

EFFORTS TOWARD EQUITY

Even as we document the health effects of biases and discrimination in medicine, many individuals, groups, and organizations have been doing important, innovative work in their local health care environments to try to alleviate and eventually solve some of these problems. This series of brief case studies offers glimpses of various initiatives, each of which aims to address a particular manifestation of discrimination in medicine or health care. We hope they will spark ideas for efforts that other physicians and health care organizations can pursue.

Designing a Legacy — Portraiture as a Tool for Disrupting Structural Sexism and Racism

Pamela Chen, M.D., and Nancy D. Spector, M.D.

PROBLEM Honor portraiture on U.S. medical school campuses has long featured solely White men, which has inadvertently created exclusionary visual environments and reinforced impostor syndrome in many students.

INTERVENTION “The Women Before Me: Dedicated to the Women After” is a gallery of oil portraiture and interviews of alumnae of color who became leaders in academic medicine.

INSTITUTION Harvard Medical School (HMS).

DESCRIPTION Art can be a powerful storyteller. This gallery is meant to expose the structural sexism underlying the disproportional representation of men in leadership roles (and consequently in the portraits featured on the medical school’s walls), while also providing a visual celebration of women of color in medicine. In collaboration with the Center for

the History of Medicine in Countway Library, the HMS Alumni Association, and the Office of Recruitment and Multicultural Affairs, one of us (P.C.) researched the living history of discriminatory practices in medical school admissions, residency selection, and faculty promotion at Harvard-affiliated institutions, and then interviewed and painted portraits of alumnae of color (see photos).¹ The portrait subjects were women who rose to prominence in their

fields despite significant barriers and who dedicated their careers to mentorship and advocacy.

One of the members of the first coeducational class (1949) recounted sitting in a single row with 11 other female classmates. Many talked about assumptions, pressures, and lack of accommodations for motherhood — being explicitly excluded from surgical residency, feeling guilt over working part time, and declining conference invitations owing to lack of childcare. They all reported having their research and advocacy dismissed or misattributed. Experiences of facing all-male promotional panels, being regularly interrupted during meetings, and lacking the casual networking of the “Boy’s Club” often left these women feeling like they were working “twice as hard for half as much.” Placing their stories on the wall was an attempt to ensure that such sexist practices were visible to all.

The gallery aims to honor these women with the same sense of legacy and permanence that their male counterparts have, with larger-than-life oil portraits, alongside their printed interviews, installed in the bustling student center. Students, both men and women, have expressed gratitude for the gallery’s existence, calling it a welcome, “needed” change. Some have noted that as students review together for preclerkship or shelf exams, the portraits often spark animated study-break discussions about sexism and representation in medicine. These pieces appear to invite more curiosity and engagement than other artwork on campus. As students read the stories and reflect on the



“Portrait of Eve Higginbotham, S.M., M.D., M.L.” (oil on canvas, 24”×30”).

Dr. Higginbotham was the first woman chair of an academic ophthalmology department, served as dean at Morehouse School of Medicine, and is now vice dean for inclusion and diversity at the Perelman School of Medicine at the University of Pennsylvania.

subjects’ career journeys, they envision their own. Implicitly, the gallery sends the message to students, especially women of color, that they are not alone and that other women have paved the way for them. It emphasizes that they are seen, they belong, and they can become leaders in their own right.

Since the gallery installation, HMS has continued to research its own archives and commission new artwork to honor other diverse pioneers — a bust of Professor Alice Hamilton, the first woman professor at Harvard Uni-

versity, and a portrait of Professor William Augustus Hinton, Harvard’s first Black professor, among others. Rotating art installations highlight and celebrate other communities as well.

RESULTS TO DATE Key sponsorship in the form of an invitation for the artist to speak at the Executive Leadership in Academic Medicine (ELAM) program’s year-end forum brought this initiative to the attention of leaders of medical institutions nationally. Developed by the Drexel University College of Medicine, ELAM is a



“Portrait of Raquel Cohen, M.D., M.P.H.” (oil on canvas, 24”×30”).

After emigrating from Peru to the United States, Dr. Cohen became one of 12 women in Harvard Medical School’s first coeducational class. She dedicated her life to mental health advocacy and policy for Latine patients, was named a distinguished life fellow of the American Psychiatric Association, and died shortly after this portrait was painted.

national fellowship program that supports women’s academic medical careers, accelerating their advancement into executive leadership positions. Fellows are spon-

sored by their deans and institutional executive leaders. The presentation catalyzed further discussions among participating deans and department chairs about

representation and the importance of visual storytelling in revealing the whole picture of medicine’s history. Several medical schools, including Weill Cornell Medical School, the State University of New York Upstate, and Southern Illinois University, have since been inspired to research their own histories, critique past practices, and laud previously unsung heroes by means of thoughtful new art installations. This movement has amplified national discussions about designing visually inclusive learning environments, with careful consideration of aligning each institution’s history with its intended legacy.

Disclosure forms provided by the authors are available at [NEJM.org](https://www.nejm.org).

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Health Equity Rounds — Root-Cause and Solutions-Oriented Discussions of Medical Racism

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PROBLEM Medical trainees, faculty, and other health care workers have insufficient opportunities to engage longitudinally in meaningful discussion and concrete prob-

lem solving to address the adverse effects of bias and medical racism.

INTERVENTION Health Equity Rounds (HER) conference series.

INSTITUTION Initially the Department of Pediatrics, Boston Medical Center (BMC), subsequently expanded to many other institutions.

Curricular Objectives and Sample Conference Topics for Health Equity Rounds.

Curricular Objectives

Identify and analyze the effects of bias, racism, and other forms of systemic oppression in clinical scenarios.
Describe the historical context and current role of structural racism and its effect on health and the health care system.
Employ evidence-based tools to recognize and mitigate personally held biases.
Use newly learned strategies to reduce the effect of bias on patient care and combat structural racism at the institutional and societal levels.

Sample Conference Topics

Covid-19 vaccine uptake
Pharmacoequity
Intergenerational trauma
Health care and the school-to-prison pipeline
Reproductive justice
Racial disproportionality in the child welfare system
Inequities exposed by the 2022 infant-formula shortage
Bias in electronic health records documentation
Prenatal substance exposure
Stigma and sickle cell disease
Disability justice
Medical mistrust vs. distrust
Immigration policy and family health
Health insurance coverage policies
Medical record “safety flags” and public safety agencies’ role in health care settings
Palliative care disparities
Inclusive health care for LGBTQ+ adolescents
Microaggressions within the health care workforce
Race-based vs. race-conscious diagnostic algorithms and treatment guidelines
Perinatal urine drug testing
The war on drugs
Family separation at the U.S. southern border

DESCRIPTION HER is a longitudinal, case-based, solutions-oriented conference series that addresses the effects of bias, structural racism, and other forms of systemic oppression on health and health care.¹ Similar to a morbidity and mortality conference, HER aims to elucidate root causes of adverse events, but with a particular focus on inequities in care delivery, outcomes, and experiences of care, as well as a commitment to recognizing potential harms in commonplace occurrences and “business as usual.” Furthermore, HER emphasizes building skills and generating solutions at the individual, institutional, and societal levels; for example, we may introduce perspective-taking as a strategy to mitigate the ef-

fect of personally held biases, propose a change in institutional practice related to the conference topic, or offer tips and opportunities for engagement in legislative advocacy. HER’s curricular objectives are grounded in naming and addressing medical racism, though presenters take an intersectional approach (focusing not just on race but on other aspects of identity as well) when choosing topics and developing conference-specific objectives (see table).

At BMC, where the original HER program was developed in 2016, conferences occur at least quarterly in an interdisciplinary departmental grand-rounds setting. Topics are researched and presented by residents with facul-

ty mentorship, and sessions usually include expert commentary from invited guests (e.g., subject-matter experts, community leaders, or patient advocates). HER programs have now been developed at institutions throughout the United States and Canada, often with initial mentorship from the BMC team. Most are sponsored by division, department, or equity leaders at academic medical centers or health professional schools, though several smaller programs exist at community sites. Though team composition and conference venue may vary among institutions, the program’s foundational goals remain consistent.

HER offers a fruitful avenue for trainees’ professional development. As HER leaders, trainees gain valuable research, public-speaking, leadership, and advocacy skills; they receive hands-on mentorship in preparing and delivering grand-rounds conferences, constructing compelling narratives to explain nuanced and emotionally charged topics for a professional audience, and motivating institutional change. Furthermore, trainees benefit from a community of faculty and peers committed to advancing health equity, which helps to foster a sense of belonging and self-efficacy during medical training.

RESULTS TO DATE The HER model has been implemented at more than 65 institutions to date, and it is still going strong at BMC. Since June 2016, a total of 68 residents and 9 faculty mentors have presented 36 hour-long grand-rounds HER conferences in the BMC Department of Pediatrics. We have demonstrated the feasibility,

acceptability, and usefulness of in-person and online HER grand-rounds models,^{1,2} as well as an abbreviated 30-minute facilitated “Health Equity Huddle” for clinical teams to incorporate brief, case-based discussions of HER concepts into busy inpatient workflows.³ As a result of expertise gained from HER, some resident alumni have been hired as faculty into leadership positions in equity, diversity, inclusion, and accessibility, and others conduct funded research on topics they first explored for HER conferences.

At BMC, HER has helped normalize conversations about medical racism, giving the community a vocabulary and framework for identifying problems. It has also catalyzed important conversations and efforts toward care transformation, including concrete institutional policy changes as well as engagement in state and national advocacy.

For example, a two-part HER series in 2018–2019 on caring for families affected by parental substance use led BMC to convene a multidisciplinary committee to review current laws and institu-

tional practice related to reporting of prenatal substance exposure to child protective services. BMC ultimately adopted new clinical guidelines in 2021 advising clinicians to report suspected abuse or neglect only when tangible concerns arise about a parent’s ability to safely care for a child, rather than automatically filing reports for all cases of exposure (such as to prescribed opioids or medications for opioid use disorder). HER team members conducted a statewide analysis that showed that the guideline change reduced child protective services reporting for opioid-exposed newborns at BMC by nearly half without influencing newborn length of stay or custody at discharge.⁴ The largest hospital system in Massachusetts has since adopted similar guidelines.⁵ HER team members also testified before the Massachusetts legislature and participated in coalition building in support of a now-pending state bill that would eliminate automatic child protective services reporting in the absence of safety concerns for substance-exposed newborns throughout the state. This successful initiative exemplifies just one way in which HER

can help spark broader, more multifaceted efforts and progress toward health equity.

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An audio interview with Heather Hsu is available at NEJM.org



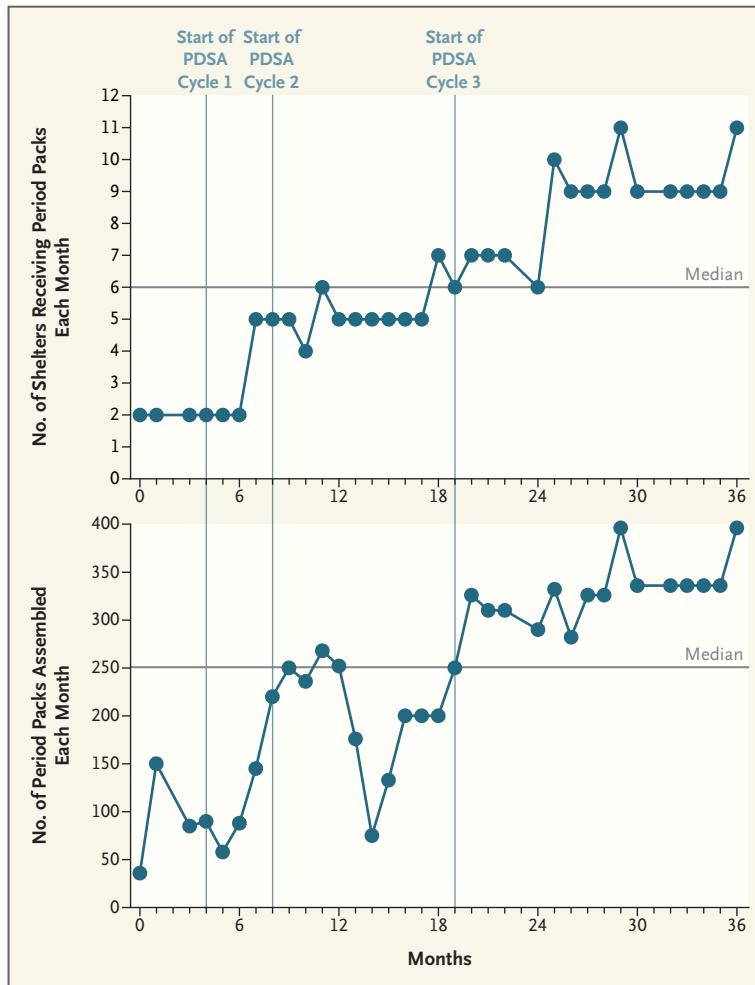
The Menstrual Health Equity Initiative — Access to Menstrual Products for People Experiencing Homelessness

Sarah Revak, M.D., Karen Cuttin, M.D., Bianca Nfonoyim Bernhard, M.D., and Shelby H. Davies, M.D.

PROBLEM Period poverty, or the inability to consistently access menstrual hygiene products and necessities, affects a high pro-

portion of adolescents and young adults, and those experiencing homelessness are disproportionately affected.¹⁻³

INTERVENTION The Menstrual Health Equity Initiative (MHEDI), an intervention that uses a quality-improvement framework to in-



Menstrual Health Equity Initiative Run Chart, December 2020–December 2023.

The top graph shows the primary outcome of the number of shelters receiving period packs each month over 36 months relative to the median (6 shelters, indicated by the horizontal line). Plan–do–study–act (PDSA) cycle 1 (April through July 2021) was focused on applying for initial grant funding; cycle 2 (August 2021 through June 2022) on increasing the number of project leaders and volunteers; and cycle 3 (July 2022 through December 2023) on increasing funding with larger-scale grants and decentralizing pack making and delivery to better utilize the volunteer base. The bottom graph shows the number of period packs assembled each month relative to the median (251 packs, indicated by the horizontal line).

crease access to menstrual products for people experiencing homelessness in the greater Philadelphia area.

INSTITUTION Children’s Hospital of Philadelphia (CHOP).

DESCRIPTION As pediatricians, we are concerned that some adolescents are unable to attend school and work because they lack consistent access to products needed to manage menstruation. A 2023 national survey found

that nearly a quarter of teens and one third of adults in the United States struggle to afford period products.¹ Period poverty among young people affects education, with studies showing important correlations between lack of access to menstrual products and students missing full or partial days of school and reporting negative effects on their ability to learn (for example, their ability to focus in class).^{4,5} Populations experiencing homelessness are particularly susceptible, since shelters’ common reliance on grant funding and private donations for menstrual products results in an inconsistent and insufficient supply. Subsequent rationing of period products can increase vulnerability to gynecologic infections and exacerbate feelings of shame and stigmatization.^{2,3}

The MHEI began after an adolescent patient experiencing homelessness disclosed to a resident physician during a visit at a shelter that she was missing school because she lacked menstrual products. With this adolescent in mind, CHOP resident pediatricians designed the MHEI to ensure that people experiencing homelessness have equitable access to menstrual products in a way that preserves dignity, minimizes school absenteeism, and facilitates participation in the workforce. In partnership with the CHOP Homeless Health Initiative, which provides free health and education services to families living in emergency housing shelters, the MHEI team conducted a needs assessment among shelter partners, who confirmed the lack of a consistent source of menstrual products.

The MHEI initially proposed stocking a cabinet at each shelter with boxes of menstrual products, but there was concern that this approach would perpetuate a scarcity mentality, making shelter residents feel the need to stockpile supplies and staff members feel the need to supervise distribution. Ultimately, the monthly delivery of individual period packs was identified as an intervention that would more reliably meet shelter residents' needs and preserve a sense of freedom of choice. Each pack contains 15 period products, including pads and tampons of varying absorbency. Partnering shelters are contacted each month to determine the quantity and variety of packs needed. Each pack also includes a survey for recipients to provide feedback and personalize future period packs with their preferred products.

Beginning in December 2020, period packs were delivered monthly to two shelters. Using a quality-improvement approach with iterative plan–do–study–act (PDSA) cycles, the MHEI aimed to triple the number of homeless shelters receiving menstrual product packs each month over a 3-year period. The primary outcome measure was the number of shelters receiving packs. Process measures included the number of monthly packs assembled and the number of packing sessions held, and balancing measures (measures used to track potential unintended consequences of project iterations) included shelter residents' and staff members' perceptions of the initiative.

Barriers to addressing period poverty included social distanc-

ing practices during the Covid-19 pandemic, the high level of funding required to purchase period products, and the need for substantial numbers of volunteers to assemble and deliver a growing number of packs each month. The MHEI achieved its aim primarily by acquiring institutional funding through the CHOP Cares Community Fund and Grants Program and by recruiting additional volunteers.

RESULTS TO DATE From December 2020 through December 2023, the MHEI underwent three PDSA cycles and ultimately increased the number of shelters receiving period packs each month from 2 to 11. During this time, 8086 individual period packs were assembled and delivered to shelter residents. Six months into the intervention, approximately 40 packs per shelter were being supplied to two shelters each month. Three years in, the total had increased to about 330 packs per month distributed to 11 shelters (see graphs).

Over 3 years, 133 anonymous survey responses were submitted. Approximately 29% (38 responses) were from respondents younger than 25 years of age, which reflected the target population of adolescents and young adults. A majority of respondents (81 [61%]) had missed work or school because they had not had products for their period. All 133 respondents indicated that period packs were helpful. A question was added approximately a year into the intervention asking whether period packs would help shelter residents attend school, work, or

a job interview that month; 87 of 89 respondents (98%) said yes.

When providing feedback on the MHEI, shelter staff reported that the initiative brings “comfort and ease” to shelter residents and helps to “eliminate any shame or stigmas” surrounding menstruation. The growth and success of the MHEI demonstrates the feasibility of leveraging community partnerships to address period poverty for persons experiencing homelessness, an important yet often overlooked area of health inequity.

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Integrating Community Health Workers in Rhode Island — A Roadmap toward Health Equity

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PROBLEM Although U.S. states have sporadically deployed community health workers (CHWs) as trusted messengers, usually in reaction to crises such as the Covid-19 pandemic, to meet the needs of people facing inequities or serve as lay coordinators of health and social care, they have not invested sufficiently in a sustained CHW workforce that could contribute to a better-integrated system and lead advocacy for addressing root causes of health inequities.¹

INTERVENTION A group of 140 multisector leaders in Rhode Island — more than half of them CHWs from marginalized communities — developed a roadmap for the future role of and investment in CHWs.

INSTITUTION The Rhode Island Department of Health (RIDOH) and a statewide CHW Strategy Team, in a process facilitated by the organization Well-Being and Equity (WE) in the World.²

DESCRIPTION Rhode Island adopted a definition of the CHW role involving both helping people access needed resources and contributing to systemic change by means of coalition building, policy work, and advocacy.³ Building on decades of piloting, learning, and will-building regarding CHWs and their role in marginalized communities, Rhode Island

used a portion of its federal resources to invest in this critical workforce as part of a wider strategy for advancing population health equity. That strategy follows the Pathways to Population Health Equity framework, which focuses on addressing upstream community and root causes of health inequities in addition to meeting the physical, mental, and social needs of individuals and families.⁴ The initial pilot confirmed the value of CHWs as civic connectors and advocates and led RIDOH to initiate a roadmapping process (see table) to chart a path to long-term sustainability for CHWs functioning in an expanded role. The state created a CHW Strategy Team, led by CHWs (who account for 50% of membership) and supported by allies (representing public health and health care organizations, payers, employers, and policymakers) to consider how this expanded role could be scaled and sustained.

Five key principles were identified: CHWs themselves should have agency and leadership roles in determining the future of CHWs; CHWs' work should address the whole person and whole family, in the context of the community; relationships are central to CHWs' work and should be valued; CHWs should play an important role in advocating for big-system change to address conditions affecting their com-

munities' health and well-being; and the full scope of CHWs' role should be valued and appreciated by all parties.³ Four roadmaps were developed for implementing this broadened role for CHWs.

RESULTS TO DATE The four roadmaps represent four key, interconnected strategies for sustainably investing in and advancing a CHW role that includes upstream, root-cause, and policy and advocacy work. The first strategy involves advancing the role, agency, and leadership of CHWs by educating target audiences about the full scope of the CHW role, empowering CHWs to participate in decision making, nurturing practicing CHWs to become supervisors, and advancing and sustaining a CHW-led oversight entity. The second is workforce development for CHW supervisors in the full scope of the role. Third is combining funding streams and a potential Medicaid Section 1115 Demonstration Waiver to support policies, supervisor and CHW training, and partnership with communities to address upstream and root causes of health inequities. Fourth is developing a place-based coordinating infrastructure to structurally support more integrated approaches to lowering health and social barriers, with CHWs positioned as key leaders in this work.³

A year after the roadmapping

Rhode Island's Roadmapping Process for Supporting and Expanding the Role of CHWs.*	
Step	Implementation
1. Identify participants inclusively to advance an equitable roadmapping process.	The team and its partners engaged more than 140 Rhode Island CHWs and allies, including relevant state agencies, employers of CHWs, and community organizations.
2. Define a Rhode Island CHW and develop key principles for implementation using a broad-based process.	After examining various definitions, the group built on the APHA definition and adopted the concept of a CHW as both a navigator and a policy and system-change advocate.
3. Examine the state and national landscapes of sustainable CHW efforts and their approaches, assets, and gaps.	The group identified key elements of sustainable CHW efforts and mapped state assets and gaps to those elements.
4. Identify points of convergence, divergence, and clarity; talk through divergent opinions; and use transparent voting processes to resolve differences.	To allow participants to feel heard and overcome their hesitance to openly disagree, facilitators surfaced points of convergence and divergence by having people physically position themselves along a continuum on a given issue. Participants then discussed their reasoning and collectively agreed on an approach for Rhode Island.
5. Convene design workgroups to work through key strategies for advancing and sustaining CHW efforts.	The team hosted virtual workgroups, which developed four roadmaps.
6. Interview key agencies in multiple sectors to identify potential implementation strategies and opportunities.	Well-Being and Equity in the World and key CHW and RIDOH leaders interviewed leaders from agencies including EOHHS, foundations, payers, innovators, employers, peer leaders, credentialing bodies, and others to help them think through implementation strategies.
7. Assess feasibility and outline implementation plans, necessary assets, and appropriate timelines.	Each workgroup presented its roadmap and recommendations to 80 to 90 CHWs and allies, who rated their importance, feasibility, and time frame. The results of these assessments were made available immediately to participants and used to develop four roadmaps.
8. Share final roadmap recommendations with all participants in the process, with a plan for ongoing implementation.	The results were shared with CHWs and allies at meetings hosted by the strategy team and key agencies, which created implementation groups to advance the recommendations. Several recommendations have already been implemented.

* APHA denotes American Public Health Association, CHW community health worker, EOHHS the Executive Office of Health and Human Services, and RIDOH Rhode Island Department of Health.

process was completed, there continues to be strong engagement in the roadmap's implementation. Attendance at CHW Strategy Team

meetings has increased from 25 to 75 people, of whom 46% are CHWs, 35% are allies, and 19% are representatives from state

agencies.⁵ Structural barriers remain, including challenges in combining funding streams to support the full scope of CHWs' role, but CHWs' engagement in this process has led to a constructive and creative approach to these challenges. CHWs are actively involved in policy and advocacy efforts related to education on housing policy and tenants' rights, air quality, and coordinated systems and have been integrated as leaders in organizations throughout the state. Rhode Island is thus demonstrating that true inclusion and partnership between marginalized communities and their allies can create change to advance health equity.

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