WHITTIER STREET HEALTH CENTER

Comprehensive. Compassionate. Community.

Whittier's Boston Health Equity Program

FY 2022 to FY 2026

The mission of Whittier Street Health Center (WSHC) is to serve as a center of excellence that provides high quality, and accessible health care and social services that achieve health equity, social justice, and the economic well-being of our diverse populations.

The people we serve:

Most of the people we serve are low-income, minority residents of Roxbury, Dorchester, Mattapan and Boston's South End.

84%	Of Whittier patients have been diagnosed with at least one of the following conditions: diabetes, hypertension, cancer, asthma or obesity
17%	Have been diagnosed with two or more of those conditions
82%	Have psychosocial issues
91%	Live at or below 200% of the poverty level
81%	Live in public housing
36%	Adults are uninsured

Health Equity: a Strategic Priority

With effective population health management through our Boston Health Equity Program (BHEP), Roxbury and other urban core neighborhoods in Boston will become among the healthiest urban communities in the nation:

- **We will improve key health indicators** of those we serve to better than national averages
- **We will eliminate health disparities** associated with race, ethnicity, environment and income in communities that have had a heavy burden of health problems
- **We will influence broad adoption of a new model of care** that produces far better health results at less cost than the current health care system.

A Care Management Program for These Times

- BHEP is a system of care designed to **promote wellness in the Boston community and beyond**. It integrates community outreach with health education, prevention of illnesses, and chronic disease management.

- In essence, the plan is geared toward achieving the Centers for Medicare and Medicaid's (CMS) Triple Aim: **better patient care**; **improved population health**; and **reduced healthcare costs**.

A Care Management Program for These Times (Cont'd)

- In order to meet these goals, BHEP employs a **risk stratification** tool adopted from the *University of Massachusetts Medical School*: Three levels of patient care and support are identified, based on point-scoring of selected markers, severity of conditions, and social determinants of health.

- These levels of care (risk levels) serve as guide to the care teams, in developing **care plans tailored to individual patient needs**: As patients engage in better self-management and achieve their goals, they are gradually moved to a lower level of care.

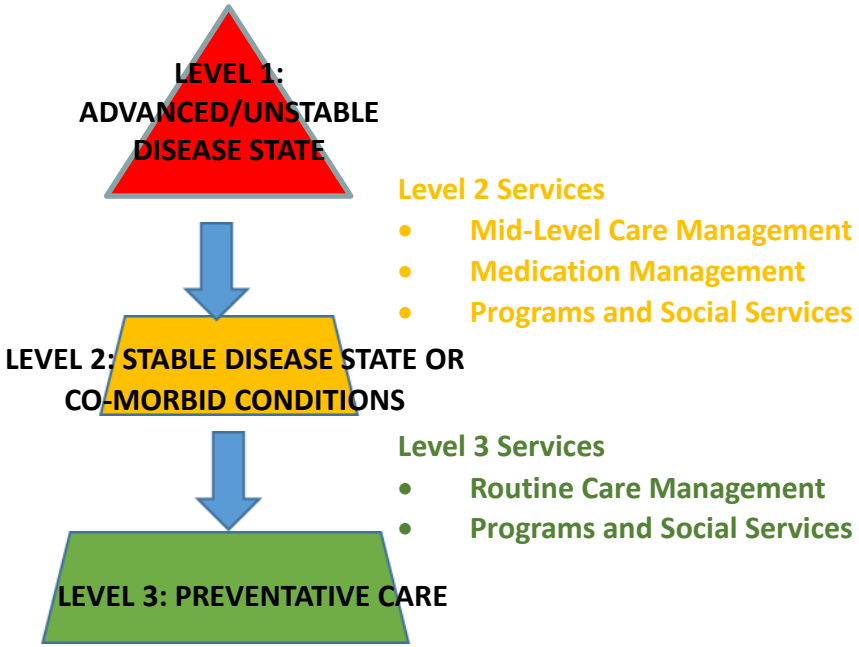
Sample from Our *Risk Stratification Matrix*

A1c Score	**Age Group**	**Result**	**Score**
	Adult (≥18)	<7.5	0
		7.5 - 9.4	1
		≥9.5	2
BP	**Age Group**	**Result**	**Score**
	18+	<140/90	0
		140-160/90-100	1
		>160/100	2
PHQ-9 Score	**Age Group**	**Result**	**Score**
	18+	< 15	0
		15-20	1
		> 20	2
ER Use	**Age Group**	**Result**	**Score**
	18+	0-1/year	0
		2-3/year	1
		4-5/year	2
		6-7/year	3
		8-9/year	4
		≥10/year	5

BHEP: Levels of Care

Level 1 Services

- **Specialty Care**
- **High Risk Care Management**
- **Medication Management**
- **Programs and Social Services**

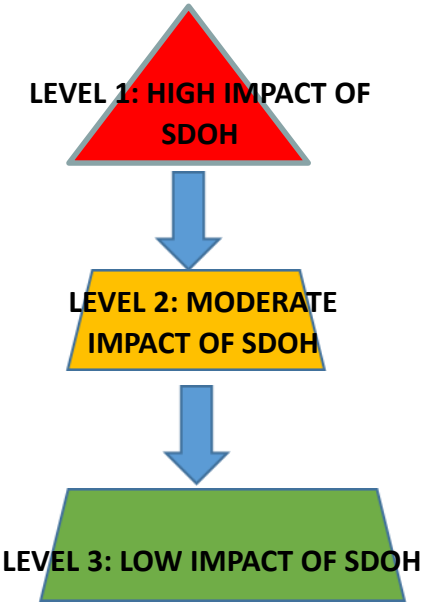


Level 2 Services

- Mid-Level Care Management
- Medication Management
- Programs and Social Services

Level 3 Services

- Routine Care Management
- Programs and Social Services



BOSTON HEALTH EQUITY PROGRAM (BHEP) 2022-2026

Whittier Street Health Center (WSHC) is at the forefront of changing the health care delivery system from expensive and episodic to proactive, wellness and prevention focused, and more cost effective. The Boston Health Equity Program (BHEP), launched in 2012, integrates community outreach, wellness support, care management and coordination. The program outlines the necessary services needed to address health care for people with chronic illness and the barriers affecting health outcomes.

This innovative health care model stratifies patients according to the severity of their conditions, in conjunction with Social Determinants of Health (SDOH), and provides services accordingly. BHEP is data-driven and has a comprehensive list of outcome measures that include cardio vascular health, metabolic and infectious disease management, prevention (screening) rates and others.

Comprehensive. Compassionate. Community.

Championing Equitable Access to High Quality Health Care

Roxbury and other urban core neighborhoods in Boston will become among the healthiest urban communities in the nation.

- We will improve key health indicators for the patient population served, surpassing national averages
- We will eliminate health disparities associated with race, ethnicity, environment, and income in communities that have had a heavy burden of health problems

PEDIATRIC & ADOLESCENT PATIENTS AT WSHC — PERCENTAGE%

Indicators	End of 2026 Goal
Patients under age 6 with Well Visits	100%
Patients over 6 with Well Visits	85%
Patients with BMI Screening and Nutritional Counseling	100%
Obese/Overweight Patients with Care Plans	100%
Reduce portion of Patients aged 2-17 considered obese	36%
Depression Screening and Follow-up Plan	100%
Depression Remission (PHQ-9<5)	100%
Patients between ages 6-9 with Dental Sealants	60%
Tobacco Screening and Cessation Plan	100%
Asthma Medication Ratio	100%
Routine Eye Screening	100%
Childhood Immunization Counseling (0-18)	100%
Fluoride Varnish (1-18)	100%
Hearing Screening (2-18)	100%

ADULT PATIENTS AT WSHC — PERCENTAGE%

Indicators	End of 2026 Goal
Patients with Physical Exam	85%
Patients with BMI Screening and Nutritional Counseling	100%
Obese/Overweight with Care Plan	100%
Depression Screening and Follow-up Plan	100%
Depression Remission after 12 Months (PHQ 9<5)	100%
Hepatitis C (HCV) Screening (18-79)	100%
Patients with HCV Linked to Care	100%
HIV Screening	100%
Patients with HIV Linked to Care	85%
HIV Positive and Undetectable Viral Load	100%
HIV Positive with with CD4 Count above 200	100%
Screening for Hypertension	100%
Controlled Hypertension (under 139/89)	100%
Screening for Diabetes	17%
Uncontrolled Diabetes (A1C>9)	100%
Breast Cancer Screening (40-75)	100%
Cervical Cancer Screening (21-64)	87%
Colorectcal Cancer Screening (50-75)	100%
Tobacco Screening and Cessation Plan	100%
Appropriate Asthma Medication Ratio (16-64)	100%
Prostate Cancer Screening (40-69)	85%
Diabetic Eye Exam	75%
Glaucoma Screening	100%
Routine Eye Screening	6.7%
Low Birth Weight	

COMMUNITY

Indicators	End of 2026 Goal
Total Number of Enrolled Patients	40,000

HEALTH SYSTEM

Indicators	End of 2026 Goal
2-day Follow-up after ER Visits	100%
Annual %Reduction in Frequency of ER Visits by High-Risk Patients	25%
2-Day Follow-up Post-Hospitalization	100%
Documented Demographics Information	100%
Sexual Orientation & Gender Identity (SOGI) Screening	100%
Social Determinants of Health (SDOH) Screening	100%
Reduce Number of Annual Hospitalizations for High-Risk Patients to	<2

BHEP: Levels of Care

The Pathway To Success

By addressing non-medical social determinants of health

By helping children and adults sustain behaviors that promote good health…

By identifying and addressing health problems at early stages…

By controlling and reducing the incidence of chronic health problems…

By providing intensive help to people with advanced disease, complex conditions and difficult psychosocial challenges…

We will create a culture of wellness and reduce the incidence of chronic and serious illness in the communities we serve.

We will improve quality of life and prevent health crises that require hospitalization and ER use.

The pathway is supported by a model of care that…

Addresses many factors that affect health, such as family and income stresses, challenging living conditions, and unhealthy behaviors.

Takes responsibility for the condition of the whole person: *physical*, *mental*, *social*. Ensures that patients are partners in their own health and well being.

Is readily accessible – part of patients' and residents' daily lives and embedded in the fabric of the community.

Measures performance and health improvements.

The Model Of Care:

Comprehensive Care

- **Primary care** that integrates medical care, mental health care and social supports
- **Emphasis on prevention and wellness** to avoid health crises and alleviate chronic conditions
- **Patient navigation and care coordination** to ensure effective use of health services and proper specialty care

Health Engagement

- **Outreach,** to enroll residents in health care home, help with appointments and assist compliance
- **Screening,** to detect health problems at an early stage
- **Health education and assistance** in properly using primary care and urgent care
- **Care coordination,** for sustained patient engagement in care
- **Risk stratification,** for tailored, needs-based care planning

Public Health

- **Identify and address larger-scale community needs**: economic, environmental, educational, social, nutritional, behavioral
- **Track and measure** health impact
- **Partner** with broad array of community organizations and schools

Wellness Support

- **Wellness programming** fully integrated with primary care, tailored to individual needs and buttressed by ongoing support to ensure patient compliance and self-management

Noteworthy Features: Community

- Health Ambassadors: peer support
- Community-based screening for cancer, cardiovascular problems, depression/stress, diabetes
- Health guidance and visit scheduling conducted in community sites
- Formal partnerships with public housing developments to provide extensive health support to residents
- Targeted health and social support for high-risk groups, including returning former inmates
- Men's Health programming a major emphasis
- Community health education

Noteworthy Features: All Patients

- Integrated primary care teams: physicians, pharmacist, dietician, diabetes educator, case managers, patient navigators, support staff
- Wellness Center: physical fitness, community garden, life coaching, nutrition management and other services to help with clinical and self-management of health
- Urgent Care Center: immediate access; reduce unnecessary ER use
- Partnership with Dana-Farber Cancer Institute and other health and social service providers: fully integrating specialized medical care with wellness, psychosocial support and primary care
- Case management of patients requiring hospitalization: improves outcomes and prevents crises requiring readmission
- Electronic Medical Records and information systems: support care coordination, measure performance and health outcomes
- Streamlined testing: reduces number of required visits

Noteworthy Features: Youth

- Maternal and child health care for healthy births and early childhood development
- Youth fitness and development programs
- Family nutrition guidance and support
- School partnerships to integrate health education into K-12 curriculum; school-based health clinic planned
- Intensive support for youth at high risk for trauma or committing violence

A Backward Approach:

Determinants of Health	Health Expenditures
10% of health is related to access to care	80% of health care spending focuses on access to care
20% is related to genetics	
20% is related to the influence of environment	
50% is related to healthy behavior	4% focuses on healthy behavior and 8% on other purposes

According to the New England Healthcare Institute, nearly 90% of all personal health care expenditures in the U.S. are for direct care.

This, despite the fact that behavioral and environmental factors play a major role in determining our health.

The status quo is unsustainable and there is an urgent search for answers. We can provide them.

We are seeking influential partners

- **To invest** in the Model of Care so that it can be highly effective.
  - Near-term investments can have major long-term beneficial impact.
- **To advocate** for policies that support the Model of Care so that it can be sustained.
  - Only a small percentage of costs associated with the model are covered through current health care funding streams.
  - Some current payment policies create barriers to care.
- **To encourage broad adoption** of the Model of Care .
  - The model is well-suited to advancing the twin goals of improving health while reducing health care costs.