BOSTON HEALTH EQUITY PROGRAM (BHEP) 2026-2031

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.

COMMUNITY

Indicators	End of 2031 Goal
Total Number	40,000

Comprehensive. Compassionate. Community.

Championing Health Equity and 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 2031 Goal
Patients under age 6 with Well Visits	100%
Patients over 6 with Well Visits	85%
Patients with BMI Screening and Nutritional Counseling	75%
Obese/Overweight Patients with Care Plans	75%
Reduce portion of Patients aged 2-18 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 (5-18)	100%
Routine Eye Screening	75%
Childhood Immunization Counseling (0-18)	100%
Fluoride Varnish (1-18)	100%
Hearing Screening (2-18)	100%

ADULT PATIENTS AT WSHC **PERCENTAGE%**

Indicators	End of 2031 Goal
Patients with Physical Exam	85%
Patients with BMI Screening and Nutritional Counseling	75%
Obese/Overweight with Care Plan	75%
Depression Screening and Follow-up Plan	100%
Depression Remission after 12 Months (PHQ 9<5)	100%
Hepatitis C (HCV) Screening (18-79)	75%
Patients with HCV Linked to Care	100%
HIV Screening	100%
Patients with HIV Linked to Care	100%
HIV Positive and Undetectable Viral Load	85%
HIV Positive with with CD4 Count above 200	100%
Screening for Hypertension	100%
Controlled Hypertension (under 140/90)	100%
Screening for Diabetes	100%
Uncontrolled Diabetes (A1C>9)	17%
Breast Cancer Screening (40-75)	80%
Colorectcal Cancer Screening (45-75)	100%
Tobacco Screening and Cessation Plan	87%
Asthma Medication Ratio (19-64)	100%
Prostate Cancer Screening (40-69)	100%
Diabetic Eye Exam	75%
Glaucoma Screening	75%
Routine Eye Screening	75%

MATERNAL WELLNESS **PERCENTAGE%**

Indicators	End of 2031 Goal
Cervical Cancer Screening	100%
Early Entry into Prenatal Care	85%
Post-Partum Visit Attendance within 7-84 days	85%
Post-Partum Depression Screening	100%
Low Birth Weight	7%

HEALTH SYSTEM **PERCENTAGE%**

Indicators	End of 2031 Goal
7-day Follow-up after ER Visits	100%
Annual %Reduction in Frequency of ER Visits by High-Risk Patients	25%
7-Day Follow-up Post-Hospitalization	100%
Documented Demographics Information	100%
Social Determinants of Health (SDOH) Screening	100%
Reduce Number of Annual Hospitalizations for High-Risk Patients to	<2

BHEP: LEVELS OF CARE