	8,350	3,648	**12,292**
Gujarati	0	20	1,275		**1,295**
Vietnamese	0	34	785	465	**1,284**
Haitian Creole	1	2	986	275	**1,264**
Arabic	0	30	711	298	**1,039**
American Sign Lang.	0	45		673	**718**
Laotian	0	16	392	185	**593**
Chinese-Mandarin	0	0	299	244	**543**
Pashto	0	1	462		**463**
Dari			319		**319**
Hindi	0	3	240	57	**300**
Swahili			249	40	**289**
French			165	97	**262**
Nepali	0	1	155	40	**196**
Russian	0	3	100	72	**175**
Korean	0	2	66	95	**163**
Greek	0	1	117	29	**147**
Chinese-Cantonese	0	1	84	24	**109**
Bengali	0		52	36	**88**
Karen			62	18	**80**
Kinyarwanda	0		77		**77**
Burmese	1		52	15	**68**
Farsi			54	14	**68**
Total	**2**	**1,920**	**52,835**	**18,273**	**73,030**

MelroseWakefield Hospital

DPH Language	In person: agency	staff	Phone	Video	Total
Spanish	0	82	800	747	**1,629**
Portuguese	0	18	1,004	531	**1,553**
Vietnamese	0	141	405	723	**1,269**
Chinese-Cantonese	1	151	460	614	**1,226**
Haitian Creole	0	34	591	286	**911**
Chinese-Mandarin	1	26	190	232	**449**
Arabic	0	22	154	121	**297**
Italian	0	26	99	101	**226**
Russian	0	20	79	100	**199**
Nepali	0		95	56	**151**
American Sign Lang.	0	14		110	**124**
French	0	5	55	35	**95**
Hindi	0	24	28	33	**85**
Khmer/Cambodian	0	1	34	34	**69**
Punjabi			15	49	**64**
Albanian	0	6	19	22	**47**
Greek	0	13	16	18	**47**
Bengali	0	2	19	16	**37**
Romanian	0		14	22	**36**
Turkish	0	1	13	21	**35**
Korean	0	2	15	17	**34**
Bosnian	0	1	15	9	**25**
English	1	24			**25**
Chinese-Toisanese	0		22	2	**24**
Amharic	0		14	9	**23**
Total	**3**	**631**	**4,277**	**3,972**	**8,883**

Tufts Medical Center

DPH Language	In person: agency	staff	Phone	Video	Total
Chinese-Cantonese	2	6,898	31,741	16,920	**55,561**
Spanish	2	1,008	18,008	8,566	**27,584**
Chinese-Mandarin	0	2,751	14,032	7,583	**24,366**
Portuguese	1	268	9,804	3,073	**13,146**
Vietnamese	0	595	5,072	2,531	**8,198**
Chinese-Toisanese	1	834	5,543	28	**6,406**
Haitian Creole	1	176	3,043	713	**3,933**
Russian	0	355	2,250	902	**3,507**
Khmer/Cambodian	0	48	1,217	728	**1,993**
Arabic	0	85	825	343	**1,253**
American Sign Lang.	0	24		796	**820**
Chinese-Fuzhounese			430	11	**441**
French	0	9	252	94	**355**
Polish	0	11	222	108	**341**
Albanian	0	6	228	82	**316**
Gujarati	0		273		**273**
Italian	0	38	162	43	**342**
Nepali	0		147	45	**192**
Hindi	0	9	129	40	**178**
Greek	0	11	103	30	**144**
Swahili	0	0	118	26	**144**
Chinese-Fukienese	0	74	61		**135**
Thai	0	0	101	29	**130**
Burmese	0	3	84	40	**127**
Korean	0	1	71	47	**119**
151,319	**7**	**13,336**	**94,969**	**42,977**	**151.319**

Research initiatives

1. **Healthy Outcomes from Positive Experiences (HOPE) i**s a community project led by Robert Sege MD PhD that is focused on changing the way care is provided to children and their families through the identification, celebration, and promotion of key positive childhood experiences that promote optimal development. All HOPE materials and training incorporate evidence-based anti-racism concepts and techniques, including a new anti-racism online course launched in the Fall of 2022. They also have diverse professional and family advisory boards. Currently HOPE has reached over 20,000 providers across the country.
2. **The "Serving Language Minority Patients Summit":** Dr. Sucharita Kher, Vice Chair for Clinical Operations and Quality in the Department of Medicine at Tufts MC led their inaugural Building Partnerships for the Health of Language Minorities summit that brought together stakeholders including patients, clinicians, hospital leaders, community members, and DEI champions. Twelve projects focusing on language access, community-hospital partnerships, providing equitable care and research, and advocacy were presented followed by a keynote on "Language and Inclusion: Opportunities to Optimize Quality in Healthcare" by Dr. Claire Pomeroy. Examples of presentations include: Doctors Utkarsh Shukla and Kathryn Huber discussed their work documenting disparities in breast cancer radiotherapy outcomes by primary language; Dr. Cristina Montalvo presented on ways to optimize care in the ICUs using communication boards; Timothy N. Bilodeau discussed challenges, approaches, and importance of enrolling language minorities in clinical trials. The Summit ended with a thoughtful panel discussion during which key areas of growth and opportunities emerged to ensure that Tufts MC continues to be a pioneer in providing linguistically and culturally appropriate care.
3. **The Center for Health Equity and Research (CHER):** directed by Dr. Karen Freund, addresses research disparities in health care and diversity in the biomedical workforce. Research on equity in science seeks to understand the factors associated with promoting and achieving diversity in biomedical careers. This includes understanding the factors associated with the recruitment, promotion, and retention of woman and minority faculty in academic biomedical careers. Research includes observation studies to understand the factors associated with disparities in biomedical career advancement and interventions to address them. The program also addresses disparities in the delivery of health care, with major focus on care to women and minority communities. CHER is part of a collaboration between Boston academic medical centers to reduce the outcomes gap between white and African American breast cancer patients and improve outcomes for all breast cancer patients.
4. **Improving Access to Behavioral Care:** Tufts Medicine is investing in improving access to a broader range of behavioral health services in the community through a joint venture with Acadia Health. This includes building a new 144-bed inpatient behavioral health facility on the site of the former Malden Hospital. Tufts Medicine is developing a formal behavioral health service line structure to better embed into primary care practices the numerous services and pilot programs currently being provided across our health system. And the Tufts Medicine Integrated Network (TMIN) is expanding access to mental health providers this year via Synchronous Health — a teletherapy platform that is payer agnostic.
5. **Tufts Clinical and Translational Research Center:** Tufts CTSI was established in 2008 with a Clinical and Translational Science Award (CTSA) from the National Institutes of Health (NIH) with a vision to exemplify excellence in research, education, and

community engagement, and overcome barriers to translation to improve the wellbeing, health, and health equity of our society. The CTSI is one of more than 50 institutions comprising the national CTSA Consortium, led by the National Center for Advancing Translational Sciences, part of NIH. From bench to bedside, to clinical practice, to care delivery and public health, to public policy and beyond, Tufts CTSI is committed to fostering collaboration and innovation across the translational spectrum. We are highlighting in this report two health equity and diversity projects of research and education. One of TM's goals is to partner with our communities to address disparities in the participation of all populations in clinical research. Tufts Medical Center (Tufts MC) and the CTSI has partnered with Boston Urban College (UCB) to develop the first Clinical Research Coordination (CRC) certificate program. The first cohort of six students graduated from in June 2021. Three of the program graduates are now working in the field — including two who are employed at Tufts Medical Center. Another graduate decided to continue her studies, and graduated from UCB with her associate degree in June 2022. The remaining two graduates are not currently pursuing work in the field. UCB will be launching the second cohort of the CRC certificate program in September 2023.

6. **DEI Mentorship:** In the Spring of 2021 Breast Surgeon Dr. Lerna Ozcan and Family Medicine Physician Dr. Sangita Pillai started the DEI Mentorship Subcommittee of the DEI Council at Lowell General Hospital. The group invests in Lowell General Hospital's Black, Indigenous, and People of Color (BIPOC) employees and volunteers by pairing those interested in becoming healthcare providers with volunteer mentors who help them with career growth and advancement goals. The DEI Mentorship Subcommittee is also dedicated to creating a diverse workforce through mentoring BIPOC youth in the community who are interested in health careers by partnering

Breaking the Silence—Confronting Exclusion in Research is a series of symposia designed to address issues of bias and discrimination influencing the experiences of faculty, staff, and students that came from the need to give voice to the lack of diversity throughout the research enterprise, including lack of representation and funding for research done by investigators of color and lack of inclusion of communities of color in clinical research.

The global COVID-19 pandemic shined a light on the pervasive health inequities in this country and the disproportionate impact of the disease on communities of color. The data is changing rapidly, but the fact remains that the inequities in outcomes are well documented. Participants to in the symposia learned what we can do to address inequities as individuals and as institutions to make a transformative impact to move us toward inclusion of all people in research. We need to look for evidence of a "two-sided sign" where the reality of some may not be the reality of others; find where our common humanity intersects; and be interested in, believe, and join in the stories of others.

We need to recognize who is not at the table and make changes that allow for impacted communities to inform research design and implementation. More people are now talking about the disease of racism. We need to address the issue of lack of diversity in research, which results in unfairly disadvantaging individuals and comunities of color, while advantaging others.

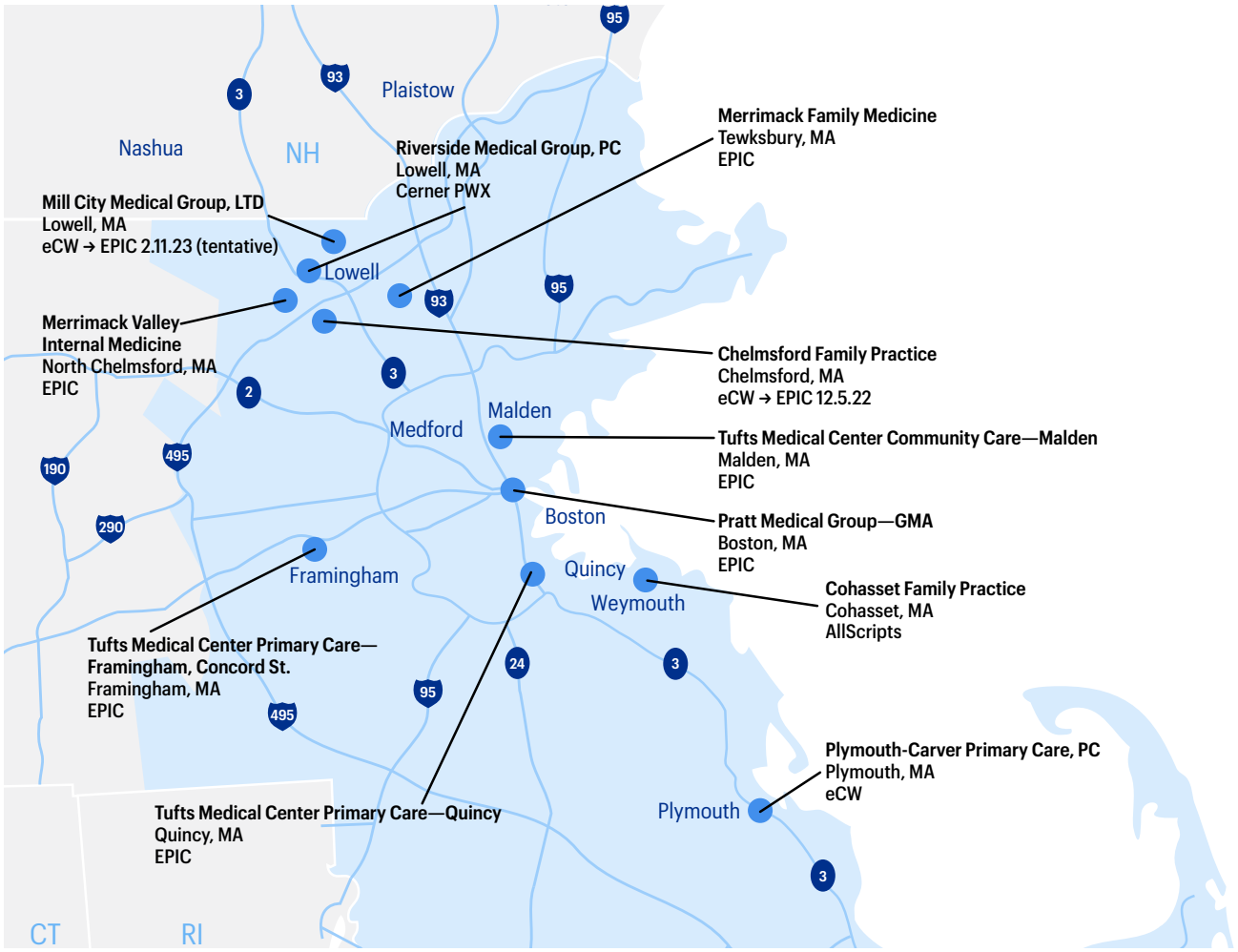
It cannot be ignored that these devastating effects impact curiosity and participation in research, and trust in the institutions that drive these pursuits. Event participants acquired new understandings of exclusion from research and felt highly motivated to take action to better meet the challenges that we face as individuals and as a community.

with local youth programs such as the Boys and Girls Club of Greater Lowell. There are plans to expand the program to other Tufts Medicine entities.

7. **TMIN Hypertension and Health Equity Program (HHEP):** Tufts Medicine Integrated Network (TMIN) has been awarded a total of $1,217,591 from Blue Cross Blue Shield of Massachusetts (BCBSMA) for the purposes of implementing a clinical intervention program focused on health equity, titled the Hypertension and Health Equity Program (HHEP). The TMIN will engage in health equity work by 1) collecting Race, Ethnicity, and Language (REaL) data, Sexual Orientation and Gender Identity (SOGI) data, and Social Determinants of Health (SDoH) data, and 2) target disparities in hypertensive population related to blood pressure control. HHEP focuses on assisting the most vulnerable populations within our Network in a payer-agnostic manner. The program starts its phased roll out in January 2023 at 11 pilot practices across our network, as shown in the map below.

8. **Wellbeing Movement in Lowell:** Tufts Medicine has partnered with Blue Zones to improve well-being and address health disparities in eastern Massachusetts. Blue Zones is a global leader in the science of well-being, with proven strategies to help people live longer, better lives. Our partnership launched in September with the Well-Being Movement in Lowell. Blue Zones and a coalition of local advocates and agencies worked together to evaluate the current state of well-being, and identify the highest priority strengths, challenges, and opportunities in Lowell. Initial findings were presented to the community in November and work is now underway to source funding for the activation of the Well-Being Movement in Lowell strategies in 2023.

The Hypertension and Health Equity Program (HHEP) pilot practice map & accompanying EMRs



9. **Meeting Accountable Care Organization (ACO) Health Equity Requirements:** Tufts Medicine has a single MassHealth ACO that includes our hospitals and employed and private providers across the Tufts Medicine Integrated Network (TMIN). The ACO also includes Lowell Community Health Center as a key clinical partner and the ACO's largest primary care site. The second iteration of the ACO has a strong focus on Race, Ethnicity, Language, Disability, Sexual Orientation, and Gender Identity (RELD SOGI) data collection, data stratification, and the creation of clinical initiatives to address disparities in care when and where results are not consistent across population subgroups.
10. **Vizient HE Strategy Alignment Tool Pilot** In May and June of 2022, Tufts MC joined a cohort of health systems across the country in a six-week Health Equity Accelerator workshop led by Vizient. The goal was to apply their tool to assess and prioritize opportunities and readi-ness to address HE issues. As part of the program, Tufts MC's medical team, led by Dr. Erik Garpestad, completed the Health Equity Alignment Tool, which provides tailored reports to help prioritize needs and strategies based on feasibility and impact indicators. The strategy alignment tool takes patient zip codes and produces a report with data SDOH correlated to health indicators. The lessons learned from this exercise include:
    - Align health equity ambitions with organizational goals
    - Examine gaps in competencies required to implement health equity initiatives
    - Understand community need and opportunities for performance improvement
    - Define strategic direction to prioritize health equity initiatives.
11. **Health Equity Initiatives Inventory and Community of Practice (CoP).** The Center for DEI convenes the leaders for health equity initiatives at each entity to discuss challenges, opportunities, and best practices. With the group's input, the Center for DEI conducted a survey and developed a database to track health-equity-related initiatives across our system. It is searchable by entity, focus area, population served, and partner organizations, among other fields. As of Nov. 2022, 86 projects, some research-based, others community-based interventions, have been inventoried: Tufts MC reported 26, MWH 35, LGH 15, the TMIN 5, Clinical and Translational Science Institute (CTSI) 2. (See appendix: Health Equity Initiatives Inventory.)

Anti-Racism

The Anti-Racism Committee (ARC) at Tufts Medical School just completed its first year of service, contributing ideas and recommendations to several projects with the goal of furthering anti-bias training in medicine, public health, and biomedical sciences.

The ARC builds on the work of the Anti-Racism Task Force for the MD program that began in 2019 in the Office of Educational Affairs, and is led by Chairman Damian Archer, Assistant Dean for Multicultural Affairs and Clinical Assistant Professor at the School of Medicine. In contrast to the Task Force, which only met for a short period to fulfill a task, the ARC exists in perpetuity as part of the school's bylaws, on equal footing to the Admissions Committee and the Curriculum Committee.

The ARC's work is centered around DEI, justice, and belonging to create a space of psychological safety and full engagement for students, faculty, and staff.

The committee has elected faculty representatives from various departments at the medical school and from academic partners, such as Maine Medical Center. There are also eight medical student representatives. The committee's responsibilities to address anti-racism at all levels of the school are outlined in the charter. However, the work of the ARC is not to implement, but to look at policies, review data, and make recommendations using an anti-racist lens.

12. **Inclusive Clinical Education: from pre-health to doctoral degrees**. The Tufts Medicine clinical learning environment offers a unique opportunity to be part of an academic and learning system committed to inclusion, diversity, and health equity. Learners in medicine, dentistry, occupational therapy, nursing, nutritional science and pharmacy are fully integrated into our clinical care teams, learning and practicing under the supervision of outstanding faculty. We graduate more than 200 new physicians and 50 physician's assistants a year, with an additional 120 physicians entering independent medical practice after completing one of our 43 residencies and fellowships.

Our goal is to contribute to the creation of a healthcare workforce that is reflective of the patients and populations we serve. We are committed to the use of inclusive teaching materials and methods.

We are also committed to equity in access to formative experiences in health care — including pipeline programs that welcome individuals who are first in college, first in medicine and those who have been historically underrepresented in medicine.

Community health improvement functions

As non-profit institutions, Tufts Medicine hospitals have an important fiduciary obligation to provide benefits to their communities commensurate with their tax-exempt status.

The provision of Community Benefits is an important component of a hospital's charitable activity. The Attorney General provides Community Benefits Guidelines for developing, implementing, and reporting on these activities. The Guidelines encourage hospitals to use their expertise and resources, as well as the expertise of their communities, to target the needs of at-risk populations in their catchment areas. Each Tufts Medicine hospital has committed human and financial resources to follow these Guidelines, led by their Community Benefits Program Directors: Eileen Dern at MelroseWakefield Hospital, Sherry Dong at Tufts Medical Center, and Lisa Taylor-Montminy at Lowell General Hospital. The latter collaborates with the Greater Lowell Health Alliance in conducting the Community Health Needs Assessment and awarding contracts to community-based programs.

Community Benefits Programs invest in communities by providing funding to community-based organizations. In FY2022, Tufts MC awarded $1.95 million, and plans to award $2 million in FY23. MelroseWakefield Hospital awarded $4.6 million in FY2022 (including charity care) and plans to award $??? in FY2023. Lowell General Hospital awarded $2,580,620 in FY2022 and plans to award $2,825,000 in FY2023.

Community Health Needs Assessments:

This section provides an executive summary of the latest Community Health Needs Assessments (CHNAs) conducted from 2019 to 2021 and published in 2022 by each Tufts Medicine hospital.

In addition to fulfilling the requirements outlined in the Affordable Care Act (2010) and the Attorney General's Guidelines, the CHNAs are a critical tool in Tufts Medicine's commitment to addressing disparities and barriers to health equity. The assessments reflect the racial, economic, and social inequities impacting our communities. Each hospital uses a comprehensive mixed-methods approach: combining primary data from key informant interviews, focus groups, and surveys with secondary data from census records and other reliable sources. Surveys were translated from English into the most common languages in the service areas, and available both online and in locations selected based on the demographics they serve.

The CHNAs are key inputs used to prioritize:

- major health concerns and vulnerable populations
- unmet needs and gaps in service
- recommendations for programs and partnerships to address needs and gaps
- focus areas for programming to improve population health
- opportunities to reduce health disparities
- the social determinants of health

The CHNAs reveal both the unique needs of their communities and common themes that provide a framework for system-level priorities. While we recognize that it is difficult to neatly categorize health care needs and barriers to care, we have identified three overarching themes that serve as a framework for understanding and addressing these needs as a system: Access to Quality Care, Wellbeing, Social Determinants of Health.

COVID-19 and Health Equity:

Conducted during the COVID-19 pandemic, the CHNAs reveal the pandemic's profound impact on our communities.

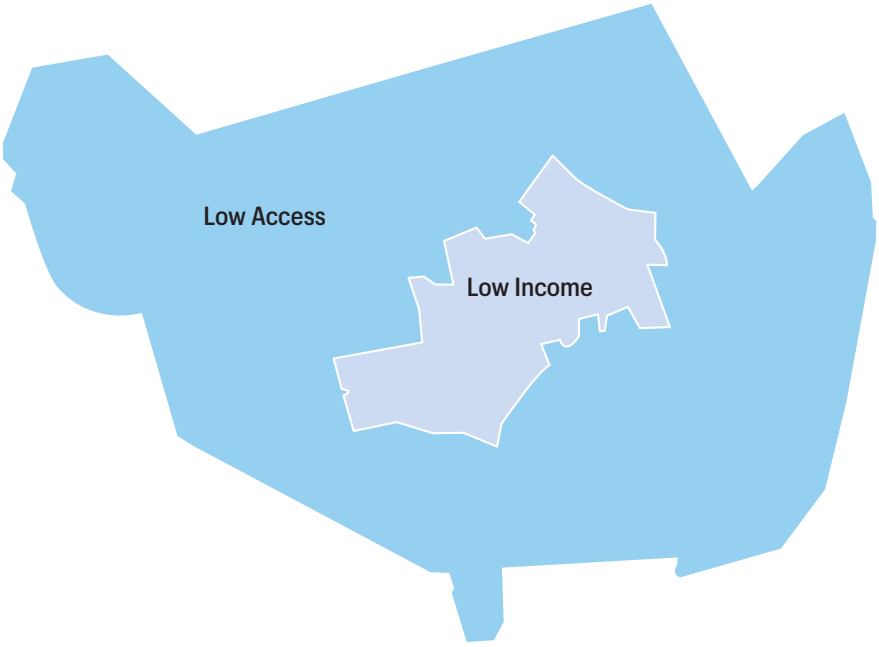
While the pandemic created new needs and concerns, it also exposed existing gaps in the social safety net. Unsurprisingly, COVID-19 was a leading concern among community members and leaders interviewed. Health implications, fear of the virus, and the immense financial, social, and emotional toll deepened existing inequities. The virus especially impacted marginalized groups including youth, the elderly, low-income community residents, non-English speakers, and Black, Indigenous, and People of Color (BIPOC). These populations in particular continue to feel the effects of the pandemic. Tufts Medicine's disaster and emergency planning remain an ongoing and renewed priority for the health system going forward.

Access the full CHNA reports here:

- **Lowell General Hospital Community Health Needs Assessment Report, 2019–2022**
- **MelroseWakefield Hospital Community Health Needs Assessment Report, 2019–2022**
- **Tufts Medical Center Community Health Needs Assessment Report, 2019–2022**

Entity-level assessments

Lowell General Hospital (LGH)



Visualization of greater Lowell low-access and low-income areas

Source: USDA Economic Research Service, Food Access Research Atlas, 2019

Lowell General Hospital (LGH) is a 400+ bed community hospital, with two primary campuses located in Lowell, Massachusetts. LGH offers a full range of medical and surgical services for patients, from newborns to seniors.

LGH's service area encompasses the primary patient population of LGH as well as the geographic locations of additional Tufts Medicine resources including Urgent Cares. The LGH service area includes eight Greater Lowell communities: Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsborough and Westford. Greater Lowell has a considerable foreign-born population, with 17.5% of residents born outside of the United States. Racial and ethnic diversity in Greater Lowell varies significantly by community, with Lowell being the most diverse and Dunstable the least. There is significant socio-economic variation in Greater Lowell. Approximately 9.6% of residents live below the federal poverty line, but the median income ranges from a high of $158,523 in Dunstable to a low of $62,196 in Lowell.

Service area demographics

	Population	% White	% Black	% Asian	% Hispanic	% Born Outside the US	% Aged 0-17	% Aged 65+	Median Income	% Under Poverty Line
Billerica	41,453	81.7	5.0	7.2	5.3	13.9	18.9	15.5	113,239	4.3
Chelmsford	35,933	87.3	1.2	8.5	3.3	10.0	21.0	17.8	117,582	4.3
Dracut	32,159	87.8	4.0	3.7	6.4	9.2	21.5	16.7	92,685	6.3
Dunstable	3,374	93.7	0.0	2.9	1.9	5.7	21.0	16.0	158,523	1.4
Lowell	113,994	60.3	8.9	21.2	17.9	26.7	21.0	11.5	62,196	17.3
Tewksbury	30,876	91.5	3.2	2.8	2.2	8.4	17.3	18.3	104,610	4.0
Tyngsborough	12,421	85.6	.8	10.6	5.0	12.9	20.1	12.0	115,280	6.7
Westford	24,446	73.1	0.6	23.1	2.6	17.8	27.0	13.2	149,437	1.9
Total/Weighted Average	**294,656**	**75.4**	**5.1**	**13.3**	**9.5**	**17.5**	**20.8**	**14.3**	**114,260**	**9.6**

Lowell General Hospital (LGH) Greater Lowell Health Alliance (GLHA) Partnership

LGH was one of the founder organizations of The Greater Lowell Health Alliance in 2006. In 2008, the GLHA merged with the Community Health Network Area 10 (CHNA 10), a coalition that is comprised of public, non-profit and private sectors working together to build healthier communities through community-based prevention planning and health promotion. The GLHA provides their expertise to LGH to design and execute the community health needs assessment collaborating with UMass Lowell. The LGH Community Benefits Program's expenditures for FY 22 were $2,580,620 and for FY 23 (anticipated) $2,825,000. To learn more visit **greaterlowellhealthalliance.org**.

Recent accomplishments include:

Lowell General Hospital partnered with community members and community-based organizations to provide over $300,000 in funding to create and support initiatives and programming designed to address the top health and social service needs identified in previous Community Health Needs Assessments.

- In 2020, LGH formed a partnership with Community Teamwork, Inc., to provide in person, as needed, social service supports to patients presenting in our emergency departments and to patients identified by hospital case managers. This allowed patients to receive assistance with housing instability, food insecurity, childcare, and many other social services. Over 150 patients received direct services including temporary housing placements, WIC (Women, Infants, and Children) benefits, childcare vouchers, and fuel assistance.
- In partnership with Mill City Grows, a food justice and access organization, and with LGH cardiac patients, provided a "Veggie RX" program. Fifteen patients from the cardiac rehabilitation program could talk with their physicians about healthy eating and then go right to a mini-farmers market provided right inside the hospital to pick out fresh vegetables and get information from the Mill City Grows staff on the nutritional value and how to prepare the vegetables at home. All patients reported an increase in their consumption of fruits and vegetables during the program.

Key community partners:

- Lowell Community Health Center
- Community Teamwork, Inc.
- Mill City Grows
- City of Lowell Housing Task Force
- The Hunger and Homeless Commission
- GLHA (Greater Lowell Health Alliance) Housing and Built Environment Task Force
- GLHA Wellness and Chronic Disease Task Force
- YMCA of Greater Lowell
- Lowell General Cancer Center

Top needs from CHNA

1. Mental Health
2. Chronic Health and Wellness
3. Substance and Alcohol Use Disorder
4. COVID-19 and Other Infectious Disease
5. Reproductive, Sexual, and Pregnancy Health

Priority initiatives (organized by 3 themes: Health and Wellbeing, Access to Care, SDoH)

LGH Priority Area 1: Behavioral Health (Health and Wellbeing)

Goal: To promote social and emotional wellness by supporting community members with behavioral health challenges and ensuring adequate access to behavioral health services and clinicians.

Target population: Elderly, Youth, LGBTQIA community members, all community members

Action plan

- Streamline the path to care for those in our community experiencing a behavioral health crisis and strive to provide support and interventions for our most vulnerable populations.
- Support community members in social-emotional wellness activities and programs to foster belonging and reduce isolation, as well as provide access to resources and eliminate barriers to care.

LGH Priority Area 2: Access to Care & Services (Chronic Disease and Substance Use Disorder)

Goal: Efforts to address substance and alcohol use disorder should simultaneously attempt to prevent engagement with substances with a focus on efforts for youth, recent arrivals, and the aging population, while also ensuring a robust, well-funded network of treatment services that offer a range of treatment options including medication assisted treatment, outpatient care, and counseling and therapy options.

Target population: Marginalized and under-served populations including Hispanic populations

Action plan

- Commit to sustainability of Lowell General Hospital's Bridge Clinic and increase their capacity to incorporate SUD/AUD services to cover night and weekend hours, as well as replicate their model into additional Tufts Medicine sites.
- Increase the number of addiction specialists, including doctors, nurses, and social workers, providing on-site addiction consult services at the bedside.
- Increase access to mobile services (for example, via a service van) to increase engagement with populations most vulnerable to overdose.
- Increase participation from agencies providing SUD/AUD services throughout Greater Lowell into existing coalitions to streamline care and advocate for services.
- Increase the number of peer specialists offering support and case management to residents interested in reducing or stopping their substance or alcohol use.

LGH Priority Area 3: SDOH (Housing Insecurity and Food insecurity and Access)

Goal: Reduce the rates of community members experiencing housing and food insecurity in our neighborhoods.

Target population: Elderly, youth, unhoused, and immigrant and refugee communities

Action plan

- Continue the partnership with Community Teamwork, to provide a housing and resource specialist to support Emergency Department and Social Work staff with in-person, real time assistance for our patients who present with housing and food insecurity, etc.
- Continue and expand our partnership with Mill City Grows to continue to provide fresh produce, nutritional information and cooking classes to patients experiencing food insecurity to ensure that they have access to fresh produce and healthy meals.
- Continue to participate in community and city initiatives and partnerships designed to alleviate housing and food insecurity for our patients.

MelroseWakefield Hospital (MWH) and Lawrence Memorial Hospital (LMH)

MelroseWakefield Hospital and Lawrence Memorial Hospital encompasses MelroseWakefield Hospital in Melrose, Lawrence Memorial Hospital of Medford, an urgent care location in Medford, Breast Health Center in Stoneham, Center for Radiation Oncology in Stoneham, a Medical Center in Reading, Tufts Medical Center Community Care, the Lawrence Memorial/Regis College Nursing and Radiography Programs, and a variety of community-based programs and services.

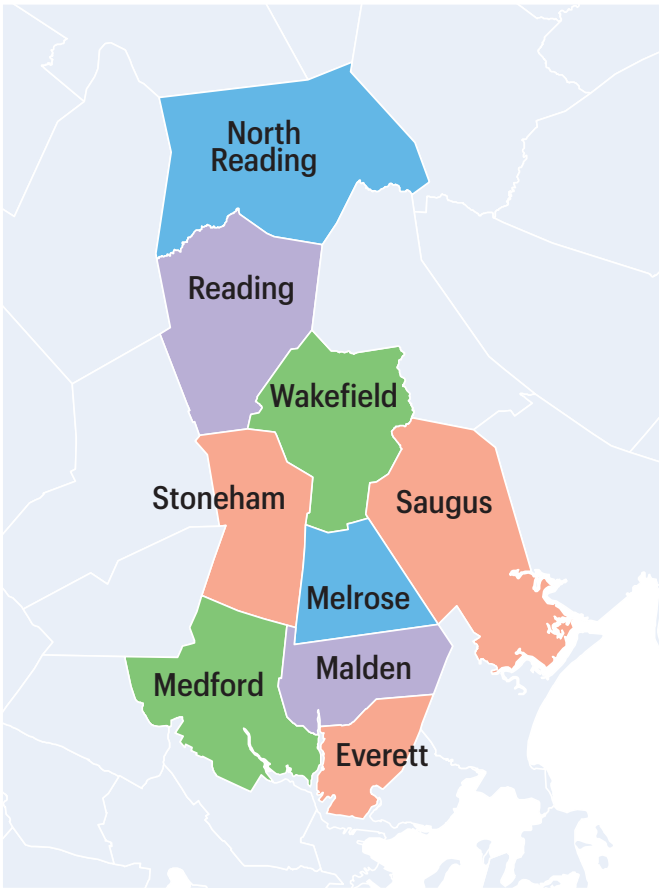
MelroseWakefield Hospital and Lawrence Memorial Hospital community benefits service area consists of Everett, Malden, Medford, Melrose, North Reading, Reading, Saugus, Stoneham and Wakefield. MWH's Community Services division oversees programs that impact both medical and social determinants of health, supported by a mix of federal, state, and private funding. These include:

- North Suburban Women, Infants, and Children (WIC) Nutrition Program
- Healthy Families Program and Massachusetts Home Visiting Initiative (HF/MHVI)
- North Suburban Child and Family ResourcebNetwork (NSCFRN)
- Aging in Balance Elder Outreach
- Community Health Education
- Onesource Lifeline Program

In addition to those listed above, MWH oversees around 90+ community benefits programs that address the community health priorities identified in the CHNA. The programming addresses the Massachusetts Attorney General's Office and IRS 990 Schedule H reporting requirements. MWH will continue to oversee community benefits programming with a health equity lens to best serve community members and their needs. MWH will also focus on enhancing engagement with other local providers with whom we overlap in service areas to strengthen our understanding through better data, shared information and collaboration.

Service area demographics:

MWH has designated nine towns as their community benefits service area: Everett, Malden, Medford, Melrose, North Reading, Reading, Saugus, Stoneham and Wakefield. There are 311,996 residents in the MWH community benefits service area, of this population, 23.8% were born outside of the United States, 30.1% speak a language other than English at home. The lowest median income town is Everett ($65,528) and the highest is Reading ($132,731).



Among the communities within the service area, Malden has the highest percentage of people describing themselves as Asian (22.5%) and Everett has the highest percentages of people identifying as Hispanic (28.3%) and Black/African-American (16.5%). Income levels in the community benefits service area also exhibit wide variation.

Service area demographics

	Population	% White	% Black	% Asian	% Hispanic	% Born Outside the US	% Aged 0-19	% Aged 65+	Median Income	% Under Poverty Line
Everett	46,118	43.6	16.5	8.1	28.3	43.1	24.9	11.2	65,258	10.9
Malden	60,984	47.0	18.0	23.0	8.0	42.6	20.5	12.7	65,965	12.0
Medford	57,637	71.1	9.1	9.8	6.5	21.9	17.8	14.8	96,445	1.8
Melrose	28,113	85.7	2.9	6.2	3.2	12.2	21.7	17.2	106,955	3.8
North Reading	15,581	89.3	0.4	4.4	3.0	8.9	24.5	21.7	128,651	2.0
Reading	25,132	91.1	0.4	4.4	3.0	8.2	25.8	17.5	132,731	2.0
Saugus	28,215	83.3	2.0	3.8	8.6	13.2	19.1	20.2	88,667	7.1
Stoneham	23,223	87.7	2.8	4.5	3.3	13.5	18.8	20.2	101,549	2.6
Wakefield	26,993	91.0	1.7	2.4	3.5	8.0	20.9	18.6	100,278	2.1
Total/Weighted Average	311,996	70.2	6.0	7.4	7.5	23.8	21.6	17.1	98,500	4.9

Besides Everett and Malden, all communities have a median income higher than the state overall. The demographic makeup of this service area is less racially, ethnically and linguistically diverse than the state as a whole, though the percentage of foreign-born residents is higher.

MWH's CHNA identified the following Community Health Priorities, in alphabetical order:

- Access to health care
- Chronic disease with a focus on cancer, cardiovascular disease, diabetes and respiratory disease
- Disaster readiness and emergency preparedness, including COVID-19 response
- Housing stability and homelessness
- Infectious disease
- Mental illness and mental health
- Preventable injuries and poisonings
- Substance use disorders
- Violence and trauma
- Social determinants of health: poverty, education, employment, food access, violence and trauma, vulnerable populations, housing stability and homelessness

5 top needs from CHNA* (in alphabetical order)

1. Access to healthcare
2. COVID-19
3. Housing stability and homelessness
4. Mental Health and mental illness
5. Substance and alcohol use disorders

*NOTE: MWHC has 9 priorities identified in their 2022 CHNA

Recent accomplishments include:

Mobile food market increases amount of food distributed and new volunteers

In March 2021, MelroseWakefield Healthcare was a recipient of The Massachusetts Service Alliance (MSA) COVID-19 Resiliency Grant for $4,000. The goal of the grant was to increase the number of volunteers we had at the Mobile Food Market so we could increase food distribution from 400 bags of food to 650 bags of food and ultimately decrease the food insecurity rate in our highest risk communities (Everett and Malden).

Between April to August 2021, 48 new volunteers worked at the Mobile Food Market, exceeding our goal of 25 volunteers by almost double. Additionally, we were able to provide nutritious food to 250 additional families each month. We served 2,600 families from 4/1/21-8/31/21 versus 1,600 served during the same period in 2020 — a 38% increase. This includes 60,878 lbs. of food served solely from our Mobile Food Market during the grant time period; an increase of 42,507 lbs. from the same time period in 2020—a 331% increase. According to Feeding America's food

insecurity estimates for Middlesex County, there has been a 2.6% decrease in food insecurity (135,900 (8.5%) vs 176,900 people (11.1%)) since 2020. According to The Greater Boston Food Bank's Meals Per Day Research Data, Everett has had a 56% increase in the number of meals distributed from 2020-2021. Malden has had a 40% increase in the number of meals distributed from 2020 to 2021.

Priority Initiatives for next 3 years:

- Health and Wellbeing
- Access to Quality Care
- SDoH

MWH Priority Area 1: Wellbeing (Behavioral Health and Health Behaviors)

Goal: Reduce stigma and increase access to mental health care through programs and infrastructure changes that offer education and support to individuals with mental illness and their families and make it easier to obtain mental health care in existing medical and community settings.

Target population: Members of vulnerable populations, including older adults, immigrants, people living in poverty, children and families (especially very low-income families, adolescents, homeless youth and working families not eligible for subsidies), people with substance use disorders, people who have disabilities, young adults, people affected by domestic violence and sexual assault, people who identify as LGBTQ+ and veterans.

Action plan

Continue to integrate behavioral health needs into primary and chronic disease models of care, including MW community-based programming and coalition efforts (HF/ MHVI, North Suburban Child and Family Resource Network).

- Continue to convene the Mystic Valley Regional Behavioral Health Coalition with the Middlesex County District Attorney, NAMI (National Alliance on Mental Illness), and the Mystic Valley Public Health leaders to address community behavioral health needs. Goals include increasing community and providers' education and supporting improved cross-agency collaboration.
- Continue work with partners on court diversion programs.
- Offer programming to reduce elder isolation.
- Offer school-based and community-based strategies to reduce anxiety and toxic stress and build resilience in youth.
- Offer sliding scale supplemental support for individuals unable to afford mental health services.
- Offer the "Savvy Caregiver Program".
- Provide a variety of support programs for elders, children, and adults suffering after the loss of a family member or friend in partnership with Tufts Medicine Care at Home.
- Offer support to Grandparents Raising Grandchildren locally and statewide.
- Continue to develop plans for a new Behavioral Health hospital in Malden.

MWH Priority Area 2: Access to Quality Care (Women and Children's Programs)

Goal: Increase access to healthcare, especially for uninsured and vulnerable populations, through the provision of programs that address barriers to care, assist with healthcare coverage applications, and provide education to improve health and social outcomes.

Target population: Members of vulnerable populations, including immigrants, people living in poverty, young first-time parents, infants and children (especially very low-income families, adolescents, homeless youth and working families not eligible for subsidies).

Action plan

- Assist families with access to family assistance programs such as those through WIC, the North Suburban Family Network, Community Health Education program, Healthy Families and the MA Home Visiting Initiative.
- Reduce child abuse and neglect by offering classes, events, groups, supports, and programming to decrease isolation and increase parenting knowledge.
- Support educational attainment for young adults.
- Offer opportunities to support optimal growth and development of children.
- Reduce second pregnancies in the teen years.

- Provide concrete supports such as clothing, childcare items, nutrition vouchers and nutrition education.
- Connect families to other local resources.

MWH Priority Area 3: SDoH (Addressing Food Insecurity)

Goal: Impact the social determinants of health, especially poverty, education and food access, through upstream efforts such as advocacy and policy change, and downstream efforts such as education, training, provision of supplies and food, and access to safety net programs. Collaborate with the Greater Boston Food Bank to achieve their "Meal Gap" goal of serving three meals a day. The GBFB had a 41% increase in meeting their goal from 2019-2021 in the MelroseWakefield service area communities.

Target population: Members of vulnerable populations, including older adults, immigrants, people living in poverty, children and families (especially very low-income families, adolescents, homeless youth and working families not eligible for benefits).

Action plan

- Promote local food pantry use.
- Mentor colleagues on food distribution strategies.
- Participate as members on the Health and Research Council of the Greater Boston Food Bank (GBFB) and the Hunger to Health Collaborative.
- Participate on local boards of directors for agencies serving the under-served such as the Tri-City Hunger Network.
- Partner with Tufts Medical Center Community Care and the Tufts Medicine Accountable Care Organization in addressing systems change through "Mobilizing Healthcare for a Hunger Free MA", allowing MW to build an electronic medical record (EMR) tool to screen for food insecurity in patients and develop ways to enhance food access.
- Host a Mobile Food Market monthly in partnership with the Greater Boston Food Bank (GBFB) and area volunteers. Regularly serve 650 families a month using a variety of strategies.
- Support the development of a food access program for students on the Lawrence Memorial Hospital/Regis College campus.
- Work with the Mystic Valley YMCA and the GBFB to support a new type of food pantry in this area.
- Support the micro-pantry project led by faith-based organizations in Medford.
- Promote policy development through partnerships such as Food is Medicine Massachusetts (FIMMA) which is striving for a hunger-free MA in 2028.
- Promote registration in government sponsored food programs through Mass in Motion local food plans to address the SNAP GAP. Enrollment rates among those with food insecurity increased from 25% in 2019 to 55% in 2021.
- Advocate for free school and summer meal programs increasing usage significantly by 63%
- Administer the North Suburban WIC Nutrition Program—growing the volume from 2,500 to 3,000+ participants over 2 years.

In response to the 2022 CHNA, MWH's CHIP (Community Health Improvement Plan) was approved and released in February 2023. The CHIP development is conducted through the review of the Community Benefits Advisory Council (CBAC) and approval by the Board of Trustees. See: **melrosewakefield.org/in-the-community/community-benefits/.**

Tufts Medical Center (Tufts MC)

Tufts Medical Center (Tufts MC), is a 415-bed academic medical center located in Boston's Chinatown and Theatre District. Tufts MC provides everything from routine and emergency care to the residents of Boston neighborhoods to treatments and care for the most complex diseases and injuries affecting patients throughout New England.

Tufts MC focuses its community health programming on the Boston neighborhoods of Chinatown, Dorchester, South Boston, and the South End, as well as the City of Quincy and the Greater Boston Asian community. The racial and ethnic makeup of Tufts MC's service area varies considerably by community. Chinatown is predominately Asian, while Dorchester is predominately Black and Latinx, and Chinatown, Dorchester, and Quincy all had a higher share of foreign-born residents than the Boston city average. Racist policies and practices like redlining have contributed to deep inequities compounded by the COVID-19 epidemic and revealed by the assessment.

Service area demographics

	Chinatown		Dorchester		South Boston		South End		Quincy		Boston	
	%	#	%	#	%	#	%	#	%	#	%	#
Age												
Under 5	6	467	6	8,259	5	2,215	4	1,244	5	4,636	5	34,039
5–19	16	1,298	19	27,682	7	3,041	11	3,206	18	10,885	15	105,854
20–34	31	2,453	27	39,644	44	18,129	34	9,826	27	25,093	35	238,796
35–64	29	2,316	36	52,810	35	14,559	38	10,934	40	37,901	33	229,353
64+	18	1,415	12	17,902	9	3,535	13	3,682	16	15,692	12	81,284
Race/Ethnicity												
White Non-Hispanic	27	1,898	22	27,411	77	33,454	57	16,681	59	55,540	45	276,031
Black or African American	4	297	35	42,714	4	1,689	10	2,959	5	47	19	129,264
Hispanic or Latino	7	477	21	35,285	10	4,203	13	3,783	3	2,908	19	126,013
Asian/Pacific Islander	60	4,281	11	13,260	6	2,559	16	4,677	30	28,532	11	75,839
Other	3	190	11	13,421	4	1,591	5	1,336	1	634	2	10,246
Education												
Less than a high school graduate	20	1,066	17	16,529	6	1,880	17	3,678	12	8,654	12	58,108
High School Graduate	14	739	29	29,007	13	4,237	13	2,956	23	16,566	19	90,520
Some college, no degree	4	190	6	5,889	3	1,097	3	725	7	5,140	5	22,052
Associate's degree	4	221	18	17,963	8	2,599	11	2,364	13	9,734	13	62,337
Bachelor's degree or higher	59	3,144	30	29,649	71	23,903	56	12,539	27	19,576	51	245,847
Nativity												
Native	51	4,018	66	97,193	87	35,947	73	21,090	67	62,808	72	494,788
Foreign-Born	49	3,931	34	49,104	13	5,532	27	7,802	33	31,399	28	194,538
Languages												
Speaks only English	41	3,101	59	82,052	82	32,112	60	16,624	58	54,878	63	412,091
Speaks a language other than English	59	4,381	41	55,986	18	7,152	40	11,024	42	39,329	37	243,196
Housing												
Owners	27	962	37	19,234	41	8,177	30	4,059	46	19,013	35	96,502
Renters	74	2,664	63	32,780	59	11,643	70	9,613	54	22,174	65	176,686
Rent costing more than 30% of income	49	1,090	57	17,867	32	3,513	51	2,371	46	10,090	49	81,961
Poverty Status												
Individuals below poverty level	28	1,937	21	31,241	11	4,699	27	7,319	10	9,172	18	116,102
Health Insurance												
No health insurance	3	256	5	6,365	2	906	2	466	3	2,919	4	24,126
Income												
Median Household Income	**$52,663**		**$57,603**		**$128,738**		**$62,850**		**$77,562**		**$76,298**	

Source: American Community Survey, 2020 5-Year Estimates. BPDA 2020 US Census Redistricting Data Release.

Recent accomplishments include:

Since 2004, Tufts MC has partnered with community-based organizations to improve the health and welfare of community residents through the Dorchester Health Initiative (DHI). Six organizations received $900,000 in funding for programs in October 2019 through September 2022.The programs range in size and scope, but all focused on addressing behavioral health issues, including substance abuse and youth violence in marginalized communities as identified as a community priority in the 2019 CHNA. One organization provided case management and helped connect youth and families to the available services in the community. Another organization provided parental education to help fathers improve relationships with their children. Another organization provided individual and group therapy to help children and families cope with stress and build resiliency. Since 2019, DHI has served more than 4,100 children and families. Of these families, more than 2,000 individuals were connected to social services to improve their health and well-being.

In 2020, Tufts MC distributed almost 300,000 among 23 community organizations to address short-term COVID-19 related needs. In 2021-2022, Tufts MC's Community Relief and Recovery RFP focused on continuous and sustainable economic recovery, providing $916,500 in support to 21 organizations. As a result of the COVID Relief and Recovery grant between 2021-2022, 4,073 community members received vital resources and support, including financial and housing literacy and counseling, and skills building and career coaching. Highlights include:

- 2,307 community members completed skills development training to improve health and wellbeing.
- 1,305 community members received education, training, and career coaching to improve future employment.
- 188 community members completed financial literary programs to learn how to manage personal finances and improve consumer behavior.
- 696 community members received housing counseling.

Other community health initiatives and partnerships include:

- The Asian Health Initiative
- School-based Education
- Tufts MC High School Summer Internship Program

As part of the implementation of our new medical record, we leveraged this project as an opportunity to develop diverse talent launching the EPIC Pipeline Program in collaboration with the Asian American Civic Association (AACA). This workforce development program trains and certifies immigrants and diverse adult learners in EPIC software. Through the Pipeline, residents of Chinatown and South Boston pursue certifications in both EPIC and the Amazon Web Services (AWS) Cloud by learning basic computer and soft skills, as well as EPIC applications. Workers certified through this program not only support our AWS and EPIC operations internally, but also earn the training necessary to seek opportunities in the healthcare IT field, closing disparities in education and opening up new pathways to economic stability.

Top needs from CHNA

1. Behavioral health
2. Access to care and social services
3. Tobacco and nicotine control
4. Economic opportunity
5. Chronic disease management
6. Housing

Priority initiatives (organized by theme, i.e., Health and Wellness, Access to Care, SDoH).

Tufts MC Priority Area 1: Behavioral Health (Health and Wellbeing)

Goal: By 2025, promote social and emotional wellness by fostering resilient communities and cultivating accessible, supportive systems.

Target population: Members of vulnerable populations, including youth, racial and ethnic minorities, low-income households in the Greater Boston area.

Action plan

- Engage community members in social-emotional wellness activities and programs to mitigate and prevent behavioral health challenges.
- Support counseling, case management, substance use disorder treatment, support

groups, and other related services provided in hospital and/or community-based settings, including schools, housing complexes, health centers, social service organizations, and other institutions.

Priority 2: Access to care and services (Access to quality care)

Goal: By 2025, increase access to health, educational, and other support services that provide culturally, linguistically, and developmentally-competent care.

Target population: Vulnerable or under-served populations in the Greater Boston area, including linguistic and cultural minority groups, youth, seniors, low-income households, and communities of color.

Action plan

- Connect community members to health providers and/or social service providers with diverse linguistic and cultural competencies.
- Assist community members in learning about and accessing health-promoting services and/or benefits for which they may be eligible.
- Improve the capacity of health and social service providers to serve vulnerable populations.
- Provide health education, screenings, and connections to care in accessible settings.
- Connect community-based services organizations and health services providers to provide seamless referrals and patients and clients.

Priority 3: Financial security and mobility (SDOH)

Goal: By 2025, increase the number of opportunities for improving socioeconomic status through education, training, employment, and other career pathways.

Target population: Marginalized and under-served populations, especially youth, women, low-income households, and racial and ethnic minorities.

Action plan

- Provide innovative pathways for individuals and families to achieve economic success.
- Create opportunities for paid or unpaid professional development opportunities for youth at Tufts MC and/or partner organizations.
- Create opportunities for youth and adults to explore and/or participate in further education, career training, or similar professional development experiences.

Diversity and Health Equity Priorities for 2023–2024

Tufts Medicine is committed to continue our journey of advancing diversity, equity, and inclusion to reflect the communities we serve and build leaders with an equity lens to foster respect and belonging. We learned from our partners in the community with humility and set priorities to address their needs. Internally, we monitor the progress of health outcomes by demographics to prioritize our work for a greater impact. We know we are not there yet, but we are committed to continue this journey with the following priorities for the next two years.

Key Priorities for 2023–2025

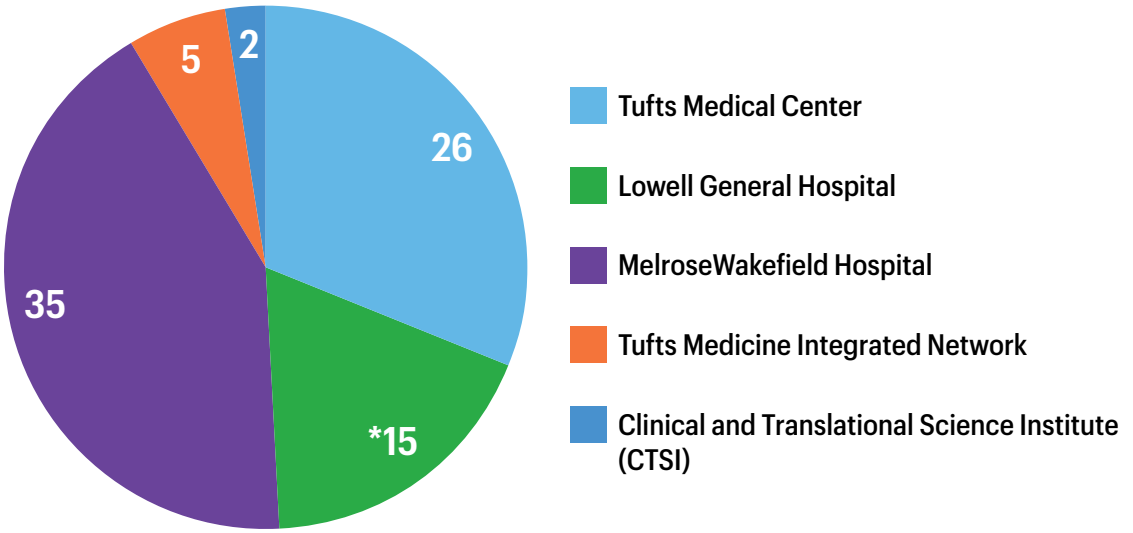
Area of Focus	Goals	Performance Indicators
Formalize Health Equity Strategy and 5-year plan to reduce health disparities	• Develop strategic plan to advance healthcare quality and equity including measures, and approach to achieve performance goals. • Becoming a learning health system • Improve access to care providing education about existing services, removing barriers to securing insurance, and consolidating available health and social services	# improvement plans # assessments # of unique patients # of research projects # of resident rotations in community hospitals
Established HE infrastructure and governance	• Formalize health equity system and local level councils aligning existing programs while building collaborative partnerships with internal experts, key community, and entity stakeholders	—local and system level priorities and equity interventions # investment and resources
Consistently collect data to drive priorities, monitor progress and continuous improvement efforts	• Improve data collection at point of care by: updating EMR to reflect new RELDSOGI and HRSN data collection standards; standardizing new workflows and training on culturally-competent data collection; implementing "we ask because we care" campaign.	% of data accurately collected # of services provided to address social needs — track outcomes by race and other demographics
Advance implementation of diversity, antiracism, and inclusion strategies for DEI to become part of our DNA	• Build workforce capacity through the DEI Academy: Bias in Medicine, Subtle Acts of Exclusion, Equitable Experiences, Cultural Competence, and Health Equity	# of people educated % improvement of DEI perceptions, sense of belonging, and openness to speak up # of employee in DEI councils
Partner with our communities to implement programs to address disparities	• Implement pipeline programs to increase workforce diversity • Implement equity improvement interventions to improve access and track strategies aligned with Community Health Needs Assessments (CHNAs) and Tufts Medicine's needs and opportunities.	# of diverse leaders, physicians, nurses, faculty hired % Improve in retention # of pipeline programs % improvement in disparities # CHNA equity interventions and outcomes
Advocate for policy changes to advance equitable care	• Assess processes and systems and update policies to address structural racism and equity • Prioritize advancing health equity in government affairs advocacy agenda.	# of policies updated/created # of legislations approved

Health equity initiatives inventory

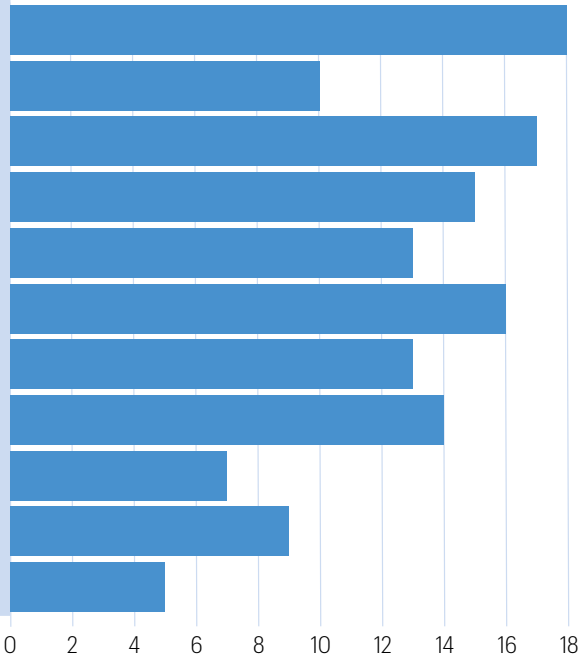
In July of 2022, as part of laying the groundwork for the Tufts Medicine Health Equity Strategy, the Center for DEI conducted a survey of across the system to inventory the myriad initiatives currently being implemented in different departments to address health disparities. Below is a high-level overview of the responses compiled. For a complete list of programs see the Appendix.

HE Inventory: Projects by Entity and Focus

Total number of responses: 86



Primary focus	%	n
Research / Education	13	18
Policy Development / Advocacy	7	10
Quality Improvement	12	17
Access	10	15
Community Outreach	9	13
SDOH (housing, employment, etc)	11	16
Disease Management	9	13
Culturally Competent Care	10	14
Data / Dashboard	5	7
Anti-Racism / Discrimination	6	9
Other (please specify)	3	5



1. **Access to Care:** 15 initiatives, including the WIC Nutrition Program at MWHC, which provides nutrition education and food benefits to low to moderate income women and children to age 5 years in 12 communities.
2. **Antiracism/Discrimination:** 9 initiatives, including Addressing Disparities in Asian Populations through Translational Research (ADAPT) at Tufts MC), a collaboration of administrators, researchers, clinicians, and students affiliated with Tufts Medical Center, Tufts University, and community leaders from five community organizations in Boston's Chinatown. The collaboration follows principles of community-engaged partnerships, including community-identified goals and priorities, shared decision-making, and co-learning.
3. **Community Outreach:** 13 initiatives, including a Housing Support Specialist at LGH, which provides in-person assistance to patients presenting in the ED or by referrals from case managers who need housing supports, food access, fuel assistance.
4. **Culturally Competent Care:** 14 initiatives, including Community Dialogues on Vaccine Trustworthiness and Confidence at Tufts MC , which addresses the disproportionate disease impact of COVID-19 infection in communities of color by identify barriers to vaccine acceptance among individuals in communities of color and developing, implementing, and assessing the feasibility, acceptability, and impact of structured community dialogues.
5. **Data/Dashboard:** 7 initiatives, including Lowell General Hospital Readmission Prevention and Reduction Initiative, which identifies those at risk for readmission, by screening for SDOH and other contributing factors for readmission, and implementing initiatives to address those needs and medical issues.
6. **Disease Management:** 14 initiatives, including HIV Testing at Tufts MC , which identifies and reduces racial disparities in access to HIV testing for people who inject drugs.
7. **Quality Improvement:** 17 initiatives, including MWHC Mobile Market, which during the pandemic prepared hard produce and shelf-stable items and delivered improves access to healthy food locally and reduces food insecurity through community partnerships with senior centers, shelters, Head Start and many more.
8. **Policy/Advocacy:** 10 initiatives, including Regional Support for Behavioral Health at MWHC, which increases access to care, creates and promotes strategies to support vulnerable populations, and break down barriers between provider communities.
9. **Research/Education:** 18 initiatives, including LGH Community Health Events which provide education and health resources to greater Lowell residents at community organizations, health fairs, etc.
10. **SDOH:** 16 initiatives, including Eliminating Healthcare Disparities through Payer-Adnostic Quality Improvement at Tufts MC , which reduces and eliminates healthcare disparities through quality improvement processes that are payer-agnostic.

Top recommendations:

1. **Improve access** of existing healthcare services; this includes providing education about existing services, removing barriers to securing in-surance, and consolidating available health and social services into a centralized resource hub.
2. **Advocacy:** engage with local and state officials to reduce the cost of living, with a particular focus on housing and utilities cost, as the primary recommendation for improving their health.
3. **Community partnership:** Improvements in communication with the community, including transparency in data collection and reporting.
4. **Diversity and Cultural Competence:** increasing the multilingual health care provider workforce, increasing the number of print and online materials available in languages other than English, and addressing racism and its impacts in both the health system and the broader community. Specific suggestions for actions within the healthcare system and the community system.

Our health equity promise:

At Tufts Medicine, we understand that health equity work is not a one-and-done effort. We promise to work diligently and sustainably on eliminating the inequities that drive disparities in healthcare access, quality, and outcomes. We promise to nurture relationships with stakeholders that will help identify and address the community's health priorities. This is not something we must do in addition to our work, but how we must do our work.

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine Institute for Clinical Research and Health Policy Studies (ICRHPS)				
Healthy Outcomes from Positive Experiences (HOPE)	Robert Sege MD PhD	Change the way care is provided to children and their families through the identification, celebration, and promotion of key positive childhood experiences that promote optimal development	Community Outreach	HOPE has reached over 20,000 providers across the country
Tufts Medicine Lowell General Hospital (LGH)				
Veggie RX Program	Lisa Taylor-Montminy	Provide cardiac rehab patients with direct access to fresh fruits and vegetables and guidance on nutrition and healthy recipes	Community Outreach	Cardiac Rehab Patients
Housing Support Specialist	Lisa Taylor-Montminy	Provide in-person assistance to patients presenting in the ED or by referrals from case managers who need housing supports, food access, fuel assistance, etc.	Housing/ Homelessness	LGH patients, ED and Case Management
Interpreter Services	Gabriella Bradburn	Provide culturally competent interpreter services to the Greater Lowell Community	Culturally Competent Care	Inpatients and community members at various community events
Lowell Housing Coalition	Lisa Taylor-Montminy	Participate in city wide task force to address homelessness and housing insecurity in the city.	Housing/ Homelessness	Homeless Population
Careers In Healthcare	Lisa Taylor-Montminy	Provide exposure to, and promote interest in, health care careers for area high school students	Community Outreach	Youth
In-kind Space	Lisa Taylor-Montminy	Provide in-kind space for various community support groups, activities	Community Outreach	Community Groups
Community Health Events	Lisa Taylor-Montminy	Provide education, health resources, at community organizations, health fairs, etc.	Community Outreach	Greater Lowell residents with health issues, community groups
COVID Response	Amy Hoey	Provide education and vaccines to reduce the impact of COVID 19 on the community	Access to Care	Greater Lowell Residents with barriers to vaccine education and access
Lowell Homeless Services Monthly Provider Meeting	Amanda Ford	Updates from the City on employment, insurance assistance, housing, youth services, DMH, home care services, addiction treatment and recovery, clothing, food, legal aid	Housing/ Homelessness	Housing unstable or unhoused
Lowell General Hospital Readmission Prevention and Reduction Initiative	Amanda Ford	Identify those at risk for readmission, identify SDOH and other areas that cause readmission, and implement initiatives to address those SDOHs and medical issues.	Culturally Competent Care	Individuals with health-related social needs
Mobile Integrated Health program	Wendy Mitchell MD	Provide mobile health care to the homebound	Access to Care	Those without access to outpatient care either due to closed clinics, transportation, or homebound status
ConnectCare Hub	Wendy Mitchell MD	Provide coordinated care and services including heart failure clinic, transitions clinic, remote patient monitoring, referrals to Resource Bank (a la carte SW and CHW services to address social determinants of health). Zoom visits with provider coordinated with MIH paramedic in home to get vitals, labs, administer iv medications, etc.	Access to Care	Most complex patients

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine Lowell General Hospital (LGH) continued				
Mentorship: Internal (Employee and Volunteer) and External (Youth) Programs	Dr. Sangita Pillai	Mentor current employees and volunteers to help with career growth and advancement goals. Create a diversified future workforce by mentoring young people in the community who are interested in health careers.	Employment/ Income	Urban Youth within the Greater Lowell Area Interested in Health Careers
Tufts Medicine MelroseWakefield Hospital (MWH)				
MWHC Mobile Market — Food Access	Eileen Dern	Strategically improve access to healthy food locally and reduce food insecurity in our service area through community partnerships. During the pandemic, the program prepares hard produce and shelf stable items and delivers them to vulnerable community members in partnership with senior Centers, Shelters, Head Start and many more.	Community Outreach	Program serves 600 families monthly
Regional Support for Behavioral Health	Eileen Dern	Increase access to care, create and promote strategies to support vulnerable populations, and break down barriers between provider communities	Access to Care	Individuals and families with behavioral health needs
Care Coordination for high-risk patients using text outreach	Mary Hajjar	Ensure high risk members are prioritized for care with an additional call and/or received multiple outreach attempts.	Access to Care	High risk members who have not been seen recently
Athletic Trainers in Schools	Jen Sturtevant	Provide low cost Athletic Trainers to 6 local high schools to prevent and/or reduce adolescent injury. Safe space to talk for teens.	Community Outreach	High School students: Malden, Stoneham, and many others
Aging in Balance	Stephanie Ramy	Provide evidence-based or evidence-informed programs to assist elders to be safer and healthier. Also offer community BP monitoring and counseling. Deliver healthy foods to Senior Centers and Housing.	Culturally Competent Care	Aging Adults
Healthy Families-MA Home Visiting	Beth Chockley	Reduce child abuse and neglect, support optimal child growth and development, reduce second pregnancies in the teen years, promote educational attainment and self-sufficiency.	Violence/ Education	First time young parents under 25 years and their partners and children until the child is age 3 yrs.
Community Health Education	Katie Barnes	Provide culturally competent community education for skills development (CPR) and ensuring residents seek care when needed (stroke education translated)	Community Outreach	Classes based on need- such as for children home alone, babysitting, childbirth classes, menopause programs etc.
WIC Nutrition Program	Saratha Sivasitham-param	Provide nutrition education and food benefits	Community Outreach	Classes based on need, such as for children home alone, babysitting, childbirth classes, menopause programs etc.
Baby Cafe's	Saratha Sivasitham-param and Mary Foley	Support Breastfeeding Mothers- healthier children, and reduction in breast and ovarian cancer for women.	Community Outreach	Women who need breast-feeding support and their infants.
Creative Coping	Karen Andrews	Support women and infants through the use of the Protective Factors out of the Center on Social Policy	Culturally Competent Care	First time mothers that could use support and connections.

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine MelroseWakefield Hospital (MWH) continued				
North Suburban Child and Family Resource Network	Katie Barnes	Promote Literacy and Prepare children and families for entering school	Education	All parents and caregivers with children under school age. Focused on hard to reach for school readiness.
Diabetes Education	Tufts MC CC	Improve the health outcomes of patients with diabetes	Education	Patients and their families with diabetes to improve their diabetes outcomes.
Breastfeeding Education	Mary Foley- just left MWHC	Promote breastfeeding to improve the health of women and infants	Education	Outpatient visits and classes to support breastfeeding. Acts as a coach and mentor to other hospitals trying to achieve Baby Friendly status.
Breast Health Navigators	Elisa Scher	Support women to improve screening and follow-up services for breast cancer identification and treatment	Culturally Competent Care	Supports women with breast health issues such as cancer.
School of Nursing and Radiology	Nancy Bitner	Provide culturally competent nursing and radiology training to local diverse students	Culturally Competent Care	An Associate degree program focused on developing Nurses from diverse populations.
Financial Counselors	Aminda Monteagudo	Ensure access to care for all residents in our communities	Access to Care	Supports residents with enrollment and re-enrollment on state and other health plans. Sets up payment plans, helps with applications for SNAP etc.
Medication Assisted Treatment in Primary Care	Eileen Dern	Reduce stigma of MAT through normalizing this program in primary care	Education	Utilized grant-funding to train and plan a program for MAT at Malden Family Health Center.
Student Placements	Differs for each	Train a diverse group of students to prepare for future hiring and to expand medical knowledge across our communities.	Education	Mentors and trains students from many local schools and colleges.
Nursing Preceptors	Beth Campbell	Train diverse graduate nurses to prepare for future hiring and to expand medical knowledge across our communities	Education	Monitors all student placements for reporting.
Continuing Medical Education	Dr. Butler	Provide latest medical and social service information for physicians and other providers in the community. The on-line breastfeeding education is offered around the world.	Education	Provides education for community physicians on relevant community needs such as breastfeeding education.
Domestic Violence Programs	Eileen Dern	Provide local office and group space for a provider of DV/IPV services in the community.	Violence/ Criminal Justice	Offers space to a local provider of Domestic and Intimate Partner Violence services.
In-kind Space	Eileen Dern	Offer space to community groups in alignment with the hospital's mission and community health priorities.	Community Outreach	Offers space for other groups such as MA PTA in alignment with the mission. Paused since the Pandemic.
Blood Drives	Lab	Provide space for the Red Cross to collect blood donations critical for use in emergencies and routine care.	Community Outreach	Ensures a safe local blood supply for emergencies.

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine MelroseWakefield Hospital (MWH) continued				
Community Health Events	Lori Howley & Eileen Dern	Offer time and talent to local communities as needed such as support for a tree give-a-way to support families enrolled in the local anti-poverty program ABCD.	Community Outreach	Recently supported back pack drive in Malden for back to school.
Toy Drives	Eileen Dern	To demonstrate caring for children under the care of the Department of Children	Community Outreach	Provides gifts for DCF involved children.
Care Kit Drives	Eileen Dern	Provide personal care items to those in need	Community Outreach	Serves homeless, those involved with DV/IPV, shelters, and others.
Emergency Planning	Dr. Alec Walker	Support the City of Melrose and other communities in our region with Emergency response such as upcoming Active Shooter training.	Community Outreach	Oversees Melrose EMS services. Supports EMS education for ambulance staff across the region.
Health Minute Videos	Rob Brogna	Provide education based on recent events such as heat emergencies or on topics of community interest aligned with Community Benefits priorities such as colon health.	Education	Provides education to entire community through media. Topics support things such as Stroke education, Fall Prevention- #1 Trauma at MWHC.
Support to Partnerships	Eileen Dern	Offer time and talent to local community groups aligned with our mission	Community Outreach	MWHC is represented in the community on Boards such as Melrose Alliance Against Violence, Malden Overcoming Addiction, the Bridge Recovery Center and many more.
Interpreter Services	Marianne Downey	Provide culturally competent care to diverse community members	Culturally Competent Care	Used by inpatient, employed providers, and in the community.
Behavioral Health Grants	Barbara Kaufman	Fund community projects that reduce stigma around mental health, support youth BH, and reduce elder isolation.	Access to Care	Oversee the work and the funds. Evaluation by the Institute for Community Health.
Mothers Helping Mothers Closet	Karen Andrews	Provide support to families to reduce child abuse and neglect- protective factor-concrete support in times of need. Also distribute parenting resources as needed.	Community Outreach	Provides free lightly-used clothing and care supplies for children.
COVID Response	Dr. Steven Sbardella	Provide education and vaccines to reduce the impact of COVID 19 on the community	Education	All residents but especially those determined in need by local BOH Directors
Tufts Medicine Tufts Medical Center				
Analysis of Race in Penicillin Allergy and De-labeling	Alysse Wurcel	To improve the equity of penicillin de-labeling access	Education	Primary Care patients
Trauma Informed Care (Meeting Patients Where they are)	George Guara	Optimization of trauma informed care approach	Culturally Competent Care	Inpatients with health-related social needs
Complex Care Management	George Guara	Care optimization during admission, SDoH, reduce readmissions and LOS, comprehensive TOC	Culturally Competent Care	Inpatients with health-related social needs

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine Tufts Medical Center continued				
HIV Testing at Tufts Medical Center	Alysse Wurcel	Equitable access to HIV testing at Tufts Medical Center, identify racial disparities	Access to Care	People who inject drugs
Assessing Mental Health Needs in Asian Communities in Greater Boston and Cultural-Responsiveness of a Mental Health First-Responder Training	MyDzung Chu	This project will provide important insights about the diverse mental health needs among Asian Americans and inform culturally-tailored approaches for community-level mental health trainings.	Education	Asian American communities
Asian Lung Clinic for Language Minorities	Sucharita Kher MD	Leverage community resources to improve access to and quality of culturally competent care for tobacco dependence among language minorities	Community Outreach	Language Minorities
Serving Language Minority Patients Summit and HE Dashboard	Sucharita Kher MD	Highlight the work that exists, raise awareness of the challenges, build collaborations to improve care, advocacy and community engagement.	Culturally Competent Care	Language Minorities
Pathways to Health among Low-Income Pregnant Women	Chloe Bird	Increasing dental care utilization. Identify upstream factors that predict downstream dental care utilization during pregnancy. Evaluate how dental care utilization during pregnancy affects oral health during pregnancy	Access to Care	Programs that seek to improve the oral health of vulnerable pregnant women
Developing a Framework for Assessing Identity Development, Retention and Success of STEM Social and Behavioral Scientists (STEM-SBS): The Case of Sociology	Chloe Bird	Address gaps on identity development. Generate knowledge about factors that shape identity development of social and behavioral scientists and that promote entry and success in the field. Advance knowledge about broadening participation in STEM education and STEM workforce development.	Education	Potential sociology students
Title: The Tufts Department of Medicine Visiting Clerkship Program for Students Underrepresented in Medicine	Laura K. Snydman, MD	To increase representation of students under-represented in Medicine (URiM) in the Internal Medicine Residency Program	Education	4th year medical or osteopathic students interested in pursuing an internal medicine residency
Asian Clinic, Primary Care for Chinese speakers	Shirley Huang	Provide primary care to the local Chinese speaking community	Access to Care	Chinese language speakers
Translating Research Intro Practice — 5 year grant	Amy LeClair	Decrease mortality gap between white and Black women across the city of Boston.	Culturally Competent Care	Involved 5 clinical sites and community partners
Implementing standardized collection of sexual orientation and gender identity (SOGI) data	Amy LeClair	Examine the barriers and facilitators to SOGI data collection in a primary care setting, develop implementation strategies with the input of a stakeholder advisory board, and pilot data collection/collect outcome measures	Culturally Competent Care	Sexual and gender minority communities

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine Tufts Medical Center continued				
Engaging Stakeholders to Improve Infectious Diseases Care	Alysse Wurcel	Improve infectious diseases healthcare in jails and prisons	Violence/ Criminal Justice	Incarcerated people
Food insecurity in pregnant population cared for at Tufts	Deanna Sverdlov	Screen 90% of all new patients presenting to OB clinic by August.	Access to Care	Pregnant patients in high-risk OB (MFM) clinic
Title: Eliminating Healthcare Disparities Through Insurance-Blind Quality Improvement	Deborah Blazey-Martin, MD MPH	Reduce and eliminate healthcare disparities through quality improvement processes that are payor-blind	Access to Care	Hypertensive and diabetic patients
Collecting SOGI (sexual orientation and gender identity) data	Deborah Blazey-Martin, MD MPH	Operationalizing SOGI data collection in our practice in a sensitive way in order to better serve all patients, diversification of hiring in primary care	Culturally Competent Care	Primary care staff and LGBTQ patients
Team-Based Model of Language-Congruent Care for Mandarin- and Cantonese-Speaking Patients	Deborah Blazey-Martin, MD MPH	Provide seamless, culturally-competent, linguistically-congruent care to the large population of patients whom we serve who speak Cantonese and Mandarin Chinese, from being greeted by the front desk to being checked out after their visit.	Culturally Competent Care	Asian-American and Pacific Islanders (AAPI)
Addressing breast cancer disparities using a city-wide approach	Karen Freund	Translating Research into Action	Education	African-American women
Communication Preferences among Chinese and non-Chinese Americans During Cancer Treatment	Miriam O'Leary	Identify and meet communication preferences among Chinese and other language minorities during cancer treatment	Culturally Competent Care	Cancer patients
Mental Health Support for Southeast Asian community members impacted by deportation, and Undocumented Asian immigrants.	MyDzung Chu	Provide important feedback about the quality and types of the mental health spaces needed to inform future programming for Southeast Asian deportees and Undocumented residents.	Culturally Competent Care	Southeast Asian households facing deportation; Undocumented Asian residents
Annual Research and Health Equity Breakfast	Will Decaneas	Participate in a panel discussion, highlight what has worked and what is needed now to scale solutions to reduce cancer disparities.	Education	Leaders from life sciences, health care, government, academia, and businesses. Advocating to accelerate research and innovation and advance health equity across the country.

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine Integrated Network (TMIN)				
SDoH Sceenings for contractual entities	Mary Hajjar (MWHC), Shirley Huang (Tufts MC), James Gagnon- TMIN (HPHC)	Incorporate a SDOH questionnaire and workflows into various TMIN practices. Adult and Pediatric versions are available. SDOH questionnaire is available in English, Spanish and Portuguese. Identify and increase the use of community resources and education that addresses SDOH needs and improves patient care and health outcomes	Education	• MWCH: Wellforce Care Plan Medicaid ACO patients but tool is encouraged for all patient populations • TM: child and adolescent visits • HPH: all HPHC members but tool is encouraged for all patient populations
BCBSMA Equity Action Community AQC Provider Grant	Nicole Ignachuck and Danielle White for BCBS; James Gagnon for HPHC	Improve the outcomes in Controlling High Blood Pressure for patients ages 18-85; increase REaL & SOGI data as well as SDoH barriers to further determine patients with inequities in care. Provide appropriate levels and types of care for different populations	Access to Care	Ambulatory focus with initial target population to be patients coded with hypertension; Ongoing collaboration with Data Analytics to determine areas of most inequity and disparities. Limited REaL data available int the Networks EMRs.
Tufts Medicine Clinical and Translational Science Institute (CTSI)				
Clinical Research Assistant Training Program	Robert Sege MD PhD	Train community members with the skills needed to become clinical research assistants	Education	
Asian-American Communities: Addressing Disparities in Asian Populations through Translational Research (ADAPT)	Alice Rushforth	Build trusting relationships with the Chinatown community. ADAPT is a collaboration of administrators, researchers, clinicians, and students affiliated with Tufts Medical Center, Tufts University, and community leaders from five community organizations in Boston's Chinatown. The collaboration follows principles of community-engaged partnerships, including community-identified goals and priorities, shared decision-making, and co-learning.	Community Outreach	Under-served Asian-American communities in Greater Boston
Collaboration for Research, Equity, Sustainability, and Trust (CREST)	Alice Rushforth	Promote the health and wellness of Black and Brown communities in the Greater Boston Area through trustworthy and transparent academic-community partnerships. We will achieve this goal by developing appropriate interventions, producing educational opportunities, and utilizing advocacy strategies to foster system changes.	Education	Black and Brown communities in the Greater Boston area
ACCESS Program	Alice Rushforth	Build awareness and encourage participation in science and research	Education	Underrepresented racial and ethnic groups in middle- and high-school aged populations
Community Dialogues on Vaccine Trustworthiness and Confidence	Alice Rushforth	Address the disproportionate disease impact of COVID-19 infection in communities of color. (1) identify barriers to vaccine acceptance among individuals in communities of color and (2) develop, implement, and assess the feasibility, acceptability, and impact of structured community dialogues	Access to Care	Communities of color

Appendix A: Health equity initiatives inventory

Title of program	Lead person contact info	Goals	Focus	Populations Served
Tufts Medicine Clinical and Translational Science Institute (CTSI) continued				
Social and structural determinants of health research project	Alice Rushforth	Address racial inequities in the digital divide that impact healthcare engagement, assess the knowledge and utilization of telemedicine, share results with partnering organizations and their constituents to raise awareness, enhance and improve healthcare access	Anti-Racism/ Discrimination	Caribbean community in Boston
Recruitment Retention and Support Unit (RRSU)	Alice Rushforth	Provide researchers with practical, evidence-based recruitment and retention support in pre- and post-award phases of research studies. RRSU personnel work closely with investigators to devise customized, multi-modality strategies to minimize accrual time and maximize participant retention in research studies. RRSU staff provide services ranging from general consultations to targeted advertising,	Education	All
Integrating Underrep-resented Populations in Research (IUPR)	Alice Rushforth	Create a culture and environment that prioritizes the inclusion of underserved and underrepresented populations from laborato-ry-based scientific discovery to health policy and practice. IUPR promotes the inclusion of underrepresented populations in all aspects of research, from study conception through dissemination.	Access to Care	All
Science Communications	Alice Rushforth	Use civic science frameworks to mobilize scientists to initiate community engagement work at all career stages to make science and research more accessible, inclusive, and diverse. Provide research, trainings, and workshops for internal and external partners	Community Outreach	All
ACCESS Program	Alice Rushforth	Build awareness and encourage participation in science and research	Education	Underrepresented racial and ethnic groups in middle- and high-school aged populations
Various workshops, seminars and events	Alice Rushforth	Diverse goals depending specific event. Events generally supported by out Professional Education team	Education	All
Training	Alice Rushforth	Diverse goals depending on the specific program. One example is our March 2020 “Breaking the Silence: Confronting Exclusion in Research” event to promote dialogue and awareness about racism and exclusion in research.	Anti-Racism/ Discrimination	All
Annual anti-racism report 2021-2022	Allison Stephens	Identify specific activities related to anti-rac-ism in administrative, programmatic, and communications categories for the HOPE (Healthy Outcomes from Positive Experienc-es). Identify specific goals for the upcoming year through an collaborative process that includes community partners, including parents	Anti-Racism/ Discrimination	All
HOPE and anti-racist approaches online course	Allison Stephens	Online course on how to use specific anti-bias and anti-racist approaches when implement-ing the HOPE framework in community-based settings for child and family services	Anti-Racism/ Discrimination	Children and Families

Questions?

For questions and comments about this report, please contact: **centerforDEI@tuftsmedicine.org**

Tufts Medicine
800 District Ave, Unit 520
Burlington, MA 01803

T 800.464.3908
tuftsmedicine.org

@tuftsmedicine
@tuftsmedicine
Tufts Medicine
@tuftsmedicine677
@TuftsMedicine

TuftsMedicine

13124