Abstract Compilation

THRIVING TOGETHER SUMMIT

Advancing Health, Cultivating Leaders and Collaborating on Community Solutions

April 25, 2025

Abstract Compilation

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Completed Projects

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Abstract Details

Ameden, L.

Implementation of an Electronic Health Record-Based Social Needs Screening Tool and Referral Workflow in a Pediatric Emergency Department

Lauren Ameden, et. al.

Name of Submitter	Lauren Ameden lauren.ameden@bmc.org
Project Status	2. Work In Progress
Title of Project	Implementation of an Electronic Health Record-Based Social Needs Screening Tool and Referral Workflow in a Pediatric Emergency Department
Authors	Lauren Ameden MD, Hannah Barber Doucet MD MPH, Rebecca Levin MD MPH, Pablo Buitron de la Vega MD MSc, Deborah A. Frank MD
Institutions	Boston Medical Center Division of Pediatric Emergency Medicine
Project Narrative	The purpose of this project is to improve the social needs screening and referral process for patients and families presenting to the Boston Medical Center (BMC) Pediatric Emergency Department (PED). We hope that in increasing successful referrals for patients and families with social needs presenting to our PED we are able to improve the overall health of our patient population.
Statement of Problem & Goals	BMC instituted THRIVE, a social needs screening tool and referral workflow, in the PED in Fall 2024. Thus far, screening rates have been low, and it is unknown if the established referral process is helping families connect to community resources. This Quality Improvement (QI) project therefore aims to: 1) increase rates of completed THRIVE social needs screens in patients presenting to the PED to â‰¥50% of eligible patients, and 2) ascertain rates of connection to community resources for families presenting to the PED who endorse unmet social needs.
Concept Description for Works in Progress	This is a QI project that uses the Institute for Healthcare Improvement Model as a framework, with various Plan-Do-Study-Act (PDSA) cycles throughout to make improvements. Feedback from patients or caregivers regarding the referral process will be obtained via follow up surveys.
Project Design/Methodology	An increase in screening rates will be achieved via iterative changes within each PDSA cycle. The first PDSA cycle started in October shortly after the initiation of THRIVE and has involved training nurses to administer the screen verbally. Ongoing PDSA cycles are focusing on improving the process for screening via paper form or tablet, continuing education,

	engagement with stakeholders, and identifying patterns to eliminate disparities in screening based on patient demographics. Rates of connection to community resources will be determined by follow up surveys via phone call conducted approximately 1 month after the ED visit.
Findings/Results	Data from September 30, 2024 to March 2025 shows that approximately 15-20% of patients presenting to the PED have been completing THRIVE social needs screens each month.
Evaluation Plan	Outcome measures will include percentage of completed THRIVE screens as well as percentage of families able to receive services from at least one resource to which they were referred. These measures will also be analyzed based on patient self-identified race, ethnicity, language preference, insurance type, and zip code.
Support Needed for collaboration needs and to advance the project	This work is supported by The Joel and Barbara Alpert Endowment for Children of the City and the BMC Pediatrics Center for the Urban Child and Healthy Family.
Project Design	Quality Improvement

Baker, N.

Powering change: a collaborative approach to advocating for a local clean energy transition

Natalie Baker, et.al.

Name of Submitter	Natalie Baker nbaker@hms.harvard.edu
Project Status	2. Work In Progress
Title of Project	Powering change: a collaborative approach to advocating for a local clean energy transition
Authors	Natalie M Baker, Madeleine Kline, Leann Canty, Mireille Bejjani, Regina LaRocque
Institutions	Harvard Medical School, Students For Environmental Action in Medicine/Medical Students for a Sustainable Future, Harvard Chan School of Public Health, Mothers Out Front, Slingshot, Massachusetts General Hospital, Climate Code Blue, Massachusetts Clean Peak Coalition
Project Narrative	The Medical Area Total Energy Plant (MATEP) is one of the largest sources of air pollution in Boston's Longwood Medical Area, disproportionately impacting environmental justice communities in Mission Hill, Roxbury, and Jamaica Plain. Our interdisciplinary team of medical students, public health experts, physicians, and community organizers is advocating for a clean energy transition using proven alternatives like industrial heat pumps and battery storage to reduce pollution-related health disparities and climate impacts.
Statement of Problem & Goals	MATEP emits over 400,000 tons of CO2 annually along with other pollutants, contributing to severe health disparities (Roxbury's life expectancy is 68.8 years compared to Back Bay's 91.6 years) and climate change impacts in environmental justice communities. Air pollution is linked to cardiovascular, pulmonary, obstetric, and dermatologic diseases, causing an estimated 88,400 annual deaths in the US. Our goal is to catalyze a transition to clean energy alternatives for the Longwood Medical Area.
Concept Description for Works in Progress	Our intervention centers on a multi-stakeholder advocacy campaign targeting community members, the general public, and institutional decision-makers to support MATEP's transition to clean energy. The project serves vulnerable environmental justice communities in Mission Hill, Roxbury, and Jamaica Plain. Our team combines expertise from Harvard

	Medical School and School of Public Health students, physicians from Climate Code Blue, and community organizers from the Massachusetts Clean Peak Coalition.
Project Design/Methodology	This is a community-based intervention, advocacy, and interprofessional collaboration, including: 1. Writing op-eds to raise public awareness 2. Canvassing communities surrounding MATEP 3. Organizing petition drives and community meetings 4. Engaging with Longwood Medical Area officials to propose viable clean energy alternatives based on successful implementations elsewhere, such as Kendall Square's industrial-scale heat pump for eSteam, New York City's battery storage replacement for peaker plants, and King County WA's wastewater heat recovery for life sciences buildings.
Findings/Results	Early advocacy efforts have led to increased community awareness and stakeholder engagement. We've published an op-ed in Commonwealth Beacon and been featured in Fenway News, successfully engaging dozens of stakeholders from multiple institutions. Our multidisciplinary coalition bridges academic expertise from Harvard Medical School and Harvard T.H. Chan School of Public Health with the practical experience of community organizers and energy experts. Successful models from other regions offer feasible technological solutions, contributing to a strong foundational strategy for local transition efforts.
Evaluation Plan	We will measure success through: - Number of community members engaged through canvassing and meetings - Media reach of published op-eds - Number of signatures on our current petition - Concrete commitments from Longwood Medical Area institutions toward clean energy alternatives - Long-term air quality improvements in affected communities
Support Needed for collaboration needs and to advance the project	We require continued collaboration with local and state government agencies, media, technical expertise from clean energy providers, and financial resources to support community outreach and implementation of new technologies.
Project Design	Community Based Intervention Advocacy/Policy Leadership/Change Management

Bell, Brittany

Design-4-REACH: Human-centered design for research, engagement, advocacy, and care for HTLV-1 patients

Brittany Bell, et.al.

Name of Submitter	Britney Bell britney.bell@bmc.org
Project Status	2. Work In Progress
Title of Project	Design-4-REACH: Human-centered design for research, engagement, advocacy, and care for HTLV-1 patients
Authors	Britney N. Bell, MD, Pria Anand, MD Sarah Kimball, MD, Camille Edwards, MD, Luis Malpica, MD, Tatiana Tate, CPA, Grace Ferri, MD, Daniel Li, MD
Institutions	Boston University Medical Center Department of Medicine, Hematology and Oncology, Boston University Medical Center Department of Neurology, MD Anderson Cancer Center, Chemo Divas Foundation, Boston Medical Center's Advancing Equity in Health Research Community Advisory Board
Project Narrative	At Boston Medical Center, many of our patients are from known endemic regions for HTLV-1, a neglected oncovirus that has been historically rare in the United States. While most infected individuals remain healthy, some develop aggressive cancer or paralysis. This project will co-design community-driven interventions to improve awareness, advance treatment development, and implement strategies that enhance public health outcomes.
Statement of Problem & Goals	Outdated estimates of HTLV-1 prevalence failing to account for our city's changing demographic needs hinder progress toward outcome optimization and disease understanding. Our goals are to (1) enhance provider and community HTLV-1 awareness (2) advance disease natural history understanding to inform future treatment development and (3) collaborate with the community to co-design interventions for outcome improvement.
Concept Description for Works in Progress	To achieve these goals, we will conduct a prospective natural history study focusing on individuals from HTLV-1 endemic regions (South America, the Caribbean, Sub-Saharan Africa, etc). Our team includes experts in hematology, neurology, dermatology, and infectious diseases with extensive experience in HTLV-1-associated diseases.

	Additionally, key stakeholders—leaders in immigrant and refugee health, patient advocates, community engagement specialists, co-design experts, and health literacy professionals—will play a vital role in this study.
Project Design/Methodology	This natural history study integrates clinical research with human-centered design and community engagement to improve HTLV-1 awareness through health education, treatment through deeper understanding of disease progression, and outcomes with the aid of community-based interventions.
Findings/Results	Our preliminary work includes the following: (1) stakeholder team engagement (7 health care providers, 2 trainees, and 1 patient advocate); (2) institutional needs assessment revealing through our 20-year retrospective analysis that 46% of patients were foreign-born, 36% from historically endemic regions, 7% of tested individuals were positive, and 34% developed adult T-cell leukemia/lymphoma (ATLL). Among 20 ATLL cases 65% were female, 95% born outside the United States, median age 62 years, overall survival 35%, median survival of 9.9 months; (3) community advisory board review emphasizing marginalization of target population, cultural sensitivity, language concordance, stigma associated with sexual transmission, mitigation of financial toxicity, and need for community organization partnerships; (4) development and translation of 3 disease-related patient education videos into English, Spanish, Haitian Creole, and Portuguese.
Project Design	Health Education/Training Community Based Intervention Advocacy/Policy Interprofessional Collaboration Biomedical Research

Castro, S.

Facilitating Food Justice: A Collaboration with the Hyde Park Food Pop-Up

Sara Castro, et. al.

Name of Submitter	Sara Castro saracastro@hms.harvard.edu
Project Status	2. Work In Progress
Title of Project	Facilitating Food Justice: A Collaboration with the Hyde Park Food Pop-Up
Authors	Sara Castro, Simone Matecna, Yensy Zetino, Sarah Primeau, Rebecca Riley Greene, Mariana Cohen, Ric Henry
Institutions	Neighborhood Food Action Collaborative (NFAC), Vital CxNs, Health Leads, Harvard T.H. Chan School of Public Health (HSPH)
Project Narrative	In partnership with the NFAC & Health Leads Hyde Park Food Pop Up (HPFP), we aim to explore food security and healthcare navigation in the Hyde Park community. Using a mixed-methods and community-engaged approach, we will collect resident feedback to inform program design and service delivery.
Statement of Problem & Goals	In 2020, 23% of Hyde Park residents reported being food insecure. Compared with other Boston neighborhoods, Hyde Park residents have limited access to grocery stores. Residents have also expressed concern regarding limited access to nutrition counseling at medical appointments. As of April 2024, there were only 4 primary care practices in Hyde Park and no community health centers. Navigating these "food deserts" and provider shortages, NFAC aims to expand access to nutrition counseling services and healthcare access broadly among Hyde Park residents.
Concept Description for Works in Progress	HSPH will work with NFAC to (1) document the population(s) served during the HPFPU, (2) characterize the strengths and limitations of the program (3) understand participant's healthcare access, and (4) improve service delivery.
Project Design/Methodology	Through a 2-part mixed-methods questionnaire, we will capture residents' experiences navigating food and health systems and co-create solutions that reflect the priorities of the community. The survey was initially drafted in English and will be translated to Haitian-Creole and Spanish, the most commonly spoken languages in Hyde Park.1 We will do a pre-test survey with 2-3 residents to ensure cultural relevance. Haitan-Creole-speaking volunteers and community health workers will administer the survey. Standard statistical tests will be used for analysis. Results will be

	disseminated to our collaborators and participants.
Findings/Results	For the past four years, the HPFPU has distributed culturally relevant food to 150-200 residents weekly and offered nutrition classes tailored to Hyde Park's predominantly Haitian community. In addition to providing fresh food, the HPFPU recognizes the importance of access to healthcare and patient-provider communication. A survey conducted by the organization found that 45% of participants felt they understood the information shared during their doctor's appointment, highlighting the need for further exploration of healthcare access in this community.
Evaluation Plan	We will survey 20-40 attendees across food distribution sessions. Data collection will occur weekly and will include semi-structured interviews and survey responses; these will be analyzed using logit regression to predict outcomes including patient-provider communication, regular source and availability of care, and assessment of available food options.
Support Needed for collaboration needs and to advance the project	HSPH will compensate participants and interpreters via gift cards.
Project Design	Community Based Intervention Quality Improvement

Cohen, T.

Mind the Gap: Undergraduate Student and Parent Perspectives on Healthcare Literacy and Potential Solutions

Talya Cohen, et. al.

Name of Submitter	Talya Cohen tcneamie@bu.edu
Project Status	1. Completed Project
Title of Project	Mind the Gap: Undergraduate Student and Parent Perspectives on Healthcare Literacy and Potential Solutions
Authors	Talya Cohen (early career clinical, MS1), Tanusha Tholla (early career clinical, MS1), Ayomide Egbejoda (early career clinical, undergraduate) Beamlak Mideksa (early career non-clinical, undergraduate), Riya Sandler (early career non-clinical, undergraduate)
Institutions	Boston University, Boston Medical Center
Project Narrative	Surveys were conducted in the Greater Boston area targeting undergraduate students and undergraduate student parents to assess healthcare literacy rates, their perceived importance of healthcare literacy, their understanding of healthcare literacy, and parent attitudes to improve the quality and quantity of resources available.
Statement of Problem & Goals	Healthcare literacy levels are associated with lower hospitalization rates, shorter hospitalization stays, less utilization of emergency resources, and improved overall mortality. In fact, healthcare literacy levels were found to be a protective factor in adolescents when identifying anxiety and depression prevalence. However, adolescents and adults have been shown in the literature to have low healthcare literacy levels. Our project aimed to examine the landscape of adolescent understanding in the Greater Boston area to identify effective interventions that would alleviate this pain point.
Project Design/Methodology	Setting: Greater Boston area universities Design: Anonymous Qualtrics web-based survey Population: Greater Boston area university undergraduate students (those transitioning into adulthood) and parents Measurement: 12 questions assessing respondents' perceived confidence navigating the healthcare system, understanding of healthcare literacy, and basic tenants of healthcare-related terminology (parents were assessed on their confidence in their child's ability to navigate the healthcare system)

Findings/Results	The findings from adolescents in the Greater Boston area illustrate: Lack of confidence in college students in navigating the healthcare system Large variability in perceived knowledge in key topics in healthcare literacy, suggesting large gaps related to healthcare literacy education. High utilization of emergency services highlights the need for young adults to shift from reaction to prevention and build self-advocacy skills to navigate healthcare
Conclusions	Our project findings demonstrate that young adults entering the workforce in the Greater Boston area have low healthcare literacy levels which the literature supports will ultimately affect their health. The team that conducted this research is currently engaging in next steps of developing a healthcare literacy curriculum to be implemented 1) in a 14-week class on college campuses 2) in a free workshop class at the Adolescent Center in Boston Medical Center and 3) in a virtual, asynchronous class available online.
Project Design	Healthcare Literacy Education Health Education/Training

Dubsky, D.

Improving Diagnosis and Referral for Elevated Blood Pressure Among ED Patients - Collaboration Addressing Modifiable Risk for Cardiovascular Disease

Daniel Dubsky, et. al.

Name of Submitter	Daniel Dubsky ddubsky@bwh.harvard.edu
Project Status	2. Work In Progress
Title of Project	Improving Diagnosis and Referral for Elevated Blood Pressure Among ED Patients - Collaboration Addressing Modifiable Risk for Cardiovascular Disease
Authors	Daniel V Dubsky, Giovanni Rodriguez, Cassandra Georges, Charlotte Croteau, Shada Rahouni, Regan H Marsh, Sangeeta S Sakaria, Thiago M Oliveira
Institutions	- Office of IDEaS (Inclusion, Diversity, Equity, and Social Programs), Department of Emergency Medicine, BWH - BWH Transitions Clinic, Department of Medicine, BWH - Walgreens Community Care, Community-Based Clinical Program, MGB - Clinical Process Improvement Leadership Program, MGB - Phyllis Jen Center for Primary Care - Brookside Community Health Center - Brigham and Women's Primary Care Associates, Longwood - Southern Jamaica Plain Health Center
Project Narrative	This project aims to improve hypertension detection and management among ED patients, especially underserved patients who may lack consistent access to primary care. By implementing a standardized discharge protocols including education, diagnosis, treatment, and follow-up, the ED can be a critical intervention point to reduce long-term cardiovascular risk.
Statement of Problem & Goals	Hypertension disproportionately affects non-Hispanic Black and Hispanic populations, with earlier onset, lower control rates, and higher mortality. While hypertension is not typically diagnosed in the ED, we have an opportunity to intervene. From January to May 2024, the BWH ED saw 1,287 patients with blood pressure elevated above 160/100 at discharge, most of whom were non-white (39% Black, 19% Other Race). This project implements a structured management, referral, and follow-up pathway for patients discharged with elevated BP, aiming to improve hypertension care

	for patients, reduce disparities in hypertension outcomes, and inform broader efforts across MGB.
Project Design/Methodology	We developed a multi-step protocol to systematically identify and support ED patients with elevated blood pressure at discharge. Interventions include: 1) identifying patients via discharge vital signs, 2) provider-driven education on hypertension, and 3) diagnosing, treating, and initiating antihypertensive therapy as needed. Patients are referred for follow-up with their PCP, the BWH Transitions Clinic, or Walgreens community-based clinic based on insurance status. The protocol is embedded into the ED workflow, supporting early intervention for at-risk patients. While applied to all patients discharged with elevated blood pressures from the ED, our interventions address hypertension management disparities among racially and socioeconomically diverse adults.
Findings/Results	To evaluate our ED-based hypertension protocol, we will track key process and outcome measures including the use of the discharge dotphrase, addition of â€œElevated BPâ€ to the Epic problem list, hypertension diagnosis, referrals placed and completed, medications started, and blood pressure control at 6 and 12 months. BP cuff distribution will be recorded, though supply is limited. These metrics will be correlated with patient volume presenting with elevated BP to assess reach and effectiveness.
Evaluation Plan	Next steps include finalizing the hypertension discharge algorithm, integrating it into ED workflows, and launching provider education around protocol use and follow-up pathways. We will monitor protocol adoption through EHR-based metrics and refine the process from frontline staff feedback. Data from the pilot will guide protocol adjustments and inform broader implementation across MGB EDs. Long-term, we aim to embed this model into standard care to improve hypertension outcomes, advancing health equity within our patient population.
Project Design	Quality Improvement

Fain, R.

A Standardized Approach to Identifying and Addressing Health-Related Social Needs in Oncology Through Universal Patient Navigation

Robert Fain, et.al.

Name of Submitter	Robert Fain robert.fain@bmc.org
Project Status	2. Work In Progress
Title of Project	A Standardized Approach to Identifying and Addressing Health-Related Social Needs in Oncology Through Universal Patient Navigation
Authors	Robert Fain, Erin Rosenberg, Erika Christenson, Debi Amburgey, Julia Vance, Pablo Buitron De La Vega, Alyssa Georgantas, Abigail Haugen, Marina Perez, Katrina Steiling
Institutions	Department of Medicine, Section of General Internal Medicine, Boston Medical Center; Boston University School of Medicine; Cancer Center, Boston Medical Center; Internal Medicine Residency Program, Boston Medical Center; Department of Medicine, Section of Pulmonary and Critical Care Medicine, Boston Medical Center
Project Narrative	Through institutional and community partnerships and comprehensive workflow assessment, the Oncology Equity Alliance (OEA) at Boston Medical Center (BMC) identified a gap in patient navigation policy limiting the reach and effectiveness of health related social needs (HRSN) screening. Co-design of a new Cancer Center workflow policy leveraging the THRIVE screener enabled proactive identification of HRSN and referral to community-based resources prior to a patient's first cancer care appointment. Findings will inform future strategies for optimizing HRSN identification and intervention in oncology care.
Statement of Problem & Goals	Patient navigation improves timely cancer care by assisting patients in overcoming barriers to accessing health care. Comprehensive workflow assessments across four key cancer types (breast, lung, head and neck, gastrointestinal) at BMC and collaboration with institutional and community partners identified a lack of uniformity in screening and management of HRSNs in cancer care.
Concept Description for Works in Progress	The OEA and BMC Cancer Center co-designed a standardized HRSN assessment workflow policy that uses the THRIVE screening tool and extends professional patient navigation (PN) services to every newly diagnosed patient in the Cancer Center.

Project Design/Methodology	The OEA catalyzed the hiring of two intake navigators to screen new patients using the THRIVE tool. The team updated the Cancer Center PN Training Protocol and trained 9 PNs and 67 care team members in the new workflow policy.
Findings/Results	The universal THRIVE screening workflow policy was implemented in the BMC Cancer Center on November 18, 2024. Between implementation and February 2025, BMC intake navigators have reached out to 202 newly diagnosed patients. A total of 116 HRSN screenings using THRIVE were completed (57%). Housing insecurity, lack of transportation, and food insecurity were the most common HRSNs identified.
Evaluation Plan	Process and operational outcomes included the number of Cancer Center patients that PNs attempted to contact prior to their first appointment, number of patients who completed a THRIVE questionnaire by their first appointment, number of patients with HRSN identified during screening, and number of patients who received resources prior to their first appointment. The research team will conduct phone surveys with patients and qualitative interviews with staff and PN to assess the acceptability, reach, and adoption of the intervention and evaluate perspectives on barriers, resource utilization, and experience.
Support Needed for collaboration needs and to advance the project	To advance the project's goals, the OEA will require ongoing engagement from strategic partners in support of evidence-based PN services, real-time implementation data to monitor program impact, and clinical champions and operational leadership to highlight the program's successes and potential for adoption beyond BMC.
Project Design	Quality Improvement Interprofessional Collaboration Leadership/Change Management

Gettings, M.

Facilitators and Barriers to the Access of Social Services and Long Term Outcomes in Traumatically Injured Patients
Gettings, M. et. al.

Name of Submitter	Macie Gettings gettings@bu.edu
Project Status	1. Completed Project
Title of Project	Facilitators and Barriers to the Access of Social Services and Long Term Outcomes in Traumatically Injured Patients
Authors	Macie Gettings1,2, BS, Leah Froehle1,2, MPH, Anne Buck1,2,5, SPH, Saba Ilkhani3, MD, MPH, Juan P. Herrera-Escobar3, MD, MPH, , G.A. Anderson3 MD MPH, J.O. Hwabejire4 MD, MPH, MBBS, Sabrina E. Sanchez1,2, MD, MPH
Institutions	1 Boston Medical Center, Boston, MA, USA; 2 Boston University Chobanian & Avedisian School of Medicine; 3 Brigham And Women's Hospital, Center For Surgery And Public Health, Boston, MA, USA; 4 Massachusetts General Hospital, Boston, MA, USA; 5 Boston University School of Public Health
Project Narrative	Traumatically injured patients face physical, social, and financial challenges post-injury that may impact their long-term outcomes. It is well established that social determinants of health impact patients' quality of life and health outside of the hospital. Prior studies have found that social determinants of health were helpful predictors of long-term physical recovery rather than injury severity score, age, or hospital length of stay. Social services may help fill the gap of support that affects patients once they leave the hospital and improve their outcomes. We specifically want to identify the challenges faced by traumatically injured patients at any one of 3 level 1 trauma centers in Boston.
Statement of Problem & Goals	While social services aim to minimize the financial and social challenges faced by patients, there can be barriers to accessing these resources. This project aims to identify the barriers faced by traumatically injured patients post injury in accessing social services according to their reported social needs. We will also examine the long term outcomes of those who are able to access social services to better inform how we can support patients post injury and connect

	them to resources that may positively impact their recovery.
Findings/Results	Moderately to severely injured trauma patients from three level 1 trauma centers were included, 3/1/2022-12/31/2023. Data was obtained from trauma registries and telephone surveys 6-12 months post-injury. Social needs (food insecurity, unemployment, and functional disability), use of services, and long-term outcomes were patient reported. All data has been collected into a large cohort of patients and now is being analyzed for trends amongst those accessing social services versus not.
Conclusions	We have identified demographic characteristics that are more common amongst those accessing social services which allows us to identify the populations not being reached. We are also looking at the long term outcomes of those who access social services versus not; specifically in terms of their long term social stability, financial security, and rates of different mental health conditions. The goal is to both identify the gaps of patients we are not supporting adequately while also creating evidence in support of the benefits of strong social services resources.
	Trauma patients reporting social needs access services at low rates, though patients with post-injury financial problems, social dysfunction, and PTSD are more likely to do so. Trauma patients with social needs may benefit from education and encouragement to utilize all the services available to them to optimize their recovery. Next steps will be directed towards how we can close the gap between demonstrated social needs and accessing resources in this population.
Project Design	Patient Access to Resources

Goldfarb, D.

Restorative Justice: A Path for Improving Care

Deborah Goldfarb, et. al.

Name of Submitter	Deborah Goldfarb Deborah.Goldfarb@bmc.org
Project Status	2. Work In Progress
Title of Project	Restorative Justice: A Path for Improving Care
Authors	Deborah R Goldfarb, MSW, LICSW
Institutions	Boston University School of Social, Boston Medical Center Health System, Transformational Prison Project
Project Narrative	To improve care for those released from incarceration at Boston Medical Center (BMC), a community engaged research grant was pursued and awarded from Boston University's Clinical and Translation Science Institute (CTSI) to BMC and Transformational Prison Project (TPP). This grant allowed TPP, a restorative justice (RJ) organization led by formerly incarcerated individuals, to facilitate several RJ circles, bringing together those who have recently been released from incarceration and BMC health care staff and providers to engage in meaningful dialogue. Our goal is both to provide a space to heal and connect across populations but also identify best practices and recommendations to change the way BMC delivers care to the incarcerated and formerly incarcerated population.
Statement of Problem & Goals	Mass incarceration and an unjust criminal legal system continue to devastate communities of color and have become a primary driver of health for our BMC patients. Historically the health care system hasn't appropriately served the needs of those marginalized by their criminal legal system involvement, resulting in decades of mistrust and mistreatment. These listening sessions, conducted in restorative justice circles, provided a space to address these disparities seen within the BMC system. The first purpose was healing and restoration through sharing the space and discussing the harm done. The second purpose of the circle was to develop best practices and policy suggestions for better meeting the health care needs, including substance use, of formerly incarcerated individuals at BMC
Concept Description for Works in Progress	Two listening sessions occurred in 2024 at Record Co., a community non-profit recording studio. Half of each circle consisted of physicians, addiction experts, public safety staff, and chaplains. The other half were those with lived experience, including both men and women, many of them

	were individuals served large amounts of time incarcerated, and some identified as BMC patients. Those with lived experience were paid for their time.
Project Design/Methodology	Community engaged research/Quality Improvement Project. Community partner (TPP) identified and invited community members were paid for their time. Individuals signed releases and agreed to be recorded anonymously. Transcripts will be reviewed and analyzed to create recommendations for health system.
Findings/Results	Initial findings showed that there is a strong desire by BMC staff to have access to these restorative justice spaces, and overwhelming those who participated felt they were powerful tools. Formerly incarcerated individuals reported feeling heard and included. Initial themes from the circles were providers experience of moral injury and burn out, providers not understanding the experience of incarceration and/or not reflecting their identity, healthcare provided in the community mirroring the subpar healthcare while incarcerated, and the deep mistrust of healthcare post-release.
Evaluation Plan	N/A
Support Needed for collaboration needs and to advance the project	Need further support to analyze (Thematic analysis) listening session transcripts

Project Design	Community Based Intervention

Gupta, A.

Emergency Contraception Vending Machine Implementation: A Combined Political and Institutional Analysis

Anshika Gupta, et. al.

Name of Submitter	Anshika Gupta anshikag@bu.edu
Project Status	1. Completed Project
Title of Project	Emergency Contraception Vending Machine Implementation: A Combined Political and Institutional Analysis
Authors	Anisha V. Patel, Anshika Gupta
Institutions	Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA; anishavp@bu.edu (A.V.P.); anshikag@bu.edu (A.G.)
Project Narrative	In this study, we examined the implementation of emergency contraception (EC) vending machines at 124 higher education institutions across 29 U.S. states. Our findings reveal significant disparities in implementation by state political climate, institution type, and institution level, offering critical guidance for expanding this reproductive health resource.
Statement of Problem & Goals	College students often face barriers to accessing emergency contraception due to limited pharmacy hours and privacy concerns. EC vending machines provide a promising solution by offering 24-hour, low-cost, and discreet access on campus. We aim to investigate patterns of EC vending machine implementation across different institutional and political contexts to inform targeted expansion strategies.
Findings/Results	We analyzed a dataset of 124 higher education institutions with EC vending machines from the American Society for Emergency Contraception. Institutions were categorized based on the political climate of their state (Blue, Swing, or Red), institution type (public or private), and institution level (2-year or 4-year). We conducted Chi-square and regression analyses to examine distribution patterns and assess the likelihood of implementation across political environments.

Conclusions	Our analysis showed that 76% of the institutions were located in Blue states, 18% in Swing states, and only 6% in Red states. Public institutions made up 67% of the sample, while private institutions accounted for 33%. Chi-square analysis revealed a significant association between political climate and institution level (Ï‡Â² = 9.99, df = 2, p < 0.01), with all 25 two-year institutions located exclusively in Blue states. Additionally, a significant association was found between institution type and level (Ï‡Â² = 15.47, df = 1, p < 0.001), with all two-year institutions being public. Public institutions in Blue states were more likely to implement EC vending machines than those in Red states (OR = 2.36, 95% CI: 0.55â€“10.10), though this difference did not reach statistical significance (Ï‡Â² = 2.10, df = 2, p = 0.350). Five statesâ€”Washington (n=21), California (n=17), New York (n=17), Illinois (n=13), and Massachusetts (n=10)â€”accounted for 63% of all implementations.
	Our findings indicate that public institutions in Blue states have a higher likelihood of EC vending machine implementation. The exclusive presence of two-year institutions in Blue states also underscores the impact of political climate on implementation practices. These results point to the need for advocacy strategies and tailored approaches for private institutions and two-year colleges in other regions.
Project Design	Community-Based Intervention Advocacy/Policy

Hernandez, P.

Project Legacy: Community-Based Mental Health Education and Leadership Development for At-Risk Youth in Boston

Patricia Hernandez, et. al.

Name of Submitter	Patricia Hernandez phernandez9@mgb.org
Project Status	1. Completed Project
Title of Project	Project Legacy: Community-Based Mental Health Education and Leadership Development for At-Risk Youth in Boston
Authors	Patricia Hernandez MD, Jossie A. Carreras Tartak, MD MD, MBA, Jennifer Jolivert, MD Taneyri De Jesus, Andrew Marshall, MD, MBI, Thiago Oliveria, MD,MPH
Institutions	Massachusetts General Emergency Department, Brigham and Women's Hospital Emergency Department, Harvard Affiliated Emergency Medicine Program, The Office of Ideas Beth Israel Emergency Department
Project Narrative	Project Legacy is a six-month educational and leadership initiative targeting BIPOC high school students in the Greater Boston area, with a focus on Roxbury, Mattapan, Dorchester, and Jamaica Plain. The program integrates mental health literacy, social-emotional learning, and leadership development through workshops and physician-led sessions to reduce stigma, build resilience, and promote health equity among youth facing systemic barriers to care.
Statement of Problem & Goals	Youth from marginalized communities face disproportionate mental health challenges, often compounded by stigma, delayed access to care, and lack of culturally relevant support. These challenges contribute to long-term academic, emotional, and health-related consequences. Research has demonstrated that providing youth with proper support and fostering health-promoting identities can serve as a basis for personal and social resilience and empowerment and can mitigate the aforementioned risks of poor health behaviors and outcomes. Project Legacy aims to address these gaps by improving participants' understanding of mental health, increasing openness to discuss mental health issues, fostering leadership potential, and promoting social-emotional development and healing.
Project Design/Methodology	From November 2024 to April 2025, ten high school students from four Boston-area schools participated in monthly sessions at Orchard Gardens Pilot School. The program included six workshops led by a leadership

	consultant focused on social-emotional learning, restorative practices, and skills building. In addition, three physician-led sessions covered topics such as the neurobiology of mental illness, Mental Health First Aid, leadership development, and career pathways in healthcare.
Findings/Results	The program fostered a safe and affirming environment where youth felt empowered to discuss mental health, apply new tools in daily life, and share resources with peers. Seven of nine participants reported pursuing additional health-related programs. Success was driven by strong mentorship, culturally relevant content, and a flexible format responsive to participants' complex personal and academic responsibilities.
Conclusions	Project Legacy highlights the value of community-based, youth-centered mental health education. Lessons learned include strategies to navigate school systems, balance social justice and research aims, and create meaningful, accessible programming. Future directions include curriculum refinement, expanded partnerships, and longitudinal evaluation to assess sustainability and broader community impact.

Project Design	Health Education/Training Community-Based Intervention Leadership/Change Management

Hong. H.

Implementing a Telephonic AI-Driven for SDOH Referrals in the Emergency Department

Haeyeon Hong, et. al.

Name of Submitter	Haeyeon Hong haeyeon.hong@bmc.org
Project Status	2. Work In Progress
Title of Project	Implementing a Telephonic AI-Driven for SDOH Referrals in the Emergency Department
Authors	Haeyeon Hong, Brigid Garrity, Jessica Lin, Michael Ray, Julia Kuno, Rashmi Koul, Ifeoma Muoto, Krishna Varela-Poole, Pablo b de la Vega
Institutions	Boston Medical Center, Department of Emergency Medicine BMC Thrive Initiative ThriveLink
Project Narrative	Emergency departments (EDs) serve as a key access point for identifying patients with unmet social needs. At Boston Medical Center, we are implementing ThriveLink, a telephonic, AI-assisted referral platform embedded into the ED workflow, to improve access to benefits and resources for patients facing barriers such as limited digital access, language, or navigation challenges. This intervention aims to advance equity by meeting patients where they are and removing traditional barriers to care navigation.
Statement of Problem & Goals	Patients frequently present to the ED with pressing social needs but are often discharged without successful linkage to community services due to fragmented systems and digital divide issues. Our goal is to embed a telephone-based, AI-enabled solution into ED workflow to streamline social needs referrals, and ensure reliable follow-up for public benefit access, including SNAP, housing application, utility assistance, as well as medicaid application and social security benefit application.
Concept Description for Works in Progress	ThriveLink is a third-party, telephonic, AI-assisted platform that facilitates benefit enrollment without requiring smartphones or internet access. The program is now embedded in BMC's adult ED through the Thrive Directory, a customized version of the FindHelp platform within Epic. Following a positive SDOH screen, ED providers initiate referrals directly in the EHR. Patients receive follow-up via text or phone call post-discharge. Patients can also directly access this service via a phone number given to them at discharge.

Project Design/Methodology	This is a quality improvement initiative using an implementation science-informed approach. The project included stakeholder engagement across BMC Thrive leadership, ED operations leadership, ThriveLink, FindHelp, and BMC IT teams to integrate this service into the existing EHR-dependent workflows and design clinician training. Initial rollout emphasized streamlining the referral mechanism to minimize ED provider burden, and ensuring equitable access to the service through multilingual capability.
Findings/Results	Prior to this recent ED pilot, preliminary success was demonstrated through a geriatrics pilot at BMC, which showed high engagement and cost-effectiveness. Since launching in the ED, preliminary data suggests that ED providers are able to engage in this new referral service when properly trained and are reminded on shift.
Evaluation Plan	The initial evaluation strategy focuses on key process measures, including referral volume, follow-up completion rates, and benefit enrollment outcomes. Over time, we aim to assess impact on healthcare utilization metrics such as ED revisit rates, clinical outcomes, and patient-reported satisfaction. Data from the Thrive Directory and ThriveLink dashboards will support ongoing quality improvement and inform future scale-up efforts.
Support Needed for collaboration needs and to advance the project	We are seeking financial support from the hospital and philanthropic partners to sustain and expand implementation of this service for emergency department patients. In addition, we aim to build partnerships with organizations specializing in benefits navigation and community-based resource provision to strengthen our referral network and enhance patient outcomes.
Project Design	Health Education/Training Community Based Intervention Quality Improvement

Johnson, K.

PEACH (Pregnancy Equity Accelerator for Codman Health): Improving Group Perinatal Care at an Urban Federally Qualified Health Center
Kayla Johnson, et. al.

Name of Submitter	Kayla Johnson MD, MPH kayla.johnson@bmc.org
Project Status	2. Work In Progress
Title of Project	PEACH (Pregnancy Equity Accelerator for Codman Health): Improving Group Perinatal Care at an Urban Federally Qualified Health Center
Authors	Kayla M Johnson MD, MPH, Samuel Gonzalez MD, Jennifer Vanderweele MD
Institutions	Boston Medical Center, Codman Square Health Center
Project Narrative	Codman Square Health Center (CSHC), a Federally Qualified Health Center in the Dorchester neighborhood of Boston, MA, was recently awarded a grant to rebuild its reproductive health efforts, and a portion of this grant was used to restart group prenatal care at the clinic. Through Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), this qualitative study explores the experiences of former Group Prenatal Care (GPC) patients at Codman Square Health Center in Boston, MA. Data from this study will be used to inform the clinic's ongoing reinstatement of GPC so that it can be best tailored to CSHC's pregnant patient population.
Statement of Problem & Goals	The challenges the United States faces regarding perinatal, peripartum and maternity care, health outcomes and health inequities is well known. Discovering, investing, designing, and implementing effective solutions is imperative to tackling this complex issue. Group Prenatal Care (GPC) is a model of care that's been widely utilized across the United States and has been proven to positively influence perinatal and peripartum health outcomes. This qualitative study seeks to use Focus Group Discussion (FGD) methodology to understand the experiences former GPC patients have had at Codman Square Health Center (CSHC), a Federally Qualified Health Center in Boston, MA.
Concept Description for Works in Progress	Focus Group Discussions were conducted by 2 facilitators (1 main facilitator, 1 note taker) via zoom. Focus group participants were previous group prenatal care patients. 2 Key Informant Interviews will be conducted through zoom. Key informants will be non-patient members of the Boston community who have experience with or involvement in prenatal and perinatal care.

Project Design/Methodology	Key informant interviews alongside FGD data will be triangulated to guide GPC improvement efforts to best meet the needs of the patient population at CSHC. Three participants attended one FGD that was conducted via zoom, recorded, and transcribed. A rapid qualitative data analysis approach, which included using the FGD question guide and constructs from Social Cognitive Theory to identify codes and themes, was combined with the transcription software's generative artificial intelligent technology to complete the FGD analysis process. Aspects of CBPR principles were adopted to craft plans for intentional data dissemination and post-study engagement of participants
Findings/Results	Four dominant themes were identified: beneficial social support and friendships, beneficial access to information about resources, changing GPC to improve the timing of introducing certain topics, and changing GPC to include and educate fathers on supporting their partners. Preliminary FGD data highlights the importance of considering cultural contexts and particular risk factors of one's patient population when planning GPC programming.
Evaluation Plan	The main objective of this study, at its core, is evaluative in nature and seeks to measure the success of an existent intervention (group prenatal care) at Codman Square Health Center.
Support Needed for collaboration needs and to advance the project	Collaboration with Codman Square Health Center's Perinatal steering committee was required for project planning purposes. Collaboration with the clinic's perinatal team was required for focus group discussion participant recruitment and correspondence.
Project Design	Community Based Intervention Quality Improvement

Kamin, J.

Increasing Access for Refugee and Immigrant Patients in BMC Family Medicine

Jessica Kamin, et. al.

Name of Submitter	Jessica Kamin jessica.kamin@bmc.org
Project Status	2. Work In Progress
Title of Project	Increasing Access for Refugee and Immigrant Patients in BMC Family Medicine
Authors	Jessica Kamin and Mihoko Tanabe, DO
Institutions	BMC Department of Family Medicine
Project Narrative	To improve access to care for refugees and non-literate, non-English-speaking immigrants, an AmeriCorps Fellow supports these families at BMC Family Medicine. The Fellow addresses social barriers to health and acts as an advocate to reduce no-shows, reduce time to care, and improve health access.
Statement of Problem & Goals	Compared to other BMC departments, Family Medicine lacks a role to provide social support to refugee and non-literate, non-English-speaking patients. Newly-arrived patients experience difficulty navigating complex social and healthcare systems, especially if they are non-literate in their preferred language or have difficulty accessing transportation. Consequently, patients have faced delays in care since the time of diagnosis. For example, no refugee patient with a confirmed positive Hepatitis C surface antibody with positive viral load diagnosed from 9/1/2023-4/1/2024 had a completed abdominal ultrasound or hepatitis clinic visit.
Concept Description for Works in Progress	The goal of the Fellow is to help reduce time to care and loss to follow-up for newly arrived refugees and other non-literate, non-English-speaking immigrants. By working as an advocate for patients, the Fellow helps address social determinants of health that impede patients' quality of life and access to care. The Fellow works closely with the BMC Immigrant and Refugee Health Center (IRHC) and StreetCred to provide support so that patients are equipped to navigate systems on their own.
Project Design/Methodology	Based on directly expressed needs, or as documented in the THRIVE screener, the Fellow connects patients to transportation, financial assistance, public libraries, or other community and hospital resources to help address barriers to care. The Fellow also helps schedule visits for

	patients or connects them to community health centers closer to home.
Findings/Results	To date, the Fellow has worked with upwards of 80 patients and their families to facilitate access to care and share resources. Patients who had regularly missed appointments in the past have been able to attend with this new support.
Evaluation Plan	We are measuring time to care from time of diagnosis for positive Quanteferon Gold, Hepatitis B, and Hepatitis C, given the frequency of positive tests. We anticipate that time to care will decrease as a result of the AmeriCorps Fellow's active engagement with patients to ensure follow-up.
Support Needed for collaboration needs and to advance the project	This project is a collaboration with Lead for America's ACC AmeriCorps program, with funding from the IRHC. Given the pause on refugee resettlement, and funding cuts to resettlement agencies supporting those already resettled, we are looking for ways to sustain this position and secure resources for patients and their families.
Project Design	Quality Improvement

Kennedy, H.

Primary Care Community Participatory Initiative for Immigration-Related Concern Screening & Referral

Helena Kennedy, et. al.

Name of Submitter	Helena Kennedy helena.kennedy@bmc.org
Project Status	1. Completed Project
Title of Project	Primary Care Community Participatory Initiative for Immigration-Related Concern Screening & Referral
Authors	Helena Kennedy, Catherine Sutton, Sarah Kimball, Krishna Varela, Pablo Buitron De La Vega
Institutions	Boston Medical Center, Boston University School of Medicine, Boston University School of Public Health.
Project Narrative	Limited data exists on immigration-related concern screening in primary care, despite growing recognition of immigration as a driver of health. This community participatory quality improvement initiative updated an existing health-related social needs screening (HRNS) and referral workflow, evaluating IRC screening and its impact on resource connections among patients self-reporting immigration-related concerns.
Statement of Problem & Goals	In prior work updating the BMC HRNS, language concordant, community-based working groups identified immigration as a gap and constructed an IRC question linked to a resource guide. The purpose of the qualitative improvement project was to evaluate the barriers that exist for patients screening positive for IRC when connecting with community resources.
Project Design/Methodology	Between 1/2024-4/2024, a subgroup of positive screenings for IRC within an academic safety net primary care clinic was followed up to evaluate acceptability and resource connections. Televists and missed appointments were excluded.
Findings/Results	Between 11/15/2023-4/30/2024, 17,046 HRSN screenings were conducted within Internal Medicine clinics. Of 165 positive IRC screenings between January and April, 50 patients were contacted by phone. Seventy percent (N=35) confirmed IRC, of which 37% (N=13) connected with resources, 46% (N=16) were unable to connect, and 17% (N=6) had inactive IRC needs. Barriers included time constraints, misplaced resources, wait times, language barriers, unanswered calls, and eligibility requirements.
Conclusions	Given recent requirements from regulatory agencies like CMS for HRSN

	screening, our findings demonstrate the acceptability of IRC screening. However, challenges in connecting patients to resources highlight the need for increased support, process improvements, and crucially, more funding for community-based organizations (CBOs). Without adequate CBO investment, the impact of screening on health outcomes will be limited.
Project Design	Quality Improvement

Khazanchi, R.

Ending Mandatory Child Protective Services Reporting for Prenatal Substance Exposure: A Quasi-Experimental Analysis of Differential Impacts by Race and Use of Medications for Opioid Use Disorder

Rohan Khazanchi, et. al.

Name of Submitter	Rohan Khazanchi rohan.khazanchi@bmc.org
Project Status	1. Completed Project
Title of Project	Ending Mandatory Child Protective Services Reporting for Prenatal Substance Exposure: A Quasi-Experimental Analysis of Differential Impacts by Race and Use of Medications for Opioid Use Disorder
Authors	Rohan Khazanchi MD MPH; Elisha M. Wachman MD; Anna Modest PhD MPH; Heather E. Hsu MD MPH
Institutions	1. Harvard Internal Medicine-Pediatrics Residency Program at Brigham and Women's Hospital, Boston Children's Hospital, and Boston Medical Center, Boston, MA. 2. FXB Center for Health and Human Rights at Harvard University, Boston, MA. 3. Harvard Medical School, Boston, MA. 4. Department of Pediatrics, Boston University Chobanian & Avedisian School of Medicine, Boston, MA. 5. Department of Pediatrics, Boston Medical Center, Boston, MA. 6. Department of Obstetrics & Gynecology, Beth Israel Deaconess Medical Center, Boston, MA.
Project Narrative	In May 2021, Boston Medical Center revised our clinical guidelines to report suspected abuse after a child is born only when there are tangible concerns about the parent's ability to safely care for the child, rather than automatically filing Child Protective Services (CPS) reports for all cases of prescribed use of opioids or medications for opioid use disorder. Until 2024, BMC was the only birthing hospital across the state taking this approach. Our institution's guideline shift reduced reporting to CPS by 44 percentage-points, eliminating reporting in the absence of child safety concerns. Our research findings contributed to the passage of a new state law mandating similar changes in hospitals across the state.
Statement of Problem & Goals	In 2016, provisions were added to the federal Child Abuse Prevention and Treatment Act (CAPTA) which required that states collect child protective services (CPS) notifications for newborns â€œaffected byâ€ prenatal substance use or withdrawal symptoms from prenatal drug exposure.

	Federal stakeholders have since made clear that the nature of these notifications does not necessarily constitute child abuse. Even still, the vague language of CAPTA's updated mandates were handled heterogeneously between states, hospitals, and even individual clinicians. In Massachusetts, until December 2024, state law required that a CPS report must be filed when a mandated reporter â€œhas reasonable cause to believe that a child is suffering from physical or emotional injury resulting from: physical dependence upon an addictive drug at birth.â€ Amidst this lack of clarity in mandating reporting requirements, clinicians at most birthing hospitals in Massachusetts and across the country file CPS reports for suspected abuse or neglect for infants with prenatal substance exposure (IPSE) ” including in cases involving the use of prescribed opioids for pain or medications for opioid use disorder (MOUD). In May 2021, Boston Medical Center implemented a new clinical guideline which recommends reporting IPSE to CPS only if specific protective concerns were identified. Prior work in California identified that Black IPSE were five times more likely to be reported to CPS after adoption of a guideline to standardize substance use assessment, concluding that â€œprotocols as a strategy to reduce disparities [in CPS reporting] may be misguided.â€ Our research examined the overall impact of BMC's guideline, as well as differential effects by race or use of MOUD.
Project Design/Methodology	Using deidentified data on opioid-exposed birthing parent-infant dyads across 17 Massachusetts birthing hospitals from 2017-2024, we conducted difference-in-differences (DiD) analyses using average marginal effects from adjusted logistic regressions to compare changes in CPS reporting rates at BMC and other birthing hospitals following BMC's guideline change. Analyses were stratified by birthing parent race and type(s) of prenatal opioid exposure.
Findings/Results	We identified 3,939 dyads; 513 (13.0%) had birth hospitalizations at BMC. In adjusted DiD analyses, guideline implementation led to a 44.1 percentage-point (95%CI -47.2, -41.0) decrease in CPS reporting. As shown in Figure 1, the guideline led to significantly larger decreases in CPS reporting for IPSE with only MOUD or prescribed opioid exposure (-77.4pp [-81.5, -73.4]), compared to IPSE with any non-prescribed opioid exposure (-16.4pp [-18.9, -13.9]) or both prescribed and non-prescribed opioid exposures (-16.5pp [-18.0, -15.0]). There were no significant differences in the impact on CPS reporting by birthing parent race.
Conclusions	Adoption of a clinical guideline which recommended assessment of protective concerns instead of categorically mandated CPS reporting led to larger decreases in CPS reporting for IPSE whose only prenatal opioid exposure was MOUD and had no disparate effects by birthing parent

	race. Publication and dissemination of our early findings contributed to the passage in December 2024 of "An Act relative to treatments and coverage for substance use disorder and recovery coach licensure", which mandates similar changes to state law so that a parent who is stable in recovery will no longer automatically require a CPS report for abuse or neglect. Our research supports decoupling CPS reporting from prenatal substance use treatment to destigmatize MOUD and mitigate downstream racial inequities initiated by this â€œfront doorâ€ to the child welfare system.
Project Design	Advocacy, Interprofessional Education

Killian, C.

Let's Talk HIV Boston

Clare Killian, et. al.

Name of Submitter	Clare Killian CKillian@bphc.org
Project Status	1. Completed Project
Title of Project	Let's Talk HIV Boston
Authors	Clare Killian and Jacqueline Huynh
Institutions	Boston Public Health Commission, Infectious Disease Bureau, Education and Community Engagement Division in partnership with The STUDIO Production and Animation Company
Project Narrative	The Let's Talk HIV Boston Campaign is a multi-pronged media campaign that encourages open, fact-based conversations about HIV, HIV-related stigma, and how it affects prevention, care, and treatment. The campaign features a cast of community advocates, public health leaders, people living with HIV, and doctors and health care providers. In addition to its focus on U=U, the campaign aims to help Boston residents learn about diverse topics related to HIV care, including testing, treatment and medication, counseling services, and peer support.
Statement of Problem & Goals	Based on the results of the Infectious Disease Bureau's 2023 HIV/STI Needs Assessment, there is a clear need to prioritize stigma reduction initiatives among providers and build public trust in the U=U messaging, including the benefits of maintaining the HIV care continuum. We identified several ways to improve these initiatives: investing in more peer-to-peer education; educating on treating addiction and HIV prevention within safe drug use programming; and reinforcing trauma-informed and non-stigmatizing communication while enhancing our capacity for multilingual and culturally sensitive outreach and educational materials. This project aims to address the gaps in public advertisements and social media in conversations about HIV prevention and treatment. Our objectives were to co-create a public media campaign with people living with HIV focused on general awareness and education to destigmatize HIV through a culturally responsive and intersectional lens. This campaign centers around clarifying the U=U messaging, both scientifically and socially. This campaign includes four panel or interview-style films, social media assets, print

	brochures about U=U in over 10 languages, and advertisements on the MBTA.
Findings/Results	In early 2024, in response to our Needs Assessment results and strategic planning for stigma reduction initiatives, a community-based request for proposals was publicized for a design and production company to collaborate with our team on this media project. After that process, The STUDIO was awarded the grant to serve as our creative lead and production company for Let's Talk HIV Boston. Creative discussions and the scope of the project were solidified between September and casting calls and pre-interviews began in October 2024. At least one of the authors on this project were in attendance during all weekly planning meetings and facilitated the casting calls. Weekly meetings took place from September 2024 - February 2025 between The STUDIO and BPHC. Throughout the project, several staff across BPHC were involved in reviewing and revising copy for the website, brochure, and MBTA advertisements including IDB's Medical Director, staff in the Education and Community Outreach division, and BPHC's Communications department. In December 2024, we held our first community feedback session, inviting people living with HIV to offer feedback on the various assets of the campaign. Additional people living with HIV who participated in the cast of the campaign videos consulted on the campaign assets as well. The videos were shot in a 2-day filming session here in Boston in December 2024 and editing took place between December 2024 and early February 2025. Brochures were translated and sent for print early in February 2025. Videos were finalized and reviewed in mid-February, and the social media plan was developed in late-February. The campaign officially launched publicly on February 24, 2025. The following are the deliverables included in this campaign: - 1x WordPress Microsite - 1x Hero Brochure with 12x language translations - 4x Out of Home Print ads - 4x static digital ads - 4x 8-10min Hero Videos - 12x :15s OOH videos / 4x Triptychs - 9x translated :15s OOH single videos - 16x :15-30s Social Videos - Social Media Toolkit for BPHC / Community Outreach use
Conclusions	Our measures of success include total views per video on YouTube, total

	page views on the website, total impressions on the MBTA advertisements, total clicks on various social media advertisements and average click through rates. We will also measure number of follows to the BPHC social media accounts as a result of the campaign. Finally, we will have a small amount of qualitative/anecdotal data from comments left on various social media posts or advertisements and the YouTube page. This data is currently being collected and will be available for the poster presentation.
	"This campaign is one project under our division's efforts to scale up and institutionalize HIV stigma reduction efforts, prioritizing shared decision-making with people living with HIV. In order to do this, we lead a Stigma Reduction Committee focused on reducing silos across BPHC to implement and evaluate intersectional stigma reduction projects. This project has improved cross-team collaboration and communication, enabled us to expand our work and our trust out into the community, and has improved the availability of U=U messaging broadly. We plan to continue to scale up stigma reduction media campaigns by providing best practices and lessons learned to BPHC and our community stakeholders such as the Boston EMA Ryan White HIV/AIDS Services Planning Council, who also have their own stigma reduction campaign. The 2023 HIV/STI Needs Assessment also highlighted the need for client-centered care and providers who are open, trustworthy, approachable, and the importance of addressing health through intersecting identities. In tandem with the ""Let's Talk HIV Boston"" campaign, a series of six vignettes, Caring for All of Me, was developed for Boston providers and will be sustained through the Ryan White Case Management Training Program, to expand education across the Boston EMA. The goal of the series is to humanize and convey multifaceted stories of people of color impacted by HIV. By continuing the scale-up of this effort, the Caring for All of Me series, and the Planning Council's campaign, we can continue to embed accurate information about HIV prevention and treatment and highlighting the power of U=U in our public media. " implement and evaluate intersectional stigma reduction projects. This project has improved cross-team collaboration and communication, enabled us to expand our work and our trust out into the community, and has improved the availability of U=U messaging broadly. We plan to continue to scale up stigma reduction media campaigns by providing best practices and lessons learned to BPHC and our community stakeholders such as the Boston EMA Ryan White HIV/AIDS Services Planning Council, who also have their own stigma reduction campaign. The 2023 HIV/STI Needs Assessment also highlighted the need for client-centered care and providers who are open, trustworthy, approachable,

	and the importance of addressing health through intersecting identities. In tandem with the "Let's Talk HIV Boston" campaign, a series of six vignettes, Caring for All of Me, was developed for Boston providers and will be sustained through the Ryan White Case Management Training Program, to expand education across the Boston EMA. The goal of the series is to humanize and convey multifaceted stories of people of color impacted by HIV. By continuing the scale-up of this effort, the Caring for All of Me series, and the Planning Council's campaign, we can continue to embed accurate information about HIV prevention and treatment and highlighting the power of U=U in our public media.

Lange, P.

Flexible Services/HRSN Services: Collaboration between health systems and social service organizations to support health related social needs

Paulina Lange

Name of Submitter	Paulina Lange Paulina.Lange@bmc.org
Project Status	2. Work In Progress
Title of Project	Flexible Services/HRSN Services: Collaboration between health systems and social service organizations to support health related social needs
Authors	Paulina B Lange (non-clinical) - team of coordinators (all early career, non-clinical)
Institutions	Boston Medical Center Health System, Population Health Department
Project Narrative	The MassHealth Flexible Services Program/HRSN Services is an example of innovative healthcare delivery in Massachusetts, bringing together health care providers and community based organizations in supporting patients' full health picture. These partnerships and services are aimed at addressing patient's housing and nutrition needs to improve health outcomes and total cost of care.
Statement of Problem & Goals	Addressing social determinants of health for the Medicaid Accountable Care Organization (ACO) patient population via housing and nutrition supports with the goal of improving health outcomes and reducing total cost of care.
Concept Description for Works in Progress	Intervention/Target Population: Medicaid ACO patients meeting specific eligibility criteria for the housing and nutrition services are referred by their health care team to community based organizations that have contracted with the ACOs to provide these specific supports.
Findings/Results	Preliminary findings show early promising results (improvements in health and social outcomes); evaluation is ongoing
Evaluation Plan	Both social and health improvements are being measured by MassHealth, participating social service organizations, and ACOs.
Project Design	Community Based Intervention Advocacy/Policy Interprofessional Collaboration

Leggiero, N.

Equitable Access to Biologic Therapy in IBD: Examining Racial and Ethnic Differences

Nicole Leggiero, et. al.

Name of Submitter	Nicole Leggiero nicole.leggiero@bmc.org
Project Status	1. Completed Project
Title of Project	Equitable Access to Biologic Therapy in IBD: Examining Racial and Ethnic Differences
Authors	Nicole Leggiero MD, Sharmeel Wasan MD, Mira Sridharan MD, Krisyah Clemons
Institutions	Center for Digestive Disorders at Boston Medical Center
Project Narrative	After observing variable treatment response rates among patients of different racial and ethnic backgrounds with inflammatory bowel disease (IBD), we sought to investigate whether these disparities were statistically significant and, if so, to identify the socio-economic factors contributing to them. Conducted at a safety net hospital, our study underscores the critical importance of ensuring equal access to healthcare for all patients.
Statement of Problem & Goals	Racial and ethnic minority groups have been underrepresented in clinical trials evaluating efficacy of many of the biologic and small molecule therapies used to treat inflammatory bowel diseases such as Crohn's and ulcerative colitis. This lack of representation has resulted in limited data on clinical response rates seen in these patient populations. Our study aims to assess whether response rates to biologic therapies differ among patients with IBD that are of diverse racial and ethnic backgrounds.
Project Design/Methodology	We performed a retrospective chart review of 489 patients with IBD on biologic therapy at Boston Medical Center, an urban safety net hospital. Data collected included each patient's first dose of biologic or small molecule therapy and date of clinical remission, as defined by disease-specific symptom severity scoring indices (HBI <4, DAI ï‚£2, SSCAI ï‚£2.5). Survival analysis was performed to compare the time to achieve clinical remission amongst patients of different ethnic and racial backgrounds.
Findings/Results	Of the 489 patients on biologic therapy, 285 patients achieved clinical remission and 121 patients did not by the end of the study period

	(12/31/2023). A survival analysis including patients that did and did not achieve clinical remission did not show a statistically significant difference between racial and ethnic groups ($p = 0.81$). Similarly, amongst patients who did achieve clinical remission, the average amount of time required to reach remission did not differ significantly between groups ($p = 0.45$).
Conclusions	Historically, patients of minority racial and ethnic groups have been underrepresented in studies of biologic and small molecule therapies. We were able to study a patient population that closely represents the racial and ethnic diversity of the United States in the setting of a safety net hospital where patients of all backgrounds had equal access to therapy despite insurance status. The results of this study highlight that when access to treatment is not restricted, patients of all backgrounds have similar chances of achieving disease control. The disparities in patients' access to equal and effective treatment can have lasting impacts on their morbidity and mortality, therefore we hope that future efforts can focus on minimizing or eliminating such inequities.
Project Design	Biomedical Research

Louis-Jame, L.

Patient Experiences Among Minority Communities in two Urban Emergency Departments

L. Louis-Jame, et.al.

Name of Submitter	Lainie Louis-Jame llouisjame@mgb.org
Project Status	2. Work In Progress
Title of Project	Patient Experiences Among Minority Communities in two Urban Emergency Departments
Authors	Lainie L Jame, Cassandra Georges, Michael Wilson, Regan H Marsh, Alice K Bukhman, Thiago M Oliveira
Institutions	Department of Emergency Medicine; Brigham and Women's Hospital / Brigham and Women's Faulkner Hospital
Project Narrative	Patient experience surveys are the healthcare industry's standard tool to gather feedback, measure satisfaction, and inform quality improvement initiatives. National data highlights that responses from non-white and non-English speaking communities are underrepresented. This project collects patient experience surveys from these underrepresented communities to identify strengths and opportunities for quality improvement during their ED encounters.
Statement of Problem & Goals	A positive experience in the ED supports patient safety, trust, engagement with treatment plans, and better health outcomes and satisfaction. Evaluation of patient experience in the ED typically involves survey assessment completed after the encounter. Given underrepresentation of minority respondents to patient experience surveys, data is needed to guide quality assurance and improvement for patients from these communities. This project aims to gather representative data from these under sampled communities, and enhance our understanding of our opportunities to improve ED care.
Concept Description for Works in Progress	A standardized 13-item patient experience questionnaire was adapted to assess key domains routinely assessed via commercial surveys. 100 surveys will be administered across two urban hospitals (one community teaching hospital and one academic medical center). Once 100 surveys are gathered, responses will be compared to data obtained through our commercial patient experience survey vendor.
Project Design/Methodolo	In a convenience sample driven by ED volunteer availability, the survey is offered in-person to patients before completion of their ED visit. Patients

gy	who are non-white or non-English preferring are approached by the volunteer and invited to complete the survey on a tablet.
Findings/Results	50 surveys have been gathered at our community hospital ED. We expect to complete data acquisition by June 2025 and analysis by end of year. Findings from our community ED were compared to our vendor-acquired responses. Preliminary results indicate that non-white patients and non-English preferring report better ED experiences than average responses compiled by our vendor. Our cohort's responses also outperform national trends in domains such as having input in their care and observing positive communication between healthcare team members. Survey responses may be biased by the collection of data while still in the ED.
Evaluation Plan	Data collection from our AMC is ongoing. Responses from the AMC and community site will be compared, and aggregate data across sites compared to our vendor data. In addition to giving voice to perspectives that are under-surveyed, we hope to identify opportunities to enhance patient experience for all cared for in our emergency departments. Our data, analysis and conclusions will be shared with departmental leadership to guide operational and quality initiatives.
Project Design	Quality Improvement

Marin, N.

Barriers and facilitators to healthy eating and using food support resources among families with children with failure to thrive at an urban safety net health system

Nicolas Marin, et. al

Name of Submitter	Nicolas Marin\ nmarin@bu.edu
Project Status	1. Completed Project
Title of Project	Barriers and facilitators to healthy eating and using food support resources among families with children with failure to thrive at an urban safety net health system
Authors	Nicolas D Marin, Emily Guerrero, Olivia W Thomas
Institutions	Boston University Chobanian & Avedisian School of Medicine, Boston Medical Center (BMC) GROW Clinic, Boston Medical Center Nourishing Our Community Program
Project Narrative	This IRB approved project explored the experiences of parents in the BMC Grow Clinic who are raising children with failure to thrive (FTT), focusing on their efforts to access healthy foods, food assistance, and nutrition education programs. Through in-depth interviews, we gathered parent narratives related to using food support resources. These insights informed the development of a program partnering with Nubian Markets.
Statement of Problem & Goals	In FTT, a child fails to gain weight or grow at expected rates for their age. The Grow Clinic at BMC serves families who have children with FTT and offers food and nutrition services designed to improve access to food. Although many families reported difficulty accessing healthy food and wanting more food-based services, existing programs have low participation rates. Thus, it is unclear what barriers parents face when using food support resources. The goals of this project were to identify barriers and facilitators to food access, as well as to gather participants' perceptions and insights on the use of food vouchers and participation in cooking classes.
Project Design/Methodology	Parents of children aged four and above with FTT who were seen at the BMC Grow Clinic between June and July of 2024 were recruited to participate in interviews. Semi-structured interviews were conducted with the use of interpreters as needed and the audio was recorded. Information was grouped into meaning units, codes, and themes as they pertained to eight research questions.

Findings/Results	Significant barriers identified included financial strain, time constraints, issues using food support resources, and limited transportation options. Facilitators included access to financial resources, support from family members, and access to food pantries. Participants were interested in vouchers and in-person cooking classes.
Conclusions	Barriers to obtaining healthy food for parents of children with FTT are consistent with barriers faced by low-income families in other populations. This population faces several challenges when accessing food support resources such as transportation, timing, and administrative barriers that must be accounted for when designing a successful community-based food support initiative. This knowledge was used to design a food access and nutrition education program partnering with Nubian Markets.
Project Design	Community Based Intervention

Mesias, M.

THRIVE Digital Equity: Enhancing Telehealth Use and Accessibility in Adult Primary Care Clinics.

Miguel Mesias, et. al.

Name of Submitter	Miguel Mesias andresmiguel.mesias@bmc.org
Project Status	2. Work In Progress
Title of Project	THRIVE Digital Equity: Enhancing Telehealth Use and Accessibility in Adult Primary Care Clinics.
Authors	Andres M. Mesias, MD (3), Demetri Goutos, MBA (2), Uma D. Khemraj, M.S (3), Antonia Araya (3), P. Buitron de la Vega, MD (1,3).
Institutions	1. Boston University Chobanian & Avedisian School of Medicine, MA, United States. 2. Department of Health Law, Policy & Management, Boston University School of Public Health, Boston, MA, United States. 3. General Internal Medicine, Boston Medical Center, Boston, MA, United States.
Project Narrative	The THRIVE Digital Equity Program addresses disparities in telehealth access among high-risk Adult Primary Care patients at a safety-net institution. Through targeted outreach, digital literacy support, and in-person assistance, the program improves patient engagement in virtual care, enhancing healthcare accessibility and reducing digital barriers.
Statement of Problem & Goals	Significant disparities exist in the accessibility and utilization of telehealth services among patients seeking care from safety net institutions. THRIVE aims to close this gap by identifying and supporting patients facing digital barriers, enhancing telehealth connectivity, and fostering long-term digital health equity.
Concept Description for Works in Progress	THRIVE supports high-risk patients by identifying those needing telehealth assistance due to device limitations, internet access issues, or chronic conditions. A multidisciplinary team including a Digital Health Navigator (DHN), Specialist (DHNS), and project managers conducts outreach and provides technical support to improve connectivity and digital literacy.
Project Design/Methodology	This initiative integrates community-based intervention and quality improvement strategies to enhance telehealth access. Patients identified with digital barriers receive outreach 30 minutes before their telehealth appointment. The DHN provides real-time support, and unresolved

	technical issues may require in-person assistance. Success is measured by connection rates, follow-up calls, and sustained telehealth use. The program focuses on optimizing resources for high-need patients while promoting long-term digital health equity.
Findings/Results	Between December 2024 and March 2025, 679 patients were contacted for telehealth support. 397 self-identified as Black or African American, and 116 as Hispanic or Latin American. Of the 679 patients, 443 (65.2%) requested telehealth assistance. Among them, 266 (60.0%) successfully connected to their telehealth session, while 177 (40.0%) connected just by audio. Additionally, 115 patients (16.9%) did not require assistance, and 121 (17.8%) declined support.
Evaluation Plan	Program success is evaluated using quantitative metrics, including the number of patients who successfully connected to telehealth after support and those who connected via audio only. Additionally, we track patients who did not require assistance, declined support, or needed in-person help. Follow-up success is measured by patients' ability to resolve technical issues and sustain telehealth access. Key lessons include prioritizing early outreach (30 minutes pre-appointment) and focusing resources on high-need patients. Long-term success is determined by patients' ability to use telehealth platforms independently.
Support Needed for collaboration needs and to advance the project	Currently we need more volunteers or funding to expand the program due to higher than expected volume.
Project Design	Quality Improvement

McDaniel, K.

"In Haiti, the bed was flooded with milk": insights on infant feeding from Haitian mothers in Boston

Katherine McDaniel, et.al.

Name of Submitter	Katherine McDaniel katherine.mcdaniel@bmc.org
Project Status	1. Completed Project
Title of Project	"In Haiti, the bed was flooded with milk": insights on infant feeding from Haitian mothers in Boston
Authors	Katherine G McDaniel, MD, MSc, Thamarah Crevecoeur, CNM, MSN, DrPH, Kettie Louis, DNP, WHNP-BC, ANP-BC, Samirah Toussaint, Audrey Montgomery, MSW, Katherine Standish, MD, MS
Institutions	Boston Medical Center Refugee Women's Health Clinic; Boston Medical Center Department of Family Medicine; Boston University
Project Narrative	As part of work to understand and address racial inequities in infant feeding outcomes, BMC staff asked for additional guidance on supporting newly arrived Haitian patients in fulfilling their infant feeding intentions. We conducted focus groups with pregnant and recently postpartum Haitian women in the Refugee Women's Health Clinic at BMC. Participants spoke frankly about infant feeding beliefs, practices, and challenges, while suggesting improvements for supporting recently arrived Haitian parents which will be incorporated into maternal-infant health services.
Statement of Problem & Goals	Breastfeeding benefits both infants and parents, yet racial and social inequities in breastfeeding persist. Hospital staff sought guidance on supporting newly arrived Haitian patients in fulfilling their infant feeding intentions.
Project Design/Methodology	We conducted Kreyol-language focus groups with pregnant or postpartum Haitian patients, exploring infant feeding concerns, experiences, medical care, and support needs. Participants completed a brief survey and received compensation. Recordings were transcribed in KreyÃ²l, translated to English, and analyzed in both languages using Rapid Qualitative Analysis.
Findings/Results	Eighteen patients participated (n=17 with data, mean age 32, ten pregnant and seven â‰¤6 months postpartum) across two focus groups. Most had prior children born in Haiti, Chile, Brazil, U.S., or the Dominican Republic. Several participants disclosed that they were living in a shelter. Key findings included (1) more milk production in Haiti (attributed to family

	support, appropriate foods, traditional practices to promote lactation, and lower stress); (2) more support to breastfeed by medical authorities in other countries vs. the U.S.; (3) influence of older relatives on feeding practices, especially grandmothers; (4) recommendations for improved nutrition in shelters and peer support.
Conclusions	Participants spoke frankly about infant feeding beliefs, practices, and challenges, while suggesting improvements for supporting recently arrived Haitian parents which can be incorporated into maternal-infant health services.
Project Design	Advocacy/Policy Interprofessional Collaboration BIomedical Research Focus Groups

Mital, Riya

THRIVE: Expanding HRSN Language Screening Accessibility

Riya Mittal, et. al.

Name of Submitter	Riya Mittal rmittal@bu.edu
Project Status	2. Work In Progress
Title of Project	THRIVE: Expanding HRSN Language Screening Accessibility
Authors	Riya Mittal*[1], Brittney Anderson*[1], Jessica Czapla*[1], Lauryn Lu[1], Sowmya Potluri[1], Shruti Misra[1], Kevin Singh[1], Pablo Buitron de la Vega[1] *These authors contributed equally to this work.
Institutions	[1]Boston University Chobanian & Avedisian School of Medicine; Boston Medical Center
Project Narrative	Health related social needs (HRSN) significantly impact health outcomes, particularly for patients with language barriers. While universal HRSN screening is increasingly common at safety net hospitals, screening disparities persist as current tools are only available in limited languages, creating barriers for patients who speak other languages.
Statement of Problem & Goals	This study evaluates the feasibility and effectiveness of a medical student-led initiative to conduct screenings and referrals for HRSN before patient visits specifically targeting patients who do not speak languages available for in-person screening. This approach aims to decrease screening disparities, reduce pressure on in-person staff who must otherwise screen through interpreters during limited appointment times, and allow clinical teams to focus more on medical care.
Concept Description for Works in Progress	Our intervention employs medical students to conduct telephone-based HRSN screenings with interpreter services for Boston Medical Center (BMC) patients who speak languages not supported by current in-person screening tools. Students contact patients prior to scheduled appointments, administer the THRIVE HRSN screener, and connect those with identified needs to appropriate resources.
Project Design/Methodology	Every two weeks, medical students generate lists of patients due for HRSN screening who speak languages not available for in-person screening and who have upcoming outpatient general internal medicine appointments. Students call these patients following a standardized workflow, connecting with interpreters when needed. With patient permission, students administer the THRIVE screener to identify HRSN. Patients screening

	positive receive resource connections via text or email using the THRIVE Directory, an online based community repository of social services.
Findings/Results	Over six weeks (February-March 2025), 57 eligible participants were identified (average 9 patients/week). Students contacted 32 patients through single phone calls, with 12 (37.5%) answering, 5 (15.6%) agreeing to screening, and 3 (9%) screening positive for HRSN. All three patients were connected with resources through the THRIVE Directory.
Evaluation Plan	Initial results demonstrate the feasibility of this medical student-led pre-visit screening initiative. While we successfully identified and connected at-risk patients with resources, our pilot suggests more PDSA (Plan-Do-Study-Act) cycles are needed to improve patient engagement and test the approach with a larger patient population.
Support Needed for collaboration needs and to advance the project	To expand this program, we need additional medical student volunteers to increase call capacity and strategies to address patient mistrust when contacted by unfamiliar callers. We also need support to improve tracking of resource utilization and patient outcomes following referrals.
Project Design	Quality Improvement

Phicil, S.

The COMPASS Project: Leveraging AI and Patient Narratives to Advance Equity in Health Tech

Sheila Phicil, et. al.

Name of Submitter	Sheila Phicil hello@phicil-itatechange.com
Project Status	2. Work In Progress
Title of Project	The COMPASS Project: Leveraging AI and Patient Narratives to Advance Equity in Health Tech
Authors	Sheila Phicil, MPH, MS, PMP, FACHE
Institutions	Phicil-itate Change LLC
Project Narrative	The COMPASS Project is an AI and blockchain-powered platform designed to reduce social isolation and improve health outcomes for individuals with chronic conditions, particularly diabetes, by surfacing and connecting shared patient experiences. Focused on underrepresented communities across Greater Boston, COMPASS enables radically patient-centered innovation by turning real-world patient narratives into actionable insights for health tech solutions, increasing access, equity, and effectiveness in care delivery.
Statement of Problem & Goals	Despite billions invested in digital health, most innovations fail due to misalignment with patient needs, lack of inclusive design, and poor engagement strategies. Communities of color and low-income populations in Greater Boston face additional challenges such as social isolation, fragmented care, and exclusion from traditional health innovation pipelines. The COMPASS Project aims to reverse this trend by using AI to amplify diverse lived experiences and ensure that healthcare solutions are built with and for patients. Goals include: Empowering patients with ownership and control over their health data Identifying systemic barriers and shared challenges across communities Driving inclusive health innovation rooted in real patient experiences
Concept Description for Works in Progress	COMPASS combines AI-powered narrative analysis with blockchain-enabled data sovereignty to collect, analyze, and mobilize patient stories at scale. The target population includes individuals managing chronic conditions, especially Black and Latinx residents of Greater Boston who face disproportionate barriers to healthcare access

	and quality. The project team includes data scientists, UX designers, public health strategists, and early-stage startup partners. Notably, COMPASS is incubated at Phicil-itate Change and has secured Boston Medical Center as its initial beta site for real-world testing.
Project Design/Methodology	The COMPASS platform is a community-based digital intervention that integrates natural language processing, system dynamics modeling, and human-centered design. Narratives are collected via a secure platform and analyzed using AI to identify themes such as emotional distress, meal planning, or medication adherence. COMPASS then generates design recommendations for health tech innovators and facilitates peer connections for patients based on shared challenges. The project leverages the SEEDS Frameworkâ€”centered on systemic problem identification, equity design, and ecosystem alignmentâ€”to guide implementation across healthcare and community settings.
Findings/Results	While full patient narrative analysis is forthcoming, the COMPASS Project has achieved significant early-stage momentum by establishing strategic partnerships to support real-world validation. We have secured Boston Medical Center's Pediatrics Department as a beta partner, positioning COMPASS to pilot its platform with diverse patient families and youth managing chronic conditions. Additionally, COMPASS is supporting its first early-stage startup pilot, QPER Health, which is focused on integrating patient-centered insights into digital diabetes care for underserved populations. These partnerships mark critical milestones toward deploying COMPASS in real-world settings and validating its AI-powered methodology. Early feedback from stakeholder interviews has affirmed the platform's potential to bridge gaps in community voice, accelerate product-market fit for health innovations, and address systemic disparities in healthcare design.
Evaluation Plan	We are using a mixed-methods framework that combines qualitative tracking of peer engagement and satisfaction with quantitative metrics such as reductions in self-reported isolation, improved confidence in disease management, and behavioral indicators like app retention and feature utilization. Evaluation is being conducted in partnership with Boston Medical Center and community-based health organizations. Future plans include measuring health outcomes longitudinally and assessing startup product-market alignment based on COMPASS-informed recommendations.
Support Needed for collaboration needs and to advance the project	We seek strategic partners to expand COMPASS implementation across community health centers and early-stage startups. Specific needs include: Collaborations with Greater Boston-based clinics and advocacy groups to onboard new patient storytellers

	Funding support to enhance platform features and scale AI model precision Co-design partners from health systems and public health agencies interested in using COMPASS insights for new program development
Project Design	Quality Improvement Health tech innovation

Sabharwal, M. - Bridging

Collaborative Exploration in Bridging Health: Traditional Healing Practices with Western Preventive Medicine in Community Settings

Mallika Sabharwal, et.al.

Name of Submitter	Mallika Sabharwal mallika.sabharwal@bmc.org
Project Status	1. Completed Project
Title of Project	Collaborative Exploration in Bridging Health: Traditional Healing Practices with Western Preventive Medicine in Community Settings
Authors	Mallika Sabharwal (3,4), Lisa Maya Knauer (1,5), Andrea Jaramillo (6), Adrian Ventura (1), Sergio MejÃa Lux (1), Estrella de la Cruz (1), Christopher Llerena (3,4), Ulum Pixan Athohil Suk'il (2), Pablo Buitron de la Vega (3,4)
Institutions	1. Centro Comunitario de Trabajadores (CCT), 2. Indigenous People's Network (IPN), 3. Boston Medical Center, 4. Boston University Chobanian & Avedisian School of Medicine, 5. University of Massachusetts Dartmouth, 6. Forest Nurse
Project Narrative	The Centro Comunitario de Trabajadores (CCT) serves Central American immigrant workers in New Bedford, Massachusetts, whose communities maintain and utilize rich traditional healing practices (including ancestral, indigenous, and community-based healing knowledge) while simultaneously facing significant healthcare barriers. This exploratory initiative engages local populations to establish community-derived recommendations for the integration of diverse healing practices, with the objective of ensuring equitable access to a comprehensive spectrum of healthcare modalities according to individual preferences and needs.
Statement of Problem & Goals	Health disparities in immigrant communities have roots in their countries of origin, with limited access to Western biomedicine including geographic, cultural, and linguistic barriers, as well as discriminatory practices and culturally insensitive attitudes that denigrate and criminalize traditional healing practices and practitioners. These historical barriers lead to a deep mistrust of Western biomedical models. Linguistic and cultural barriers are still key factors in the U.S. context. Our research aims to deconstruct hierarchical dynamics in healthcare by co-creating knowledge through participatory processes that identify optimal integration pathways that ensure universal access to both traditional healing and Western preventive approaches, while addressing structural barriers to care.

Project Design/Methodology	Using participatory research, we conducted a community gathering with 70 participants through participatory mapping, followed by four focused conversations exploring various health dimensions. Analysis maintained balanced community representation throughout.
Findings/Results	Our analysis revealed that addressing mistrust of Western medicine is prerequisite to effective collaboration. Communities emphasized maintaining traditional practices while integrating culturally-sensitive health education, ensuring gender-concordant care, respecting religious perspectives, and creating dedicated spaces for traditional healing. These insights, generated through collaborative dialogue between community members, Western medicine practitioners, and social scientists, inform implementation frameworks that ensure all community members can access appropriate care across healing traditions according to their preferences.
Conclusions	This exploration revealed pathways for culturally-responsive health integration that values traditional knowledge alongside preventive medicine. Next steps include developing a community-led health navigation model, creating training programs validating traditional healing knowledge, and designing pilot interventions that harmonize both traditions. This approach centers community expertise while addressing historical power imbalances that perpetuate health inequities.
Project Design	Community Based Intervention Interprofessional Collaboration Community participatory mapping

Sabharwal, M. - Anemia

Bridging the Gap- Anemia During Pregnancy is a Health Equity Issue

Mallika Sabharwal, et. al.

Name of Submitter	Mallika Sabharwal mallika.sabharwal@bmc.org
Project Status	1. Completed Project
Title of Project	Bridging the Gap- Anemia During Pregnancy is a Health Equity Issue
Authors	Mallika Sabharwal, Jennifer Pfau
Institutions	Boston Medical Center
Project Narrative	With global prevalence of more than 30%, anemia in pregnancy is a significant public health and health equity issue associated with increased risk of multiple maternal and fetal complications that often affect people of color. Applying a quality improvement framework during the antepartum period may be used to address peripartum outcomes.
Statement of Problem & Goals	Iron deficiency anemia in pregnancy is a significant public health and health equity issue. At Boston Medical Center (BMC), an urban safety net hospital, the annual rate of anemia on admission to Labor and Delivery increased from 44% in 2019 to 53% in 2023, with higher rates consistently noted in Black birthing people. Our project's aim was to decrease the rate of anemia (HCT < 32%) on admission to Labor and Delivery at BMC for Black birthing people from 15.55% to 13% in one year using an interdisciplinary QI approach.
Project Design/Methodology	An interdepartmental QI Antepartum Anemia working group was convened consisting of obstetricians (1), midwives (3), family medicine physicians (2), and administrators (2), with completion of a driver diagram to help guide interventions.â€‹ Stakeholders with expertise in nutrition (representatives from the Teaching Kitchen and pediatric Growth and Development clinic) were included. Patient focus groups were conducted to better understand the experience of individuals diagnosed with anemia during pregnancy.
Findings/Results	During the last month of study data collection (July 2024), the rate of anemia on admission for Black birthing people was 10.56%. Although we did not demonstrate a sustained decrease during the study period, the trend persisted.
Conclusions	Given the structural and social challenges faced by BMC's patient population, reducing anemia in pregnancy is challenging. Although

	unsuccessful in achieving our aim, other improvements resulted from our team's efforts including updating BMC's prenatal anemia guideline and creation of perinatal nutrition resources.
Project Design	Quality Improvement Interprofessional Collaboration

Smith, S.

Promoting Equity Throughout the Spectrum of Trauma Care
Sophia Smith, et.al.

Name of Submitter	Sophia Smith sophia.smith@bmc.org
Project Status	2. Work In Progress
Title of Project	Promoting Equity Throughout the Spectrum of Trauma Care
Authors	Sophia M Smith MD, Anne K Buck MS, Ella Cornell MD, Miriam Neufeld MD, MPH, Timothy Munzert MSW, LICSW, Lisa Allee MSW, LICSW, Megan G Janeway MD
Institutions	Department of Surgery, Boston Medical Center, Boston, MA Department of Surgery, Boston University Chobanian & Avedisian School of Medicine, Boston, MA Boston University School of Public Health, Boston, MA Department of Medicine, University of California San Francisco, San Francisco, CA DeWit Daughtry Family Department of Surgery, Miller School of Medicine, University of Miami, Miami, FL Division of Surgical Critical Care, Department of Surgery, Jackson Health System, Miami, FL
Project Narrative	Victims of violence experience discrimination in post-acute care. Legislative protections for victims of violence would promote optimal healing, potentially improving physical and mental health, productivity, and community and healthcare engagement.
Statement of Problem & Goals	Rehabilitation services are a crucial driver of outcomes after trauma, with are poorer in victims of violence. However, existing protections, such as the Emergency Medical Treatment and Active Labor Act (EMTALA) do not extend to post-acute care, leaving the potential for discrimination. We aim to evaluate equity in access to rehabilitation services and propose expansion of state policies to ensure nondiscrimination throughout the continuum of care.
Concept Description for Works in Progress	We first evaluate disparities in receipt of rehabilitation services in victims of violent trauma. Next, using a multidisciplinary team of clinicians, policy professionals, and advocacy experts, we propose expanded anti-discrimination legislation at the state level.
Project Design/Methodology	In a retrospective cohort study (1/1/2014-12/31/2021), we examined the association between violent injury and receipt of rehabilitation services. A subgroup analysis evaluated discordance between recommended and obtained disposition and reasons for rejection from services. Subsequently, our proposes to draft state-specific EMTALA legislation to address

	discrimination throughout the spectrum of care. Such legislation would codify nondiscrimination for victims of violence, and for others who may be discriminated against due to sociodemographic factors.
Findings/Results	Among 7500 patients, 1677 (22.4%) were violently injured and 5823 (77.6%) were nonviolently injured. Patients were 45% White, 67% male, and 52% had public insurance. Adjusting for age, sex, race, ethnicity, injury severity score, insurance, and length of stay, violently injured patients were 77% less likely to receive inpatient rehabilitation (RR 0.23, 95% CI 0.18-0.30, $p<0.001$) and 46% less likely to have home services (RR 0.54, 95% CI 0.43-0.69, $p<0.001$). Review of case management documentation demonstrated that 33% of violently injured patients recommended for acute rehabilitation were rejected specifically due to the nature of their injury. These data support the conclusion that victims of violence experience discrimination related to the nature of their injury, with associated inadequate access to necessary post-acute care.
Evaluation Plan	We consider the passage of state-level antidiscrimination policies or legislation to represent the primary outcome of our research. Subsequently, ensuring accountability from payors and rehabilitation facilities will require further study.
Support Needed for collaboration needs and to advance the project	Collaboration with policy experts and state legislators will be crucial in promoting legislative change.
Project Design	Advocacy/Policy

Stanton, E.

Addressing Food Insecurity among BACO Clients through Community & Healthcare Partnerships

Eliot Stanton, Emily Tejada, et.al.

Name of Submitter	Eliot Stanton, Emily Tejada eliot_stanton@projectbread.org, emily_tejada@projectbread.org
Project Status	1. Completed Project
Title of Project	Addressing Food Insecurity among BACO Clients through Community & Healthcare Partnerships
Authors	Eliot Stanton, Emily Tejada, Anoud Bakri, Hannah Koehn, Jennifer Obadia, Laura Siller
Institutions	Project Bread
Project Narrative	Project Bread, a Massachusetts-based social service organization, co-designed a Food Is Medicine (FIM) program with local Accountable Care Organizations aimed at enhancing food and nutrition security among individuals with chronic health conditions. This poster presentation will showcase Project Bread's FIM model through an analysis of programmatic data for WellSense Community Alliance clients referred from BMC health centers to the program at any point between 2021 and 2024. The research will highlight the program's successes, focusing on its impact on participants, to provide attendees with actionable insights for cultivating leadership and collaboration on community-based food-security solutions.
Statement of Problem & Goals	A growing body of research has identified food insecurity as a critical social determinant of health, linking it to an increased risk of chronic conditions such as diabetes, cardiovascular disease, hypertension, and kidney disease. Furthermore, food insecurity often coexists with multiple chronic conditions, compounding health challenges and contributing to decreased life expectancy. In response, FIM interventions have emerged as a promising strategy to mitigate the impact of food insecurity on chronic disease management and overall well-being. Massachusetts leveraged a federal waiver to secure approval from the Centers for Medicare and Medicaid Services to allocate Medicaid funds toward addressing health-related social needs. As part of this initiative, Project Bread designed its FIM program targeting food insecure individuals with chronic health conditions. In 2021, Project Bread expanded its partnership ACOs to include WellSense Community Alliance (formerly BACO).

Project Design/Methodology	The program employs a comprehensive case management approach. Clients meet with case coordinators at three key touchpoints (i.e., an initial assessment, a three-month follow-up, and a six-month follow-up) to evaluate their needs and provide tailored support. Tailored support services include monthly grocery store gift cards, nutrition education, cooking classes, kitchen supplies, kitchen appliances, and referrals to SNAP. Clients have the flexibility to choose which services best meet their needs and are often matched with case coordinators who share their cultural and linguistic backgrounds, fostering a more personalized and supportive experience.
Findings/Results	As part of the pilot phase of Project Bread's FIM program, case coordinators collected data on food and nutrition security indicators to evaluate the program's impact on clients from baseline to immediate posttest. The measures presented here for BMC clients include food security, fruit and vegetable consumption, and SNAP participation, as well as health center satisfaction, nutrition knowledge, and ability to prepare healthy meals.
Conclusions	Analysis of this program has contributed to evidence that FIM interventions help food-insecure Medicaid patients in Massachusetts, like those served in partnership with BMC, to manage their chronic health conditions. In 2025, MassHealth permanently incorporated health-related social needs programming. Going forward, Project Bread will run a modified version of its program with several partner ACOs, including WellSense. Ultimately, this poster aims to provide insights into Project Bread's FIM program's structure while presenting emerging evidence of its efficacy.
Project Design	Health Education/Training Community Based Intervention

Taffel, L.

On-Demand Patient Navigation: An AI-Supported Solution for Addressing Health Related Social Needs in a Geriatrics Clinic

Leah Taffel, et. al.

Name of Submitter	Leah Taffel leah.taffel@bmc.org
Project Status	2. Work In Progress
Title of Project	On-Demand Patient Navigation: An AI-Supported Solution for Addressing Health Related Social Needs in a Geriatrics Clinic
Authors	Leah S. Taffel, Sheila Phicil, Krishna Varela, Kwamane Liddell, Yesenia Tinoco, John Wilson, Pablo Buitron de la Vega.
Institutions	Section of Geriatrics, Boston Medical Center/Boston University Chobanian & Avedisian School of Medicine, Boston, Massachusetts, UNITED STATES Boston University Chobanian & Avedisian School of Medicine, Boston Medical Center, Boston, Massachusetts, UNITED STATES; THRIVELINK, Black Jack, Missouri, UNITED STATES;
Project Narrative	Healthcare institutions struggle to address patients' health-related social needs (HRSN) due to limited resources, with the cost of patient navigators (PNs) often being prohibitive. On-demand, AI-supported PN services offer a feasible, cost-effective model for older adults in a Geriatrics Clinic.
Statement of Problem & Goals	Healthcare institutions struggle to address patients' HRSN due to limited resources. Geriatrics patients in a health safety net hospital often require increased help navigating complicated resource applications and services. PN can help alleviate this burden but are often cost prohibitive.
Concept Description for Works in Progress	A pilot program was created to compare cost-effectiveness of traditional versus on-demand PN models in a Geriatrics Clinic of a health safety net hospital.
Project Design/ Methodology	From July 2024- March 2025, we implemented a novel HRSN program in a Geriatrics Clinic. The intervention allowed providers to electronically refer patients to an external organization providing AI-supported PN services. PNs offered: 1) education for navigating services, 2) assistance with city/state/federal applications, or 3) facilitation of community referrals. The program team met weekly to review outcomes and address barriers. We evaluated provider referral completion rates and successful patient contacts. Impact was measured by tracking education provided, applications submitted, referrals made, and monetary value of secured

	benefits.
Findings/Results	AI supported PN services outreached 100% of 149 referrals placed and successfully reached 52% (78/149). This resulted in education of services and 57 applications (e.g., housing, Medicare, Medicaid, SNAP, SSI, transportation, and community resource referrals). Of the 57 applications, 24.5% (14/57) were approved, generating $25,880 in patients benefits, 75.5% (43/57) are pending. In addition, 2 SNAP applications were denied, and 1 Medicare and 2 Medicaid applications were withdrawn due to personal preference. The cost of the PN service was $5,000 for 9 months versus an estimated $ 51,750 for a full-time PN per year.
Evaluation Plan	Success was defined by connecting patients to community services, helping to complete applications, and cost effectiveness of PN pilot program. Weekly program oversight enables effective troubleshooting while preserving frontline staff time. The largest barriers to this intervention included successfully connecting with patients via telephone and wait times for housing/insurance resources. Though upstream determinants require systematic attention, this model provides impactful interim patient support with substantial return on investment.
Support Needed for collaboration needs and to advance the project	Continued funding for the on demand PN by hospital administration is required to further connect patients with needed resources and services
Project Design	Community Based Intervention

Totman, M.

Engaging Black Patients and Primary Care Team Members in Developing Strategies to Reduce Mistrust in Healthcare

Molly Totman, et.al.

Name of Submitter	Molly Totman mtotman@mhqp.org
Project Status	1. Completed Project
Title of Project	Engaging Black Patients and Primary Care Team Members in Developing Strategies to Reduce Mistrust in Healthcare
Authors	M Totman, A Bailey, D Grayson, N Martins, T Polk, K Gergen Barnett, A Bazemore, R Rudel, B Rabson
Institutions	Massachusetts Health Quality Partners (MHQP); American Board of Family Medicine (ABFM); Boston Public Health Commission (BPHC); Boston Medical Center (BMC); Building Your Dreams, LLC
Project Narrative	Medical mistrust is a deeply rooted barrier to health equity among Black communities. This project, funded by PCORI, engaged Black patients and primary care team members through focus groups and a multi-stakeholder convening to co-develop strategies and priorities for future patient-centered outcomes and comparative effectiveness research (PCOR/CER). The resulting Roadmap identifies actionable, stakeholder-informed directions to reduce medical mistrust and improve primary care experiences.
Statement of Problem & Goals	Despite being the cornerstone of healthcare, primary care has not adequately addressed persistent racial disparities in trust, with Black patients in Massachusetts consistently reporting lower trust scores on MHQP's Statewide Survey. This project addresses a gap in patient-centered research by engaging stakeholders to understand factors contributing to mistrust and to co-create research directions grounded in lived experience. The goal was to identify and prioritize community-informed strategies to reduce medical mistrust and guide future PCOR/CER efforts.
Project Design/Methodology	The project was grounded in a community-based participatory approach, featuring continuous co-creation with partner organizations and Black patient and primary care team co-creators. Between Fall 2024 and Winter 2025, MHQP and partners conducted two focus groupsâ€”one with Black patients and one with diverse primary care team membersâ€”followed by a multi-stakeholder convening. Participants explored definitions and

	experiences of trust, ranked 13 focus areas, and collaboratively identified and refined strategies.
Findings/Results	Participants identified multiple barriers to trust in healthcare, including racism, interpersonal challenges (e.g., patients feeling dismissed or disrespected by care teams), and systemic issues (e.g., lack of diversity in the primary care workforce). Facilitators of patient trust included meaningful inclusion in decision-making and the ability to access timely, reliable care. From these insights, participants prioritized four key areas for addressing mistrust: â€œCommunicate with Compassion,â€ â€œWork Together on Decisions,â€ â€œSupport Patient Agency Through Education and Tools,â€ and â€œFoster Equitable and Inclusive Care.â€ Together, patients and primary care team members co-developed nine actionable strategies to foster trustâ€”such as structured follow-ups, training in team-based communication and active listening, and embedding cultural humility and anti-racism into care delivery. Participants also identified a range of patient-centered outcome measures to evaluate progress, including patient experience surveys, continuity of care metrics, provider self-evaluations, and clinical outcomes.
Conclusions	Key learnings emphasize the importance of empathy, agency, cultural humility, and systemic accountability in rebuilding trust. Future directions include co-designing and testing PCOR/CER interventions addressing mistrust based on community priorities, with emphasis on measurable, stratified outcomes. The Roadmap serves as a tool for researchers and healthcare organizations aiming to equitably improve trust and health outcomes in Black communities.
Project Design	Interprofessional Collaboration Narrative Medicine/Written Pieces Community-Engagement

Vora, H

National Undergraduate Student Health Metrics Survey and BU Prevent Program Outline

Hassan Vora, et. al.

Name of Submitter	Hassan Vora
Project Status	2. Work In Progress
Title of Project	National Undergraduate Student Health Metrics Survey and BU Prevent Program Outline
Authors	Ayah Aboyoussef, Andres Alcocer, Esha Patel, Hassan Vora, Zane Zaidi
Institutions	Boston University Chobanian and Avedisian School of Medicine
Project Narrative	BU Prevent is a student-led initiative dedicated to advancing preventive health within the Boston University community. We aim to enhance student wellness through targeted health campaigns, health crisis response training, and guest lectures with preventive care expertsâ€”fostering a safer, healthier campus.
Statement of Problem & Goals	Preliminary polling and campus conversations reveal key health gaps among students, including limited exercise and nutrition, poor mental health and sleep hygiene, infrequent medical checkups, and inadequate substance use support. Our objectives focus on addressing these issues through student-led service and education, while instilling a preventive care mindset in future healthcare professionals.
Concept Description for Works in Progress	BU Prevent is organized into three teams: Outreach, Service, and External Affairs. Outreach will lead visual health campaignsâ€”flyers, digital ads, and QR-linked resources. Service will run student-driven initiatives such as wellness kit distribution and basic health screenings. External Affairs will host guest lectures with preventive medicine experts. Each team targets the BU student body with focused strategies to improve wellness.
Project Design/Methodology	Our intervention follows a three-pronged approach: - Service will partner with BU Student Health Services (SHS) to lead wellness kit assembly, naloxone training/distribution, Alcohol Intoxication response education, and a student resource guide. - Outreach will develop health education campaigns on nutrition, exercise, sleep, mental health, substance use, and access to care, based on survey data and input from BU Student Government. - External Affairs will organize expert-led speaker events in collaboration

	with BU preventive medicine and addiction fellows, Dr. Najam Zaidi (Brown, Infectious Disease), and Dr. Saira Hussain (RI, mindfulness and holistic care). They will also engage BU administration to advocate for policy changes regarding affordable dining options and incentives for physical activity.
Findings/Results	Our expansive national survey of undergraduate students (n=140, as of April 8, 2025) reveals 55% of students fall short of recommended exercise levels, 61.5% eat one or fewer healthy meals daily, and 20% do so only every few days. Furthermore, 82% lack a local primary care provider, and 84.6% miss annual checkups. Nearly 40% report serious health issues during college. These findings support the need for additional preventive care measures.
Evaluation Plan	We will survey BU students one year post-implementation, asking if they used BU Prevent resources, how their health was affected, lifestyle changes made, and what unmet needs remain. These responses will guide future improvements.
Project Design	Health Education/Training Community Based Intervention Advocacy/Policy

Whalen, K.

Equity Now & Beyond: Advancing Immigrant Health Equity through Community-Driven Change

Kevin Whalen, et. al.

Name of Submitter	Kevin Whalen kevin@csioboston.org
Project Status	2. Work In Progress
Title of Project	Equity Now & Beyond: Advancing Immigrant Health Equity through Community-Driven Change
Authors	Emily Kumph, Jovanni Gonzalez, Kevin Whalen
Institutions	Equity Now & Beyond is coordinated by Center to Support Immigrant Organizing and led by True Alliance Center (Haitian community), ACEDONE (African), Brazilian Women's Group and Agencia ALPHA (Latinx). EN&B's lead researcher is BUMC Professor Lance Laird.
Project Narrative	Equity Now & Beyond (EN&B) is a grassroots-led health equity initiative addressing the systemic barriers to good health among Haitian, African, Brazilian, and Latinx immigrant communities in greater Boston. Through addressing the social determinants of health via culturally competent community engagement activities, leadership development and opportunities, access to provider care, social and economic resources, legal and policy advocacy EN&B improves community and individual health while supporting immigrant leaders to drive systemic change.
Statement of Problem & Goals	Low-income immigrant populations face health disparities due to the social determinants of health, limited healthcare access, language and cultural barriers. EN&B seeks to eliminate these inequities by organizing community-driven health, social, economic and political interventions. Recent federal attacks on immigrant communities have caused widespread crisis for tens of thousands of Massachusetts immigrants. Our goals are to engage immigrants and their allies to defend communities against these attacks while we continue to build long-term and sustainable initiatives in the solidarity economy to build immigrant social and economic capacity.
Concept Description for Works in Progress	EN&B's key engagement strategy is to provide 4-6 community wellness & equity clinics each month. These clinics bring social and economic resources as well as health care providers to community settings to reach immigrant populations often isolated from health care access and other resources. Clinics integrate medical, dental, wellness and preventative care with resources like food security, affordable housing applications, workforce

	development and immigration support. We engage participants in EN&B advocacy campaigns in immigration, housing, menstrual justice and health care access. We will continue to provide Know Your Rights trainings to immigrant populations (so far over 45 trainings have reached over 5200 people) and mobilize allies to support immigrants via ICE watches, legal advocacy, mobilization at community actions and court hearings to show community commitment to immigrant dignity, immigration clinics and more. We will also build alternative solidarity economy systems via worker cooperatives and a community land trust to acquire land and develop affordable housing.
Project Design/Methodology	15-20 EN&B leaders meet weekly to plan and develop all activities. We organize community wellness and engagement clinics each week - rotating neighborhoods and focuses. We engage allies to support immigrants at legal clinics, court hearings, community actions, hearings and other activities. We are providing 4 worker cooperative training institutes (20 hours) to our communities this year; launching community engagement processes in our four communities to build community leadership into our community land trust; we are providing KYR trainings in gateway cities with sister organizations; and we are working with statewide partners NOW, MIRA and HCFA on health equity, immigration and menstrual justice legislative proposals.
Findings/Results	-Over 7,700 immigrants participate in wellness & equity clinics -3,200+ enrolled in health insurance -$80,500 distributed in farmers market food assistance -405 units of permanent affordable housing in planning phase -Legislative advocacy advances bills at State House -Worker cooperative institute completed in the Haitian community for 65 participants. - Helped over 1,250 people apply for jobs, job training programs and/or affordable housing.
Evaluation Plan	EN&B tracks impact through clinic participation, policy wins, and leadership engagement, using community participatory research methods led by Boston University School of Medicine Professor Lance Laird. We use qualitative and quantitative criteria, and have completed research on health equity in immigrant communities during Covid.
Support Needed for collaboration needs and to advance the project	We rely on the support of over a dozen health care providers, several state-wide advocacy groups, legal advocates, neighborhood partners, the BPHC, MOIA and other government officials, and training partners like Center for Cooperative Development and Solidarity.

Project Design	Community Based Intervention Advocacy/Policy Leadership/Change Management

Young-Sileo, N.

Online ESOL Pilot Program: Pre-Pilot Thematic Analysis

Nicole Young-Sileo, et. al.

Name of Submitter	Nicole Young-Sileo MD Nicole.Young-Sileo@childrens.harvard.edu
Project Status	2. Work In Progress
Title of Project	Online ESOL Pilot Program: Pre-Pilot Thematic Analysis
Authors	Nicole Young-Sileo, MD; Abigail Temple MD; Prabhjot Minhas MD; Amanda Dalmau, MD; Jenna Harowitz MD; Amanda Laine MS3; Regine Albin; Megan Sandel MD
Institutions	Boston Medical Center Pediatric Department, Rian Immigrant Center, and Family Aid Boston
Project Narrative	Our project aims to explore motivations, benefits, barriers and long-term feasibility of a sponsored online ESOL pilot program for newly arrived immigrants in the surrounding Boston area. Implementing such a program would allow participants to access the benefits of knowing English including improved educational and job opportunities, health outcomes, financial stability and more.
Statement of Problem & Goals	32% of patients at BMC do not speak English.1 This number is rising as immigration to Massachusetts has increased over the last two decades. 2 While there are free ESOL courses available for patients, they are often difficult to access due to waitlists, transportation and inadequate duration. Programs that are more comprehensive with no waitlists cost money. These barriers prevent newly arrived immigrants from accessing the benefits of knowing English in the U.S. including job and educational opportunities, communication skills and self-sufficiency. From a health standpoint, knowing English allows for better health outcomes through improved healthcare access, mental health, chronic disease management and health literacy. 3 Our project aims to partner with newly arrived immigrant families to create a pilot program that bridges these gaps in access to learning English.
Concept Description for Works in Progress	Participants were recruited through Family Aid Boston and included newly arrived immigrant families. Participants were offered free participation in an online ESOL pilot program. The team working on this pilot included ESOL instructors at RIAN, workforce development and social workers from Family Aid and researchers at BMC.

Project Design/Methodology	Pre-pilot analysis was performed using anonymous semi-structured interviews, which were transcribed, translated and analyzed for thematic analysis. Results were utilized to guide the implementation of the pilot program. Pilot program design included ESOL placement exams, followed by a digital literacy course, then an 18-week ESOL online course with ultimate goal of ending with additional workforce development programs.
Findings/Results	Our pre-pilot survey analysis findings showed that participants arrived to the U.S. through complex immigration journeys, shared similar motivators for learning English including job and educational opportunities, communication skill building and support the next generation. They identified similar barriers to prior ESOL class participation including transportation, schedule constraints, duration and financial barriers. Our goal was to create a fully sponsored online ESOL class to help eliminate some of these barriers. Analysis is ongoing but participation in the ESOL placement exam and digital literacy portion of the pilot were 100%, while ultimate participation in the online ESOL course was only 33% with the workforce development portion ongoing requiring further analysis. One key barrier not addressed included scheduling constraints given the limited flexibility of course dates and times. We are currently conducting post-pilot interviews to work with participants to create an improved program in the future that we hope to be able to offer to patients at BMC. We also hope to create an employment/educational pipeline program to bridge participants into the workforce and/or higher educational opportunities.
Evaluation Plan	Participants have currently completed the ESOL course portion and are being interviewed about their experiences with the program and ideas on the workforce development portion moving forward.
Support Needed for collaboration needs and to advance the project	Employers and workforce development teams to help support with job training and employment opportunities. Community college support to help with ongoing educational opportunities. Financial support to help create a similar program at BMC to offer to our patients.
Project Design	Community Based Intervention