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321 Main Street, Worcester, MA 01608
e-mail: wdms@massmed.org
web: www.wdms.org
phone: 508.753.1579

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Production and advertising sales by Pagio Inc.
88 Winter St., Worcester, MA 01604
508.756.5006

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Greater Worcester Community Health Plan

Jane Lochrie, MD



Jane Lochrie, MD

The Greater Worcester Community Health Improvement Plan (CHIP) is one of the most exciting developments in Worcester's public health history since the Polio Vaccine Program; moreover, it is just as important to our public health. The CHIP processing has two components. The first is to complete a Community Health Assessment (CHA) to identify the health-related needs

and strengths of the greater Worcester region; and the second, a Community Health Improvement Plan (CHIP) to determine major health priorities, goals and objectives and strategies that can be implemented. This issue of *Worcester Medicine* explores the five priorities that CHIP has identified and will be working on over the next few years. Their vision is to make Worcester the Healthiest City in New England by 2020. The charge is led by Commissioner of Public Health Dr. Michael Hirsh, who is also the president of the Worcester District Medical Society. I'm not sure when Mike sleeps!

In the first article, City Manager Michael O'Brien clarifies how it all began. In 2009, he convened a task force to improve the health of the city. More than 100 community partners came together and formed the Community Health Improvement Plan, the first CHIP in the state. He explains that 85 percent of life expectancy is related to the quality of jobs, education, food, affordable transportation and housing and clean air.

The project manager for the Worcester Food and Active Living Policy Council, Liz Sheehan Castro, is well on the way to creating an environment that supports healthy choices regarding food and lifestyle. Her work has involved starting several farmers' markets, healthy cooking classes, significant changes in the school lunch programs and improvements in walking and biking conditions in the city and around schools. She has several ambitious projects planned through 2015.

Behavioral health demands far exceed the capability of hospital beds and providers in the city. Karyn Johnson, coordinator of substance abuse prevention at the city of Worcester's Di-

vision of Public Health, reviews her strategies for addressing these problems. Clara Savage, Ph.D., as director of Common Pathways, will join Karyn Johnson and will be a co-convenor of CHIP's Behavioral Health Domain No. 2. Plans include holding an annual mental health summit, training for front-line workers and supporting mental health education and curriculum in schools and youth agencies. Programs are planned to prevent substance abuse, including tobacco use and opioid overdose, particularly among our youth.

Monica Escobar Lowell, vice president of community relations at UMass Memorial Health Care; Frances M. Anthes, president and CEO of Family Health Center of Worcester; and Antonia McGuire, RN, MPH and president and CEO of Edward M. Kennedy Community Health Center, discuss the barriers to accessing health care in Worcester, including the shortage of primary care providers, limited public transportation, difficulty in navigating complex health care systems, cultural and language barriers and the growing uninsured and underinsured population.

Dr. Hirsh, the commissioner of public health, is well-known for his work in injury prevention for the past several years. His domain has carefully reviewed the data and found that 75 percent of injuries are from falls and motor vehicle accidents, yet the community's main concern is for violence. He will focus on reducing injuries in three major categories.

The Worcester community has once again demonstrated its commitment to addressing health care disparities by making this one of the five priorities. Health care disparities and health care literacy are becoming more of an issue in Worcester as the immigrant population keeps increasing. *Worcester Medicine* devoted the entire January/February 2013 issue to this topic. This subdivision is lead by Director of Public Health Derek Brindisi, MPA, who has taken the lead role in CHIP. He has brought together key leaders to eliminate racism and discrimination by reducing the structural and environmental factors that contribute to inequality.

I hope many of you will join in the effort to make Worcester the Healthiest City in New England by 2020!



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In a firm commitment to the long-term health and well-being of the vibrant and diverse community members of our region, The City of Worcester Division of Public Health in partnership with UMass Memorial, Common Pathways, and over 90 other community partners, drafted the Community Health Improvement Plan (CHIP). The CHIP utilizes the knowledge and expertise of individuals and organizations from all spheres of our community and aims to improve the quality of life and prosperity of residents of greater Worcester including the communities of Holden, Leicester, Millbury, Shrewsbury, West Boylston, and Worcester. In recognition of the many intricacies of health, The City and its partners performed a comprehensive Community Health Assessment to identify the health-related needs and strengths of the Worcester area, and model the CHIP grounded in those findings.

As such, The City and its partners decided to structure the CHIP around five principal domains with specific, measurable objectives to advance Worcester to the healthiest city in New England by the year 2020.

Priority 1: Healthy Eating, Active Living	Priority 2: Behavioral Health	Priority 3: Primary Care and Wellness	Priority 4: Violence and Injury Prevention	Priority 5: Health Equity
Create an environment and community that support people's ability to make healthy eating and active living choices that promote health and well-being.	Foster an accepting community that supports positive mental health; and reduce substance abuse in a comprehensive and holistic way for all who live, learn, work, and play in greater Worcester region.	Create a respectful and culturally responsive environment which fosters prevention, wellness, and access to quality comprehensive care for all.	Improve safety, reduce violence and injury, and inform public perceptions by educating and mobilizing the community around effective, targeted prevention, and intervention strategies.	Improve population health by systematically eliminating institutional racism and the pathology of oppression/discrimination by promoting equitable access to, and use of, health promoting resources in the community, and significantly reducing the structural and environmental factors that contribute to health disparities.

To learn how you can get involved, contact Zach Dyer at DyerZ@worcesterma.gov

Greater Worcester Community Health Improvement: Roadmap to a Healthy City

Worcester City Manager Michael V. O'Brien



Michael V. O'Brien

In 2009, I convened a Public Health Task Force to provide a road map to restructure our Department of Public Health, with the overall goal of improving the health of our city. The Centers for Disease Control defines a healthy city as “a community that is continuously creating and improving those physical and social environments and expanding

those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.”

One key recommendation from the task force was to “use quantitative and qualitative data to inform needs assessment, set priorities, respond to public health threats and continually evaluate effectiveness.”

Led by Derek Brindisi, director of public health, and Monica Lowell, of UMass Memorial Health Care, more than 100 community partners came together to address this recommendation and formulated The Community Health Improvement Plan (CHIP) initiative. Part of a growing national movement, CHIPs are being implemented in major cities across the country as the strategic plan for 21st century public health departments that recognize the importance of health in creating a vibrant and strong community. I take great pride knowing that Worcester is the first community in the Commonwealth to launch a CHIP initiative.

Research shows access to care accounts for, at most, 15 percent of the life expectancy. The other 85 percent of the difference is heavily impacted by hidden health factors, such as access to quality jobs, education, food, places to play, affordable transportation and housing and clean air.

The CHIP has helped to establish an agenda that incorporates numerous facets of city government, such as economic development, transportation, housing, education, public safety and land use as they pertain to the health and well-being of not only our city but all towns incorporated in our newly formed Regional Public Health Alliance.

Worcester is a city on the move. The CHIP is the result of a development process of a community-wide, collaborative, strategic plan that has set priorities for health improvement by engaging our partners and organizations to develop, support and implement the plan. I commend all who have stepped forth to join our efforts to earn the title of Healthiest City in New England by 2020 ~ a vision we can achieve together as we set forth as a proactive, resilient and innovative community, a role model for communities across the country.

Appointed city manager in 2004, the overarching theme of City Manager Michael O'Brien's administration has been to preserve, protect and enhance the quality of life for all residents and resident businesses in Worcester.

Priority 1: Healthy Eating and Active Living

Public Health and Social Justice

Liz Sheehan Castro



Liz Sheehan Castro

Improving everyone's access to healthy food and safe environments, in which everyone can be active, will make Worcester a healthier, more sustainable, more equitable community. Many organizations, agencies and individuals have been working towards these goals (in some form or another) in Worcester for a long time. The Worcester Food & Active Living

Policy Council is a network and a forum in which all these groups and people can come together and work to make them a reality.

The Worcester Food & Active Living Policy Council is leading the "healthy eating and active living" work for the Worcester Division of Public Health's (DPH) Community Health Improvement Plan (CHIP). Our goal is to "create an environment and community that support people's ability to make healthy eating and active living choices that promote health and well-being." It is important to note that we are working to "create an environment" that supports healthy choices, not simply to tell people to make healthy choices or even teach what healthy choices are. We know the work is much more complicated than that, and the playing field is not equal for people across race, class and neighborhoods.

The Worcester Food & Active Living Policy Council was founded in 2006 with a focus solely on food issues, primarily healthy food access. Healthy food access is the idea that a number of

factors can limit a person's access to healthy food. They can include geographic proximity to healthy food, economic means to afford healthy food, knowledge of how to prepare and eat healthy foods and access to culturally appropriate foods that are familiar and enjoyable. With a grant from the Health Foundation of Central Massachusetts, the group worked for more than five years to develop programs and policies that would create the necessary changes in systems and people's environments to support access to healthy food. The work was very successful and resulted in the development of the Main South Farmers' Market, the Mobile Farmers' Market, the School Gardens Program, Cooking Matters Cooking Classes, significant changes to the Worcester Public Schools food programs, great improvements in access to and participation in the SNAP (formerly Food Stamp) program, as well as many lasting relationships.

In 2010, the group recognized a need to add "active living" to our work, and we expanded and invited new partners to the table. The active living work has included improving walking and biking conditions in the city and around schools; developing relationships with city departments to understand the process of developing and affecting the design of spaces, streets and bridges, so that pedestrians and cyclists are better accommodated; and building awareness around the issues that affect people's ability to be active within their everyday lives.

The development of the CHIP is a natural extension of our work and helps us to take it to the next level. The objectives that we'll be working towards by 2015 include:

- Increase availability of and access to affordable fresh and local fruits and vegetables for low-income residents.
- Identify, prioritize and implement improvements for opportunities for physical activity and active living.
- Decrease the proportion of children in grade 1 who are overweight annually.
- Develop and implement a region-wide, multi-component obesity prevention/reduction initiative by 2015.

Within each objective area, we have a number of strategies that range from expanding the current Mobile Farmers' Market stops to developing policies to support better nutrition standards in early childhood care facilities and improving our city's parks. The core of our work will be working to make changes that will create permanent change and improvement in our community, not just temporary programs that will go away once the money runs out.

Working to improve our communities' abilities to eat healthy and stay active within a busy, convenience-driven culture will not be an easy task. We need to reshape our communities, our lifestyles, our priorities and work to create a movement that truly values all the work that goes into eating healthy and leading an active life. We also need to be cognizant of all the barriers people face in making healthy choices, ranging from income to access to transportation, mental health, knowledge of choices and resources and where in the city they may live. Improving access to healthy food and active living opportunities is not only a public health issue but also a social justice issue. We invite anyone in the community interested in our work and mission to join us in this endeavor.

To learn more, visit our website at worchesterfoodandactiveliving.org. Join us on Facebook and on Twitter, as well. Contact Liz Sheehan Castro at hungerfree@worchesterfoodpolicy.org. Liz Sheehan Castro is the project manager of the Worcester Food & Active Living Policy Council.



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Priority 2: Behavioral Health Addressing Mental Health and Substance Abuse through Prevention and Response

Karyn Johnson



Karyn Johnson

During the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process, substance use and abuse and mental health were considered interrelated. Both community members and agencies expressed their growing concerns relative to current prevention and treatment services that do not adequately address individual needs.

While current treatment does exist, participants explained that demand exceeds the number of providers and beds currently available. Holistic and wrap-around care are particularly essential, especially when addressing the issue of stigma. Various strategies were selected to address mental health, including conducting a gap analysis and increasing connections to mental health services for vulnerable populations. Plans also include holding an annual mental health summit to bring awareness and resources to those individuals and families coping with this complex issue. This conference will build capacity for a mental health, anti-stigma campaign that will promote a better understanding among health care providers and the community at large. The first of these events was held May 1, 2013, at Clark University by Common Pathways (CHNA 8) and attracted a large number of students, providers, support services and policy-makers.

In addition, we will pursue training for front-line workers such as schools, law enforcement, clergy, refugee groups, youth agencies and health care providers in mental health crisis response. This will be accomplished, in part, by promoting Mental Health First Aid course opportunities, as well as enhancing and expanding training for health care providers regarding emerging

issues in health care reform and new best practices, especially regarding cooperative, integrated care approaches and alternative strategies. And finally, we will explore and support current mental health education and curriculum in the schools or youth-serving agencies.

Substance abuse was noted as a concern, in particular among our youth. This concern is supported by the 2011 Regional Youth Health Survey results, included in the Health of Worcester Report. To that end, the Division of Public Health continues to administer four Massachusetts Department of Public Health (MA DPH) Bureau of Substance Abuse Services (BSAS) prevention grants and programs relative to opioid overdose, underage drinking, prescription drug abuse and our long-standing tobacco control program through the Worcester Regional Tobacco Control Collaborative. These programs are driven by the community and utilize research, evidenced-based strategies and policy to reduce substance abuse and youth access to tobacco and other nicotine delivery products.

The Division will work with its coalitions and key stakeholders to address these issues by conducting a 2013 Youth Health Survey to monitor trends; develop social norm campaigns and social media campaigns relative to alcohol, tobacco, opioids and prescription drugs; develop prescription drug education and awareness campaigns for the medical community; develop and implement a safe drug disposal program for prescription and over-the-counter drugs; support youth tobacco cessation programming in the schools; promote policy initiatives relative to smoke-free college campuses and housing; and continue to enforce laws against selling tobacco and alcohol products to minors.

Karyn Johnson is the coordinator of substance abuse prevention at the city of Worcester's Division of Public Health.

Priority 3: Primary Care/Wellness

Bridging the Gaps in Care

Monica Lowell, Frances M. Anthes and Antonia “Toni” McGuire, RN, MPH

Massachusetts has made great strides in making health insurance attainable for nearly all residents. However, there remains a churning of enrollments, with many individuals dropping off. While health insurance is mandatory in the state, nearly 4 percent remain uninsured. Though health insurance status is a key factor affecting access to care, it is not the only barrier impacting health. With growing racial/ethnic diversity, we must respond to the health disparities that are present in our vulnerable populations, who experience higher incidence of chronic disease, lower quality of care and higher mortality rates than white Americans.



The city of Worcester recently ranked fourth among the top 10 U.S. metropolitan areas for lowest percentage of uninsured residents, according to the Gallup Healthways Well-being Index. While the percentage of remaining uninsured individuals seems small, many in the city and state still lack health insurance or have inadequate coverage. Additional factors, such as a shortage of primary care providers, difficulty navigating today's complex and fragmented health systems and limited public transportation, are obstacles. A lack of understanding of socio-economic, cultural and linguistic factors also emerge as added barriers to care, particularly for low-income and vulnerable groups, including immigrant, asylee and refugee populations and the uninsured.

These factors were evident in the Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHIP), leading to the establishment of Domain Area Three: Primary Care/Wellness. The working group for this domain will focus on addressing these and other factors and monitoring progress in overcoming barriers to care.

Identifying the Need

The CHA process included the compilation of relevant data from multiple primary and secondary sources. Primary sources included key informant interviews with diverse medical providers such as emergency, specialty and primary care, as well as focus group discussions and one-on-one interviews conducted on site at community events and through an online survey, to which more than 1,200 individuals responded. Participants in these methods described personal and known barriers to accessing health care and discussed services

that were considered unequal or less accessible to vulnerable populations. As noted above, challenges that were indicated by participants as key barriers to receiving care included being uninsured or underinsured, limited provider availability and insufficient transportation options. They also cited challenges such as long wait times for appointments, fragmentation of services, perceived unequal treatment and linguistic and cultural barriers as additional obstacles to obtaining or pursuing care.

Emergency personnel and EMT professionals we spoke with said an indicator of these barriers ~ an important focus area, both in terms of continuity of care for individuals and economic impact for providers ~ is evidenced in the unnecessary use of hospital emergency rooms for non-emergent issues and management of chronic illnesses. Use of ERs for such episodic care is not ideal, is expensive and adds to ER congestion.

Health Disparities

We know, and data shows clearly, that disparities in health care access and health outcomes exist, particularly among racial and ethnic groups and low-income populations. As a Refugee Resettlement Site, Worcester is very ethnically diverse. According

to U.S. Census 2010 figures, the Hispanic population and other non-Hispanic, non-white ethnic groups have notably grown, while the white, non-Hispanic population has decreased. The number of Hispanics living in the city of Worcester has grown by 35 percent ~ and by more than 46 percent statewide ~ over the past 10 years. As a result, whites today account for the minority of school-age children in the city. The city's foreign-born population is significantly higher than that of Worcester County as a whole, accounting for the majority of this population in the region. The city of Worcester's foreign-born population is also significantly higher compared to the nation and state overall.

Because Worcester is a Refugee Resettlement Site, we also are regularly adding newly arriving members to our community and new immigrant groups. As a result, we must be vigilant to ensure better coordination and understanding of the social-cultural factors that impact access to care. This growing diversity, for example, has broadened the need for interpreter services for medical care. In its fiscal year 2012, UMass Memorial Medical Center alone delivered 144,320 documented interpretations for medical services in approximately 133 languages.

Seniors in our community locally ~ and nationwide ~ additionally account for the fastest growing sector of the population as baby boomers reach 65. While many needs for this group overlap with the challenges already discussed, seniors face unique barriers that must also be addressed, such as isolation, depression, mobility, transportation and difficulty affording co-pays for appointments and prescriptions.

Connecting to Primary Care

The city of Worcester and its surrounding region are home to outstanding health and social service providers that are providing excellent care. Bridging the gap of access barriers for the underinsured, uninsured and vulnerable populations is a critical community health need that must be addressed. Current low numbers of ethnically-diverse providers is considered to be another contributing factor to the poor connection of at-risk patients to the health care system.

Family Health Center of Worcester and the Edward M. Kennedy Community Health Center are playing a critical role in meeting the needs of these groups. Combined, these health centers serve more than 40,000 patients in Worcester alone. Free care clinics are also playing an important role, as well as UMass Memorial's 55 primary care locations and other providers throughout Worcester County.

We also have the UMass Memorial Ronald McDonald Care Mobile, a mobile unit that serves as a "sweeper," providing medical and preventive dental services to the uninsured and underinsured and helping to connect them to a medical home. The

Oral Health Task Force is playing an important role in ensuring preventive dental services for these vulnerable populations ~ specifically among children ~ given that Worcester does not fluoridate its water supply. Improving access to oral health is also a key need and focus of this domain.

Insurance enrollment assistance is an ongoing service that is provided by several local health care organizations. At UMass Memorial alone, approximately 12,000 insurance enrollment applications were completed in Fiscal Year 2012. Both Edward M. Kennedy Community Health Center and the Family Health Center of Worcester have a long history of providing insurance enrollment, as well. Combined, the two health centers also complete more than 13,000 applications. But more needs to be done to coordinate this work among all providers. For example, what has not happened as yet, but will happen as part of the CHIP initiative, is convening these key stakeholders ~ including our local ED units ~ together with a common agenda to jointly examine the root causes of these challenges and develop a system to address them in a cohesive way for a greater collective impact. By coming together, we believe we can determine and institute some unique interventions tailored to local needs.

Other issues associated with this CHIP domain area are the need for adolescent sexuality education, improved preventative care and identifying system barriers that prevent access to culturally-competent care (e.g., infant mortality prevention for at-risk, ethnically diverse women).

Next Steps

The CHIP, which is intended to be a living document, has outlined key objectives in each identified domain area. The Primary Care/Wellness Domain is in the process of identifying co-chairpersons and setting an agenda that will include opportunities to improve the health of all Worcester residents, including refugees, immigrants and vulnerable populations, by addressing these and other cultural and systemic issues. Interested providers are welcome and encouraged to join this effort as this Task Force progresses.

Monica Lowell is vice president of community relations at UMass Memorial Health Care, Inc. She can be reached at Monica.Lowell@umassmemorial.org.

Frances M. Anthes is president and CEO of Family Health Center of Worcester. She can be reached at frances.antesFHCW@umassmed.edu.

Antonia "Toni" McGuire, RN, MPH, is president and CEO of Edward M. Kennedy Community Health Center. She can be reached at Toni.McGuire@kennedychc.org.

Priority 4: Violence/Injury Prevention

Acting Commissioner Michael P. Hirsh, MD, WDPH



Michael P. Hirsh, MD

The Community Health Assessment (CHA) that the city of Worcester commissioned through the Division of Public Health at the request of the city manager’s Public Health Task Force accrued a great deal of data regarding injury in Worcester. As the director of Pediatric Trauma at the UMass Pediatric Trauma Center and co-founder of the Injury Prevention Program, I

was, of course, very invested in seeing this area thoroughly covered by our CHIP process. During the seminal meetings to craft our Community Health Improvement Plan (CHIP), the stakeholders who gathered at the Massachusetts College of Pharmacy in October of 2012 clearly had grave concerns about violence in the community. It is a testimonial to the process that ensued that the focus of this particular domain of the CHIP began to embrace not just violence but injury, as well. When the data was reviewed, including state DPH, local DPH and UMass Trauma Center data, it could easily be seen that penetrating trauma (knife/gun wounds) and assaults represented less than 10 percent of all trauma admissions to our regional Level 1 trauma center. (Tables 1 and 2)

Table 1

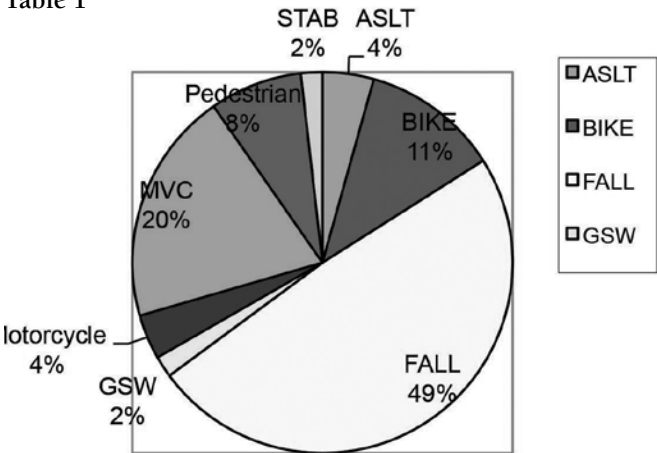
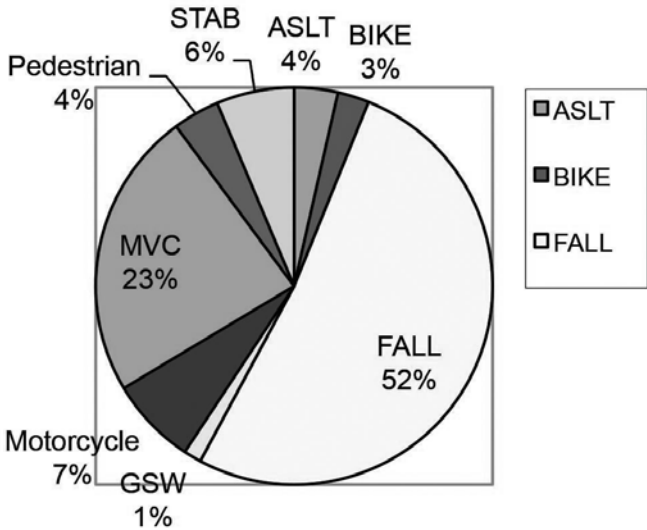


Table 2



Yet, the perception of violence in the community was a pervasive one that affected many of the other domains.

As an example, we interviewed many community members about some of the health living/nutrition choices they were making as part of our exploration of what would eventually become Domain 1 of the CHIP. Parents told us that they would love their child to eat healthier, so they had switched to a more laborious form of cooking with healthier ingredients. But during this cooking process, their concern regarding community violence made them uncomfortable about allowing their children to go outside to play unsupervised while the parents cooked. So this led to sedentary activity and video game playing instead of healthy exercise and play.

Conversely, some parents did prioritize that play and outdoor/sporting activity was important for their children, but then lacked the time to cook and eat more healthily. So fast food consumption and poor nutrition was the result of the perception of violence. Concerns about violence also impeded residents from pursuing primary care because of fear of travel.

But in the halls of the Massachusetts College of Pharmacy, where the CHIP was crafted, the community stakeholders agreed that when the statistics were completely analyzed, the biggest injury risk that the citizens of the Greater Worcester Health District faced was not violence-related but rather, the results of falls or motor vehicle-related injury events (either as motor vehicle occupants, pedestrians or bicyclists). So the CHA/CHIP process allowed us to craft a plan to divide this domain into three subcategories:

1. Falls Prevention Program ~ with emphasis on two disparate age groups that were at risk:

- a) The pediatric group, whose falls included falls from windows, playground equipment and during play.
- b) The geriatric age group, whose falls caused the No. 1 reason for admission to the Adult Trauma Program at the medical center and led to a great deal of geriatric morbidity and mortality.

2. Motor Vehicle-Related Injury Prevention ~ this two had a two-part component process:

- a) Adolescent motor vehicle injuries related to these drivers' inexperience, risk-taking, distracted driving and lack of access to driver's education.
- b) Geriatric driving injuries related to poor reaction time, physical and mental disabilities and lack of re-certification and support.

3. Violence prevention:

- a) Child abuse.
- b) Domestic and intimate partner violence.
- c) Elder abuse.
- d) Bullying.
- e) Gang-related violence.
- f) Gun safety.

It is our hope that in crafting this domain's roadmap, we will be able to reduce the numbers of preventable injuries in our community and potentially spare the medical system a huge amount of expenditures that could be better applied to care for preventable illness or primary care access.

We have recruited a cadre of local/regional experts to help move this process forward.

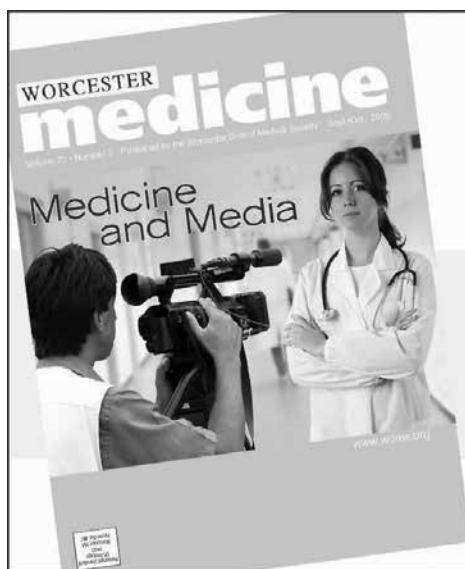
Dr. Mariann Manno, the co-director of the Injury Free Coalition of Worcester and the Mass Medical Society's 2013 Community Clinician of the Year, will take the lead on the motor vehicle part of the domain. Esther Borer, injury prevention coordinator for the UMass Injury Prevention Program, will lead the falls prevention section. And lastly, yours truly will lead the violence prevention effort.

Preliminary objectives are seen in Table 3. You can view some of the preliminary strategies at the CHIP document on our Worcester DPH webpage. We are doing our best in this domain to meet the overarching goal of making Worcester the Healthiest City in New England by 2020. We welcome your participation and contributions, as well. Come join us! For more information, go to worcesterma.gov and look at the Division of Public Health website.

Table 3

VIOLENCE/INJURY PREVENTION	
Goal 4: Improve safety, reduce violence and injury, and inform public perceptions by educating and mobilizing the community around effective, targeted prevention and intervention strategies.	
Objective 4.1:	Reduce fall-related injuries in all age groups by x% by 2015.
Objective 4.2:	Reduce physical assaults and violence as they pertain to domestic abuse, child neglect, bullying, and gang violence by x% by 2015.
Objective 4.3:	Reduce the number of motor vehicle-related pedestrian and occupant injuries among elderly and adolescents by x% by 2015.

Michael P. Hirsh, MD is the Acting Commissioner of the Worcester Department of Public Health and the President of the Worcester District Medical Society



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Priority 5: Health Equity/Health Disparities Undoing Racism

Derek S. Brindisi, MPA, Director of Public Health



**Derek S. Brindisi,
MPA, Director of
Public Health**

During the past six years, the Division of Public Health has partnered with health care providers, community-based organizations and ~ most importantly ~ “the community” in identifying root causes of health disparities and the inequities in health. Through the assistance of the Massachusetts Department of Public Health, a coalition (Worcester Partnership for Racial and Ethnic Health Equity, aka Part-

nership) has been engaged in a collaborative planning process to help identify systemic issues for change that impact racial and ethnic health disparities in the city of Worcester. Among this group is deep local knowledge of gaps in access, quality and many of the physical, financial, cultural, attitudinal and institutional barriers that reduce residents’ opportunities for better health outcomes.

In alignment with Healthy People 2020, our community has once again demonstrated its commitment to actively addressing the institutional systems that result in these disparities through the development of the CHIP Domain 5: Health Equity and Health Disparities. The goal of Domain 5 is to “improve population health by systematically eliminating institutional racism and the pathology of oppression/discrimination by promoting equitable access to, and use of, health-promoting resources in the community and significantly reducing the structural and environmental factors that contribute to health disparities.”

Embedded within this domain are four main objectives:

- By 2015, modify/implement two key, city-level public health policies that have the greatest impact on the systems that contribute to health disparities (e.g., zoning

changes, housing policies, general education policies, etc.).

- By 2015, increase the capacity of more than 100 grassroots adult/youth leaders (people who have lived in and experience with communities with disparities) to effectively influence the development of policies that address health disparities.
- By 2015, develop the capacity and will of 20 cross-sector institutions to address and eliminate institutional oppression in their own organizations.
- Ensure that each public health priority area in the CHIP identifies strategies to address oppression and the social determinants of health. During the life of the CHIP, we will gather experience and expertise by working together, with continuing input from an ever-enlarging representation of diverse community residents. We hope to increase community awareness that these disparities are not fated to exist and that there are community coalitions and institutions dedicated to ending them.

This work has already begun with a two-day Undoing Racism Training in March, which brought together key leaders and community residents to unpack their biases and recognize that there is so much work ahead of us if we are committed to true change.

If you would like to participate, the Partnership meets on a quarterly basis at Worcester Division of Public Health, 25 Meade St., and has taken on the challenge to lead the Worcester community through this effort.

Derek S. Brindisi is the director of public health for the city of Worcester and also co-chairs the Worcester Partnership for Racial and Ethnic Health Equity.

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How to Play the ‘Pay or Play’ Game Under the Affordable Care Act

Peter J. Martin, Esq.



Peter Martin, Esq.

One aspect of national health reform that is causing the most wide-ranging agitation is how employers are to determine whether they may be subject to federal penalties. The so-called “shared responsibility” payments may be due not just from employers that do not offer their employees health insurance but also those employers who do offer such insurance. Whether

an employer should worry about such payment liability, which specific penalty the employer may be liable for and how to calculate that penalty are all critical questions for employers determining whether it is better to “play” (by offering employee health coverage) or “pay” the shared responsibility payment. This calculation is subject to complex rules that must be applied to each employer’s particular circumstances. What is offered here is a brief primer on how to think through the rules of this new “pay or play” game.

The first question is to ask whether the employer is an eligible large employer, because only eligible large employers are subject to the shared responsibility payment liability under the Affordable Care Act. (Note that some employers who are subject to Massachusetts’ own “pay or play” rules will not be subject to the federal rules if they employ more than the state minimum but fewer than the federal minimum number of employees.) Basically, the federal rule applies to employers that employ at least 50 full-time employees. For purposes of the Affordable Care Act, a full-time employee works 30 hours per week. However, in order to calculate whether the employer falls above or below the 50 full-time employee line, it is necessary not only to count the full-time (30 hours/week) employees but also all part-time employees, converting them to full-time equivalents

by totaling their hours per month and dividing by 120. Special rules apply to seasonal workers. The calculation of whether an employer is an eligible large employer is to be made on an annual basis, but for 2013 only, an employer may take any six consecutive months to make this calculation.

Employers who are close to the 50 full-time employees mark may contemplate disaggregating themselves into multiple employing entities, each employing fewer than 50 employees. This is not likely to work in many cases, since the Affordable Care Act applies pre-existing tax law principles that treat as a single employer multiple entities that are under common control or are part of an affiliated service group. However, special rules apply to governmental entities, churches and church groups.

The next question to ask, if an employer is an eligible large employer, is whether any of the employees has obtained a form of subsidized health insurance through an exchange (in Massachusetts, the Connector). Subsidies come in two forms: a premium tax credit and cost-sharing reductions. The subsidies are available to persons whose household income is between 100 percent and 400 percent of the federal poverty level. The cost-sharing reductions reduce the employee’s total health insurance-related, out-of-pocket costs (for example, deductibles, co-payments and co-insurance, but not premiums) based on level of household income. For example, if household income is between 100 percent and 200 percent of the FPL, then total out-of-pocket costs are reduced by two-thirds; if that income is between 300 percent and 400 percent of FPL, those costs are reduced by one-third.

The premium tax credit likewise is based on how household income compares to the federal poverty level. For example, if an employee has household income of 133 percent of the FPL, the cost to the employee of the employer’s offer of self-only coverage that exceeds 2 percent of that household income is a tax

credit to the employee. If the employee's household income is at 400 percent of FPL, any premium cost over 9.5 percent of that income is a tax credit.

The difficulty for employers here is that while they know their employees' W-2 incomes, they do not know the employees' household incomes, so it is difficult for employers to predict whether their offer of employee health coverage is likely to entitle their employees to either of these health insurance subsidies. It should be noted, however, that if the employee is eligible for MassHealth, she or he would not be eligible for either subsidy.

A subsidy may also be available to an employee if the employer's offered health insurance plan does not provide "minimum value." This term basically means that the employer's contribution for the offered coverage covers at least 60 percent of the plan's costs. Regulations promulgated under the Affordable Care Act provide a number of ways to establish whether this standard has been met ~ a "minimum value calculator" offered through the CMS website, any safe harbors that may be established by the government (none have yet been set out in final form), an actual certification of "minimum value" or coverage that meets a minimum exchange-offered plan.

The next question to ask, if the employer is an eligible large employer one of whose employees has obtained subsidized health insurance through an exchange, is whether health insurance coverage has been offered to at least 95 percent of the employees and their dependents. For purposes of this question, "dependents" does not include spouses. Note that this question goes to whether the coverage has been offered, not whether 95 percent of the employees have collectively chosen to take up that offered coverage.

If the answer to this question is "no," then the employer will be subject to the no-offer prong of the shared responsibility penalty. This means that the employer will have to pay \$2,000 times the number of all of its full-time employees, minus 30 employees. The penalty is calculated on a monthly basis, because the offering percentage and the number of employees obtaining subsidies may vary from month to month. There are complicated rules regarding who is to be considered a full-time employee for purposes of calculating either of the shared responsibility penalties, which seek to reduce the monthly variability of these calculations.


If the answer to the question "Did the employer offer health insurance coverage to 95 percent of its full-time employees and dependents?" is yes, and at least one of the full-time employees obtained subsidized coverage through an exchange, the shared responsibility penalty is \$3,000 times the number of such subsidized employees. Again, special rules apply to new employees, variable-hour and seasonal employees and employees who could afford, but did not accept, the offered coverage. In no event will the offering employer penalty exceed the non-offering employer penalty.

It bears repeating that this is only a very summary description of how an employer may analyze its potential shared responsibility liability. The plethora of special rules, alternative measures and transitional rules in the federal "pay or play" game make it imperative that an employer that might be subject to the shared responsibility payments consult with its advisors now to apply these complex rules to the employer's particular situation.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and nonprofit law.

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Lewis P. James Jr., MD
1933-2012

Lewis P. James Jr., MD, was born in Hartford, Conn., in 1933 and died on Dec. 25, 2012, after a long illness. The 79 years he lived were filled with great achievements, medical leadership, close friendships of long duration and devotion to his family.

He graduated from the Kingswood School in West Hartford, Conn., in preparation for Yale College, from which he graduated summa cum laude in 1954. Lew then graduated from Harvard Medical School, where he was the recipient of the Henry Christian Prize, awarded to the top graduate of the class.

Lew was chosen as an intern in surgery at the Mass General Hospital, but after one year, he made a career change and became a resident in pathology at the Mass General Hospital, to the chagrin of the surgical staff. In 1963, he was appointed chief resident in pathology and remained a member of the staff as an assistant for many years. In 1963, he entered the U.S. Army as a captain and was director of many laboratories of the 98th General Hospital in Neubrucke, Germany, for two years.

In 1966, Lew and I joined in a professional partnership that lasted for more than 30 years. His original appointment was to the Pathology Department at The Memorial Hospital but through the years, expanded to include staff membership at UMass, Hahneman, Fairlawn, Clinton and Leominster (eventually Health Alliance) hospitals. He was also a partner in both Worcester Pathologists and Pathology Associates Laboratory.

Lew was a member of the pathology faculty at UMass Medical School from its inception. For many years, he organized and lectured in the cardiovascular and orthopedic sections of the second year class in pathology. In recognition of his major contributions to the course, he was appointed as a professor of pathology.

During his career, he held many positions of importance, the most significant of which was president of the American Society of Clinical Pathologists, the largest organization of pathologists in the United States. He was also president of the New England Society of Pathologists, an academic group of practicing pathologists. Lew was chosen to be president of the medical staff of the Memorial Hospital and, at a later date, president of the staff at the Medical Center of Central Massachusetts, during which time he served on the board of trustees of both institutions. He was also a member of the board of trustees of the New England Region of the American Red Cross.

In his high school years, Lew was a panelist on an NBC radio and television show, *Mind Your Manners*, hosted by Allen Luden. His theatrical personality surfaced at Harvard Medical School, where he was one of the authors and producers of the annual student show spoofing the faculty. In later life, he made an appearance as a ballet dancer, dressed in a tutu and balloons, in the hospital benefit show, High Fever Frolics.

He is survived by five children and seven grandchildren, all of whom were the delight of his life. Lew was an accomplished pathologist, a source of great knowledge, a great colleague and a dear friend and surrogate brother. His is sorely missed by all who knew him.

Robert S. Harper, MD

WDMS congratulates Becky Spanagel

WDMS congratulates Becky Spanagel, who is the recipient of the 2013 Mentor of the Year Award at UMass Medical School. Dr. Spanagel also won the Outstanding Medical Educator of 2013 for Internal Medicine from the graduates of the Class of 2013. She is also vice president of the Worcester District Medical Society

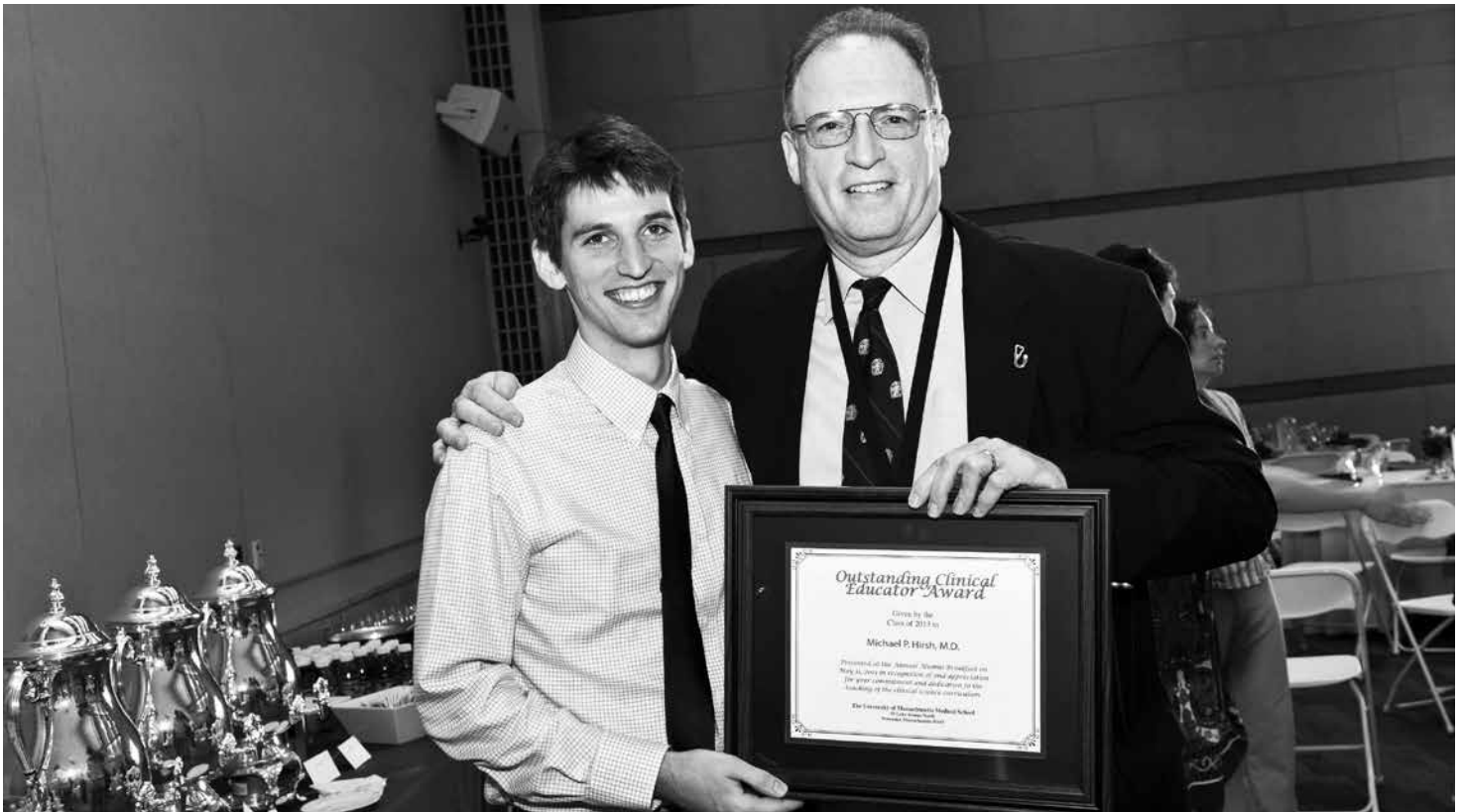
The Learning Communities at UMass is an initiative to foster collaborative learning and mentoring relationships among medical students and faculty. There are five vertically integrated communities, consisting of 25 students from each of the four medical school years, as well as four mentors. These mentors are faculty members who serve as instructors in the classroom and at the bedside, academic advisors and general advocates for their students throughout their time in medical school. The minimum time commitment to be a mentor is already significant, yet there are several faculty who go above and beyond expectations in service of their students.

This year, the Student Advisory Board for the Learning Communities solicited nominations from the general student body for the inaugural Mentor of the Year Award. Based on these nominations and in recognition of her dedication to all students, her leadership within the Learning Communities and her service to the entire UMass Medical School community, Dr. Rebecca Spanagel was named the 2013 Mentor of the Year.



Dr. Rebecca Spanagel (left) was presented with the 2013 Mentor of the Year Award at UMass Medical School on May 10, 2013, on behalf of the entire student body, by the co-chairpersons of the Learning Communities Student Advisory Board, Caitlin Fogarty (center) and Tom Akie (right)

Many of Dr. Spanagel's students submitted statements of support that highlight her dedication and her role as a positive role model for aspiring physicians. One student commented, "Dr. Spanagel goes out of her way to really get to know each student and sends her students personalized information about events, research, contacts, summer opportunities and even news articles that she knows we will find interesting or helpful." Another student noted that Dr. Spanagel "is an exceptionally caring and compassionate human being, as exemplified through her care of both patients and students. She epitomizes what being a physician should mean ~ to care for the whole patient and to make every patient interaction count."



Michael P. Hirsh, MD, receives the 2013 Outstanding Clinical Educator Award. From left, Michel Epstein, UMMS class of 2013 speaker, presents the 2013 Outstanding Clinical Educator Award to Michael P. Hirsh



Hooding Ceremony at the 2013 UMMS Commencement Exercises.

From left, Phillip Fournier, MD; Julia Grant Ciampe, Class of 2013; and Michael Hirsh, MD.

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Annals from the Archives: Feb. 1, 2013

Nancy Barthelemy, Archivist

A Message from the Editor: The following article was given to me by Monsignor Peter Beaulieu, director of pastor care at St. Vincent Hospital. It was originally published in TGIF, a weekly publication of the Sisters of Notre de Namur, Boston and Ipswich provinces. It is republished with permission of the author. As we do not have a Spoken History article for this issue, I thought it would be fun reading for all the history buffs.

~ Jane Lochrie, MD

In archives, treasures are everywhere. The best are found unexpectedly, like the one I discovered a couple of weeks ago. I had gone to check on some information in the annals kept by the sisters at the Vernon Street Convent in Worcester. As I skimmed the year 1888, I read a surprising entry. "It is gratifying to be able to relate that this good Superior improved so rapidly, thanks to the skillful treatment of Dr. O'Callaghan. It may be said [that] to this skillful physician Dr. Mary V.

O'Callaghan the community of Notre Dame owes an immense debt of gratitude."

Dr. Mary V. O'Callaghan? Who was she? As I began my quest to learn of her life, I met the usual roadblocks when researching women's history. Despite Mary O'Callaghan's remarkable achievement in obtaining her medical degree when women still did not have the vote, there is almost nothing written about her. Her life, it seems, was as hidden as the sisters she served. My search led me to the work of Worcester historian Sande Bishop. Her 2004 article for the Worcester District Medical Society on Mary O'Callaghan offered a window into her life. Mary was born in 1852 and died unexpectedly in 1930. In 1885, Mary graduated from the Women's Medical College of Pennsylvania. No doubt, setting up her practice was difficult. But she found grateful patients at the Sisters of Notre Dame at their Vernon Street Convent. Mary became their doctor not long after receiving her medical degree and remained their physician for the rest of her life.

Dr. O'Callaghan was one of the founders of St. Vincent's Hospital in Worcester. She never married. Instead, she became an example for her niece, Clara Fitzgerald, of women's resilience in what was assuredly a difficult climate for a woman physician. After Clara finished her medical training, she opened an office with her aunt.

In 1930, Mary was struck and killed by an automobile. The sisters wrote in their annals that they had "lost a most devoted friend in the passing away of dear Dr. Mary. ... For over forty years she had given devoted service to our Sisters and they in turn loved and trusted her." And in a move that reveals just how special Mary was, the provincial superior, Sister Rosalia of the Blessed Sacrament, gave a special dispensation for the sisters to leave the convent to attend Mary's funeral.

Nancy C. Barthelemy
Archivist, Sisters of Notre Dame de Namur,
Ipswich, MA



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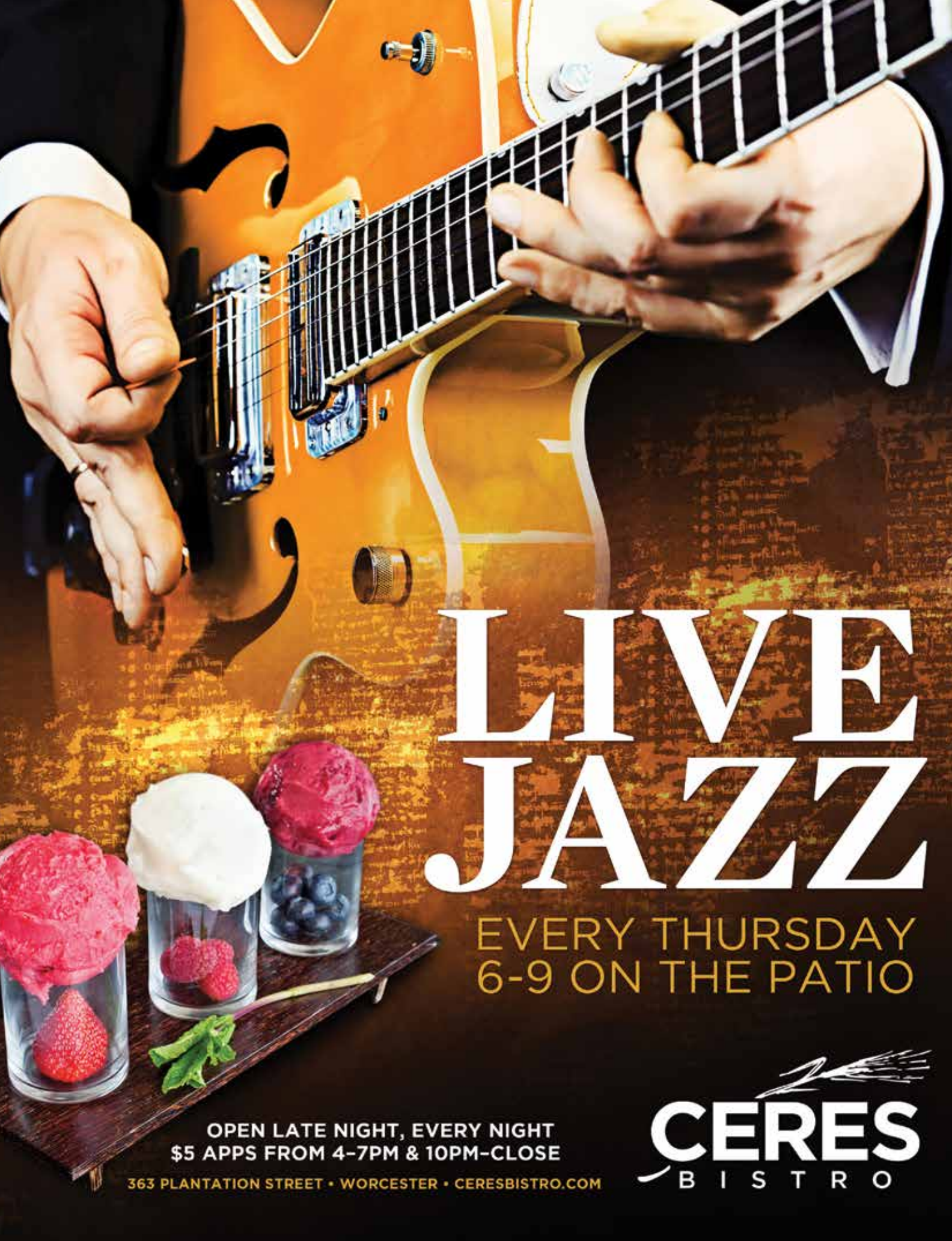
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