

# Mass Cultural Council

## CultureRx Report

### Findings from the Berkshires & Springfield

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Public Health Institute of Western Massachusetts

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# Table of Contents

- Executive Summary ..... 4
  - Key findings ..... 5
  - Special note: Impact of COVID-19 ..... 5
- Methods ..... 7
  - Berkshires ..... 7
  - Instruments ..... 7
  - Hypotheses ..... 9
  - Analyses ..... 9
  - Springfield ..... 10
  - Instruments ..... 10
  - Guiding Questions ..... 12
- Findings ..... 14
  - Berkshires ..... 14
  - Springfield ..... 19
- Limitations ..... 26
- Appendix A: Participating organizations and contributors ..... 27
- Appendix B: Berkshires Original Evaluation Plan ..... 28
- Appendix C: Springfield Original Assessment Plan ..... 35
- Appendix D: Berkshires Revised Evaluation Plan ..... 39
- Appendix E: Springfield Revised Assessment Plan ..... 46
- Appendix F: Berkshires’ Instruments ..... 47
- Appendix G: Immediate Experience Survey Findings ..... 53
- Appendix H: Cultural Humility Trainings Summary & Impact ..... 56
- References ..... 64

## Executive Summary

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Research continues to accumulate demonstrating the importance of the arts and culture to health (e.g., All-Party Parliamentary Group (APPG) on Arts, Health and Wellbeing, 2017; Chatterjee et al., 2018; Fancourt & Steptoe, 2018 & 2019; WHO report, 2019). With a strong foundation in this literature and an existing mission that views access and participation in arts and cultural experiences as central to health and well-being, the Massachusetts Cultural Council (MCC) enlisted the Public Health Institute of Western Massachusetts (PHIWM) to evaluate a pilot project and perform an assessment of a community considered key to understanding and expanding their “CultureRx” initiative, one situated in Springfield and the other in the Berkshires. Specifically, this work focuses on: (1) A “Social Prescription” pilot in the Berkshires whereby free “tickets” were provided as “prescriptions” to families by a pediatric practice nurse care coordinator to experience one of five arts or cultural organizations located in that region. (2) An assessment in Springfield whereby members of the arts, cultural, and healthcare communities provided advice and guidance as to how bridges between the two sectors could enhance quality of life for residents in our area while at the same time increase access to arts and culture programming.

Through both the pilot evaluation in the Berkshires and the Springfield assessment, PHIWM:

- Tested the concept of increasing access to the arts through partnering with healthcare providers
- Tested the concept that healthcare providers would consider arts and culture programming as a potential “healing outlet” for ailing patients;
- Examined the ways arts and cultural experiences may be beneficial to health and well-being;
- Identified what supports or processes are needed in order for arts prescription programs to become fully integrated into community health centers’ prescription practices; and
- Gathered perspectives across residents, healthcare, arts and cultural organizations to understand what types of strategies could help create partnerships across two sectors that rarely or untraditionally work together.

The Pilot evaluation and assessment participants included health care providers, community health workers and patient navigators, community partners, a cultural council, representatives of arts and cultural institutions and programs, individual artists, and most importantly, patients, and participants in the program offerings.

- To support the work of the cultural institutions and healthcare practices involved in the evaluation and assessment, the Mass Cultural Council also enabled a set of in-person trainings and webinars exploring Cultural Humility led by Sandra Bonnici. The purpose was to explore barriers to participation in arts and cultural institutions and best practices for creating a welcoming, inclusive experience for all visitors. As

evaluating the benefits of these training sessions was outside the scope of this project, Mass Cultural Council is collecting data and reporting on results in a separate document.

## Key findings

Across sites, the main agreements between the arts, cultural, and health care sectors were as follows (an asterisks denotes a similar finding across both sites):

1. Fostering formalized relationships and connections was positively perceived and essential for sustainability.\*
2. Addressing at least some barriers to equity or access was understood as a foundation for a successful partnership.\*
3. Some artists and the arts or cultural institutions seemed more primed to engage in the aforementioned process than others.
4. The concept of health and cultural providers co-creating programs, possibly located at a health center, resonated with some study participants.
5. Some artists and arts or cultural institutions appeared better primed to co-create programs with healthcare.
6. Using health centers as a place to engage artists and residents to learn and create healing for specific health issues was welcomed and encouraged by many interviewees.
7. Specific populations/communities were identified as important to outreach to and include in this new vision and idea. Interestingly, some were identified for both arts, cultural, and healthcare sectors—examples include young artists, artists with disabilities, and young girls who have experienced trauma.
8. Structuring opportunities to create collaborations and programs grounded in an understanding of intersectionality between and among health care and arts and cultural sectors and the community was perceived as key to building successful projects and a sustainable partnership.\*
9. Designating time for learning from each other was called out as one key mechanism through which relationships and successful, sustainable partnerships could be created. For example, a training about a health care issue or community practice or opportunities for arts and cultural organizations to share best practices in arts access and engagement with each other.\*

These findings will be discussed in more detail below.

### ***Special note: Impact of COVID-19***

At the outset, the impact of COVID-19 on this work must be noted, though obviously, nothing in comparison to people's lives being lost. Only about 20% of the ticket holders (n = 60) in the Berkshires were able to take advantage of cultural or arts experiences before most organizations needed to close their buildings and/or program offerings. Understandably, the Collaborative Care Coordinator also shifted her focus to the immediate structural and administrative changes to how healthcare would be provided. Similarly, in Springfield the community health center involved in this work had to quickly transition to primarily a tele-health practice, requiring immense effort and concentration to accomplish. Also, although videoconferencing with most Springfield arts and cultural

organizations was an easy transition, participants were quite gracious with their time and amazingly willing to imagine a better future, more pressing worries about financial sustainability and what may come next cast a pallor over conversations, even if this concern was not explicitly discussed. In response, PHIWM adjusted the scope of the assessment and evaluation plans. As Springfield was engaged in a design phase, the effect was not as great as for the Berkshires. Perhaps the greatest loss to the project is that there is not much available in terms of patient perspectives, participant experiences, or lessons learned at the end of the intended 6-month Berkshire pilot.

Despite the difficulties, one of the most heartening of occurrences was the nimbleness and ingenuity of the arts and cultural organizations involved in CultureRx in finding alternative ways to connect, reach, and support the wider public. It seemed their concerns immediately turned outwards towards what could be done to help others and make their art accessible through this unprecedented time. While it is unfortunate that the evaluation and assessment was compromised, their actions serve as a testament to the power and beauty of arts and culture to sustain and heal us no matter the severity of our present circumstances.

## Methods

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For a list of all participating organizations and contributors to this report see Appendix A. The original evaluation (Appendix B) and assessment plans (Appendix C) as well as documentation of what was changed in light of COVID-19 also are included as Appendices (see Appendices D and E). This section expands upon key details of those plans.

### Berkshires

#### *Instruments*

Three types of instruments (see Appendix F) were used to evaluate the Berkshires' pilot:

1. ***Immediate Experience survey (Adult/Teen & Child versions)***

- **Purpose:** The purpose of this survey was to capture participants' experiences after attending an event, program, or museum: Specifically, to measure the extent to which an experience had a positive effect on a participant's mood, increased a sense of belonging or connection (i.e., decreased social isolation) and felt valuable.
- **Development:** This survey was developed by PHIWM in collaboration with the Collaborative Care Coordinator at MACONY and Mass Cultural Council. Final edits and review were provided by the 5 participating arts and cultural organizations in the Berkshires and the cultural humility trainer, Sandra Bonnici. Questions were based on short-item measures of well-being, sense of belonging, and studies of arts engagement from the research literature (Sonke, J. et al., 2019)) and the arts and cultural organizations' own years of experience administering participant/audience satisfaction surveys.
- **Format:** The "adult/teen" version of the survey is 14 items and intended to take 5 or fewer minutes to complete. The "child" version of the survey is 5 items and also intended to be quick. Both surveys asked some retrospective pre-post questions about mood (e.g., (a) before I came here today I felt--; (b) Now after being here I feel--). However, the child version of the survey used both pictures of happy - to - sad faces and also invited the child to draw a set of pictures whereas the adult survey used a likert-scale (calibrated from "not at all" to "extremely") for these items.
- **Administration:** Administrators of the survey were arts or cultural staff and instructed to allow children to pick which of the two versions of the survey they wanted to complete. As each arts or cultural organization anticipated unique challenges in administration of the surveys, PHIWM met with the group in early February to brainstorm each situation and ensure best practices and advice was shared across institutions. Using a spreadsheet developed by the Collaborative Care Coordinator at MACONY (see "note" below), PHIWM would periodically check-in with arts and cultural organizations via email to determine if there were any barriers or aspects that could be improved in terms of collecting these data. As theater tickets were event dependent, in coordination with the RN, these families received gentle reminders of the performance date. At the mid-point meeting (3/9), all

completed surveys were mailed to PHIWM for data entry. Due to **COVID-19**, data collection ended in early March.

## 2. *Successes & Challenges in the Implementation of CultureRx: Feedback form*

- **Purpose:** The purpose of this feedback form was to understand the accomplishments and challenges in implementing the social prescription program and solicit recommendations and advice based on the five organizations' and the RN's experiences.
- **Development:** The form was developed by PHIWM based on typical questions asked in evaluations of program implementations.
- **Format:** The form contained five open-ended questions with large enough answer boxes to allow participants plenty of space to write as much as they chose.
- **Administration:** The form was sent via email and distributed at a midpoint check-in to at least one member of each of the participating organizations. Originally, the plan was to slightly revise the form to add in "lessons learned" and administer it again towards the end of the pilot (late May). However, the midpoint became the end point as **COVID-19** curtailed any further implementation of social prescribing.

## 3. *Reflections on the "Social Prescribing" Experience: Follow-up Interview protocol*

- **Purpose:** The purpose of this interview protocol was to understand what families who participated liked about their arts and cultural experiences, what was viewed as challenging, and to provide advice on how to improve the program in the future. For those families who did not- or "not yet" - attend, the interview was to understand more about the possible barriers to participation and solicit advice on how to improve the program in the future.
- **Development:** The form was developed by PHIWM based on typical questions asked in evaluations of program implementations.
- **Format:** The interview protocol was created using Google forms, originally contained six questions, and was intended to take not more than 15 minutes.
- **Administration:** The plan was for the Collaborative Care Coordinator to "follow-up" with a family (one adult) via phone approximately two months post the original ticket being provided. PHIWM worked with the Collaborative Care Coordinator using a spreadsheet she developed (see "note" below) to select enough ticket holders from each organization to ensure that the variations of experience and attendance would be captured. As both reasoned that not everyone would be reachable and there were not enough project resources or time to call back families more than twice, the expectation was that approximately 20% to 25% of families would participate in the interviewing process (resulting in 20 to 25 completed interviews). After explaining the purpose of the phone call, the first question was intended to be used to determine whether a family had- or had not yet- participated in an experience. If there were fewer families calling back that had not - or not yet gone- a letter was to be sent out to them in May on MACONY letterhead emphasizing how important their opinions were about this effort and encouraging them to call. **COVID-19** changed these plans.

There was no way of knowing which families may have participated had the pilot been able to continue through until the end of May. Consequently, PHIWM redesigned the interview protocol to begin by recognizing the impact of COVID-19 on a family and assume any families who had not yet gone might want to provide some advice for future CultureRx initiatives.

Note: The Collaborative Care Coordinator created a “**Referral-Prescription-Communication-Engagement**” (RPCE) shared spreadsheet that documented some demographic characteristics of ticket recipients, when a ticket was given, the type of ticket given, the reason why a “match” was made (focused on the child’s diagnosis or needs), and the reaction to a ticket being given. The arts or cultural organization then filled in when/if/who attended, supplemental activities (if applicable), whether or not an incentive was given or received (e.g., yearlong free membership), and anecdotes shared by participants. Although around 60 “prescriptions” were provided to families, due to **COVID-19**, not all organizations had opportunities to receive ticket holders.

Arts and cultural organizations also developed collateral like flyers or brochures advertising what type of experience a family might have if they decide to participate. One organization also worked with the Collaborative Care Coordinator to plan a weekly entertainment event in the waiting room.

### ***Hypotheses***

In consultation with Mass Cultural Council, four evaluation questions were developed to examine the potential benefits of the social prescription pilot.

1. To what extent did the referral criteria and social prescription match?
2. To what extent did attendance at an event or experience have its intended positive outcomes on participants as indicated by a; (a) change in emotional state, (b) sense of belonging, (c) worthwhile use of time, and (d) general expression of satisfaction with the prescribed experience?
3. To what extent did participants have an overall positive perception of an arts, culture, or nature experience?
4. [Process] What were the greatest successes or challenges in the implementation of CultureRx: Berkshires?

### ***Analyses***

Due to COVID-19 the extent to which each of these hypotheses could be studied was irrevocably altered. There is no way of knowing who might have used their ticket had the pilot not ended in early March. Moreover, some organizations had not had any attendees yet and therefore could not detail observations (to be noted briefly in the RPCE spreadsheet). Similarly, providing useful feedback as to what worked or did not in the implementation of the pilot was challenging given it had only been in operation for about a month and a half. The Collaborative Care Coordinator also needed to focus on the crisis at hand and place conducting any further follow-up interviews on hold. The consequence is that there was little survey data collected, follow-up interviews conducted, or documented notes or observations.

PHIWM used every scrap of information available and conducted the following analyses:

1. A descriptive analysis (e.g. frequencies) of the Immediate Experience survey data provided by adults. There was not enough data from children to analyze (<5).
2. Categorization of the RN's notes on the reactions to receiving a ticket.
3. A thematic analysis of responses to the "Successes & Challenges in the Implementation of CultureRx" feedback form. The goal of this methodology is to determine common patterns across each individual's feedback.

As some follow-up interviews with families were conducted prior to COVID-19 and are still continuing now, PHIWM hopes to add an Addendum section to this report in July. Families provide a unique and invaluable perspective regardless of whether they were able to participate prior to March.

## Springfield

### ***Instruments***

Four instruments (see Appendix C) were designed for the Springfield assessment.

1. ***Experiences with Arts & Culture: Focus Group protocol***

- **Purpose:** The purpose of this protocol was to ground any future intervention plans between sectors in the context of the special characteristics and experiences of the Springfield, MA community, particularly patients of Caring Health Center.
- **Development:** *As all instruments were developed by the Design Team (members detailed above) the origins of the protocol will only be noted once.* The group brainstormed questions together rooted in their subject area and community expertise with PHIWM providing some final editing or revisions based on a quick scanning of the arts engagement and social prescription research literature. The Advisory Group also had an opportunity to comment on the protocols.
- **Format:** The focus group protocol contained six questions and was estimated to take approximately 45 minutes to an hour of time.
- **Administration:** Originally, the focus group was intended to be co-moderated between Caring Health Center and PHIWM. The plan was for one member of the team to facilitate discussion and the other to take notes and keep time. At least two focus groups were scheduled to occur, one in English and the other in Spanish. Each focus group was intended to include < 10 people. Research leadership from PHIWM and CHC completed and submitted a determination of research protocol through the Baystate Health Institutional Review Board. The quality improvement project was deemed "not research" and thus, IRB review was not required. Due to the advent of **COVID-19**, reaching out to patients to ask if they would participate in a focus group about their relationship with arts and culture did not seem sensible or feasible given the situation. With Mass Cultural Council's permission, Caring

Health Center put this activity on hold until (possibly) late June or as soon as it is feasible to host a virtual focus group with patients.

2. ***Feasibility of integrating Social Prescribing into health care practice: Discussion Group protocol***

- **Purpose:** The main purpose of this protocol was to brainstorm with various health care personnel what types of communication or additional events need to take place in order to create authentic and successful collaborations among the arts, culture, and health organizations and to gain knowledge of how to build these experiences effectively into a community health center setting.
- **Format:** The discussion group protocol contained six questions and to take approximately 30 minutes of time.
- **Administration:** Originally, the group was to be moderated by two members of Caring Health Center’s staff during a routine biweekly meeting of CHWs, patient navigators, and a few providers. One member of the team was to facilitate discussion and the other to take notes and keep time. Post the advent of **COVID-19** Caring Health Center still conducted this discussion group in May. The group had so much to contribute that an additional discussion occurred at a separate time. However, back in mid-March there was some concern that they may not have the time to discuss non-COVID-19 matters and so the design team decided to add an additional discussion group through the Springfield ACO direct care committee. PHIWM and Caring Health Center co-moderated this group which took place via teleconference call in April.

3. ***Experiences with Arts & Culture: Feedback form***

- **Purpose:** The main purpose of this form was to gain knowledge from primary care providers regarding what were existing arts and culture preferences of their patients and how to build connections to arts and culture for their patients effectively into a community health care setting.
- **Format:** The form contained six questions and was meant to take approximately 15 minutes to complete.
- **Administration:** Originally, there was a plan for PHIWM to administer this form (including gentle reminders to complete it) to approximately 25 providers at Caring Health Center via a survey data collection tool. However, after three separate discussion groups occurred with various health personnel including medical providers (see above) there was agreement that there would not be time or energy for them to complete a non-essential form, especially in light of **COVID-19**, the design team agreed there was no reason to administer it.

4. ***Perspectives on integrating Health care and Arts & Culture Institutional practices: Interview protocol***

- **Purpose:** The purpose of this protocol was to ascertain from arts and cultural providers their current connections or experience with health care and what types of communication, training or relationship building need to

take place in order to create authentic and successful collaborations among the arts, culture, and health organizations and to ground any future intervention plans in the context of the special characteristics and experiences of the Springfield, MA community.

- **Format:** The interview protocol contained seven questions and was designed to take approximately 45 minutes to an hour.
- **Administration:** PHIWM conducted individual interviews based on recommendations of Design Team or Advisory Board members. In one instance, the interrelatedness of the institutions made it sensible to talk to two informants at the same time. As post the advent of **COVID-19** these key informant interviews no longer required scheduling a visit, the design team decided to increase the number of interviews conducted by PHIWM to around eight and add on a discussion with the Springfield Cultural Partnership conducted via videoconference. Caring Health Center also contributed by interviewing two more cultural organizations and an artist with a career in community engaged arts.

**Note:** There was one common purpose across all groups-- to understand how participants encounter arts and culture personally and how- or if- they associate it with health or healing. Also, the introduction to each protocol was amended to incorporate acknowledgment of COVID-19 and the changes it wrought upon us. Caring Health Center groups were perhaps focused more on the new reality than some of the others. As the protocols were designed to be flexible and accommodate natural conversation flow, if a certain question did not make sense or already had been answered, the moderator dropped it.

Similar to the Berkshires, if Caring Health Center is able to interview some patients in June, PHIWM hopes to add an Addendum section to this report in July.

### ***Guiding Questions***

In order to explore how, for whom, and what types of cultural prescribing might work within the Springfield context, the following questions served as a backdrop to the assessment and creation of the interview protocols for CultureRx: Springfield:

1. What is crucial to understand about different groups' sociocultural beliefs about engagement in arts, culture, and how, if at all, do they perceive these fields relating to health?
2. What are the unique characteristics of the Springfield community that might make an implementation of an arts and culture based-intervention successful or challenging?
3. What types of activities or processes need to be in place to make this a scalable, sustainable, and holistic intervention?
4. What types of communications or understandings will help cross-sector partnerships be most effective?

## **Analyses**

PHIWM performed a thematic analysis of the group discussions and interviews based on the notes taken during these conversations. The goal of this methodology is to determine common patterns across groups. Given that each group had certain unique perspectives, where relevant, those themes are incorporated into the summary as well.

# Findings

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## Berkshires

The following themes emerged based on a descriptive analysis (e.g. frequencies) of the “Immediate Experience” survey data, categorization of the RN’s notes on families’ reactions to receiving a ticket, and a thematic analysis of responses to the “Successes & Challenges in the Implementation of CultureRx” feedback form. Any theme that is similar to Springfield is denoted with an asterisk.

All organizations who provided feedback (5 of 6):

1. Viewed fostering a formalized relationship between arts, culture, (AC) and health care (HC) sectors as a net positive.\*
2. Saw addressing at least some barriers to equity or access as necessary to creating a successful partnership between health care and arts and cultural sectors.\*
3. Advised structuring these partnerships to enable and strengthen supportive collaborations between and among health care and arts and cultural sectors.\*
4. Advised designating time for learning from each other- both between arts, cultural, and health care sectors and among arts and cultural organizations.\*
5. In addition, data from the nine adult participants who completed an “Immediate Experience” survey hints that there is an emotional benefit to even a one-time visit to an arts or cultural experience and that the arts and cultural organizations that were able to receive families were perceived as welcoming.

These findings are explained in more detail below.

### ***Fostering a formalized relationship between arts, culture (AC) and health care (HC) sectors is viewed as a net positive.***

As exemplified in these quotes, organizations were “excited” about building this relationship:

- “This initiative provided a valuable opportunity to forge a new relationship with MACONY Pediatrics.” - AC
- I can’t stress enough how valuable it has been to join forces with [the RN- called out by name], pediatricians and staff members at MACONY. This partnership will serve everyone as we move forward.” - AC
- “It is wonderful to continue our care coordination efforts to now include [arts and] cultural organizations. We are always proud to enhance the care we give to our patients and their families. This opportunity has opened conversations in the office, in our exam rooms we might not have happened upon without this pilot. These conversations have given us an opportunity to deepen our connection to our families which we hope results in overall increased patient satisfaction as well as increased engagement with their healthcare partners.” - HC

### ***Addressing at least some barriers to equity or access is necessary to creating a successful partnership between AC and HC organizations.***

There was general acknowledgement that even with the enthusiasm and warmth of the relationships built, some time and attention is needed to figure out how best to serve

specific patient populations. Although the RN's notations in the RPCE spreadsheet were not intended to be exact transcriptions of the prescription process, in about 13% of the entries (8 of 60), she mentioned that the patient or family had never been to an arts or cultural organization in the area. One child had never heard the word "play" used to represent going to an activity at a theater. Some of the words used to describe why she or the doctor prescribed one of the five possible experiences available were that the patient had a developmental disability such as Autism or Downs Syndrome (approximately 8% or 5 of 60), depression or anxiety (approximately 8% or 5 of 60), or another type of challenge such as complex grief, a social problem, or being placed in a new foster home. On a more positive note, about 13% of the patients (8 of 60) were known to like "to draw" or "do artwork." While there is no way of knowing the extent to which the specific prescription given "matched" or how an arts or cultural experience might have been beneficial, participating organizations understood that creating appropriate accommodations and welcoming these families would take some adjustments:

- "We have gained insight on how we can better serve our community, encouraging us to brainstorm ways that we can modify our programs to better meet the needs of families and young people with disabilities. Modification and adaptability has always been at the forefront [of our] mission of inclusivity. Even within the limited time frame of this pilot program, we have remained flexible, changing our program offerings as we learned how [our programming] experiences could be more effective." - AC
- "[We are proud to] welcome families into our organization, and [hear] the excitement and stories of what it means to them to be able to participate in our [program offerings]. Ensuring that our staff is trained and understands that each patron who comes through our doors should be treated with empathy and kindness. While this has always been an unspoken policy of ours, this initiative gave us the opportunity to speak more openly about the importance of cultural humility and make it a more formal policy." - AC
- "Language barrier is another factor [challenge]. I believe one family may have stayed longer had there been more accessibility for their language. -AC
- "Two out of the three RX families didn't call ahead of time and just showed up. They still got the warm welcome." -AC
- "I also think expanding the initiative to include mental health professionals and working with the medical professionals to develop or shape what programs are offered through prescription would be beneficial." - AC

Similarly, other suggestions for improving access included; (1) consider adding more signage in Spanish, (2) developing a process to help ensure that the institution is "ready" to receive a family and that the family knows something about what is available ahead of time and (3) consider seasonality in prescribing as some organizations are more popular and accessible in the spring and summer.

***Structuring these partnerships to enable and strengthen supportive collaborations between and among health care and arts and cultural sectors is advised.***

Organizations involved in CultureRx seemed to be quite willing to quickly trust each other and the process. Still, all cited the importance of the communication tool that was

developed and utilized between the cultural organizations and the Collaborative Care Coordinator, as being crucial to the success. In addition, the RN's existing expertise in coordinated care was essential to creating a workable model and way of collaborating:

- “The communication with MACONY has been key in making this initiative successful. Having the spreadsheet set up gave us a great starting place to track and share data across all sectors [including internal to our organization]. Having an open flow of information across the board . . . has been the best way to be sure that all the moving pieces of this initiative runs smoothly.” - AC
- “The collaboration with MACONY has been wonderful. I can't say enough great things about [RN-called out by name] and all she's done to set up the RX families. The Google spreadsheet has also been a valuable tool to capture data for each family.” -AC
- “The database is great! I feel the communication with the cultural organizations has been very good overall.” - HC
- [Advice for other HCs] “It is likely helpful if they have a care coordination program in place already that they can expand upon. A practice that has already done some work within the community and appreciates the value of “outward facing” connections.” - HC

***Designating time for learning from each other- both between arts, cultural, and healthcare sectors and among arts and cultural organizations is advised.***

Organizations spoke highly of the occasional opportunities to meet and learn from each other as well as the valuableness of participating in the cultural humility training sessions (See appendix for more details)

- “We have found it extremely valuable to get facetime with the other [organizations] in the CultureRx pilot program – asking questions, sharing ideas, creative problem-solving and brainstorming the process.” -AC
- “Connecting with other cultural organizations has been meaningful, and another important step in creating future partnerships and collaborations. Through hashing out the details of the CultureRx pilot program in early meetings, really significant topics emerged in ways we can all be more inclusive, reach underserved populations, provide access to all, and share resources.” - AC
- “Working directly with the Mass Cultural Council to help develop a survey to track data, and to brainstorm best practices has been invaluable and helped shape what we are currently doing. Also, being able to meet with and discuss other organizations' experience in this program has proven to work well.”

One organization with a very small staff who really appreciated the sharing also hoped that future iterations of CultureRx would perhaps set up a calendar of meetings at the outset to increase the likelihood of all being able to attend.

***There is a suggestion that there is an emotional benefit to even a one-time visit to an arts or cultural experience and that the arts and cultural organizations that were able to receive families were perceived as welcoming.***

Decreasing social isolation and an increase in well-being are noted positive effects of social prescribing. Analysis of data collected in the first month of the Berkshires: CultureRx

intervention signal that participants in this program may reap a similar benefit as evidenced by their reporting that their particular cultural experience contributed to their general satisfaction (see Figure 1), increased happiness (see Figure 2), decreased stress, and sense of connection to others. The majority of respondents indicated that the experience helped them to *learn about culture* and *try something new* (though not as many). In addition, cultural organizations seemed to do well at engaging with participants as suggested by positive ratings on items such as feeling welcomed, comfort, and valuing the experience overall (see Figure 3). Eight of nine respondents stated that they would come to the experience again. For visualizations of complete results see Appendix G.

Figure 1: Overall, participants were satisfied with their experiences.



Figure 2: After participating in a cultural experience, over half (55%) of participants reported an increase in their level of happiness as compared to before they attended.

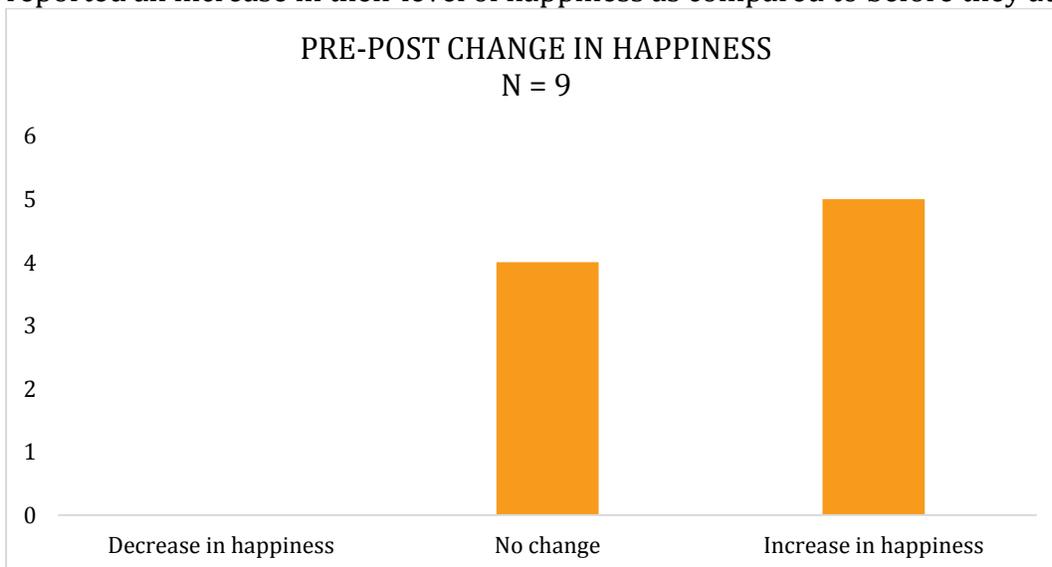
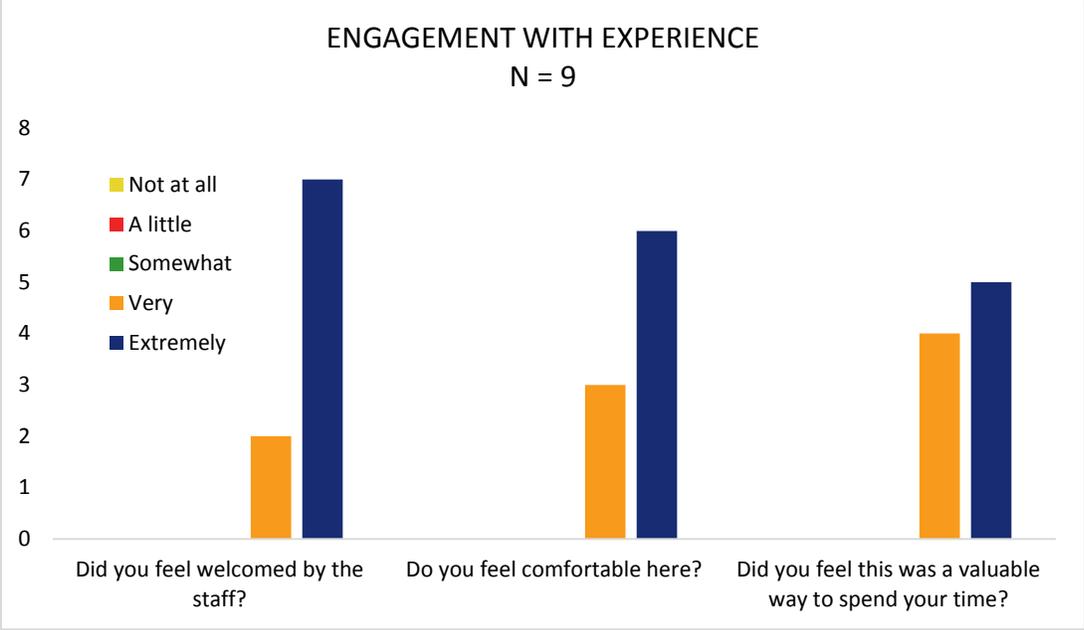


Figure 3: Participants seemed to be engaged with their experiences as evidenced by positive ratings of being welcomed, comfort, and the value of the experience overall.



## Springfield

These findings are based on an analysis of interviews with healthcare providers, community health workers and patient navigators, community partners, the Springfield Cultural Partnership, and representatives of arts and cultural institutions, cultural practices, programs, and independent artists (n = 45) (see Appendix A for a complete list). As some participants in discussion or focus groups came late or left early and there are a few participants who were voices in more than one group the number of participants is a fairly, but not totally accurate estimate. Also, some individual interviews as well as a focus group were conducted with arts and cultural participants. The different methods by their very nature potentially solicit different types of responses. As such, words (e.g., some or most) versus numbers may be more meaningful in explaining certain themes or patterns. Only a selection of quotes or other supporting material is presented here. Any theme that is similar to the Berkshires is denoted with an asterisk.

The main findings are:

1. The majority of interviewees easily saw a connection between arts, culture and health.\*
2. The majority of interviewees also understood that a successful partnership would need to address some barriers to equity or access.\*
3. Some artists or arts or cultural institutions seemed more primed to engage in the aforementioned process than others.
4. Some artists and arts or culture institutions are better primed to collaborate to co-create programs with health care.\*
5. The concept of health and cultural providers co-creating programs, possibly located at a health center, resonated with some study participants.
6. Using health centers as a place to engage artists and residents to learn and create healing for specific health issues is welcomed and encouraged.
7. Specific populations/communities were identified as important to outreach to and include in this new vision and idea; interestingly they were identified for both arts and cultural sectors, healthcare and residents: young artists; artists with disabilities; young girls who have experienced trauma
8. Designating time for learning from each other was called out as one key mechanism through which relationships and successful, sustainable partnerships could be created. In particular, training came up as very important – training young artists how to co-create with different sectors; training artists on different health issues so they understand content area in which they might create; training health care providers in the mediums of art and what health issues might be better fits for partnerships and collaboration.\*

Greater details are provided below.

**Health care (HC) and arts and cultural (AC) providers see a connection between arts and health.**

- “In so many ways, arts and culture feed us as human beings. Feeds our sense of self and identity and humanity in any way that we create anything – writing, music, gardening, dancing, sewing – feeds our sense of who we are in the world. Arts and culture feeds us intellectually, we learn about the rest of the world, content, academic or cultural – we learn through our senses and it piques our curiosity and digs deeper. Students learn by embodying geometry – they learn by doing – visual and muscle memory. It also feeds us interpersonally – knowing where interpersonal connections that help us realize that we are not alone in the world.” – AC
- “[Arts are] hugely important in helping people connect and relax; When I was practicing in Holyoke- a major way that we could get folks exercising was salsa dancing. Turning exercising into dance and communal dance was very powerful. Another example is the use of art in exam rooms as a way to relax people- art from different cultures- so that people feel more welcome. If you come in and you see the art on the walls is from the country or culture you come from, I think it’s a way for people to feel connected to an alien place- which the health center can certainly be. – HC
- "I do believe that “art heals”; it lends to marginalized communities . . . Art brings coherence...coherence meaning a greater feeling of themselves as a group; they are aware of their own unity and potential for acting as a group and against all the challenging forces around them.” - AC

Many types of art and cultural practices were cited as examples of the healing powers of artistic expression. Table 1 may not cover every activity mentioned, but rather demonstrates a wide range of possibilities for engagement and relationship across arts, cultural, and healthcare institutions.

**Table 1: Selection of activities mentioned as having a relationship to healing**

Bomba & Plena groups (Puerto Rican traditional dance)	Décima poems	Making lotions or soaps	Planting/Gardening	Weaving
Collages	Drawing	Making masks	Poetry	Woodworking
Coloring	Festivals	Making muda (traditional Nepali stools)	Pottery	Writing/Writers circle
Cooking/nutrition	Journaling	Making theater	Publishing stories	
Crafts	Listening or creating music	Murals	Salsa Dancing	
Creating a newspaper that shares local stories	Looking at art	Museum going	Sewing (e.g, making pillows, COVID-19 masks)	
Crocheting/Knitting	Making bookshelves	Music concerts	Sharing stories	
Cultural events	Making candles	Painting	Singing religious songs	
Dance	Making cuatros (Puerto Rican 10-string instrument)	Piano playing	Walking through the park	

Some of the activities listed above, were cited as particularly important within a community. For example, the making of; (1) (non-medical) masks was discussed as a venerable Puerto Rican tradition, (2) soaps and lotions important to African American health and wellbeing, or (3) sewing pillows and tablecloths, sometimes painting them, in and around Ramadan as an expressive art form for Muslim women. Some interviewees also expressed pride in their communities' gifts. As a member of the Bhutanese community stated, "In terms of arts, our people are really good; knitting, webbing, basins, shawls, back in the refugee camps we used these crafts as microfinance [opportunities]."

***Both HC and AC providers identified some barriers to equity and access.***

Accessibility issues were mentioned by both cultural and healthcare providers, with Healthcare providers emphasizing the challenge of getting to a medical appointment, let alone going to a museum or other cultural event.

- "Even before COVID-19, the patients we deal with on a regular basis, their resources are very limited. I know you mentioned there would be fee reductions and things like that. Our patients need to go above and beyond just to get transportation to a visit- to pick up their medications. So, I don't know if there's 1, 100, or 1000 things that would make it work better- just to look at what our patients go through on a daily basis to live life. You look at the struggles they go through for housing, for food, for transportation, and that's just so that they can function. And now you're saying, "well, let's get you to another place, somehow," I don't know if I had to think a week in advance to go somewhere, to go to a Dr's appointment, alongside everything else I had to do, if I would really be up for thinking about what cultural event do I want to go to." – HC
- "Our community has experienced a lot of hardships and trauma; mostly subsistence-level farmers, [they] really [like] doing hand crafts and arts . . . now they can't, because [of] the limited resources or transportation barriers. Children of the elderly are mostly at work and can't be driving their parents or grandparents everywhere" - AC
- "To get these things off the ground I think these things take a lot of energy and regularly touching base with people. Even when they are excited about it." –HC

Transportation barriers are perhaps a key challenge to greater access to arts and cultural activities. One AC provider detailed the many important programs she had instituted to create a more welcoming, inclusive, and comfortable space. To paraphrase one HC, however meaningful an experience might be to a potential visitor, the frustration and stress of trying to navigate a way to get there could prove too much.

Language barriers also were mentioned. Two of the ACs familiar with Caring Health Center's model of care, discussed how valuable they find the CHWs language facility in helping to navigate, interpret, and explain certain health issues while still being sensitive to and supportive of cultural or religious practices. As this subject was not the focus, it is unclear if they were implicitly recommending that arts or cultural institutions like

museums should have some employees ready to play a similar role, but it is certainly an accessibility issue to be noted.

The perceived racism of certain arts and cultural institutions was another barrier mentioned by a few of the ACs. Stories were shared of how they or others like them felt excluded from participation by certain Springfield arts or cultural institutions. While only a select number of ACs were interviewed in this study, their stories suggest that there may be a larger pattern of (presumably unintentional) exclusion of artists of color in the Springfield community that needs to be addressed.

Two cultural organizations that worked with health providers in the past also mentioned needing to navigate and ensure HIPAA compliance or some other type of confidentiality process, perhaps an unanticipated startup cost. On the other side of the relationship between ACs and HCs, power dynamics were mentioned: Healthcare centers and doctors in particular are seen as “powerful”; if relationships with individual artists or cultural practitioners were to occur, it appears there would need to be some level grounding and understanding of the equal importance of all perspectives at the table.

***All AC providers were invested in increasing arts engagement, though some seemed more primed to address barriers and begin to collaborate.***

Before detailing HC or AC provider’s suggestions for how to build a relationship between sectors that do not traditionally work together, a note about the AC providers: Even though every artist and organization interviewed discussed the importance of identifying and addressing access or equity issues, there seems to be considerable variation in approaches to inclusivity across the Springfield community.<sup>1</sup>

The most common patterns that emerged were:

**The “embedded” organization:** Synonyms: Immersion, awareness, situatedness: Some organizations are organically and/or intentionally collaborating within one or a multiplicity of Springfield’s communities. In interviews, they explained their approach to art creation with concepts like “listening, patience, connectedness, adaptability, meaning-making, helping, empathy, working together” and “social justice.” In general, these organizations seemed less tied to a particular physical place or ritualized experience.

**The “eager” organization:** Synonyms: Impatient, longing, hopeful: Some organizations yearned for progress but seemed unsure as to why their programming or space was not always perceived as welcoming or inviting to a diversity of groups. In interviews, the phrase, “how do we” frequently was used, such as “how do we move forward?” or “how do we reach communities of color?” Interviewees mentioned engaging in various types of sensitivity trainings as a way of learning how to further cultivate trust and sense of belonging within the community. While certainly worthwhile, these activities may not quite

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<sup>1</sup> These “types” were presented at the last meeting of the Advisory Board (5/29) with the intention of allowing the group time and space to reflect on their resonance. Without hesitation, the group immediately saw how all three types could work together and benefit from each other’s strengths and wisdom.

be as outward facing as needed if the goal is to create a successful partnership immediately with a healthcare clinic. Importantly, these organizations seemed thirsty to learn more.

**The “advocate artist”:** Synonyms: supporter, promoter, activist: Some organizations/artists have many years’ experience working with different sectors including healthcare and co-creating; also they already have as a mission creating opportunities for artists that are not considered to be in the elite or mainstream (e.g., artists with disabilities; young artists; artists of color). Even some from eager and embedded organizations suggested that these artists should be tapped into by Mass Cultural Council to help create the next phase of this effort.

***Although the individual social prescription scenario was introduced, both HC and AC seem to lean towards co-creating communal activities or events as a preferred first step towards building relationships and trust between health care practices and cultural and arts institutions.***

- As one cultural provider put it when discussing the success of the Fresh Paint festival at attracting a wide demographic swath of Springfield, the activities were, “very participatory. People were invited to play a role in it and I think that increased engagement. I think people stayed a bit longer than if they were perhaps just observing.” -AC
- Similarly, a health care provider recommended, an affinity group model. “Everybody with diabetes gets together and they learn from each other. . . it has to come to its own life and people are flocking to it in parallel to their health, it has to be local, specific to the population, it has to be something that people want- not just, “oh, go see the symphony.” It has to be something onsite with the patient- with the need coming from the group. Very similar to the empower group projects- similar to saying, “What is it that you want looking at art or playing music? How do we make that happen?” That seems like it has more legs than I’m going to write a prescription to go to [somewhere else].” -HC

There are quite a few local, national, and international examples of successful programs based on a co-creation approach to the relationship between arts and other sectors of the community that can be drawn on in Springfield (e.g., the Center for Arts in Medicine at the University of Florida or the Center for Performance and Civic Practice- see references for weblinks). Beyond Fresh Paint some local efforts were cited such as a creative writing program situated at the Treehouse Community in Easthampton that involved participants from 14 to 80+ years old writing and rowing on the river together, a group of elderly Jewish and Latinx residents of Holyoke coming together to interview each other for a “Memory Café,” an art show at a local health community clinic where children created the art and there was a competition with prizes, Nueva Esperanza in Holyoke which was a small instrument making workshop with young people at risk, an annual Bhutanese Society of Western Mass festival sponsored by Mass Cultural Council, a poster contest for people with disabilities that took place in the Brightwood neighborhood, a collage project involving students in Springfield schools and the Armory, and various music and dancing activities throughout different communities in the area.

Interestingly some HCs and ACs mentioned how co-creating with each other would not only benefit the patients, but also each other. The potential of engaging in art or helping to facilitate an art class to “heal the healer” became an important discussion during one of Caring Health Center focus groups. It was also highlighted that many artists have health issues, particularly mental health issues. In other words, partnerships with HCs could help the artist as well – perhaps, as one suggested, accepting mental health issues.

**Relatedly, some providers suggested starting with activities or events centered, if not always located, at the health care centers.**

- In a large discussion group (n = 18) at Caring Health Center, CHWs, Navigators, Social workers and Nurses enthusiastically agreed that not only could the Wellness Center (when it is safe to do so again) be a place for hosting events but; “we should engage our own staff who have skills or connections within the community to [help] drive the programming.”
- A member of the ACO discussion not affiliated with Caring Health pointed out the value of Caring Health Center’s Wellness Center, adding on that a designated coordinator role might be helpful in enabling the partnership to thrive. “We haven’t yet been very successful in getting people to come together in addition to a visit to their doctor. We have managed to have a culture of a drop-in session, but it’s really more a waiting room activity than a true drop-in. The limitations in our health center- is maybe, a dedicated person who has expertise in that area. Caring has been the outstanding, forward thinking in terms of the wellness center and it being comprehensive and the cooking classes, that level of support- I know it’s been a 10 year process- that level of dedicated money and time- it has to be that big- it’s not just an add on – it has to be true integration.”
- Reflecting on the common cultural practices among one of the larger refugee populations served by CHC, “[If] there is a place to gather weekly [and have a] CHW/interpreter volunteer, [they] could go and talk about the issues to tell of and talk about stories of the past; similarly women all they get to do usually is cooking and cleaning; if they could come together to share their stories that would be wonderful; and mothers and sisters would be happy to have those things.”
- An AC provider also discussed the success and longevity of a project that is hospital-based where she was invited by the nursing staff to co-create an arts program for people living with AIDS. She suggested that the artists chosen for the partnership should be, “young, up and coming people of color” as that would, “increase the artist’s capacity to create open, trusting, welcoming opportunities for community members.”
- Another idea expressed was creating an art contest opportunity by letting the patients vote and then holding an exhibit at the Wellness Center for the winner.

**Specific populations or communities were identified as important to outreach to and include in this new vision and experiment.**

Engaging new, young, or emerging artists in this effort was mentioned by a few ACs (regardless of whether representing an “eager” or “embedded” organization or “advocate”).

One AC stressed the importance of “supporting” these artists and viewed this process as a way to build “capacity” and “deepen relationships within the community.” As one AC put it, “Money toward young and up and coming artists of color for training—increases the artists capacity to create open, trusting, welcoming opportunities for community members – training could be done by the health care sector [explaining] what are the health issues.” The importance of including the voices and perspectives of artists with disabilities also was mentioned. HCs also pointed towards various local artists or musicians who continued reaching out to connect within their communities despite the challenges incurred since the onset of COVID-19.

Echoing comments already discussed, a few HCs suggested the first efforts of cocreation should be centered around those with a particular health problem- like asthma or diabetes- or around a cultural identity such as within the Nepali or Puerto Rican community. Although not quite put together this way, it could be imagined that a younger artist could work with a CHW to learn about a health issue or needs of a particular community and co-create a program designed to serve that specific health care population’s need.

**Designating time for learning from each other was called out as one key mechanism through which relationships and successful, sustainable partnerships could be created.**

However, these partnerships might evolve, embedded throughout these findings is an emphasis on structuring time to share wisdom between arts, cultural, and health care providers as well as within and among these fields. The number of times participants discussed an eagerness to engage in more training, create trainings, or share learnings was striking. Suggestions included; (1) training young ACs on how to co-create with different sectors; (2) training ACs on different health issues so they understand content areas in which they might create; (3) HCs sharing more of their own artistic abilities with each other; (4) creating more opportunities for “healing the healer” through arts and culture, (5) training HCs in the mediums of art and what health issues might be better fits for partnerships and collaboration, and (6) arts and cultural organizations working together to learn best practices and ways to incorporate knowledge of intersectionality into their programs and practices. As a testament to this commitment, some arts and cultural organizations and Caring Health already began a co-discovery process to learn from each other and imagine what might be possible to do now and in the months ahead.

## Limitations

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From the outset of this project, there was acknowledgement that this initiative's goals were quite ambitious given the relatively short time frame from its kickoff to its wrap up ( $\approx$  6 months). Creating a set of interventions that bring together the arts and health sectors is expected to take time, repeated engagement, shifts in accessibility, understanding, cross-sector relationship-building, and often, minimal-to-intense institutional mindset change. Despite the challenges, the Berkshires efficiently and effectively ramped up its social prescribing in the form of "tickets" to various events, experiences, museums and programs by the 2nd week of January. Similarly, the Springfield Design team was prepared to complete their assessment by approximately mid-March.

It is assumed that results of these projects might have looked differently had COVID-19 not hit--causing MACONY to cease social prescribing, cultural institutions throughout the Berkshires and Springfield to close to visitors, and Caring Health Center to focus acutely on care provision for their patients during a crisis, including adapting personnel, patients, programs, and systems to a telehealth model. The need to be agile, responsive, and adapt the evaluation and assessment tools to the new realities and interview people or groups that were not considered in the original plans also changed the project. Ultimately, the pivots made in Springfield had unanticipated benefits: First, an even wider variety of perspectives was included in this report than originally planned for and second, particularly for health care staff, the discussions allowed time and space to reflect, imagine, and creatively contribute to a future not entirely focused on mitigating the effects of the virus.

Also due to COVID-19, very few in-person focus groups or interviews were conducted. Interactions and dynamics between people might have changed or stiffened the types of responses participants offered. One focus group conducted via telephone was particularly challenging. Most distressing of the consequences has been the lack of representation in this report of the voices of patients from Springfield or families who participated in the Berkshires. If there is an opportunity for this information to be gained, it will be analyzed and written up in an Addendum to the current report.

# Appendix A: Participating organizations and contributors

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## Berkshires

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### *Instrument design:*

- Adrien Conklin, MACONY Pediatrics
- Käthe Swaback, Massachusetts Cultural Council
- Public Health Institute of Western Massachusetts (PHIWM)

### *Pilot participating organizations:*

- Berkshire Theatre Group
- Community Access to the Arts
- Norman Rockwell Museum
- MACONY Pediatrics
- Massachusetts Audubon Society: Berkshire Wildlife Sanctuary
- Massachusetts Museum of Contemporary Art

### *Other:*

- Patients & Families of MACONY Pediatrics

## Springfield

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### *Design team:*

- Cristina Huebner Torres, Caring Health
- Jacqueline Johnson, Caring Health
- Johanna Lopez, Caring Health
- Eileen McCaffery, Community Music School of Springfield
- Käthe Swaback, Mass Cultural Council
- PHIWM

### *Organization contributors:*

- Community Music School Springfield
- Enchanted Circle Theater
- The Springfield Museums
- Art for the Soul Gallery
- Teatro Vida
- Islamic Society of Western MA
- Bhutanese Society of Western MA

### *Advisory Committee members:*

- Alisa Ainbinder, Consultant, PHIWM
- Jessica Collins, PHIWM
- Karen Finn, Springfield Cultural Partnership Inc.
- Cristina Huebner Torres, Caring Health Center
- Julie Jaron, Springfield Public Schools
- Jacqueline Johnson, Caring Health Center
- Priscilla Kane Hellweg, Enchanted Circle Theater
- Johanna Lopez, Caring Health Center
- Eileen McCaffery, Community Music School of Springfield
- Kay Simpson, Springfield Museums
- Käthe Swaback, Mass Cultural Council
- Karen Fisk, Springfield Museums

### *Springfield Cultural Partnership members*

- Steve Cary, Focus Springfield
- Shera Cohen, Historical Classical Inc.
- Kelly Fellner, Springfield Armory
- Karen Finn, Springfield Cultural Partnership Inc.
- Richard Griffin, MassDevelopment
- Scott Hanson, City of Springfield Office of Planning
- Eileen McCaffery, CMSS
- Martin Miller, New England Public Media
- Jim Puhala, MassMutual
- Kay Simpson, Springfield Museums
- Lynn Nichols, Springfield Symphony Orchestra
- Sommers Smith, Springfield Cultural Partnership Inc.
- Marie Waechter, (WGBY) New England Public Media

### *Other:*

≈21 Arts & Cultural providers participated in the assessment, including:

- The Springfield Cultural Partnership focus group attended by members listed above
- 3 individual artists who work in the community
- 3 cultural institutions that support religious, regional, and/or ethnic practices
- 4 representatives of arts or cultural organizations

### *Other:*

≈ 24 Health Care providers participated in the assessment, including:

- Care Navigators
- Community Health Workers
- Doctors
- Nurses
- A Social worker
- A focus group of Accountable Care Organizations (the direct care committee) with representation of different types of the aforementioned health care staff from both Baystate Health and Caring Health Center

# Appendix B: Berkshires Original Evaluation Plan

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## Evaluation Questions and Plan

### Methods

#### TOOLS

Immediate Experience survey

#### ADMINISTERED TO WHOM?

All participants (Child/Teen/Adult (Parent))

Reflections on the “Social Prescribing” Experience: Follow-up Interview protocol

Select participants (1 Adult (Parent) per family only) [Adrien Conklin administering]

Successes & Challenges in the Implementation of CultureRx: Feedback form

(1) Cultural organizations (2) MACONY-Adrien Conklin,

Other:

- “Referral-Prescription-Communication-Engagement” (RPCE) spreadsheet that documents demographic characteristics of ticket recipients, when ticket given, type of ticket given, reason why “match” made (focused on child’s diagnosis or needs), reaction to ticket, when/if/who came to cultural org., supplemental activities at org. (if applicable), incentives at org. (e.g., yearlong free membership) & anecdotes shared by cultural orgs.
- Data on (1) how many/who from cultural orgs attended the Cultural Humility trainings (2 trainings & webinar), (2) documentation of what was covered, and (3) responses to learning (from survey collected after training).
- Collateral like flyers/brochures from each organization advertising what type of experience a family might have if they decide to participate.

Note: Given a need to respect privacy and HIPPA concerns, we will not be able to interview families on their thoughts as to how MACONY presented the original prescription and the cultural organizations. Also, we will know which organization provided the survey data, but submitted surveys will not be matched to individuals.

### Evaluation Questions

#### **Overarching theme: What works? for whom? Under what circumstances?<sup>2</sup>**

1. To what extent did the referral criteria and social prescription match?
2. To what extent did attendance at an event or experience have its intended positive outcomes on participants as indicated by a; (a) change in emotional state, (b) sense of belonging, (c) worthwhile use of time, and (d) general expression of satisfaction with the prescribed experience?

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<sup>2</sup> This idea is taken from Bertotti’s et al.(2018) article on a “realist evaluation approach to social prescribing” who attribute the original methodology to Pawson & Tilley (1997).

3. To what extent did participants have an overall positive perception of an arts, culture, or nature experience?
4. [Process] What were the greatest successes or challenges in the implementation of CultureRx: Berkshires?

## Plan

### 1. To what extent did the referral criteria and social prescription match?

Indicator	Notes	Assessment Methods	Timing
Summary of referral criteria (a) per cultural organization & (b) overall	Criteria = e.g., age group, behavioral health need of the child & family situation	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.
# of prescriptions (i.e., tickets) used (a) per cultural organization and (b) overall	Used = There is a record on the spreadsheet that the child/family participated in an event/experience at a cultural org.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.
# of incentives used (a) per cultural organization and (b) overall	Used = There is a record on the spreadsheet that the incentive was accepted.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.
% of patients & families with a positive change in emotional state from experience	This indicator will be derived from answers to questions such as their pre-post retrospective happiness or stress or whether they indicated feeling satisfied.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
Types of positive versus negative experiences patients & families identify	This indicator will be derived from answers to open-ended questions such as what they liked or wanted improved upon. If some children draw pictures, that can potentially be included as well.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
% of families who indicate a “sense of belonging” (a) per cultural organization and (b) overall	(for the adults) The “sense of belonging” concept will be measured based on responses to questions such as how comfortable or welcomed they felt and whether they indicated feeling “more connected to others”	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
Types of reasons adults (parents) identify for not – or not yet-	Interviews will be conducted approx. 2 months after	Reflections on the “Social Prescribing” Experience: Follow-up	Data will be accessible immediately after each interview is conducted,

Indicator	Notes	Assessment Methods	Timing
participating in experience.	prescription given & are not contingent upon whether the prescription has been used yet.	Interview Protocol	but a final product will be delivered in late April.
Types of reasons adults (parents) identify for participating in & liking the experience.			
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.
Stories of successes or challenges in making matches.		Successes & challenges in the Implementation of CultureRx: Feedback form (MACONY) (+ the notes Adrienne Conklin is keeping about why each match was made)	TBD (likely mid-April)
Stories of successes or challenges in the match itself.		Successes & challenges in the Implementation of CultureRX: Feedback form (cultural orgs)	TBD (likely mid-April)

\* MACONY will share an anonymized dataset with PHIWM rather than the complete, raw data version of the spreadsheet which contains Personally Identifying Information.

**2. To what extent did attendance at an event or experience have its intended positive outcomes on participants as indicated by a; (a) change in emotional state, (b) sense of belonging, (c) worthwhile use of time, and (d) general expression of satisfaction with the prescribed experience?**

Indicator	Notes	Assessment Methods	Timing
% of patients & families with a positive <b>change in emotional state</b> from experience	This indicator will be derived from answers to questions such as their pre-post retrospective happiness or stress.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
% of families who indicate a “ <b>sense of belonging</b> ” (a) per cultural organization and (b) overall	(for the adults) The “sense of belonging” concept will be measured based on responses to questions such as how comfortable or welcomed they felt and whether they indicated feeling “more connected to others”	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%

Indicator	Notes	Assessment Methods	Timing
% of families who indicate it was a <b>“worthwhile use of their time”</b> .	(for the adults) The “worthwhile use of time” concept will be measured based on responses to questions such as how valuable they found the time or the amount of time spent at the institution or whether they might return again.		
% of families who indicate <b>“satisfaction”</b> (a) per cultural organization and (b) overall	The “satisfaction” concept will be measured based on responses to questions such as overall satisfaction with the experience.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
Types of positive versus negative experiences patients & families identify	This indicator will be derived from answers to open-ended questions such as what they liked or wanted improved upon. If some children draw pictures, that can potentially be included as well.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience: Follow-up Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.
Types of reasons adults (parents) identify for participating in & liking the experience.			
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.

### 3. To what extent did participants have an overall positive perception of an arts, culture, or nature experience?

Indicator	Notes	Assessment Methods	Timing
% of families who feel the experience helped them in some way (a) per cultural organization	Being “helped” in some way is measured based on a set of responses being checked like	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%

Indicator	Notes	Assessment Methods	Timing
and (b) overall	whether they “feel healthier” or “tried something new”		
Types of positive versus negative experiences patients & families identify	This indicator will be derived from answers to open-ended questions such as what they liked or wanted improved upon. If some children draw pictures, that can potentially be included as well.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience: Follow-up Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.
Types of reasons adults (parents) identify for participating in & liking the experience.			
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.

#### 4. [Process] What were the greatest successes or challenges in the implementation of CultureRx: Berkshires?

Indicator	Notes	Assessment Methods	Timing
Stories of what worked well or could be improved upon in the various stages of CultureRx: Berkshires implementation [Cultural orgs]	This could be divided into (1) early-stage (Jan-Feb) (2) late-stage (Mar-April)	Successes & challenges in the Implementation of CultureRx: Feedback form	TBD (likely mid-April)
Stories of what worked well or could be improved upon in the various stages of CultureRx: Berkshires implementation [Adrien]	This could be divided into (1) early-stage (Jan-Feb) (2) late-stage (Mar-April)	Successes & challenges in the Implementation of CultureRx: Feedback form	TBD (likely mid-April)
Feedback on what worked well or could be improved upon in CultureRx: Berkshires [Provider/s]		Successes & challenges in the Implementation of CultureRx: Feedback form	TBD (likely mid-April)

Indicator	Notes	Assessment Methods	Timing
Perspectives on the extent to which the Cultural Humility training/s were integrated into work routines [Cultural Orgs]		Successes & challenges in the Implementation of CultureRx: Feedback form	TBD (likely mid-April) [Not part of SOW]
Perspectives on the strength of the collaboration between MACONY & the Cultural orgs [Cultural Orgs & Adrien]		Successes & challenges in the Implementation of CultureRx: Feedback form	
Perspectives on the reimbursement/voucher and/or incentive processes [Cultural Orgs]		Successes & challenges in the Implementation of CultureRx: Feedback form	
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience: Follow-up Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.
Types of reasons adults (parents) identify for participating in & liking the experience.			
Recommendations made by adults (parents)		Immediate Experience Survey & Reflections on the “Social Prescribing” Experience : Follow-up Interview Protocol	
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.

**Introduction:**

There is strong evidence to suggest that cultural engagement has a positive relationship to well-being and health. More specifically, studies have shown that medical patients who participate in programs that connect them to the arts (e.g., music) not only experience a decline in anxiety, depression or social isolation, but also show enhanced physical health, motivation, and sense of purpose (Chatterjee et al., 2018).

Based on this promising literature, the Mass Cultural Council identified 4 priority health issues to be explored through the CultureRx design phase (Springfield) and implementation (Berkshires) pilots.

**Priority Health Issues:**

1. Social Exclusion (loneliness, social isolation)
2. Mental Health (general sense of wellbeing, mood)

3. Racism (diversity, advocacy, stories of intent and impact)
4. Collective Trauma (caregiver burnout, stress and anxiety)

As was understood at the outset of this initiative, creating interventions that adequately address the identified health issues takes time, repeated engagement, shifts in accessibility, understanding, and also, minimal- to -intense institutional mindset change. Still, while positive effects are generally the result of repeated, longer-term cultural engagement and programming, the Berkshires' initiative hypothesizes that even a single visit to a museum or attendance at a theater performance may have some small but important benefit to a participant's emotional state or sense of connection.

The purpose of the CultureRx: Berkshires initiative is to explore whether a one-time cultural engagement intervention may create a positive change in; (1) a participant's immediate emotional state, (2) a sense of belonging, and (3) perception of the arts or cultural programs. The implementation of this initiative also will be studied in order to understand what worked well or could be improved upon in the future.

## Appendix C: Springfield Original Assessment Plan

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### Assessment Methods

#### INSTRUMENT

#### ADMINISTERED TO WHOM?

Experiences with Arts & Culture: Focus Group protocol

Patients at Caring Health

Feasibility of integrating Social Prescribing into health care practice: Discussion Group protocol

Community Health Workers at Caring Health

Experiences with Arts & Culture: Feedback form

Provider/s at Caring Health

Perspectives on integrating Health care populations into Arts & Culture Institutional practice: Interview protocol

Cultural organizations

Other:

- Notes from Advisory board meetings (the Advisory board will be comprised of a wider swath of organizations serving the Springfield community to ensure a multiplicity of stakeholders and voices are involved in this initiative)

Note: Caring Health will be touching base with the Community Music School about having some community-based, cultural event (perhaps at Caring Health or some other space) as this was a component of their grant. No assessment is expected to be involved in this event.

### Guiding Questions<sup>3</sup>

In order to explore how, for whom, and what types of cultural prescribing might work within the Springfield context, the following questions will guide the assessment of CultureRx: Springfield:

1. What is crucial to understand about different groups' sociocultural beliefs about engagement in arts, culture, and how, if at all, do they perceive these fields relating to health?
2. What are the unique characteristics of the Springfield community that might make an implementation of an arts and culture based-intervention successful or challenging?
3. What types of activities or processes need to be in place to make this a scalable, sustainable, and holistic intervention?
4. What types of communications or understandings will help cross-sector partnerships be most effective?

**Group:** Patients of Caring Health (2 groups)

**Mode of data collection:** Experiences with Arts & Culture Focus group

**Main Purpose:** 1) To understand how community members encounter arts and culture personally and how- or if- they associate it with health or healing and (2) To ground any future intervention

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<sup>3</sup> These questions were influenced by Bowen et al.'s (2010) article entitled, "How we design feasibility studies."

plans in the knowledge of the special characteristics and experiences of the Springfield, MA community.

**Timing:** Caring Health will recruit in February. Conduct FG in late February/Early March

#	Question text
1	When you hear the words “culture” or “arts” what comes to your mind? What does it feel/look like?
2	Do you dance, sing, act, draw, or write or perform some other way? Can you tell me about what you do and how you feel about it?
3	Are these activities and experiences with your family? [If applicable] Can you tell me about an activity or experience you used to do like this before you came to the United States? Is there something you do now in the United States like that?
4	How able are you able to get to the types of activities and experiences you want?
5	Have you ever been to a museum? Here in Springfield or somewhere else? [If so] What was it like for you?
6	How do these activities and experiences relate to health for you?*

\* We may need to have some way of defining “health.”

**Group:** Community Health Workers at Caring Health

**Mode of information gathering:** Feasibility of integrating Social Prescribing into health care practice Discussion Group

**Main Purpose:** (1) To understand how providers encounter arts and culture personally and how- or if- they associate it with health or healing, (2) To determine what types of communication or additional events need to take place in order to create authentic and successful collaborations among the partner organizations and, (3) To gain knowledge of how to build these experiences effectively into a community health setting.

**Timing:** Caring health will put this on the agenda/explain about it during a weekly meeting in February and announce a date at the end of February. Conduct FG in Early March. If we only have 30 minutes, the workflow question (indicated by an asterisk) is key.

#	Question text
1	How do the arts and culture relate to health for you [personally]?
2	Right now, what resources for culture and art do you think patients could benefit from most? (e.g., Could you envision a place here for people to come to participate? Or other events or activities in the area?)
3	*What do you think would need to happen in order to make the workflow incorporate arts and culture interventions? (e.g., Could you add something to the Electronic medical record? How would outreach work? How might you decide what type of activity or experience to connect a patient with?)
4	What might collaborations with a local arts or cultural organization be like? Do you anticipate any challenges?

5	What do you hear patients talk about? Is there a common reference – music, singing, dance, stories?
6	Can you provide an example of a patient that seems perfect for this type of intervention/treatment option?

**Group:** Providers

**Mode of information gathering:** Experiences with Arts & Culture Feedback form

**Main Purpose:** (1) To understand how providers encounter arts and culture personally and how- or if- they associate it with health or healing and (2) To gain knowledge of how to build these experiences effectively into a community health setting.

**Timing:** Create in February and keep in open for as many providers to fill out before closing it at the end of March/early April. Ideally, only one question will be “required” of them - how or if they think prescribing an arts intervention might “help them” (and we’ll do a “soft” requirement – so they can move on if they don’t answer).

#	Question text
1	In a few sentences, please tell us how arts and culture relate to health for you [personally]?
2	Do you think prescribing the arts or a cultural experience to some of your patients could help you? [yes/no] If no, why not? If yes, describe in a few sentences what ideally, what would need to happen for this type of intervention to work for you?
3a & 3b	Do you think prescribing the arts or a cultural experience to some of your patients would be helpful to <u>them</u> ? [yes/no] Why or why not?*
	Do you think prescribing the arts or a cultural experience to some of your patients would be helpful to <u>your practice</u> ? [yes/no] Why or why not?*
4	If you have an example of patients talking about music, singing, drama, or dance or some other arts or cultural activity please share it here.
5	If you have an example of a patient that seems perfect for this type of intervention/treatment option, please describe that patient here:
6	[SUGGEST OMITTING] Have you seen the literature on the positive relationship between arts and health? (YES/NO) If YES, what do you think?

\* Social determinants of health can be overwhelming to try and address all the time, so it would be helpful to get a sense if they can envision where arts and culture fit or potentially see it as a stressor (i.e., proclivity or resistance to this type of intervention).

**Group:** Cultural organizations

**Mode of data collection:** Perspectives on integrating Health care populations into Arts & Culture Institutional practice Interview

**Main Purpose:** 1) To understand how providers encounter arts and culture personally and how- or if- they associate it with health or healing, (2) To determine what types of communication or additional events need to take place in order to create authentic and successful collaborations

among the partner organizations and (3) To ground any future intervention plans in the knowledge of the special characteristics and experiences of the Springfield, MA community.

**Timing:** Schedule and conduct through February and March

#	Question text
1	How does arts and culture relate to health for you [personally]?
2	Who do you currently identify as arts and culture stakeholders?
3	Thinking about the Springfield community, are there groups you want to connect with that aren't already connecting with you?
4	[After identifying those groups in Q3] What are your current approaches to attracting these groups?
5	What do you do to ensure that people feel they belong at your organization/institution? What do you do to build trust?
6	What might collaborations with Caring Health or other organizations different than yours be like? Do you anticipate any challenges?
7	Is your organization's physical structure welcoming to all abilities, families, or art seekers?
8	[Post interview] Note a few characteristics of the space.

The CultureRx Springfield team found the research and approach relevant and exciting but decided that key stakeholders needed to be engaged first in order to explore what types of interventions would be meaningful and feasible within the local community context.

### PURPOSE OF THIS PROJECT

CultureRx Springfield will host events such as trainings, advisory group meetings, and convenings, and interview key community, cultural, and health provider stakeholders in order to:

- Explore what terms like “culture” or “the arts” mean to different stakeholders and how- or if- they associate it with health or healing.
- Ensure that the design of any future intervention incorporates a diversity of stakeholders’ opinions and experiences.
- Ground any future intervention plans in the knowledge of the special characteristics and experiences of the greater Springfield, MA community.
- Share any information gleaned about community culture entities with the Springfield Cultural Partnership for their resource database effort.
- Determine what types of communication or additional events need to take place in order to create authentic and successful collaborations among the partner organizations.
- Gain knowledge of how to build these experiences effectively into a community health setting (potentially through both on-site programming for patients and off-site experiences at selected cultural organizations) through the evaluation process.

Information gathered through these efforts will be synthesized into a set of recommendations on how to move forward with implementing a cultural engagement initiative in Springfield.

NOTE: Exploration of what terms like “culture” or “the arts” mean and incorporating a diversity of stakeholders’ opinions and experiences will be an aspect of information gathering for all groups.

## Appendix D: Berkshires Revised Evaluation Plan

### 1. To what extent did the referral criteria and social prescription match?

Indicator	Notes	Assessment Methods	Timing	Changes made 3/14/20
Summary of referral criteria (a) per cultural organization & (b) overall	Criteria = e.g., age group, behavioral health need of the child & family situation	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	Examined RPCE notes for 60 tickets to be distributed prior to week of 3/9/20 (when closures/changes began)
# of prescriptions (i.e., tickets) used (a) per cultural organization and (b) overall	Used = There is a record on the spreadsheet that the child/family participated in an event/experience at a cultural org.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	<b>Unable to examine</b> as < 20 participants were able to use prescriptions before the shutdowns began. There is no way to determine how many more might have attended an event or program if this had not been the case.
# of incentives used (a) per cultural organization and (b) overall	Used = There is a record on the spreadsheet that the incentive was accepted.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	<b>Unable to examine</b> this. Few of the arts & cultural institutions were able to use their incentives. Also, the pilot was not long enough to gain an understanding of how or if these incentives made a difference.
% of patients & families with a positive change in emotional state from experience	This indicator will be derived from answers to questions such as their pre-post retrospective happiness or stress or whether they indicated feeling satisfied.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.
Types of positive versus negative experiences patients & families identify	This indicator will be derived from answers to open-ended questions such as what they liked or wanted improved upon. If some children draw pictures, that can potentially be included as well.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small (n < 13) and analyses are more like hints versus evidence of the experiences.

Indicator	Notes	Assessment Methods	Timing	Changes made 3/14/20
% of families who indicate a “sense of belonging” (a) per cultural organization and (b) overall	(for the adults) The “sense of belonging” concept will be measured based on responses to questions such as how comfortable or welcomed they felt and whether they indicated feeling “more connected to others”	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small (n< 13) and analyses are more like hints versus evidence of change.
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience Follow-up Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.	After shutdown, the Collaborative Care Coordinator had to focus on the crisis. In June, Collaborative Care Coordinator may be able to conduct more interviews. If that happens, analysis will be added in an Addendum document in July.
Types of reasons adults (parents) identify for participating in & liking the experience.				
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	As there was documentation of only 1 family speaking to a representative of an arts or cultural organization, this information was not utilized.
Stories of successes or challenges in making matches.		Successes & challenges in the Implementation of CultureRx: Follow-up interview	Ongoing (beginning in late February)	After shutdown, Collaborative Care Coordinator had to focus on the crisis. In June, Collaborative Care Coordinator may be able to conduct more interviews. If that happens, analysis will be added in an Addendum document in July.
Stories of successes or challenges in the match itself.		Successes & challenges in the Implementation of CultureRx: Feedback form	TBD (likely mid-March & late May)	Organizations filled out a feedback form on 3/9 which was utilized for analyses. Due to the shutdown, no final feedback form was

Indicator	Notes	Assessment Methods	Timing	Changes made 3/14/20
		(cultural orgs)		administered.

\* MACONY will share an anonymized dataset with PHIWM rather than the complete, raw data version of the spreadsheet which contains Personally Identifying Information

**2. To what extent did attendance at an event or experience have its intended positive outcomes on participants as indicated by a; (a) change in emotional state, (b) sense of belonging, (c) worthwhile use of time, and (d) general expression of satisfaction with the prescribed experience?**

Indicator	Notes	Assessment Methods	Timing	Changes made 3/14/20
% of patients & families with a positive <b>change in emotional state</b> from experience	This indicator will be derived from answers to questions such as their pre-post retrospective happiness or stress.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.
% of families who indicate a <b>“sense of belonging”</b> (a) per cultural organization and (b) overall	(for the adults) The “sense of belonging” concept will be measured based on responses to questions such as how comfortable or welcomed they felt and whether they indicated feeling “more connected to others”	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.
% of families who indicate it was a <b>“worthwhile use of their time”</b> .	(for the adults) The “worthwhile use of time” concept will be measured based on responses to questions such as how valuable they found the time or the amount of time spent at the institution or whether they might return again.			After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.
% of families who indicate <b>“satisfaction”</b> (a) per cultural organization and (b) overall	The “satisfaction” concept will be measured based on responses to questions such as overall satisfaction with the experience.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.

Indicator	Notes	Assessment Methods	Timing	Changes made 3/14/20
Types of positive versus negative experiences patients & families identify	This indicator will be derived from answers to open-ended questions such as what they liked or wanted improved upon. If some children draw pictures, that can potentially be included as well.	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.	After shutdown, Collaborative Care Coordinator had to focus on the crisis. In June, Collaborative Care Coordinator may be able to conduct more interviews. If that happens, analysis will be added in an Addendum document in July.
Types of reasons adults (parents) identify for participating in & liking the experience.				
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	Examined RPCE notes for 60 tax able to be distributed prior to week of 3/9/20 (when closures/changes began)

**3. To what extent did participants have an overall positive perception of an arts, culture, or nature experience?**

Indicator	Notes	Assessment Methods	Timing	
% of families who feel the experience helped them in some way (a) per cultural organization and (b) overall	Being “helped” in some way is measured based on a set of responses being checked like whether they “feel healthier” or “tried something new”	Immediate experience survey	Data will be compiled twice (in March & May); Response rate estimate = 50%	After shutdown, data were compiled in March. The number of respondents was small and analyses are more like hints versus evidence of change.
Types of positive versus negative experiences	This indicator will be derived from answers to open-	Immediate experience survey	Data will be compiled twice (in March & May);	After shutdown, data were compiled in March. The number of

Indicator	Notes	Assessment Methods	Timing	
patients & families identify	ended questions such as what they liked or wanted improved upon. If some children draw pictures, that can potentially be included as well.		Response rate estimate = 50%	respondents was small and analyses are more like hints versus evidence of change.
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience Follow-up Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.	After shutdown, Collaborative Care Coordinator had to focus on the crisis. In June, Collaborative Care Coordinator may be able to conduct more interviews. Also, there is now no way of knowing who might have participated or not. If Collaborative Care Coordinator able to conduct the interviews, analysis will be added in an Addendum document in July.
Types of reasons adults (parents) identify for participating in & liking the experience.				
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	Examined RPCE notes for 61 tix able to be distributed prior to week of 3/9/20 (when closures/changes began)

**4. [Process] What were the greatest successes or challenges in the implementation of CultureRx: Berkshires?**

Indicator	Notes	Assessment Methods	Timing	
Stories of what worked well or could be improved upon in the various stages of CultureRx: Berkshires implementation [Cultural orgs]	This could be divided into (1) mid-stage (Feb-Mar) (2) late-stage (April-May)	Successes & challenges in the Implementation of CultureRx: Feedback Form	(1) mid-stage (Feb-Mar) (2) late-stage (April-May)	Organizations filled out a feedback form on 3/9 which was utilized for analyses. Due to the shutdown, no final feedback form was administered.
Stories of what worked well or could be improved upon in the	This could be divided into (1) mid-stage (Feb-	Successes & challenges in the	(1) mid-stage (Feb-Mar) (2) late-stage	MACONY filled out a feedback form on 3/9 which was utilized for

Indicator	Notes	Assessment Methods	Timing	
various stages of CultureRx: Berkshires implementation [MACONY]	Mar) (2) late-stage (April-May)	Implementation of CultureRx: Feedback Form	(April-May)	analyses. Due to the shutdown, no final feedback form was administered.
Perspectives on the strength of the collaboration between MACONY & the Cultural orgs [Cultural Orgs & MACONY]	This could be divided into (1) mid-stage (Feb-Mar) (2) late-stage (April-May)	Successes & challenges in the Implementation of CultureRx: Feedback form		Organizations & MACONY filled out a feedback form on 3/9 which was utilized for analyses. Due to the shutdown, no final feedback form was administered.
Perspectives on the reimbursement/voucher and/or incentive processes [Cultural Orgs]		Successes & challenges in the Implementation of CultureRx: Feedback form	late-stage (April-May)	Unable to examine this. Few of the arts & cultural institutions were able to use their incentives. Also, the pilot was not long enough to gain an understanding of how or if these incentives made a difference.
Types of reasons adults (parents) identify for not – or not yet-participating in experience.	Interviews will be conducted approx. 2 months after prescription given & are not contingent upon whether the prescription has been used yet.	Reflections on the “Social Prescribing” Experience Interview Protocol	Data will be accessible immediately after each interview is conducted, but a final product will be delivered in late April.	After shutdown, Collaborative Care Coordinator had to focus on the crisis. In June, Collaborative Care Coordinator may be able to conduct more interviews. Also, there is now no way of knowing who might have participated or not. If Collaborative Care Coordinator able to conduct the interviews, analysis will be added in an Addendum document in July.
Types of reasons adults (parents) identify for participating in & liking the experience.				
Recommendations made by adults (parents)		Reflections on the “Social Prescribing” Experience Follow-up Interview Protocol		After shutdown, Collaborative Care Coordinator had to focus on the crisis. In June, Collaborative Care Coordinator may be able to conduct more interviews. If Collaborative Care Coordinator able to conduct the interviews, analysis will be added

Indicator	Notes	Assessment Methods	Timing	
				in an Addendum document in July.
Types of anecdotal comments made by patients & families	Both MACONY & cultural orgs. are documenting this information. Given other work demands & administrative burden, if the number of entries is low, this indicator will not be used.	RPCE spreadsheet*	Final spreadsheet will be delivered to PHIWM in April 2020.	As there was documentation of only 1 family speaking to a representative of an arts or cultural organization, this information was not utilized.

## Appendix E: Springfield Revised Assessment Plan

<b>ORIGINAL PLAN</b>	<b>POST MARCH 14th</b>	<b>FINAL STATUS</b>
Administer the “Experiences with Arts & Culture: Focus Group protocol” to two separate groups of Patients at Caring Health	<b>In late April:</b> CH may conduct a FG with Patient Advisory Committee (made of partnership health centers). May be 2 <sup>nd</sup> opportunity: Gathering info from patients about possibility of talking to a diabetes chronic disease class (via video). Ideally still 2 focus groups- 1 in English & 1 in Spanish] <b>In May:</b> Patient groups- trying to transition into zoom platforms. Not an easy transition. Technological challenges.	<b>TBD:</b> Too challenging. Not appropriate to ask patients any additional questions right now. <b>May try in late June/July</b>
Administer the “Feasibility of integrating Social Prescribing into health care practice: Discussion Group protocol” to Community Health Workers and some providers at Caring Health	Adapt the protocol to be thoughtful to current context & administer to Community Health Workers who attend the ACO Direct Care Committee monthly meetings & similar group at Caring Health (Includes nurse care managers, clinical providers, and some CHWs)	Protocol was adapted. ACO discussion group held on 4/23 Caring Health facilitated a discussion group with 18 Caring Health staff including CHWs, Behavioral Health CHWs, LICSW, Navigators, Refugee Health Coordinator, RNs, RN care managers on 5/6
Administer the “Experiences with Arts & Culture: Feedback form” to Providers at Caring Health	With the 2 focus groups conducted above, no longer need to administer this survey.	<b>Design group agreed that we no longer need a survey administered.</b>
Administer the “Perspectives on integrating Health care populations into Arts & Culture Institutional practice: Interview protocol” to Key Informants from Arts and Cultural institutions in Springfield	Protocol was administered – decision was made to ask more people to participate (given the easier mode of phone or video).	By 6/15, Caring Health interviewed 3 more arts and cultural representatives.
N/A	Adapted the “Perspectives on Integrating Health Care...” protocol to be thoughtful to current context & facilitated a discussion group at a monthly Cultural Partnership meeting	Discussion group was held by PHIWM on 4/6
Take notes at Advisory Board meetings & integrate them into final report	(1) Notes taken at Advisory Board meeting 3/25. (2) Advisory Board meeting scheduled on 5/27 when some preliminary findings will be presented & a discussion of further links to be formed btwn arts & health care organizations.	5/27: Had the group read through the themes- PHIWM facilitated conversation: asked what stands out to them, what is problematic, what needs additional information/work

# Appendix F: Berkshires' Instruments

## Immediate Experience survey (Child version)

[Note: the font on the printed version of both of these surveys and card stock size is bigger than it appears here.]

<p> <b>Mass Cultural Council</b></p> <p>Please circle how you feel...</p> <p><b>BEFORE</b> you came here today, how did you feel?</p> <p></p> <p><b>RIGHT NOW</b>, how do you feel?</p> <p></p> <p><b>OVERALL</b>, my time here today was...</p> <p></p> <p>What did you like about it?</p> <p>What didn't you like about it?</p> <p>Thank you for giving us your opinion.</p> <p>Feel free to draw on the other side!</p>	<p> <b>Mass Cultural Council</b></p> <p><u>Before coming here... How did you feel?</u></p> <p><u>Draw it out!</u></p> <p><u>How do you feel now?</u></p>
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**Immediate Experience survey (Adult/Teen version)**



We appreciate you completing this survey (front and back).  
It should take less than 5 minutes to complete.

**OVERALL, I was satisfied with my experience today.**

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**BEFORE** I came here today, I felt:

Not at all happy	A little happy	Somewhat happy	Very happy	Extremely happy
<input type="radio"/>				

**NOW**, after being here, I feel:

Not at all happy	A little happy	Somewhat happy	Very happy	Extremely happy
<input type="radio"/>				

**BEFORE** I came here today, I felt:

Extremely stressed	Very stressed	Somewhat stressed	A little stressed	Not at all stressed
<input type="radio"/>				

**NOW**, after being here, I feel:

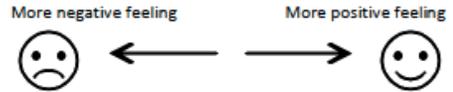
Extremely stressed	Very stressed	Somewhat stressed	A little stressed	Not at all stressed
<input type="radio"/>				

This experience today helped me to ...  
(pick any that apply)

- feel healthier
- feel more connected to others
- feel more positive about where I live
- learn about culture
- try something new

Is there anything you did here today that you really liked a lot?

Is there anything that you think we could do better?



Did you feel welcomed by the staff?

Not at all	A little	Somewhat	Very	Extremely
<input type="radio"/>				

Do you feel comfortable here?

Not at all	A little	Somewhat	Very	Extremely
<input type="radio"/>				

Did you feel this was a valuable way to spend your time?

Not at all	A little	Somewhat	Very	Extremely
<input type="radio"/>				

The amount of time I spent here was:

Not enough	Just right	Too much
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever been here before?

No	Not sure	Yes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If YES, have you come here as...

- Part of a school group
- A family
- Other \_\_\_\_\_

Would you like to come here again?

No	Not sure	Yes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If you have any more feedback for us, please write it here:**



**NOTE: The last page of this document provides some examples to help you answer the questions. Feel free to use them or not.**

**MACONY first began providing tickets on January 9<sup>th</sup>, 2020.**

**1. Since about that time, what are your organization's proudest accomplishments in relationship to this initiative? Feel free to write about more than one accomplishment.**

[BOX WAS BIGGER IN THE VERSION SENT TO ORGANIZATIONS]

**2. Since about that time, what has worked really well for your organization in relationship to this initiative? Feel free to write about more than one success.**

[BOX WAS BIGGER IN THE VERSION SENT TO ORGANIZATIONS]

**3. Since about that time, what has been most challenging for your organization in relationship to this initiative? Feel free to write about more than one challenge.**

[BOX WAS BIGGER IN THE VERSION SENT TO ORGANIZATIONS]

**4. Looking towards the future, what one or two pieces of advice would you give to improve the initiative (to MCC, other organizations, medical practices, or even state funders)?**

[BOX WAS BIGGER IN THE VERSION SENT TO ORGANIZATIONS]

**5. Free form. Use this space to relate any other stories or opinions (or even a drawing) you'd like to share.**

[BOX WAS BIGGER IN THE VERSION SENT TO ORGANIZATIONS]

## **EXAMPLES**

**1. Since about that time, what are your organization's proudest accomplishments in relationship to this initiative? Feel free to write about more than one accomplishment.**

EXAMPLES OF POSSIBLE TOPICS TO DISCUSS:

- How your organization incorporated this initiative into your existing processes.
- What your organization did to prepare for families (e.g., to visit, to receive tickets).
- The flyers you prepared for MACONY.
- A memorable experience with one participating family.
- Feedback you received from a family (e.g., when receiving a ticket or after an experience).
- An experience you had in a Cultural Humility training which changed the way you interacted at work.

**2. Since about that time, what has worked really well for your organization in relationship to this initiative? Feel free to write about more than one success.**

EXAMPLES OF POSSIBLE TOPICS TO DISCUSS:

- The timing of the initiative.
- The implementation of the initiative (e.g., the incorporation of this initiative into your existing processes or the welcoming process).
- The communication flow of the initiative.
- The collaboration between MACONY and the organizations involved.
- The enthusiasm of families.

**3. Since about that time, what has been most challenging for your organization in relationship to this initiative? Feel free to write about more than one challenge.**

EXAMPLES OF POSSIBLE TOPICS TO DISCUSS:

- The timing of the initiative.
- The implementation of the initiative (e.g., the incorporation of this initiative into your existing processes or the welcoming process).
- The communication flow of the initiative.
- The collaboration between MACONY and the organizations involved.
- The lack of enthusiasm of families.

**4. Looking towards the future, what one or two pieces of advice would you give to improve the initiative (to MCC, other organizations, medical practices, or even state funders)?**

EXAMPLES OF POSSIBLE TOPICS TO DISCUSS:

- What would have been helpful to know at the outset of your participation?
- What might work better for an organization like yours?
- What did you wish you were able to do more of?
- What suggestions do you have for doing anything differently bureaucratically (e.g., reimbursements)?

## ***Reflections on the “Social Prescribing” Experience: Follow-up Interview protocol***

[Note: This document was created with google forms. The format looks slightly different here. Also, the adapted interview is presented as only a few follow-ups were able to be conducted prior to the advent of COVID-19 and the closing of all arts and cultural organizations.]

### **Follow-up Interview**

Introduction: Hi. I realize it may have been a while since we spoke about this so I understand if you may have forgotten a bit about it. Back in early winter, I gave you \_\_ [#] tickets to go with \_\_ [name of child/ren] to a \_\_ [event/activity/place]. As mentioned at the time, I wanted to follow-up with you about it for two reasons:

- First, to see if you were able to go and what that was like, and
- Second, even if you didn't get a chance to go, to get a bit of feedback and advice from you.

That was then . . .

Who could have known that a pandemic would change our world so much in such a quick amount of time?

[FREE FORM IN CASE THEY HAVE SOMETHING THEY WANT TO SAY ABOUT COVID-19, HOW IT'S BEEN FOR THEM OR THEIR FAMILY, ETC.]

Honestly, I feel that it is as worthwhile as ever to talk with you. If you got a chance to go- I'll learn more about what you liked or not about it. If you didn't get to go, now feels like a good time to think about how we can make experiences like this better and more appealing to you in the future. Our arts and culture community partners are really committed to shaping the types of programming and activities they provide around what you want or would be most excited about.

I know that you are busy and that your time is very valuable. This interview is not meant to take more than 15-20 minutes. I only have a few questions.

I'd really like to talk with you in particular, because your take on this will be unique and special. No one else can really tell me about what your experience is like except you. Also, whatever you tell me today will be super helpful in improving this program. We really do need your expertise!

Whatever you say to me, please be reassured that your name (or child's name) will not be attached to any findings.

### **Any questions before we begin?**

**A. [ENTER] Family pseudonym / Family number \* \_\_\_\_\_**

**B. [ENTER] Who are you talking with ?**

- Mother
- Father
- Grandparent
- Foster Parent
- Other:

## **DID THE FAMILY ATTEND THE EVENT?**

1. It's been a few months since I gave you the ticket to \_\_\_\_ [event, activity, place]. Before everything shut down, did you have a chance to go?

- YES
- NOT YET

[If they want to comment] Please explain

## **YES: FAMILY ATTENDED**

3. Do you remember liking the experience? What stood out? Do you remember how you felt?

4. Do you remember not liking anything about the experience? What didn't go well? Do you remember how you felt?

## **YES OR NOT YET: IDEAS OR ADVICE FROM RESPONDENT**

5. We're curious, are there any arts-type activities that your family is doing right now? [If necessary] For example, does your child like to draw? Are you watching dance competition shows? singing?

- YES
- NO

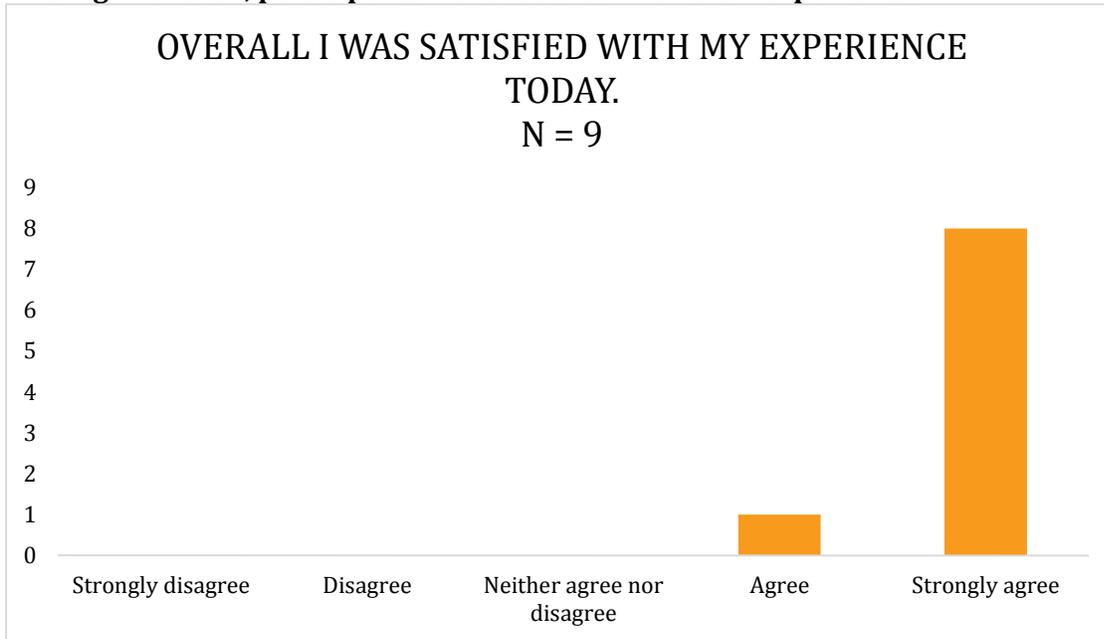
6. [If yes] Please share a story of what you or your child are doing and what that's like.

7. Depending on timing and availability, this year we were able to offer tickets to art museums, Audubon (nature trails), specialty art classes, and children's theater performances. We really want to do this type of program again. What advice would you give us?

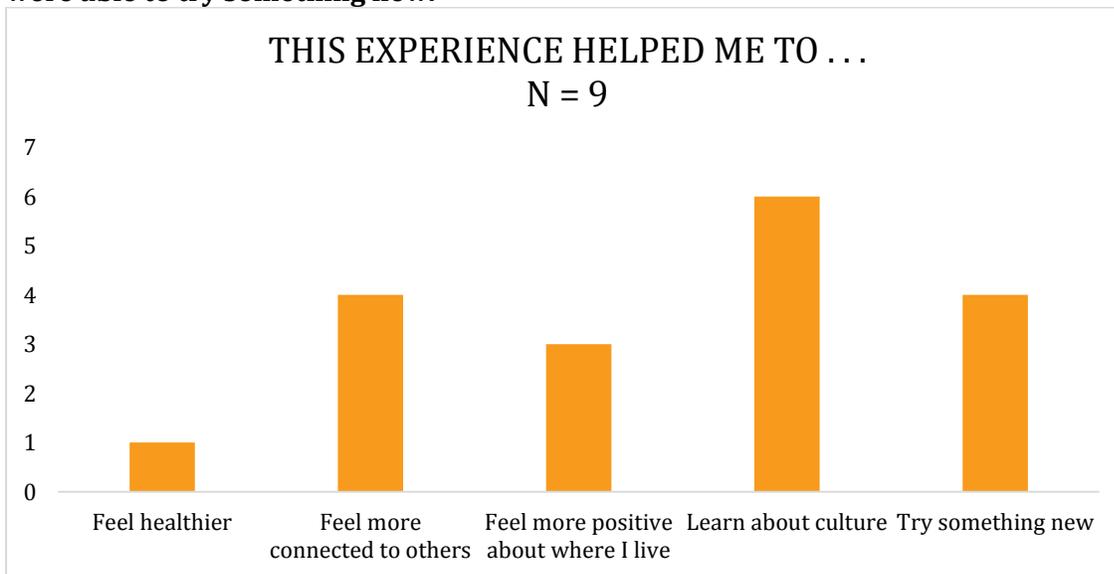
8. [Additional space just in case]

## Appendix G: Immediate Experience Survey Findings

**Finding 1: Overall, participants were satisfied with their experiences.**

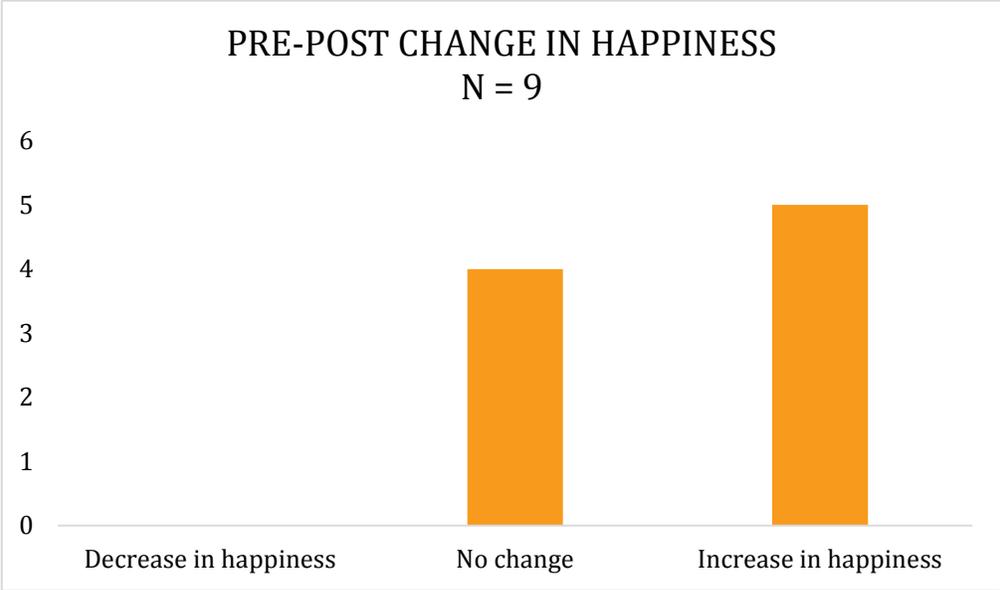


**Finding 2: Two-thirds of participants reported their experience helped them to learn more about culture, with close to 45% also reporting that they felt more connected to others and were able to try something new.**

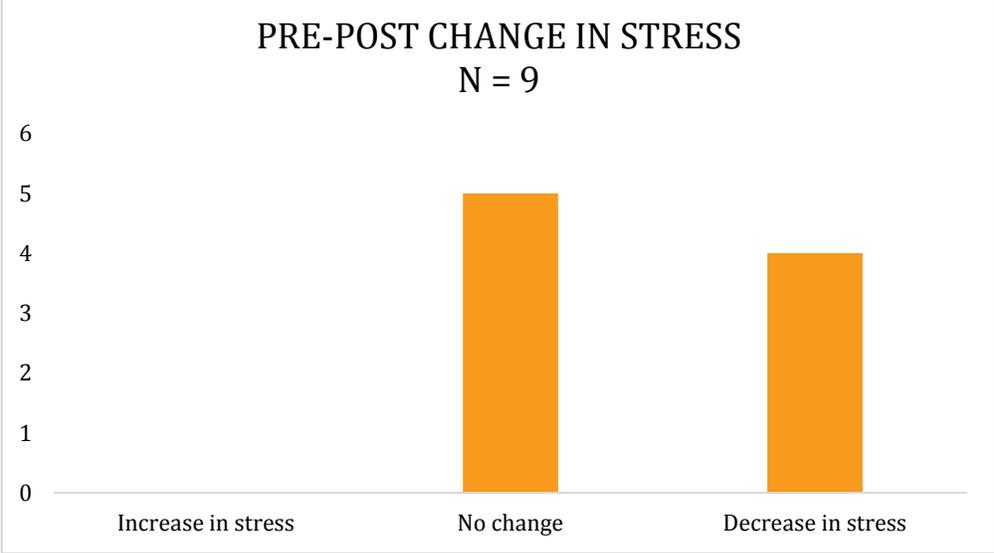


Interestingly, 4 of the 6 participants who reported the experience helping them to learn about culture" also reported feeling more connected to others.

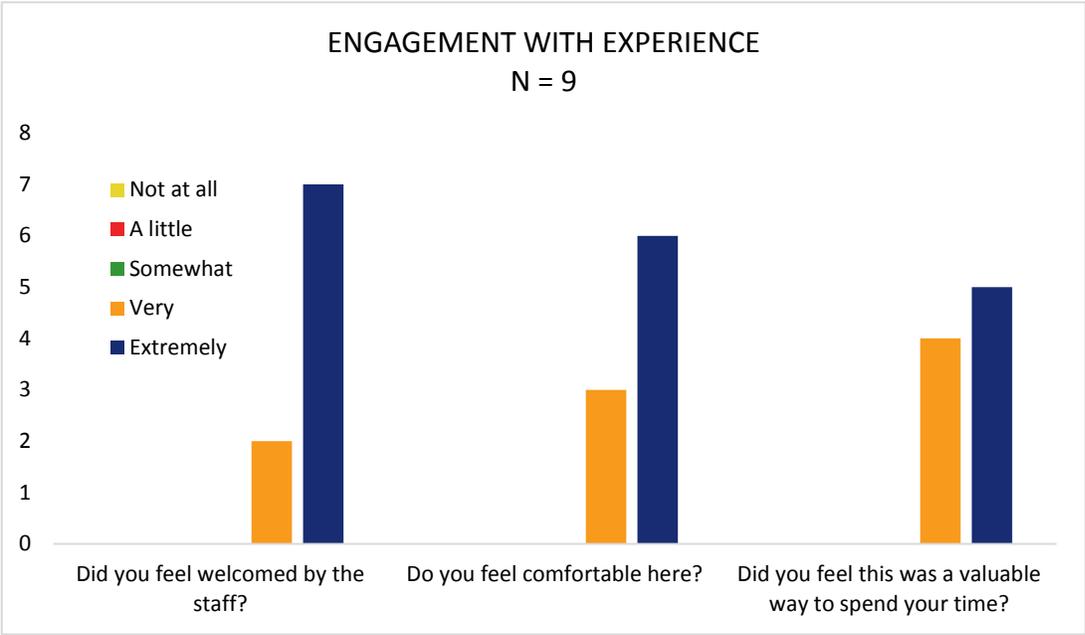
**Finding 3: After participating in a cultural experience, over half (55%) of participants reported an increase in their level of happiness as compared to before they attended.**



**Finding 4: After participating in a cultural experience, close to half (44%) of participants reported a decrease in their level of stress compared to before they attended.**

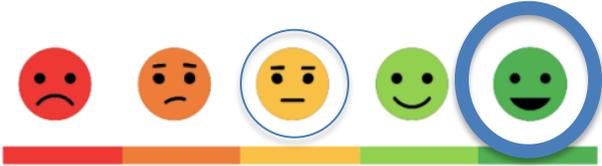


**Finding 5: Participants seemed to be engaged with their experiences as evidenced by positive ratings of being welcomed, comfort, and the value of the experience overall.**



**Finding 6: 8 of 9 respondents stated that they would like to participate in the experience again (1 was unsure).**

**Finding 7: Of the 5 surveys from children, 4 circled a “big smile” in response to the question about the experience overall (1 was neutral).**



## Appendix H: Cultural Humility Trainings Summary & Impact

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This appendix was prepared by Sandra Bonnici, Independent DEAI Consultant.

### **Cultural Humility Trainings Summary and Impact**

Two half-day trainings were developed and delivered by DEAI consultant, Sandra Bonnici (sandrabonnici65@gmail.com).

#### **Summary:**

In looking at the initial findings and reflections of the CultureRx pilot's cultural humility trainings, participants felt that the trainings provided cross-agency sharing, collaboration, and cohort building amongst the cultural organizations. The trainings also helped reframe and inspire organizations to review the sense of welcome and inclusion within their institutions and address barriers for marginalized and minoritized communities, who were also the focus of the culture prescriptions.

#### **Cultural Humility Trainings: Longing to Belong**

**Cultural humility** is a term coined by Melanie Tervalon and Jann Murray-Garcia in 1998 to describe a way of incorporating multiculturalism into their work as healthcare professionals. The concepts of Cultural Humility include a lifelong commitment to learning and critical self-reflection with the desire to fix power imbalances in the provider-client dynamic. This requires Institutional accountability and mutual respectful partnership based on trust. The Cultural Humility trainings for the CultureRx pilot participants focused on understanding how, through the examination of one's own beliefs and cultural identities, one can gain a greater insight into unconscious bias and build one's stamina for sitting with feelings of discomfort. Participants explored concepts, techniques, and best practices for creating a welcoming, inclusive experience for all visitors and especially those experiencing poverty and/or social isolation. Participants also explored and brainstormed strategies to mitigate barriers and build more equitable and inclusive norms and practices.

All participants were given a toolkit of activities, definitions, resources for reducing barriers so they could co-create with their communities more inclusive and welcoming experiences in their institutions.

### **Participant Feedback**

**When participants of the Culture Humility workshops were surveyed, they revealed two consistent benefits from the trainings for all organizations.**

**1. The opportunity to work and learn as a cohort while building cross-agency collaborations:**

- *“Some great language resources; strong cross-agency collaboration and conversations”*
- *“Many institutions are experiencing the problem of continued relevance in our evolving society.”*
- *“The comradery formed amongst colleagues in facing all of our challenges. Big takeaway was that we are all in this work together and should rely on each other more often.”*

**2. The emphasis on engaging more deeply in community conversations and co-creation:**

- *“Ask more questions - do more listening. We can't determine the barriers without asking what the barriers are.”*
- *“Talk and listen, dialog with community”*
- *“How much conversation is needed with communities”*
- *“The CultureRx training solidified the importance of clear communication with our community and the families that we work with.”*

**Additional steps that organizations were looking to take or more deeply reflect upon as a result of the trainings:**

- *“The cultural humility training reinforced our way of thinking in terms of treating every patron with respect and dignity. It had always been an unofficial policy and guideline for our staff during each interaction, and with the cultural humility training, it gave us the tools to make it a more formal policy.”*
- *“We are adding family labels and additional labels in Spanish.”*
- *“We have worked to create an environment where everyone feels welcomed and seen, introducing practices that ensure that all new visitors feel welcomed across every dimension of our organization. These have included changes to our website and to written pieces such as invitations, brochures, and programs...new training for staff and volunteers about how to welcome and direct new participants...”*
- *“Our team is presenting to staff this Thursday! We'll make changes at the admission desk and with membership to eliminate poverty shaming.”*
- *“How to set stage for a deeper relationship beyond one experience. Will we offer a membership after CultureRx visits? What conditions will we create to encourage multiple visits and to become a cultural home?”*

## Looking Ahead:

All participants valued the work and asked for additional opportunities to strategically plan and collaborate on inclusive and equitable strategies. The pilot program combined with the Cultural Humility trainings has laid the groundwork for continued growth and exploration. The Covid 19 crisis shuttered all organizations and many switched to online content as best they could, As two pandemics continue to unfold, Covid-19 and Systemic Racism and Inequity, the work of cultural institutions to engage in anti-racism to become centers of connection and healing for their full communities will be paramount both in the current virtual situations and the eventual reopening. The need for rebuilding with equity will be a priority. Continued support from MCC and practitioners in DEAI from all sectors will help organizations to engage and center the voices of marginalized and minoritized communities in order to become relevant, sustainable, and reflective of their community.

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## Resources Developed by Sandra Bonnici used in the Cultural Humility Trainings

### Common Definitions

**Cultural Humility** is a lifelong commitment to learning and critical self-reflection: Desire to fix power imbalances in provider-client dynamic; and Institutional accountability and mutual respectful partnership based on trust.

**Cultural Competence** is a process of lifelong learning. It results in knowledge, skills, behaviors, and attitudes that allow us to work effectively with others from different cultural backgrounds, increases the ability of organizations to maximize the benefits of diversity within their workforces, and improves the services we offer to our various stakeholders.

**Culture** refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

**Diversity** encompasses all those differences that make us unique, including but not limited to race, color, ethnicity, language, nationality, sexual orientation, religion, gender, socio-economic status, age, and physical and mental ability. A diverse group, community or organization is one in which a variety of social and cultural characteristics exist.

**Inclusion** denotes an environment where each individual member of a diverse group feels valued, is able to fully develop his or her potential and contributes to the organization's success.

**Equity** is fair and just inclusion into a society in which all, including all racial and ethnic groups, can participate, prosper, and reach their full potential. Equity gives all people a just and fair shot in life despite historic patterns of racial and economic exclusion.

**Poverty Shaming** is shame felt *internally* by those in poverty which is imposed upon them *externally* through victim blaming and tropes of indolence by those who are not poor.

**Definitions developed by Sandra Bonnici**

**Access** means I know where the front door is, and I can get to it and through it.

**Diversity** means I see myself reflected and respected in the organization.

**Equity** means there are systems in place that help me succeed despite historic exclusion and/or oppression.

**Inclusion** means I have a meaningful voice in the organization.

## **REFLECTION and STRATEGY BUILDING ACTIVITY and GUIDING QUESTIONS**

### **COMMON BARRIERS to PARTICIPATION IN CULTURAL ORGANIZATIONS IN ORDER OF STRENGTH OF BARRIER**

Hold these questions front of mind as you work through the barriers

- *What strategies are in place that deepen this barrier?*
- *What strategies can we co-create to help mitigate?*
- *What strategies are already in place that can be built upon?*

#### **1. Not seeing yourself, your family, or your values reflected in the staff, activities, or values of the organization**

This may be the strongest and most persistent barrier. It is one that our field has been putting effort and energy into and continues to grapple with. It is not enough to say we will diversify our staff; we must be willing to transform the culture of our institutions into inclusive places to work, visit, and champion. In the end, all of us resource with our time and energy the things we value.

#### **Guiding questions and reflections:**

- *Whose voices and experiences are we centering?*
- *Whose are we leaving out?*
- *Who is harmed by our policies and practices, and who is helped?*
- *How are programs reflecting our community's depth and richness beyond food, flags, and festivals?*
- *How are we listening to and engaging with our community? Can we go deeper?*
- *How are we incorporating the values and voices of our community into our exhibits, programs, policies, and practices?*

## **2. Being in spaces with unstated behavior and/or learning expectations rooted in dominant culture**

### **Guiding questions and reflections:**

- *Are the guiding principles and behavioral expectations for learning in your organization reflective of a multicultural perspective, or do they only reflect the dominant culture?*
- *What are ways we can learn to welcome multiple styles of learning and behavior?*
- *Who can we collaborate and co-create with to deepen our understanding and practice?*
- *Are we thinking about what the experience could be instead of "should" be?*

## **3. Having to share low-income status (aka poverty shaming)**

Throughout our field there have been great strides in making visits to our institutions affordable, and most initiatives are income-based or tied to public assistance. But many families who would qualify for these programs still choose not to use them, for fear of having to disclose this information in front of their children or being treated differently for it. Having to prove low-income status with documentation undermines the impact of these programs.

### **Field Example:**

Madison Children’s Museum removed the documentation requirement for its low-cost access memberships, which resulted in increased sign-ups and visits without any reduction in the other membership levels. There was also an increase in donations and grant funds to support the program. These goals were realized through deep community engagement and listening, as well as the courage to ask if standard practice creates additional barriers.

***Guiding questions and reflections:***

- *How might programs that make the experience affordable and inclusive actually be creating a barrier to participation?*
- *Have we created opportunities for deep listening from agencies and participants on how these programs are working?*
- *How do we talk about the programs with visitors? With staff? With donors?*
- *Do we ask for proof of low-income status for discounted admission/membership?*
- *How might a belief in program abuse be creating more barriers or a culture of judgment?*

**4. Not speaking the primary language used by the museum**

Having to navigate interactions as a limited English speaker narrows the amount of places individuals and families will go. Often, they will choose places that have significant staffing, visitation, and engagement in their native languages instead.

***Guiding questions and reflections:***

- *What strategies, policies, and procedures are in place in your museum that address multilingual communication, such as staff and volunteer expertise, multilingual signage, interpretation, and translations for print and online materials?*
- *Have you sought out an assessment of how many languages are spoken in your community?*
- *Who can you partner with to increase staff/volunteer presence and support in multiple languages?*

## 5. Not having physical or cognitive needs met

The wide array of different physical and cognitive abilities offers an opportunity to work with agencies to assess the needs of the community and adapt exhibits and experiences within our organization to meet them. ADA compliance is not full inclusion or accessibility.

### Guiding questions and reflections:

- *Who are partners that we can collaborate and co-create with to increase accessibility and inclusion?*
- *Have we built partnerships with our city and county's office of civil rights/disability rights to provide training, support, and advice on exhibit and program accessibility?*
- *How can we apply a design thinking approach to create better experiences for everyone by addressing the specific challenges faced by people with disabilities?*
- *Have we assessed whether exhibits, programs, websites, and staffing are inclusive? Who can help us examine this?*

## 6. Not having time to visit

Our most valuable and finite resource is time. The pressures on modern families who are working multiple jobs, juggling competing activities and schedules, running single-parent households, or living in crisis and poverty severely limit the time to devote to visiting and engaging in cultural experiences.

### Guiding questions and reflections:

- *How well do we understand the demands on time that all families face, and the extra time cost for marginalized and minoritized communities?*
- *What activities, events, and outreach programs are in place to address this and help expand engagement?*
- *How are we making decisions about hours of operation?*
- *Are we offering expanded events beyond regular hours?*
- *What are our field trip options?*

- *How can we engage community employers in creating opportunities within the workday to participate and visit?*

## **7. Not being able to afford the cost of visiting and transportation**

The price of a visit can be prohibitive, even when organizations offer low-cost admissions, because of the added costs for food, parking, and transportation.

### **Guiding questions and reflections:**

- *How do people get to our institutions?*
- *Is mass transit an option in your community? Is it convenient?*
- *How is this issue compounded for those without cars in areas where it is considered essential to have one?*
- *Do we allow visitors to bring their own food?*
- *How far away is the closest parking? Is there accessible and convenient parking for people with limited mobility and families with little ones?*

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