AFFILIATED HEALTH CENTERS

Throughout the Greater Boston area, 20 community health centers are connected with Partners through affiliation agreements or by operating under the licenses of Partners hospitals. This chapter describes the history, services, accomplishments, and community socioeconomic and health status of each of the 14 affiliated health centers. **The five community health centers operating under the licenses of Brigham and Women's Hospital and Massachusetts General Hospital, and the North End Health Center, which operates under its own license but has a unique affiliation agreement with MGH, are discussed within the separate chapters for those hospitals**.

An Overview of Community Health Centers in Massachusetts

History

Massachusetts' commitment to community health centers dates back some 40 years to President Lyndon Johnson's War on Poverty. In 1965, Senator Edward M. Kennedy's vision, steadfast leadership, and deep compassion for the poor led to landmark legislation that created community health centers. Geiger-Gibson Community Health Center in Dorchester was founded as one of the first two health centers in the nation.

Massachusetts Community Health Centers

According to the Massachusetts League of Community Health Centers (the Mass. League), each year, 52 Massachusetts community health centers in 184 locations provide high quality, cost effective care close to home for some 760,000 children and adults, teenagers and senior citizens. These non-profit community-based organizations provide comprehensive primary care for adults, pediatrics, specialty care, mental health care, dental health, and social services to individuals and families. Massachusetts community health centers now serve one out of every nine people in the Commonwealth, including low income people who are uninsured or underinsured, people with private health insurance, or people with publicly funded insurance (MassHealth, Commonwealth Care, Health Safety Net or Medicare).

Community health center patients represent all ages, incomes, races, and ethnicities, but 64 percent belong to an ethnic, racial or linguistic minority group. Because health centers serve the community, they often have multilingual staff and/or interpreters available on request to ensure quality service to minority populations. Health centers across the state provide 39 different translation services including: Spanish, Haitian, Creole, Portuguese, Vietnamese, Cantonese, Swahili, Tamil, Thai, Russian, Urdu, Farsi, Arabic, Portuguese-Creole, and others.

Community Health Center Services

Community health centers promote good health through prevention, education, outreach, and social services. Their services are comprehensive and, across the centers, include:

Pediatrics	Adult Medicine	Family Medicine
Obstetrics	Gynecology	Laboratory Services
Dental Care	Mental Health Care	Social Services
Dermatology	Podiatry	Acupuncture
Elder Services	Family Planning	Specialty Referrals
Home Care	Nutrition/WIC	Pharmacy Services
Public Health Programs	School Based Services	Smoking Cessation & Prevention
Substance Abuse	Immunizations	Speech & Language Pathology
Optometry	Internal Medicine	Behavioral Health Services

Cost-Effective Health Care Close to Home

According to the Mass. League, national studies indicate that every dollar invested in community health centers provides an average savings of three dollars to the overall health care system. Comprehensive case management, 340B ("best price") pharmacy programs, and comprehensive chronic disease management are other examples of health center preventive care models which help minimize emergency department visits and prevent hospitalizations among low-income patients. Based on a recent study by the health center-based HMO, Neighborhood Health Plan (NHP), patients served by community health centers had fewer hospital admissions, hospital days, and emergency department visits than did NHP patients who received their health care from hospital-based primary care.

An Economic Engine for Neighborhoods

Community health centers provide a source of stable employment for local residents, generating direct economic output, household income, and employment to neighborhood residents. In some cases, health centers have played a significant role in revitalizing business districts in which they are located, and have been key players in efforts to strengthen all aspects of community. In addition, health centers provide job training, career building, and even educational programs for their community residents.

Community Health Centers in Greater Boston

Boston is home to more than two-dozen community health centers. The majority are licensed by or affiliated with the City's academic medical centers, including Boston Medical Center, Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Massachusetts General Hospital, New England Medical Center, and St. Elizabeth's Hospital. Others are independently licensed and operated.

Today, health centers in Greater Boston are on the front lines of the effort to improve the health of underserved children and adults:

- **Preventing cancer deaths.** Thousands of uninsured women receive free mammograms and Pap tests annually.
- **Improving the health of children.** From childhood immunizations to nutrition programs like WIC, to help managing asthma, health centers provide a full range of programs to improve the health of kids.
- **Addressing infant mortality and low birth weight.** Low income pregnant women who may be homeless, uninsured, or at risk of domestic violence receive comprehensive support services for themselves and their infants including: prenatal and perinatal care, housing advocacy, nutrition, and domestic violence support services.
- **Adolescent health.** A number of community health centers operate primary care clinics in schools. These clinics enable students, especially teenagers, to have confidential care when and where they need it.
- **Job training and community employment resources.**
- **Substance abuse prevention and treatment services** including tobacco, alcohol, and other drugs.
- **HIV/AIDS prevention and education.**

Community Health Centers and Partners

Partners founding hospitals, Massachusetts General Hospital (MGH) and Brigham and Women's Hospital (BWH) have a long commitment to community health centers. MGH's licensed community health center in Charlestown was founded in 1968, and BWH's Brookside Community Health Center began in 1970. Today, there are six licensed health centers operating within the overall Partners system: three of which operate through the license of MGH in Charlestown, Chelsea, and Revere; one of which operates under its own license in the North End; and two of which operate under the license of BWH in Jamaica Plain -- Brookside and Southern Jamaica Plain. Nearly 76,000 children and adults made almost 415,000 visits to these health centers in 2008. In addition, Partners has affiliation arrangements with 14 community health centers in Dorchester, East Boston, Jamaica Plain, Lynn, Mattapan, Peabody, Roxbury, Salem, South Boston, and the South End. Since 1996, Partners and its hospitals have invested almost $60 million to rebuild, relocate, or modernize aging facilities. Annually, nearly $50 million in funding strengthens community health centers.

Partners and its hospitals have made a concerted effort to improve access to care for community health center patients, helping health centers move from cramped, outdated buildings to modern facilities with updated computer information systems and medical technology. Physicians and nurse midwives from BWH provide clinical care at affiliated community health centers in Dorchester, Mattapan, Roxbury, and the South End. MGH oncologists provide treatment for breast and cervical cancer patients from Chelsea, Dorchester, Jamaica Plain, and Mattapan. North Shore Medical Center cardiologists provide treatment for patients in Lynn. Health centers have or are working toward establishing connectivity with Partners information systems so clinical information can be electronically accessed at the health center. Other health centers collaborate with Partners hospitals on public health initiatives, including cancer screening and treatment for uninsured and low income women (the Avon MGH Breast Care Program; hunger screening (in collaboration with Project Bread); and substance abuse prevention and treatment (with the MA DPH and the U.S. Dept. of Justice.). Over time, Partners relationships with each of these health centers have uniquely evolved to provide the most responsive support possible.

Health centers are vital to public safety in the event of bio-terrorism, a bird flu epidemic, or a bad flu season, in preventing emergency department overcrowding. From public health to cost-effective care in the right place – community health centers are indispensable to the health of our community.

Health Reform

Massachusetts community health centers are on the front lines of implementing the state's landmark health insurance reform law, and health centers have been deeply involved in policy advocacy on a range of issues from insurance coverage to Medicaid reimbursement to immigration policy. Partners is working closely with the Massachusetts League of Community Health Centers and other policy advocates to ensure that health reform works for everyone and that newly insured patients have access to primary care close to home. Toward that end, Partners, the Mass. League, Bank of America, and the Commonwealth of Massachusetts have collaborated to develop an education loan repayment plan to expand the state's supply of primary care physicians at community health centers. Since 2007, 82 primary care providers have agreed to work in a community health center for up to three years in exchange for loan repayment. The Mass. League estimates that adding these providers has created capacity to provide care to 144,000 patients at community health centers.

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Codman Square Health Center
Dorchester House Multi-Service Center
DotWell

Codman Square Health Center At a Glance		*Dorchester House Multi-Service Center At a Glance*	
Year Founded	***1979***	***Year Founded***	***1887***
Community Served	***Dorchester/Mattapan***	***Community Served***	***Dorchester***
Number of Patients	***19,000***	***Number of Patients***	***23,000***
Patients Profile:		***Patients Profile:***	
Black	***80%***	***Black***	***30%***
Latino	***7%***	***Latino***	***13%***
Other	***13%***	***White***	***22%***
		Asian/Pacific Islander	***29%***
		Other	***6%***

Working together through the management service organization called DotWell, Bill Walczak, the CEO of Codman Square and Joel Abrams, the CEO of Dorchester House, lead a team that works to provide high quality health care in state-of-the-art facilities and to leverage the health care system to move an economic development agenda for the Dorchester community.

Bill Walczak says:

The Codman Square Health Center's location at 637 Washington Street in Dorchester was once an abandoned nursing home. At the time the health center moved to the Codman Square neighborhood, crime rates were high, property values had collapsed, and many buildings were looted and burned to the ground. Over time, Codman Square Health Center has acquired several neighborhood buildings including the Great Hall.

We are living out the belief that health centers are key to community development and that community redevelopment is key to improving the health of people who live here.

As part of its effort to enhance economic opportunity for the Codman Square community, the health center has moved into the educational arena. The health center co-founded Codman Academy Charter School, which, in addition to being located within the health center, has also developed plans to both teach the students to become outreach workers in the community, and also to prepare them for higher education in health professions (all graduates since the school started have been accepted to four year colleges).

Joel Abrams says:

Dorchester House was the first Reach Out and Read site, and is a robust center of youth programming. The health centers work with the community to create a vehicle for broader social change. Our health centers have recognized the changing needs of the communities we serve and have responded by hiring multilingual and multicultural staff, and by creating programs and services to meet the medical and social needs of our patients. It would have been very difficult to accomplish in the past eight years what we have without the support of Partners and Brigham and Women's Hospital.

Dorchester House Multi-Service Center – A Settlement House Tradition

In 1887, Dorchester House Multi-Service Center, then known as Gordon House, was a settlement house in the Fields Corner neighborhood of Dorchester. Started by Jane Addams in Chicago, settlement houses were established in many cities with large immigrant populations and operated as charitable organizations. All were welcome to take advantage of the settlement houses' recreational, cultural, and educational activities. Settlement houses also created economic opportunities, provided childcare, and a network of support among participants.

The Health Center Evolution in Boston

In 1966, Dorchester House became a member agency of the Federated Dorchester Neighborhood Houses. A health committee – a group of young mothers called the Determined People of Dorchester -- was part of the federation. These women were interested in expanding health care services and creating recreation programs for youth. During this same time, Andrew Sackett, the Commissioner of the Department of Health and Hospitals for the City of Boston, developed a districting plan by which hospitals would assume responsibility for providing health care in designated geographic areas throughout the city. As a result, Boston City Hospital took responsibility for working with Dorchester House, to expand primary care services to the neighborhood. In 1969, primary care services included pediatrics, OB/GYN, and adult medicine, and were offered in a trailer next to a triple-decker house at 1345 Dorchester Avenue. Over the years, Dorchester House expanded services to include family planning, nutrition, mental health, social services, adolescent health, and recreational programs.

In 1974, Dorchester House moved into a new facility at 1353 Dorchester Avenue that was built on a lot next to the building they had occupied since the 1940s. Dorchester House was renamed Dorchester House Multi-Service Center, and became known affectionately as Dot House. The demand for health services was so great that in 1978, Dot House added a second floor, which allowed it to expand its medical, mental health, and dental services. In 2002, Dot House completed a two-year renovation project and added more services, including mammography, expanded eye care, and again expanded dental services. Since then other services have been added including physical therapy and a 340B pharmacy. Joel Abrams has been the Chief Executive Officer since 1986.

The philosophy that guides facility development at Dorchester House is that its consumers deserve to receive services in physical environments that rival or exceed those found in more affluent communities, just as they deserve care from the most qualified and dedicated professionals and support staff. This philosophy is found throughout the organization from the health care services to the gym and swimming pool, which continue to offer the kinds of services to our youth and families that the original settlement house envisioned.

History of Codman Square Health Center

Between 1950 and 1980, the demography of the Boston neighborhood of Dorchester changed dramatically as many white middle-class residents moved to the suburbs, and were replaced with a poorer, more racially diverse population. During this time, Codman Square was experiencing an intense period of violence. Local groups began to emerge to address the situation and realized that as the neighborhood demography had changed, so had the pattern of health care delivery. Of the physicians practicing in the area, many were aging and the remainder had moved to the suburbs.

Local social activists proposed the creation of the Codman Square Health Center (CSHC) not only to provide health care, but also as an act of community empowerment. The health center opened its doors in 1979 in the basement of an old Boston Public Library branch. The staff was limited—three doctors and two dentists—but the goals were not. As co-founder and CEO, Bill Walczak asserted in his Dedication Day speech in 1979: "Our community will continue to meet the challenges that remain before us."

Today, the center has over 280 employees and 93,000 patient visits a year. The health center and its programs have expanded to occupy almost three football fields in space, but it has remained committed to its roots — as a visionary promoter of health in the community. It is a simple mission, upheld at the CSHC through programming that is both *responsive* to the changing needs of the community and *engaging* through its many partnerships.

Two issues have emerged as special priorities: access to health insurance and chronic disease management. The CSHC is working to ease the transition to the health insurance mandate system by uniting the uninsured with the resources they need. The health center is also adapting to the growing challenge of chronic disease, most recently through a partnership with Healthworks for Women to build a 9,000 sq. ft. fitness and nutrition facility. The Codman Square Health Center continues to meet evolving challenges, while maintaining its focus on promoting a "culture of health" in its community.

DotWell – Two Health Centers Find Opportunities to Improve Services for Patients by Consolidating Management

In 1996, as a result of anticipated changes in health care financing, Codman Square and Dorchester House developed a management service organization now called DotWell. Financial support came from several sources, including Partners. DotWell is a formalized collaborative effort of its two founding organizations: Codman Square Health Center and the Dorchester House Multi-Service Center. The mission of DotWell is to guarantee high-quality clinical and community services across both sites – addressing health disparities, meeting the complex needs of a changing Dorchester community, and building social capital in and across neighborhoods.

DotWell allows the two health centers to share the cost and operations of key infrastructure improvements such as Information Technology, Quality Improvement and

Compliance, Finance, and Development. It supports cross-site clinical innovation, including diabetes and asthma case management, breast health initiatives, and public health programs and quality improvements. By joining their efforts and sharing management expertise, the health centers are able to make a larger impact with their programs, serve more people, and more easily attract grant funding.

Services Provided

With a combined annual operating budget of $40 million and more than 500 employees, the two health centers and their DotWell partnership benefit 45,000 community members who use the services of Codman Square and Dorchester House, resulting in 200,000 visits annually from 42,000 patients, and more than 50,000 social and educational service visits from 3,000 other community residents.

With 200,000 square feet of commercial space, the two health centers have proven to be an economic engine for Dorchester. Non-clinical services have brought jobs and opportunity to neighborhood residents through classes in Civic Health, a Technology Center, tax clinics, food pantries, youth services, a fitness center, and recreation in the pool and gymnasium.

Dorchester House – A Broad Array of Health and Wellness Programs

Dorchester House serves more than 23,000 patients who average 110,000 visits each year. In addition to traditional primary and specialty health care services, the health center offers Speech and Language Pathology, Acupuncture, and a broad array of health and wellness programs for children, families, and teens. The health center is fortunate to have a community pool on-site and operates an award-winning swimming program for children with asthma.

Codman Square – Health Care and Education for the Local Community And Beyond

Codman Square serves over 19,000 patients who average 93,000 visits per year. Three out of four patients' family incomes fall below the federal poverty level. In addition to offering a full range of clinical services, as part of its commitment to expand economic opportunity in Boston, Codman Square Health Center co-founded and supports Codman Academy, a charter school with 120 high school students, located within the campus of the health center. The educational reach extends to South Africa, where DotWell operates a community technology center connected by video link to Codman Academy. All of Codman Academy Charter School graduates have been accepted to four-year colleges. The health center also is the site for adult education, youth development and entrepreneurship programs, and is building a fitness and nutrition center.

Public Health Priorities and Accomplishments

From Managing Diabetes to Providing Internet Access

The greatest health priority at both health centers is chronic disease management. In April 2006, DotWell received a five year grant from the Smith Family Foundation to support a Diabetes Initiative aimed at improving the care provided to the over 2,000 diabetic patients at Codman Square and Dorchester House. The program includes: ensuring patients receive annual screenings (eye, comprehensive foot exam, microalbuminuria, and depression), helping patients with self-management of their disease, exercise, and healthy cooking. Among diabetes patients enrolled in this initiative, hemoglobin A1Cs have decreased and are approaching the national goal. Further, self-management of diabetes has improved among participants, and cardiac risk has been reduced with medication management, keeping LDL (bad cholesterol) levels in the healthy range, and by exceeding the national goal in the management of blood pressure.

Other public health priorities include HIV, asthma, fitness, violence, the environment, health professions education and substance abuse. A health-screening component has been added to all youth programming. DotWell collaborates with Catholic Charities and the Dorchester Youth Collaborative in an effort called Safe City, targeting some of the most dangerous areas of the Dorchester community with youth services. DotWell collaborates with, and is the headquarters for the Washington-Talbot Weed and Seed Coalition, in addition to other anti-crime/violence efforts, which include an email system to alert residents of one neighborhood about crime trends there. In addition, DotWell has created a community group called the Environmental Health Coalition and, as part of this coalition, a youth program called Bold Teens trains and supports teens to do community outreach and political work on environmental issues. Overall, this ambitious and broad-based community health agenda includes the development of free or low-cost “wifi hot zones” to provide Internet access to the neighborhood.

Relationship with Partners and BWH

Partners works with Codman Square and Dorchester House on several public health performance objectives, including:

- improving pap smear and mammography rates among low income women in the community
- improving follow-up care for women with abnormal mammograms
- treatment of hypertension for patients with diabetes
- screening for tobacco use; tobacco treatment and cessation

In addition to an ongoing OB/GYN arrangement with BWH, where nurse midwives provide care within the health centers, MGH physician residents have designed and implemented community health projects at Codman Square Health Center’s Urgent Care Clinics.

Codman Square Health Center collaborates with the PACT program, a community-based project designed to improve health outcomes for underserved individuals with HIV. PACT (Prevention and Access to Care and Treatment) is a joint project of Brigham and Women's Hospital and Partners in Health at Harvard Medical School, and has offices in Codman Square.

Partners has helped support Safe City's summer youth programming. Safe City is a collaboration of community organizations and faith-based partners serving the youth of Dorchester. Formed in 2002, Safe City is comprised of three non-profit organizations in Dorchester: Catholic Charities, Dorchester Youth Collaborative, and DotWell. The collaborative provides developmentally appropriate programming in response to the needs of the young people of Dorchester, from the most at risk (outreach, mentoring, academic assistance) to those already engaging in risky behavior (crisis intervention, anger management). Activities include sports, field trips, academic tutoring and support, and social support that will keep young people out of harm's way by building self-esteem, mutual respect, and positive connections to the community.

The funding Partners provided to Codman Square and Dorchester House was critical to building state-of-the-art facilities that exist today. Partners funding also helped begin and sustain DotWell.

East Boston Neighborhood Health Center

East Boston Neighborhood Health Center At a Glance	
Year Founded	***1970***
Community Served	***East Boston***
Number of Patients	***60,000***
Patients Profile:	
Latino	***42%***
White	***35%***
Other/Unknown	***20%***
Black	***2%***
Asian	***1%***

Dr. James Taylor, President and Chief Medical Officer at East Boston Neighborhood Health Center, has been at the health center since it opened in 1970, serving as its Chief Medical Officer much of that time. He says:

During the late 1800s, when East Boston and Boston were connected only by ferry, residents of East Boston relied on a Relief Station for vital health care services. The Relief Station offered first aid and nursing services through medical residents and nurses from Boston City Hospital (BCH). Services included public health nursing, well-baby services, and public health dental services provided at the George Robert White Building.

In 1902, the Massachusetts Bay Transportation Authority (MBTA) opened a trolley tunnel and connected East Boston to the rest of the city (a car tunnel was not completed until 1939). East Boston became a neighborhood of Italian immigrants who built the MBTA tunnel and then settled in the community.

In the late 1960s, there was a primary care shortage in East Boston and as a result, most residents relied on hospital emergency departments for their health care. In East Boston, the number of primary care doctors dropped from 44 to 13, and of those 13 doctors, all but one were over 60 years of age. In an area geographically isolated from greater Boston, local residents were spending two hours traveling by public transportation to get medical care. Residents were living with untreated conditions, pregnant women did not have access to early prenatal care, and important health screenings were unavailable. A community group formed to address this critical need for local health care services.

History

As a result of strong advocacy from Dr. James Taylor and East Boston community residents, the City of Boston's Department of Health and Hospitals began plans to develop a comprehensive health center in East Boston. In 1970, the East Boston Neighborhood Health Center (EBNHC) officially opened as a licensed health center of Boston City Hospital, and began providing pediatric and adult medical services to the community. In the early 1970s, EBNHC completed two door-to-door epidemiological

studies and interviewed every East Boston household. These studies were critically important in determining the health concerns and needs of the community.

EBNHC is one of the few health centers in the nation to provide 24-hour care. In 1978, EBNHC moved to a new facility at 10 Gove Street, and since then has experienced dramatic growth in primary care and specialty services.

A Long Tradition of Serving the Elderly

In 1972, the mother of the local monsignor had a stroke and was admitted to a nursing home. Based on his mother's experience, the monsignor advocated for EBNHC to start a home care program. Through a grant from a private foundation and support from the Boston Visiting Nurses Association (VNA), EBNHC started a home care program.

During the 1980s Medicare reduced reimbursement for home care, a situation which forced East Boston to examine creative new ways to provide care to elderly members of the community. The health center took a new approach and became one of two health centers nationwide to provide a Program of All-Inclusive Care for the Elderly (PACE), which became a model for other health centers in Boston. In 1990, EBNHC began offering another elder service plan called Senior Care Options (SCO), which is a partnership between MassHealth and Medicare that provides a complete package of health care and social services for low-income seniors. Today, the health center provides services to 530 elders through its PACE and Senior Care Options program.

Throughout its history and as the community has changed, key leaders of East Boston Neighborhood Health Center have remained the same. The health center's first Chief Executive Officer, Tim Rogers (now COO), recruited Jack Cradock, the current President and CEO, who has been at the health center since 1978, and James Taylor, MD, remains EBNHC's Chief Medical Officer.

Services Provided

EBNHC is the largest health center in New England and among the largest community health centers in the country. During the past two decades, EBNHC has grown to care for 60,000 patients who generate 330,000 patient visits per year. The health center cares for a large number of uninsured and undocumented patients.

Public Health Priorities and Accomplishments

Access to primary care for patients continues to be a fundamental goal for EBNHC. At EBNHC, it is a priority to meet the needs of the diverse community. Support staff are required to be bilingual in English and Spanish and all bilingual staff are trained to be certified medical interpreters.

Infectious Disease, Obesity, and Chronic Diseases

In response to high rates of infectious disease, such as tuberculosis and hepatitis A, as well as recent outbreaks of rubella and measles in East Boston, EBNHC is working to increase awareness and surveillance of infectious disease in the community.

Obesity is a major health issue in the Latino population served by EBNHC. Through its electronic medical record system, East Boston has created a registry of 4,000 children with an elevated Body Mass Index (BMI). The health center is collaborating with the YMCA on the "Let's Get Movin" program, which has 250 children as participants. Through the program, EBNHC is working to provide more activities for youth, make local school menus healthier, and raise awareness of obesity risks at an early age. Plans are underway to expand these efforts to address obesity in pregnant women and teenagers.

The health center provides extensive services to help patients manage chronic diseases including diabetes, hypertension, high cholesterol, asthma, and depression. Group and individual teaching visits are offered, and care managers closely monitor patients, resulting in better outcomes for patients.

Developing a Workforce for the Future

EBNHC is investing in its employees (more than half of whom live in East Boston) and the community through one of its newest endeavors – the Education and Training Institute. The federal government has provided support for the Institute. It establishes career ladders for the health center's professionals and administrators, and provides the education and training needed for individual growth and advancement. Both employees and the community win; community members learn new skills to obtain jobs in health care and create a source of qualified staff to meet EBNHC's needs.

Relationship with Partners and MGH

Although EBNHC's primary hospital affiliation is with Boston Medical Center, Partners, MGH, and EBNHC work together to serve the needs of the residents of East Boston. Financial support from Partners and MGH enabled EBNHC to double the size of its facility at 10 Gove Street. The health center then worked to improve urgent care operations to better serve as an access point for primary and specialty care for community residents.

Improvements in urgent care included the addition of cardiac treatment rooms, safe rooms for psychiatric patients, suture rooms, and negative pressure rooms for community infectious diseases. Today there are 39,500 urgent care visits per year. A substantial number of these visits would otherwise occur at emergency departments at local hospitals.

Electronic Medical Records System

In 1998, with support from Partners and MGH, EBNHC implemented an electronic medical record system that integrates patient care, registration, scheduling, and billing. Using the new electronic medical record system, health center providers can track patient services across sites of care. EBNHC clinicians also have view-only access to the Longitudinal Medical Record (LMR) at MGH, so that clinicians at MGH and EBNHC who share patients can now share their complete medical records electronically.

Harbor Health Services, Inc.

Neponset Health Center
Geiger-Gibson Community Health Center
Elder Service Plan of Harbor Health

Harbor Health Services, Inc. At a Glance	
Year Founded	*1965*
Community Served	*North Dorchester, South Dorchester, South Boston*
Number of Patients	*24,806*
Patients Profile:	
Black	*14%*
Latino	*10%*
Asian	*14%*
Other	*62%*

The first health center in the nation was founded in Boston's Dorchester neighborhood in 1965 as part of President Lyndon Johnson's War on Poverty. Drs. H. Jack Geiger and Count Gibson, for whom the health center is named, were pioneers in community health practice and untiring advocates for civil and human rights. Over 40 years ago, they founded the nation's first health centers in Mound Bayou, Mississippi and Boston, Massachusetts under the auspices of Tufts University School of Medicine, Department of Community Medicine.

In addition to Geiger-Gibson Community Health Center, HHSI operates Neponset Health Center, the Mid-Upper Cape Community Health Center in Hyannis, the Ellen Jones Community Dental Center in Harwich, as well as, a day care center, WIC programs, and a PACE program for very frail elders.

Dan Driscoll, CEO of HHSI since 1977, says the organization has evolved from "a single community health center to an innovative and entrepreneurial public health organization that constantly seeks new, financially viable and sustainable ways to improve services for a growing patient population."

History

The community health center movement began on Boston's Columbia Point in 1965, with a $1 million grant from the U.S. Office of Economic Opportunity as part of President Lyndon B. Johnson's "War on Poverty." The health center was located in the Columbia Point housing development in Dorchester. Until that time, low income, predominantly Black residents of Columbia Point traveled far from their homes to downtown clinics and hospitals for routine or emergency medical care. Until 1985, Columbia Point remained a freestanding health center.

In 1970, a group of women from the Port Norfolk section of Dorchester were concerned about the lack of access to pediatric care for children in their community. At that time

there were few doctors practicing in the area, and the outpatient hospital department was three bus transfers away. The efforts of these women and other community members led to the creation of the Neponset Health Center. The Neponset Health Center opened in a storefront on 383 Neponset Avenue and was staffed by a volunteer doctor and nurse from Carney Hospital. Adult and pediatric medicine were offered. The Neponset Health Center expanded three times in its storefront location before it eventually outgrew the space and moved to its present location at 398 Neponset Avenue in 1977. The health center received one of the last federal Hill-Burton grants for its new location.

Geiger and Neponset Merge

In December 1984, the Geiger-Gibson Community Health Center was in jeopardy of losing its federal funding during a time when Columbia Point was experiencing a difficult period of racial tension and violent crime. Neponset health center leaders were committed to maintaining a strong legacy of a community health center at Columbia Point, so the health centers entered a three-month trial merger. Their work together restored financial stability to both health centers and resulted in the creation of Harbor Health Services, Inc.

In 2000, HHSI expanded its scope to Cape Cod. It opened the Ellen Jones Community Dental Center in Falmouth, at that time the only Cape Cod dental practice that accepted MassHealth and other public insurance for adult patients. In 2003, the Mid-Upper Cape Community Health Center in Hyannis joined HHSI. Today, these two facilities serve 4,000 patients who make an average of 35,000 visits each year. While primary care is growing, the two large dental practices constitute the majority of patients served.

Services Provided

Geiger-Gibson Community Health Center serves 6,000 patients who make an average of 26,000 visits each year. Geiger-Gibson shares radiology, and laboratory services with Neponset Health Center.

Neponset Health Center serves 14,000 patients who make an average of 65,000 visits each year. Fifteen percent of Neponset's patients are Asian, and the health center has one of the highest percentage of Vietnamese patients among all community health centers in Massachusetts.

Public Health Priorities and Accomplishments

Public health priorities for HHSI include chronic disease, infant mortality, HIV, substance abuse, violence prevention, and care for the elderly. HHSI's current challenge is to improve community health efforts to address these complex and challenging needs. The health centers are also working hard to identify and implement new strategies to manage and coordinate care for their highest-cost patients, using the chronic care model and assisted by its new EMR.

HHSI takes its health center legacy seriously and is working hard to improve access to care for all patients by extending operating hours to serve working families, increasing access to triage nurses, and providing a well-coordinated appointment system. Neponset Health Center is open every day of the year, except Thanksgiving and Christmas, for all types of appointments.

Relationship with Partners and BWH

BWH is addressing infant mortality and low birth weight in the community with certified nurse midwives, who provide onsite prenatal care for women at Neponset Health Center, and who choose to deliver at BWH. A BWH gynecologist also provides onsite care at Neponset.

Through 2008, Neponset Health Center and Geiger-Gibson Community Health Center participated in the Dana Farber/PartnersBreast and Cervical Screening Collaborative, which provided free, routine screening for breast and cervical cancer in collaboration with the state's Women's Health Network.Geiger-Gibson participates in the AVON Breast Health Program, which provides a nurse and patient navigator to assist patients in following up on abnormal findings and if diagnosed accessing treatment.

Geiger-Gibson Community Health Center participated in the MGH Residency Community Medicine Experience Program, which seeks to increase medical residents' familiarity with community health programs.

HHSI was among the first health centers to affiliate with Partners in 1996; at that time, HHSI was seeking a way to improve services for its growing number of elderly patients. With a grant from Partners, HHSI renovated a building at 2216 Dorchester Avenue in Lower Mills to start a PACE program. Today, the program serves more than 285 patients, and is preparing to move to a new, larger building in Mattapan.

Partners provided funding to Neponset Health Center in 1995 to enable the health center to expand and renovate an urgent care facility. The expansion enabled Neponset to maintain its tradition of providing extensive primary care service hours to its patients, now offered seven days a week.

Partners provided funding to Geiger Gibson Community Health Center to assist with space costs in its (then) new building.

Lynn Community Health Center

Lynn Community Health Center At a Glance	
Year Founded	***1971***
Community Served	***Lynn***
Number of Patients	***28,500***
Patients Profile:	
Latino	***48%***
White	***20%***
Black/African American	***25%***
Asian	***7%***

Lori Abrams Berry, the Executive Director at Lynn Community Health Center (LCHC), believes that running a health center is a job with meaning. In her words, "Every year the health center has an opportunity to do more for the community of Lynn."

LCHC is collaborating with North Shore Medical Center (NSMC) to improve care for patients who use the emergency department (ED) because they do not have a relationship with a primary care physician. Through this arrangement, patients who come to the Salem and Union Hospital EDs are provided with a next-day appointment at LCHC, and receive the necessary support services to ensure they keep their appointment.

LCHC's Electronic Health Record (EHR), which is used by all of the primary care providers, dentists, and behavioral health providers at all the practice sites, improves continuity and quality of care for patients. Lori notes that they have developed the capacity within their EHR to identify groups of patients by diagnosis and to create patient registries that allow for regular review of clinical data.

History

In the 1960s, Lynn was a community of blue-collar workers, largely working for the city's largest employer, General Electric. During this time, Bill Mantzoukas, the health center's first Executive Director, and Steve Hayes, the current Behavioral Health Director of LCHC, were instrumental in the establishment of a community health center in Lynn. Bill Mantzoukas remains active with LCHC, by serving on their board, and Steve Hayes has been the Behavioral Health Director since 1971.

The first pressing issue that LCHC sought to address was mental health and, in 1971, LCHC began as a storefront mental health and counseling center on Chestnut Street. In 1973, the clinic relocated and, in 1976, began to provide medical services. In 1977, LCHC began offering Women Infant and Children (WIC) services.

A Gateway Community for New Immigrants

Because of relatively low housing costs, Lynn has traditionally been a city to welcome immigrants. In the 1980s, LCHC was on the front lines providing care to the burgeoning Southeast Asian community and today it serves as the Massachusetts Refugee and Immigrant Health assessment center for the North Shore. As a result, the health center has attracted immigrant patients from Russia, Somalia, Liberia, Afghanistan, Cameroon, Zimbabwe, Congo, Sudan, Rwanda, Iran, Columbia, Egypt, Armenia, Gambia, Guinea, and other countries.

In 1993, LCHC relocated to 269 Union Street. Lynn Hospital closed in 1989 due to financial difficulties. As a result of the efforts of the Lynn Health Task Force, a strong and effective community advocacy group founded by local labor organizers, a walk-in/urgent care center remained open until 1992. In 1997, NSMC acquired Union Hospital/Atlanticare Medical Center after a lengthy public bidding process. As part of the acquisition/merger process, Partners and NSMC made a number of specific commitments to the Massachusetts Public Health Counsel as formal conditions of the license transfer. One of these conditions included a provision that the hospital collaborate with LCHC to develop new primary care services in the community to address the extreme shortage of primary care physicians in Lynn. As part of this commitment, Partners and NSMC provided capital and operating support for the development of the health center's Walk-In Service in September 1999. LCHC opened the Walk-In Service to provide services to residents affected by the closing of Lynn Hospital.

The Lynn Community Health Center has continued to expand. The health center opened a new dental clinic in August 2001. With federal funding and support from Partners and NSMC, LCHC developed two new facilities for patients in the underserved areas of Market Square and West Lynn.

Services Provided

As the largest provider of primary care in Lynn, LCHC serves 28,500 patients who average over 168,000 visits each year. Over 94 percent of the health center's patients live at or below 200 percent of the federal poverty income level. In an effort to provide the best care to its large immigrant population, the health center employs a significant number of bilingual and multicultural staff to ensure the delivery of comprehensive, culturally competent care to its diverse population.

In addition to its main site at 269 Union Street, the health center operates two comprehensive primary care practices in Market Square, offers comprehensive dental services at 232 Union Street, and administers the WIC program for Lynn and eight other North Shore cities and towns. The health center operates a fully licensed pharmacy and, as part of a joint venture with Greater Lynn Senior Services, the health center operates two specialized primary care programs: Program for All-Inclusive Care for the Elderly (PACE) and Senior Care Options (SCO).

LCHC opened its first school-based health center at the Lynn Voc-Tech High School in 1991. The school-based health center provides primary and preventive health care to students where and when they need it most – on school premises. Today, LCHC operates six school-based health centers. Three of the school-based health centers are in high schools, two are in middle schools, and one is located in an elementary school.

Public Health Priorities and Accomplishments

In an effort to address the community's high rates of heart disease, substance abuse, and infant mortality, LCHC is exploring ways to develop and enhance needed community health services in the areas of nutrition and obesity with healthy cooking classes, social services, behavioral health and substance abuse services, interpreter services, parenting classes, dental services especially for children, nursing case management, outreach, education, prevention, and advocacy. LCHC has made a special effort to reach out to underserved and new populations, including teens, the elderly, immigrants, and people newly insured under Health Care Reform.

Relationship with Partners and NSMC

Through grant funding and program support, Partners and North Shore Medical Center have played a critical role in the development of the health center, helping to address challenges and community health priorities. Partners and NSMC provided funding for the renovation of the health center's Walk-In Clinic and support to hire four new primary care physicians. Partners and NSMC provided significant capital support for development of the Market Square and Western Avenue sites, which offer primary care and behavioral health services.

Free Care Pharmacy

NSMC and Partners were instrumental in LCHC's effort to make prescription drugs available to Free Care patients with the opening of a 340B pharmacy through a contract with Eaton Apothecary. The effort has been successful. During FY2008, LCHC filled 94,650 prescriptions, of these, 31,357 were for Health Safety Net, 22,272 for MassHealth, 17,832 for MassHealth Managed Care Organizations, 11,941 for commercial insurances,11,118 for Medicare, 84 for government programs, and 46 self-pay. Eighty percent of the prescriptions filled were generic medications, contributing to a lower cost.

Moving the State to Change its Approach to Prescription Drugs for Vulnerable Patients

Despite its great strides in serving the varied health needs of its patients, a significant gap emerged between the needs of patients with severe mental illness and what the health center pharmacy could offer. Many patients with behavioral health needs depend on high cost, brand-name antipsychotic drugs in order to maintain their health. The high cost of

these drugs, and the fact that the Free Care Pool only reimburses providers for a percentage of charges, meant that these drugs were not accessible or affordable for many patients.

Thanks to concerted and intensive advocacy on behalf of these patients by LCHC, the state revised its reimbursement methodology for community health center pharmacy services, and made it possible for LCHC to provide a full range of behavioral health drugs to their patients. This accomplishment marks a profound advance in the provision of care to highly vulnerable patients with mental health needs and in community health centers' ability to coordinate care.

Right Care, Right Place

LCHC is working with NSMC to improve care for patients who use the emergency department (ED) because they do not have a relationship with a primary care physician. Through this arrangement, patients who come to the Salem and Union Hospital EDs are provided with a next-day appointment at LCHC's Market Square or Union Street practice sites. ED and health center staff are in communication on a daily basis to ensure that patients receive the services they need to keep their appointment. In FY2008, LCHC saw 425 new patients who were referred by Salem or Union Hospital ED. LCHC meets with ED staff regularly to identify ways to reduce the no-show rate and the health center has a well developed nurse case management group that works with the nurse care managers at the hospitals to follow up on patients who did not show up for their primary care appointments, and to contact LCHC patients who have had ED visits. Since beginning the project in July 2004, the number of referrals from the ED has been steady.

The 425 new patients referred from the NSMC ED's to LCHC made an average of 3.3 medical visits during the same year, remaining involved in ongoing care at the health center. LCHC achieved a 7.5 percent reduction in non-emergent ER visits in FY2008. Neighborhood Health Plan (NHP) data show that the health center's 10,878 enrolled patients had 4,251 ER visits during FY2008. Of these visits, 39.5 percent (or 1,678) were defined as Non-Emergent, a significant reduction from a year ago, when 42.7 percent of ER visits by LCHC patients were defined as Non-Emergent. This is notable also because of the significant increase in the number of LCHC patients enrolled in NHP during the same period. ER visits during weekday/work hours in FY2008 were 6.1 percent of the total ER visits, also a reduction from the prior year's experience of 8.8 percent of ER visits.

LCHC is continuing to look for funding to develop additional tracking capability in their Electronic Health Record (EHR) to improve the quality of care for behavioral health patients, and patients at risk for metabolic syndrome and depression. LCHC's 1,702 patients with diabetes have an average HgA1C of 7.81 -- a significant improvement from over a year ago and the direct result of the work of their medical providers, nurse case managers and patient navigators. Of the 1,702 diabetic patients, 148 were also diagnosed with depression. This group has an average HgA1C of 7.6, even better than the health center's general population with diabetes. This finding is significant because it

underlines the importance and efficacy of pro-active identification and treatment of depression among patients with diabetes.

Addressing the Health Needs of Women and New Immigrants

In 2004, LCHC, along with NSMC, began participation in the Women's Health Network (WHN), a MA Department of Public Health program to provide free breast and cervical cancer screening and diagnostic services, along with health education, to low-income, under and uninsured women. WHN also provides case management and linkage to free or low-cost treatment. In 2008, enrollment was at 643 women. These women received 2,987 visits or procedures.

The community of Lynn has a population of approximately 5,000 Cambodian patients, many of whom live near the 694 Western Avenue location of LCHC. As a result, LCHC is doing significant work to be more inclusive and supportive of the Lynn Cambodian population. LCHC operates a weekly five-session health promotion class in Khmer (Cambodian), holds an annual health awareness day at the Cambodian Buddhist temple to provide health screening and information about the health center. Additionally, LCHC offers counseling services by Khmer social workers, employs a full-time Cambodian case manager and several Khmer medical staff members and clinicians. A Cambodian HIV counselor, an RN, and administrative staff are available at other LCHC locations as well.

In 2008, Partners provided funding to LCHC for a Cambodian Community Health Worker. The Cambodian Community Health Worker is working to support and improve ongoing health promotion activities, helping to manage the social services cases with the Cambodian case manager, providing tutoring services on a weekly basis to Cambodian teenagers, organizing and operating a weekly teen group in collaboration with the Lynn YMCA, helping to organize and publicize community events, and is working with the Cambodian Mental Health Counselor and Health Promotion Coordinator to process mental health screening results to improve patient care.

Expansion of the health center's services

LCHC has developed a plan for a new facility that will accommodate the need for continuing growth in medical, behavioral health, dental, and specialty services over the next decade. Unfortunately, the health center has serious space problems now that can no longer wait until they develop a viable financing plan for the new facility. Partners has provided capital costs for pressing needs that can be addressed in the short term, which include the development of a new eye clinic in collaboration with the New England Eye Institute and the New England College of Optometry, the addition of two exams rooms at 269 Union Street, and the establishment of new space for the behavioral health department to accommodate current staff and four additional behavioral health providers. The development of the new eye clinic will improve the care that LCHC can provide to patients at risk for retinopathy and glaucoma. Additionally, LCHC expects to be able to provide preventative screenings in the Lynn Public Schools and improve access to eye care and eyewear for children in Lynn.

LCHC received funding from Health Resources and Services Administration (HRSA) for a pharmacy expansion project that allowed them to open a second 340B pharmacy location in April 2008 at 12 Market Square, in collaboration with Eaton Apothecary, and to initiate a clinical pharmacy program in collaboration with Northeastern University School of Pharmacy.

Through funding received from the MA Department of Public Health, LCHC developed a new Office Based Opioid Program (Suboxone) in collaboration with Project COPE. Since opening in February 2008, 230 patients have been enrolled in the program and there are 55 active patients.

Contributing to the success of Health Care Reform in Lynn

During FY2008, LCHC's Enrollment Services Department assisted 18,009 individuals (1,501 per month) and enrolled 9,004 individuals (800 per month) in a health plan (Health Safety Net, Mass Health, Commonwealth Care, Healthy Start, Children's Medical Security Plan, or the Women's Health Network), exceeding their goals for the year. LCHC is proud of this accomplishment and the important contribution they are making to the success of health reform in Lynn.

In calendar year 2007, only 23 percent of LCHC patients remained uninsured. By contrast, 37 percent of their patients were uninsured in CY2005 and 31 percent were uninsured in CY2006. This is a major and mostly positive change.

Martha Eliot Health Center

Martha Eliot Health Center At a Glance		
Year Founded		***1966***
Community Served		***Jamaica Plain***
Number of Patients		***9,153***
Patient Profile:		
	Latino	***78%***
	Black	***20%***
	White	***1%***
	Asian	***1%***

Martha Eliot Health Center is licensed and operated by Children's Hospital and is located in Boston's Jamaica Plain neighborhood. It embodies 41 years of the hospital's commitment to the children of Boston.

Initially, Martha Eliot Health Center (MEHC) was created to provide needed pediatric and adult health care to the families living in Bromley-Heath, a low income housing development in Jamaica Plain. Through the years, the health center has expanded its reach and now serves thousands of other families living in Jamaica Plain, Mission Hill, and other Boston neighborhoods.

In 2007, MEHC recently named Jim Cote as its Executive Director and added several new positions. The former Director of Ambulatory Services at Children's Hospital, Cote aims to support MEHC's current programs, and training and development opportunities for employees, while assessing the community's needs and expanding services accordingly. "Many of our patients come in with a barrier prohibiting them from accessing health care, whether that barrier is language, economic, or social," he says. "We want to break down those barriers. We also want the community to know that we work hand-in-hand with Children's Hospital, and our patients receive the same level of care and service they would at the hospital."

Cote notes that the health center has six employees who have worked at Martha Eliot Health Center for 20 years or more. Combined, they have dedicated more than 157 years to the health center. According to Cote, "These employees represent the foundation of the health center and are part of the fabric of what makes this health center so special."

History

Three Women Play a Key Role

The Martha Eliot Health Center (MEHC) was founded in 1966 as a community-based initiative to provide maternal and child health care services including baby care, immunizations, and preventive services for residents of the Bromley Heath Housing Development in Jamaica Plain. The health center began as a makeshift "well-baby" clinic in a woodworking room of the housing development. Bromley-Heath, founded in

1941, was the first U.S. government housing project to be managed by its own tenants. Three Boston women played key roles in MEHC history: Martha May Eliot, MD, Mildred Hailey, and Eva Salber, MD.

In 1957, Harvard University delegated Martha May Eliot, MD, a professor of Maternal and Child Health, to collaborate with the Boston Health Commissioner on the creation of a pilot health care program that would eventually become the Bromley-Heath Clinic. Martha May Eliot Health Center was established in 1966 and named in recognition of the creator's 50 years of advocating and developing health care services for mothers and children. In 1967, MEHC expanded to offer comprehensive prenatal, pediatric, and family-based primary care.

Mildred Hailey, Executive Director of the Bromley-Heath Tenant Management Corporation, is a respected community activist and a driving force behind the creation of Martha Eliot Health Center. Hailey and other Bromley-Heath leaders have been involved with the health center throughout its history. During its early years, Hailey would visit the clinic to comfort concerned families, and often brought clean sheets for exam room beds.

In 1967, Eva Salber, MD, was appointed the first director of MEHC. Born and raised in South Africa, Dr. Salber's experience in an apartheid society fueled her ambition to promote public health through community medicine and improved access to quality care. Her efforts at MEHC were welcomed by Jamaica Plain families with children, who in the past had to travel to Children's Hospital for care.

With federal funding, the clinic expanded in 1967 into a neighborhood health center, which became a collaborative project of Children's Hospital Boston, the Boston Hospital for Women, and Peter Bent Brigham Hospital.

In 1973, Children's Hospital assumed operation of MEHC, which at the time served approximately 12,000 patients annually. During the 1990s, Joseph Carrillo, MD, and Karen Darcy, RN, played an important role in the next phase of MEHC; as Executive Director and Assistant Director respectively, they worked to strengthen the partnership with Children's Hospital and were instrumental in moving MEHC to its current location on 75 Bickford Street in Jamaica Plain in 1996.

Today, MEHC represents Children's commitment to comprehensive family health care for the Mission Hill, Jamaica Plain, Roslindale, Dorchester, and Roxbury communities. The health center has expanded into a health care delivery model offering primary care services including Pediatrics, Women's Health, Adolescent Medicine, Adult Medicine, Optometry, Nutrition, WIC, Human Services, and Laboratory Services. A community-based substance abuse treatment and recovery support program, case management, and home visiting services for parenting and pregnant women, HIV education, counseling and testing, a youth peer leader program, and a youth street outreach program augment the extensive array of preventive services. Additionally, MEHC has a strong Community Advisory Board.

Services Provided

Martha Eliot Health Center is dedicated to caring for underserved children and families in and around Jamaica Plain. Its mission is to promote and provide the best comprehensive health care to diverse multicultural communities. MEHC cares for 9,153 patients, which translate into more than 56,000 visits per year. The Pediatric Primary Care department at Martha Eliot Health Center provides services to children from birth to age 13. The dedicated team of clinicians is multicultural and speaks many languages, including Spanish, French, Chinese, Haitian Creole, Portuguese, German, and Polish.

MEHC and its 120 staff members (including physicians, nurses, therapists, nutritionists, social workers, and administrators) respect the economically and culturally diverse population that they serve, and strive to deliver services in a competent and sensitive manner. The health center supports the community infrastructure by recruiting and employing staff that are directly from the community and reflect the population it serves.

Many of Martha Eliot Health Center's employees and their families are also patients of the health center, which demonstrates the health center's commitment to providing high quality, family-centered primary care. The center's staff prides itself on caring for the vibrant patient population of African-Americans, Latinos, Somalis, Cape Verdeans, and other ethnicities of Jamaica Plain and the surrounding community.

Public Health Priorities and Accomplishments

Jamaica Plain Trauma Response Team

With tough socio-economic conditions, proliferation of guns, and a street culture of gangs and violence, public health professionals have termed it an “epidemic” of inner-city violence in Boston. Areas in or in close proximity to Bromley-Heath, South Street, and Academy Homes housing developments, and Egleston, Hyde, and Jackson Square communities within Jamaica Plain, stand out as persistent violent crime “hot spots” within the City of Boston. In fact, Jamaica Plain’s violent crime “hot spots” had significantly higher rates of violence than the City as a whole, with 73 percent more murders, 19 percent more forcible rapes, and 53 percent more aggravated assaults per 1,000 residents in the last three years alone. The data for shootings is even bleaker with nine fatal shootings and 58 non-fatal shootings. Boston Police and the FBI also estimated that gang related feuds and activities in Jamaica Plain’s Bromley-Heath Housing development has reportedly resulted in over 20 local shootings since January 2005. The long-term health impact of such violence and its resulting stress on families is enormous. Studies of adults with adverse childhoods show that they are more vulnerable to heart disease, lung disease, diabetes, and obesity. Youth exposure to violence and its secondary consequences is also enormous. Many victims and witnesses experience psychological trauma as a result of exposure to violence. Post-traumatic stress disorder (PTSD) and its symptoms (e.g., anxiety, depression, and a sense of helplessness) can lead to substance

abuse, poor academic performance, inability to maintain trusting relationships, aggressive behavior, and the perpetuation of further violence.

As a community health center committed to providing exceptional, primary care and social services to families for over 40 years, MEHC feels a deep responsibility to assist health care providers and community partners to prevent violence and to aid in the physical and mental recovery of victims and their families. MEHC and its collaborative health center partners, Southern Jamaica Plain Health Center, Brookside Community Health Center, and Dimock Community Health Center, have established the Jamaica Plain Trauma Response Team (JP-TRT) to deliver effective and timely trauma response services to children and their families who live in fear of violence and/or are traumatized by violence. Since the summer of 2008, MEHC's and the other health centers' small mental health staff have been critical in providing support to families dealing with trauma, however, their efforts require additional support.

MEHC's proposal for "Jamaica Plain Community Health Trauma Response Collaborative" will help to support the work the Center is currently engaged in with other community health agencies to better connect victims of violence to psychological first aid, stabilization groups, post-trauma needs assessments, and case management and referral services. Specifically, this new trauma response collaborative will merge a model combining trauma response therapy and post-traumatic stress management (PTSM), and community empowerment with case management services and an assessment tool (The Online Advocate), which is specifically designed to evaluate the social, economic, and health needs of individuals in a culturally and linguistically competent manner. Use of a Resource Specialist and The Online Advocate will expand the Collaborative's violence intervention and prevention strategies by: better managing the physical and psychological care victims and their families need, empowering parents with culturally relevant, in-home family strategies (e.g., family advocacy and transition plans), offering parenting groups and stress-reducing tools, supporting school's anti-violence initiatives, providing referral services, and assisting families to identify youth-based alternatives to violence. The Resource Specialist will be the primary contact for victims and families in need of referrals and PTSM providers. The Resource Specialist will meet one-on-one with families to ensure that individuals are connected to resources that are age and culturally appropriate, and affordable, via The Online Advocate. The Resource Specialist will work with the entire Collaborative to help create and develop intake-follow-up and feedback systems from the community that will enable the project to be efficient and effective.

The target population for the Collaborative is Jamaica Plain's census blocks surrounding MEHC and the other health centers, which have dense Latino and Black concentrations greater than 60 percent. Approximately 12.8 percent of these families have incomes below the Federal Poverty Level, though again, with concentrations greater than 45 percent. Many of the health centers have patients who reside in the Bromley-Heath, Academy Homes, and South Street housing developments, and Egleston, Hyde, and Jackson Square, as well as, in the areas of Mattapan, Dorchester, and Roxbury (Mission Hill, Grove Hall and Orchard Park). Of the 9,200 primarily low-income, inadequately

insured children, adolescents, and adults patients MEHC serves annually, 35 percent reside in Dorchester and Roxbury.

Adolescent Services Program

Martha Eliot Health Center offers a variety of youth development programs through its Adolescent Clinic including career training, academic support, mentoring, sports physicals, STD checks, pregnancy tests, immunizations, and family planning. *We Got Next*, one of the clinic's cutting-edge programs, uses organized group sports and interactive activities to teach middle-school girls about nutrition and having a positive body image. Its *Game Time* program teaches middle-school boys athletic and developmental skills.

Because of the preponderance of adolescents in the Jamaica Plain area and because of the environment in which they live – unsafe neighborhoods with limited opportunities that can ignite high-risk behaviors – MEHC has made a special commitment to adolescents through its Adolescent Services Program. Among the services provided are:

Urban REPS (Peer Leadership)

In 2007, six peer leaders (ages 16-18) launched Urban REPS, aimed at developing and maintaining a strong team of peer leaders who will identify and act on health and social justice issues as a means of helping to build a stronger community. As they work for change in the community, the Urban REPS also are developing strong leadership skills such as self-awareness, social-emotional competence, confidence, conflict resolution, and problem solving. Current projects include securing more youth jobs in the city and promoting healthy teen relationships.

Just In Time (JIT)

This mental health and crisis intervention program helps adolescents with crises deal with the daily struggles of growing up in an urban environment – from engaging in unprotected sex to having an argument with a parent. A social worker meets individually with adolescents on a “walk in” basis to discuss specific issues and possible solutions, and makes necessary referrals. In 2008, a new JIT clinician was recruited.

Community Resources and School Advocacy

MEHC compiled a list of GED programs and job resources and linked adolescents with community resources to help them find and secure jobs. MEHC also worked with parents and caregivers, helping them navigate the Boston Public School system to access available resources for students experiencing difficulties.

MEHC’s Human Services Department offers a full range of psychiatric, psychological, and case management services to children, adolescents, adults, and families. The health

center deals with issues such as depression, anxiety, behavioral and learning problems, crisis interventions, and advocacy.

Annual Health Fairs

Every year, MEHC hosts a Community Health Fair, and the 2008 fair was one of its most successful. With the sounds of salsa music, African drums, children's laughter, and family fun reverberating through the air, Jamaica Plain's Jackson Square buzzed with excitement. Over 1,000 people participated in the Fair's interactive wellness, nutrition, fitness, injury prevention, and youth empowerment activities. Over 270 health screenings were conducted, 200 child identifications were completed, and 300 lunch bags with healthy snacks were distributed to children.

MEHC's annual Summer Safety Fair is equally successful in helping parents keep their children safe at home, at the beach, and in the car.

Relationship with Partners and BWH

BWH has had a clinical relationship with MEHC since 1970, which includes adult medicine services and obstetrics/gynecology. The relationship is part of the hospital and health center's shared commitment to meet the obstetrical, medical, and surgical needs of Martha Eliot patients and to work together to improve the health of Jamaica Plain's most vulnerable residents. Partners provides grant funding to support key positions in adult and women's health at MEHC in order to improve access to care for underserved patients. MEHC and BWH health centers, Brookside Community Health Center and Southern Jamaica Plain Health Center, provide cross physician coverage for each other as well.

BWH works with MEHC to address the social and medical needs of pregnant women in the community, infant mortality, and low birth weight. Certified nurse midwives from BWH provide onsite prenatal care at MEHC. A BWH gynecologist also provides care at the health center.

Helping At-Risk Pregnant Women to Have Healthy Babies

MEHC is part of BWH's Perinatal Case Manager Program (PCMP), a program which provides comprehensive support services for at-risk pregnant women. BWH also supports domestic violence services at MEHC.

Mattapan Community Health Center

Mattapan Community Health Center At a Glance	
Year Founded	***1972***
Community Served	***Mattapan***
Number of Patients	***7,000***
Patients Profile:	
African-American, including Caribbean immigrants	***97%***
Others	***3%***

Dr. Azzie Young, President and Chief Executive Officer of Mattapan Community Health Center (MCHC), has been a strong and effective advocate for health care issues in Mattapan and Hyde Park, by bringing the people of these communities together to address challenging health concerns, including infant mortality, breast and cervical cancer deaths, and obesity. For instance, to combat the high rate of obesity in these communities, she directed MCHC to place a high priority on reducing childhood obesity and had the health center initiate a rigorous youth sports health program. Dr. Young became the health center's fifth Executive Director in 1996.

History

In 1969, Edna W. Smith of the *Boston Family Planning Project*, helped mobilize an effort to establish a health center for the Mattapan neighborhood, where the number of private physicians had been on the decline. In 1972, the Avenue Neighborhood Health Center (ANHC) opened its doors at 1295 Blue Hill Avenue in Mattapan.

Initial services offered by ANHC were OB/GYN, primary care, and podiatry. In 1974, the health center was incorporated under its current name -- Mattapan Community Health Center, Inc. In 1980, it was relocated to its present location at 1425 Blue Hill Avenue. Thereafter, MCHC received a federal grant allowing for further expansion of its services. Today, services are provided at two locations; one on Blue Hill Avenue and the other at a School-Based Health Center located at Hyde Park High School.

MCHC is the only community health center in Mattapan and Hyde Park. It primarily serves the neighborhoods of Mattapan, Dorchester, Roxbury, and Hyde Park. Patients also come to Mattapan for care from as far away as Milton, Brockton, Randolph, and Stoughton.

Services Provided

MCHC serves 7,000 patients who average 26,000 visits each year. The population that MCHC serves is primarily Black, including a large percentage of Caribbean immigrants. Eighty percent of the patients are at or below 200 percent of the federal poverty level. Sixty percent are female and the health center also cares for a large number of children.

Public Health Priorities and Accomplishments

MCHC's Health Care Revival Initiative was established in 1997 to engage the Mattapan community in a dialogue about its health, particularly the health of its women, infants, and their families. This faith-based, community-focused, and community-led annual event is designed to focus on serious public health problems in an atmosphere that renews the health center's vision, rekindles its commitment to patients, and revives the spirit of health in the community. Every year the Health Care Revival grows. In 2002, it received international recognition in the February issue of the *American Journal of Public Health.* In 2006, it received national press coverage from NPR. In 2007, over 700 people attended the Health Care Revival and heard about MCHC's groundbreaking community-based participatory research on Vitamin D. For more information, check out the website, www.mattapanchc.org. In 2008, Mattapan Community Health Center's leadership was successful in leading a collaborative effort within the American Public Health Association to get a vitamin D policy unanimously approved by the Governing Council.

Through its annual *Community Health Report Card for Mattapan and Hyde Park*, MCHC tracks key health indicators. Some of the most frequently diagnosed conditions are vitamin D deficiency/insufficiency, hypertension, diabetes, high cholesterol, asthma, and obesity. For the Mattapan and Hyde Park communities, the leading cause of death in 2006 was cancer. To address these community health issues, MCHC participates in local, state and federal efforts to increase health care access, and to decrease health disparities.

MCHC has received a number of awards. In 2006, Dr. Young received the Outstanding Executive Director Award from the Massachusetts League of Community Health Centers, and Cleopatra Ferrao, RN (former employee), received the Kenneth B. Schwartz Center's "Compassionate Caregiver Award." In September 2002, Citizens Bank and New England Cable News selected MCHC as the "First Community Champion of Massachusetts." These public accolades are an acknowledgement that MCHC leaders and caregivers have the respect of their colleagues, other community health centers, and the community.

Relationship with Partners and BWH

Partners and its founding hospitals, Brigham and Women's Hospital (BWH) and Massachusetts General Hospital (MGH), have worked closely with Mattapan Community Health Center since 1998 to address a number of key community health challenges, including infant mortality and breast and cervical cancer. A nurse midwife from BWH provides prenatal care at the health center. The health center is also part of BWH's Perinatal Case Manager Program (PCMP), which provides support for a case manager at the health center who provides women with comprehensive support services.

Through 2008, MCHC participated in the Dana-Farber/Partners Breast and Cervical Cancer Screening Collaborative, which provided free, routine screening for breast and cervical cancer in collaboration with the state's Women's Health Network. Mattapan Community Health Center participates in the AVON Breast Health Program, which

provides patient navigators to assist in accessing cancer treatment. Since beginning this outreach program in June 2001, the Mattapan patient navigators have assisted 650 patients, and 28 patients have been diagnosed with breast cancer and have received follow up support and treatment.

North Shore Community Health, Inc.

North Shore Community Health Center At a Glance	
Year Founded	***1978***
Communities Served	***Peabody, Salem and Gloucester***
Number of Patients	***8,626***
Patients Profile:	
Latino	***33%***
White	***30%***
Unreported	***19%***
Portuguese	***15%***
Black	***3%***

Gloria Riley, Chief Operations Officer, has been part of North Shore Community Health, Inc. since 1988. She is proud of the work the health centers have accomplished over the years. Robert Hendershott, EdD, was hired as Executive Director in 2003. As Executive Director, Dr. Hendershott has helped to develop a more comprehensive affiliation between NSCH and North Shore Medical Center (NSMC) and continues to work closely with Lynn Community Health Center.

North Shore Community Health is focused on providing cancer screening and treatment for low income women, dental preventive care through a residency program with Tufts University School of Dental Medicine, chronic disease management for diabetes and heart disease, improved access to prescription drugs, and improved access to care to prevent the unnecessary use of local emergency departments through a collaboration with NSMC.

History

In 1978, the Peabody Family Health Center opened on the corner of Walnut and Wallis Streets in Peabody, in the center of a large blue-collar community of Portuguese immigrants. (Before 1978, Peabody Family Health Center shared providers and resources with the Lynn Community Health Center.) The first services offered at Peabody Family Health Center were internal medicine, pediatrics, OB/GYN, and Women Infant and Children (WIC).

Flood Results in a New Partnership

In 1990, the Peabody Family Health Center relocated to a larger location in a mini-mall at 150 Main Street in Peabody. Unfortunately, two catastrophic floods at the location interfered with the health center's ability to provide care. The first flood was so severe that the health center was closed for three months due to extensive water damage. The

second flood resulted in closing its Peabody location for some time, with an offer of help from North Shore Medical Center (NSMC) to find a new location for the health center.

Looking to expand its services to the neighboring community of Salem and its large community of Polish, French-Canadian, and Spanish-speaking immigrants, North Shore Community Health, Inc. (NSCH), began its search for a new location. In 1996, the organization opened the new Salem Family Health Center at 47 Congress Street, one of the town's original cotton mills.

In 2002, the Peabody Family Health Center location was opened on 89 Foster Street, Peabody and there are current plans to expand the facility in order to increase medical access and behavioral health services.

Helping the Health Center Recover

In 2003, North Shore Community Health, Inc. was struggling financially. With strategic guidance and financial support from the Massachusetts League of Community Health Centers, Partners, and NSMC, the organization was able to recover and thrive. Dr. Hendershott, who has extensive experience in government and health center finance, became the health center's Chief Executive Officer. Subsequently, the health center developed a more comprehensive affiliation with NSMC, and continues to work closely with Lynn Community Health Center.

North Shore Community Health, Inc. opened a new satellite in Gloucester in October 2008. The service site provides primary care, dental, and behavioral health services. The community of Gloucester has limited primary care services, and residents frequently rely on hospital emergency rooms for care.

Services Provided

North Shore Community Health, Inc. operates three health centers and one school based health center: Gloucester Family Health Center, Salem Family Health Center, Salem High School Based Health Center, and Peabody Family Health Center in Peabody. Combined, the health centers provide medical and dental care for over 8,000 patients who make more than 31,944 visits each year. The 60 health center employees provide linguistically and culturally appropriate care to a diverse patient population.

The health centers offer family medicine, OB/GYN, and women's health services. For over ten years, Salem Family Health Center has been the outpatient placement site for the Internal Medical Residency program affiliated with NSMC. Twenty residents per week provide care to Salem Family Health Center patients. Some of these residents finished their training and went on to become providers at the health center. Additionally, Salem Family Health Center has a dental residency program through Tufts University School of Dental Medicine. Through NSMC, a full-time nurse midwife is located at Salem, a half-time OB/GYN provides care at Salem, and an OB case manager provides birthing classes at NSMC in Spanish and Portuguese. The Salem Family Health Center has two family

nurse practitioners and one adult nurse practitioner. One of the family nurse practitioners splits her time between chronic disease case management and primary care. The Peabody Family Health Center offers family and internal medicine. The Gloucester Family Health Center offers family medicine, dental, and behavioral health services.

Public Health Priorities and Accomplishments

The public health priorities at North Shore Community Health include cancer screening and treatment for low-income women and chronic disease management.

In July 2004, NSCH, as part of its affiliation with North Shore Medical Center, became part of the Women's Health Network (WHN), a MA Department of Public Health program, which provides free breast and cervical cancer screening, diagnostic services, treatment, and health education to low-income, under, and uninsured women. The WHN also provides case management and is linked with primary care at the health center. Calendar year 2008 provided care to over 300 women.

Improving Cancer Screening and Treatment

Women's Health Network is vital to the community; findings from patients who receive breast and cervical cancer screening indicate an abnormal rate of around 20 percent in NSMC sites along the North Shore. These rates are significantly higher than the 12 percent abnormal rate for women in WHN statewide and demonstrate the critical need for the treatment NSMC has made available.

Helping Patients Manage Diabetes and Heart Disease

In order to improve the management of chronic disease among health center patients, NSCH has added a new diabetes program, which includes group visits for diabetes patients. A similar approach is being used in the treatment and management of heart disease; a cardiologist holds a monthly group clinic to provide cardiology services. These disease management supports are available to both insured and uninsured patients.

Improving Access to Low Cost Prescription Drugs

North Shore Community Health, Inc. operates a pharmacy program in partnership with Eaton Apothecary. Patients are able to get their medications for a reasonable co-payment ($1 or $3 depending upon the medication). Before the program with Eaton, patients often went without medications or were forced to rely on sample medications that the health center had in stock.

Relationship with Partners and NMSC

North Shore Community Health, Inc. has been a key contributor to ensuring the success of health care reform by enabling patients to get the right care in the right place. NSCH has worked with NSMC in the Emergency Department Primary Care Connection

program. Through the program, patients who seek care from the NSMC ED and do not have a relationship with a primary care physician, are provided with a next-day appointment at NSCH and are given necessary supports to ensure that they keep the appointment. ED personnel and health center staff are in communication on a daily basis to ensure that patients receive the services they need and are not lost in follow-up. To date, several hundred patients now receive primary care through this program. In calendar year 2008, 633 patients were booked with follow-up appointments from the Emergency Department and 337 kept appointments at a 53 percent kept rate.

NSCH also participates in the High-Risk Community-Based Nursing Case Management Program along with NSMC. Launched in the fall of 2004, the program uses two community-based nursing case managers to coordinate care for a small group of patients who require intensive case management and are at high risk for excessive use of emergency department care, poor outcomes, and unnecessary and unduly long inpatient stays. Outcomes from all four years of program experience continue to show that the program has been successful in reducing emergency room visits and the average length of stay for inpatient hospitalizations.

Over the past four years, grant support from Partners and NSMC has helped North Shore Community Health, Inc. to reach its clinical and financial goals. Partners has helped to strengthen the relationship among North Shore Community Health, Inc., Lynn Community Health Center, and NMSC, allowing the three entities to work together and combine resources when possible to offer more comprehensive care to the North Shore communities they serve.

South Boston Community Health Center

South Boston Community Health Center At a Glance	
Year Founded	***1970***
Community Served	***South Boston***
Number of Patients	***14,442***
Patients Profile:	
White	***82%***
Latino	***8%***
Asian	***1%***
Black	***5%***
Other	***4%***

William J. Halpin, Jr., CEO of South Boston Community Health Center (SBCHC), notes: "The word 'community' comes alive at our health center. It is our culture to jump right in to solve problems when we see them, without fear of failure and with a commitment to doing what is right for our patients and the community, especially with a changing patient population."

Dr. Nisha Thakrar, Medical Director, says: "We strive for top quality care for our patients, and the caliber of providers at the health center is impressive. The implementation of an electronic medical record system has allowed for cross coverage and better clinical care. Now we are working to enhance the role of the nurses in order to create a model of care that increases productivity for the physicians."

History

Thirty years ago, in response to a shortage of physicians in city neighborhoods, the then Boston Department of Health and Hospitals instituted a Districting Plan which charged local hospitals with responsibility for providing health care in neighborhoods throughout the city. One result of that plan was the founding of South Boston Community Health Center (SBCHC) in 1970 at 133 Dorchester Street in the George Robert White Fund Municipal Building. The health center initially offered pediatrics, dental care, and nutrition education services.

From the start, SBCHC had two key physicians, Drs. Harvey Bidwell and Larry Muldoon, who were the driving force for the health center. Over 20 years, these two physicians built a loyal patient following and created a reputation for quality and high-touch medicine that provided the foundation for the health center.

Diverse Patient Population with a Growing Number of New Immigrants from Albania

The original patient population at SBCHC was predominantly Irish immigrants. Today, the health center serves a large number of Latino patients and a growing number of Albanian patients. The health center staff reflects the diverse populations it serves.

Over the years, the health center has expanded its services to include adult medicine, family medicine, cardiology, physiatry, podiatry, eye care, OB/GYN, mental health, and social services. The South Boston Community Health Center's primary affiliation is with Boston Medical Center (BMC), and in 1997, BMC provided a forgivable loan to SBCHC for the renovation of its current sites at 368 and 409 West Broadway. The health center has a secondary affiliation with Partners.

The health center also has a strong, committed, and influential community board.

Services Provided

The South Boston Community Health Center is the only comprehensive health care provider in South Boston. The health center provides care to many patients who would not seek care if it were not provided locally.

SBCHC provides care to 14,442 patients who made 56,000 visits in 2008.

Public Health Priorities and Accomplishments

SBCHC's providers and staff are driven to work towards the health center's primary mission of taking care of its most vulnerable patients, regardless of their ability to pay. Specific public health priorities at SBCHC are substance abuse, smoking cessation, obesity, lifestyle issues related to cancer, and cardiovascular disease.

The health center has worked hard to collaborate with community members, especially youth, to address the significantly high rate of substance abuse in the community.

While the health center is reaching many disadvantaged people in South Boston, there is a constant need to continue to reach out to individuals and families in the local low income housing developments and other neighborhoods.

Relationship with Partners and MGH

Throughout the ten-year affiliation, Partners has worked closely with SBCHC to address many community health issues including cancer, heart disease caused by smoking, and substance abuse.

Tackling the Problem of Substance Abuse

Currently, Partners provides support to SBCHC's adolescent substance abuse prevention work through programs like *Young at Arts*. This is an arts-infused substance abuse prevention model targeting at-risk youth, ages 12 to18, which aims to change the norms and attitudes about substance abuse among adolescents of South Boston. Launched in 2005, *Young at Arts* celebrates youth, fosters adult and youth relationships, and provides positive activities and arts education in the areas of painting, performance, photography, and writing.

After moving to its present locations at 368 and 409 West Broadway in 1997, SBCHC experienced a period of financial instability caused by slower than anticipated patient growth. Boston Medical Center and Partners were instrumental in helping the health center stabilize and continue its important service to the community during a time of transition. With this support, SBCHC was able to continue to deliver quality care to the residents of South Boston, and focus on the challenging public health issues that affect the South Boston neighborhood. Today the health center is strong and vibrant.

Creating a Medical Home

South Boston Community Health Center is participating in Dr. Allan Goroll's demonstration project to reform how primary care is delivered and paid for. Dr. Goroll has raised private money to test a Medical Home model where doctors are paid per patient, instead of per visit as a way to foster comprehensive care and take some much needed pressure off physicians. The Medical Homes model is a comprehensive approach to caring for patients by providing as much on-site care as possible and coordinating all care that happens at other sites through a personal touch and electronic medical record. Partners is providing support for this endeavor at SBCHC. Additionally, SBCHC has submitted a proposal to the Massachusetts Executive Office of Health and Human Services (EOHHS) to help fund this project.

South End Community Health Center

South End Community Health Center At a Glance	
Year Founded	***1969***
Community Served	***South End***
Number of Patients	***13,000***
Patients Profile:	
Latino	***61%***
African-American	***24%***
Other	***15%***

Tristram Blake has been Executive Director of South End Community Health Center (SECHC) for the last 38 years. He says:

In the late 1960s a group of Latina women living in the South End committed themselves to finding the best health care for their children. At the time, the only available pediatric care in the South End was at the outpatient clinic at Boston City Hospital (BCH), which was characterized by long waits, inadequate facilities, limited language capacity, and a lack of comprehensive care. A health study done during this time revealed that more people died prematurely per capita in the South End -- in the shadows of large health care institutions -- than anywhere else in the state.

At that time, there were "dispensaries" throughout Boston that offered health services to the community, including well-baby visits, immunizations, and public health nurses. The South End Community Health Center evolved from a municipal building, at 65 West Brookline Street. The health center moved five times before settling in its current location at 1601 Washington Street in April 2000. The health center building was the cornerstone of a revitalization that has had a dramatic impact on the neighborhood.

Because it is not licensed through a hospital, SECHC can work with numerous hospital partners in the city to create arrangements that provide the best care for its patients at the best price. Over the past decade Partners, BWH, and MGH have always been supportive partners to the health center, providing top quality health care to the patients of SECHC.

History

A Doctor and a Shoemaker Working Together

In the late 1960s, Dr. Gerald Hass, Chief of Pediatrics at Boston City Hospital, teamed up with Mel Scovell, a retired shoe business executive, to work with South End residents committed to enhancing pediatric care in the area. With a grant from the Boston Department of Health and Hospitals and the Tuberculosis and Respiratory Disease Association, they were able to open a pediatric clinic in the basement of a municipal building on 65 West Brookline Street in May 1969.

The clinic started with just three exam rooms, but quickly grew with the addition of an obstetrician and provided primary care for the mothers of pediatric patients. Tristram Blake became the Executive Director in 1971.

Caregivers for a Lifetime

The medical staff of SECHC has shown its commitment through their many years of service; 50 percent of the staff have worked at the health center for more than ten years; the health center's first physician hired in 1969 is still on staff; and six other SECHC physicians have practiced at the health center for more than 25 years. Caregivers at SECHC are now caring for several generations of the same families.

Services Provided

The Largest Heath Center Provider of Comprehensive Care to Boston's Latino Population

Today, the SECHC serves a diverse population of over 13,000 patients who average 65,000 visits each year. More than half of SECHC patients are women and children. The majority of patients are Latino (61 percent) and Black (24 percent).

More Mental Health Services than Any Other Massachusetts Health Center

SECHC has a long history of providing comprehensive mental health care to its patients, and currently provides more mental health services than any other Massachusetts health center. Shortly after it opened, SECHC expanded its services to include mental health care, and in 1985, SECHC received Massachusetts Department of Mental Health contracts for outpatient pediatric and adult mental health care to support the Dr. Solomon Carter Fuller Mental Health Center.

SECHC's Mental Health services include: Individual, Family and Group Treatment; Psychological Testing; Triage and Emergency Response; Psychopharmacology, and School-Based Services.

Medicaid and Medicare insure 60 percent of SECHC patients, and 20 percent are uninsured.

Public Health Priorities and Accomplishments

The South End Community Health Center's major public health priority is to provide a "medical home" for their patients by integrating medical and mental health services. One way the health center is working toward this is through Win-Win, a new program that is focused on incorporating obesity treatment and prevention into all aspects of patient health care.

Because SECHC serves a significant number of homeless patients, the health center has partnered with Boston Health Care for the Homeless to offer dental services.

Relationship with Partners and BWH

BWH is committed to working closely with SECHC to address the social and medical needs of pregnant women in this community, and to working together to address infant mortality and low birth weight in the community. Certified nurse midwives from BWH provide onsite prenatal care at the health center. A BWH gynecologist also provides care at the health center.

Helping At-Risk Pregnant Women to Have Healthy Babies

SECHC is a part of BWH's Perinatal Case Manager Program (PCMP), which provides a case manager at the health center who provides comprehensive support services for at-risk pregnant women, in addition to the clinical care they receive through the health center's partnership with BWH. This case manager ensures that culturally sensitive care continues for pregnant women through pregnancy and after giving birth.

For the past decade, Partners, BWH, and MGH have worked with SECHC to find creative solutions to improve care and service to the South End community. In 1995, BWH provided much needed support for a capital campaign, which enabled the health center to relocate to its new location at 1601 Washington Street. Medicaid and public health cuts in 2002 hit SECHC hard, but with support from BWH and Partners, the health center was able to stabilize financially.

Clinical support from MGH also enabled SECHC to hire a podiatrist. In response to SECHC serving neighborhoods (Roxbury, South End, Dorchester) with the city's highest rates of asthma hospitalization in young children, Partners and MGH began a three-year commitment to the development and implementation of a pediatric asthma program. In 2007, SECHC recruited a Spanish speaking pediatric pulmonologist to lead this program.

In 2008, Partners provided support to the SECHC for a project to enhance the financial, operational and programmatic performance of the Mental Health Department at South End Community Health Center.

Upham's Corner Health Center

Upham's Corner Health Center At a Glance	
Year Founded	***1973***
Community Served	***North Dorchester***
Number of Patients	***15,920***
Patients Profile:	
Latino	***34%***
African-American	***25%***
Cape Verdean	***24%***
Haitian	***10%***
Other	***7%***

Edward Grimes, a lifelong resident of Upham's Corner, has been the Chief Executive Officer of UCHC since 1973. In his words:

From the 1890s through the 1940s, Upham's Corner was a streetcar suburb between Boston and Franklin Park. It was a vibrant neighborhood. The first supermarket to open in the United States was in Upham's Corner. There were also several banks and five physicians and dentists practicing in the neighborhood. However, by the late 1960s, the neighborhood had changed dramatically. Many residents had moved out of Boston and people from the Southern U.S. and the Caribbean were taking their place; there was significant racial strife. Because there was little market for real estate, there were occasional incidents of people setting their homes on fire to collect the insurance money. By 1969, all of the neighborhood's private physicians and dentists had either retired or moved their practices out of Upham's Corner. As a result, neighborhood residents went to Boston City Hospital for medical care; often, they might wait all day on one of the many long benches to see a physician. Our health center was created to address this access problem, and for more than thirty years, the health center has remained true to its mission of providing high quality, low-cost, culturally sensitive, community-based health and social services to the residents of Dorchester.

The relationship between Partners, BWH and UCHC has been outstanding. With Partners' help in supporting critical public health programs, UCHC has been able to improve access to services for the community. Partners and BWH provided significant funding to assist UCHC in creating a facility that is first rate and accessible. BWH also provided state-of-the-art technology by sharing its electronic medical record with clinical providers at UCHC. This has dramatically enhanced the clinical care provided at UCHC.

History

In the late 1960s, during a measles outbreak in the Latino community, the Upham's Corner neighborhood came face-to-face with their urgent need for local physicians. In response, a community task force of 30 local residents was formed and in 1971, the Upham's Corner Health Committee was officially incorporated. Grants were provided by the Boston Family Planning Project and the Boston Department of Health and Hospitals.

On January 1, 1973, UCHC began providing care on the second floor of a municipal building at 500 Columbia Road. Initial services included a weekly session of adult medicine and twice weekly sessions of pediatrics, plus laboratory services.

In March 1973, the health center was able to move downstairs into permanent quarters on the first floor. UCHC renovated the first floor space to provide a waiting room, six new exam rooms, and office and laboratory space. By September, OB/GYN, family planning, and optometry services were added. In 1974, the health center received a grant to open one of the first Women, Infants and Children (WIC) food programs in Massachusetts; more than three thousand women and children in the community were eligible. UCHC developed a home care program in 1975 to provide medical and nursing services to homebound elderly in Dorchester. After securing a loan, UCHC opened a dental facility in the basement.

A State-of-the-Art Medical Facility

Since the 1970s, the health center has grown dramatically and has expanded from its 500 Columbia Road site to four additional locations in the area. In 1997, health center leadership found a site to renovate which enabled them to expand services and consolidate existing services in one location. The current 415 Columbia Road location had been a nursing home that had been closed for ten years. With financial support from Boston Medical Center, Partners, Brigham and Women's Hospital, and private funders, the building was converted into a state-of-the-art medical facility and opened in1999 – the largest economic development project in the neighborhood since the local post office was constructed in 1960.

Services Provided

Today, UCHC serves nearly 16,000 patients who average 210,000 visits each year. UCHC offers a wide range of primary care and specialty services, guidance, and counseling, as well as, comprehensive home care and adult day health services for elderly and disabled patients.

Public Health Priorities

The public health priorities at UCHC are asthma, diabetes, child and adolescent obesity, violence prevention, and drug addiction. UCHC's Teen Clinic, which has been in place for ten years, recently received a grant to help overweight and at-risk-for-overweight youth identify, pursue, and sustain physical activities. Grant funding from Partners supports UCHC's provision of comprehensive adolescent care, including a teen clinic coordinator, adolescent social worker, and adolescent health educator. Additionally, HIV counseling and testing services are now available to teens by appointment and walk-in. UCHC also has three physicians credentialed to follow patients being treated with suboxone for opiate addiction.

Keeping Senior Citizens Independent and At Home

The Upham's Corner Elder Service Plan has 145 patients enrolled in PACE, the Program of All Inclusive Care for the Elderly, and 175 enrolled in Senior Care Options (SCO). Upham's Elder Service Plan has been successful in helping medically frail elderly patients remain independent in their own homes. In addition, a second PACE site was opened in April of 2008 at 36 Dearborn St, Roxbury, to serve elders of Roxbury and the South End. Partners has provided funding to pilot a home visiting practice as part of an existing clinical practice at UCHC. The funding supports a UCHC physician who dedicates one-half day per week to making house calls, and provides administrative services in connection with the Primary Care at Home Project. Enrollment in the Primary Care at Home Project has been associated with increased use of existing UCHC programs including Homecare Visiting Nurses, SCO, and PACE. Additionally, the physician who developed the program provides one-hour case conference and teaching sessions each week for SCO nurse practitioners on topics they choose and feel would be helpful to their ongoing care of seniors at home.

Relationship with Partners and BWH

Although UCHC's primary relationship is with Boston Medical Center, as noted above, Partners and BWH have provided significant grant funding to assist UCHC in creating a facility that provides quality medical care and is accessible to thousands of area residents. BWH also shared its technical expertise to create an electronic medical record system for UCHC, and continues to provide application and technical support. BWH is addressing infant mortality and low birth weight in the community by providing prenatal care on site, including the services of a certified nurse midwife. UCHC has also participated in the Partners-wide Breast and Cervical Cancer Initiative, which provides breast and cervical cancer screening for uninsured women.

In 2008, Partners helped to fund a pilot Walking Prescriptions Program with WalkBoston at UCHC. The program is an innovative combination of personalized walking prescriptions delivered to health center clients accompanied by improvements to neighborhood walking conditions.

In the past, Partners has funded several key public health initiatives at UCHC including:

- An asthma clinic
- An adolescent health clinic
- An community health advocate serving the Haitian community

Whittier Street Health Center

Whittier Street Health Center At a Glance	
Year Founded	***1933***
Community Served	***Roxbury***
Number of Patients	***12, 589***
Patients Profile:	
Hispanic	***47%***
Black/African American	***47%***
White	***5%***
Other	***1%***

Frederica Williams, President and CEO of Whittier Street Health Center says:

WSHC was unlike many health centers that started through community support and activism. The driving force for the development of the health center was municipal government. The city had provided public health services at the Whittier site since the 1930s with well baby services. The original building was located in the Whittier Street housing development. In the mid-1960s, WSHC received funding from the Boston Department of Health and Hospitals to provide comprehensive medical services including primary care. The health center became affiliated with Boston City Hospital through the City's Outreach Program.

WSHC has maintained its commitment to serving a diverse population and providing care for illnesses that affect the entire community. Today, WSHC leases three floors of a building owned by Northeastern University. To ensure our independence and capacity for growth, WSHC is working on a capital campaign to raise funds for a new 60,000 square foot Whittier Health and Wellness Center that will double the size of the existing facility, and allow the health center to increase efficiency and capacity.

WSHC merged with the 25-year-old Boston Institute for Arts Therapy, allowing the health center to expand behavioral health services to a larger population by adding expressive arts therapists to our staff. The Arts Therapy Department at Whittier is dedicated to using the creative arts for growth, learning, healing and hope, the program provides educational and therapeutic programs to 2,000 mentally, physically and emotionally challenged children and their families throughout Greater Boston, as well as some 500 adults and elders. In 2006, WSHC launched its Public Health Initiatives Department to improve the health of all patients across all clinical areas through special programs focused on wellness, and disease prevention and management. Some of these public health initiatives include improving the quality of care for Type II diabetic patients, men, patients with cardiovascular disease, children with asthma, children who are overweight, and patients with cancer (cervical, prostate, breast, and colon).

Over the years, WHSC has received great support from BWH and Partners, which has included funding for the build out of our current site, clinical support for medical priorities, and strategic development support.

History

With funding from the city of Boston, Whittier Street Health Center consolidated existing community health services and opened as a comprehensive health center in 1967 in Roxbury. Over time, new services were offered, including adult medicine, optometry, podiatry, and dermatology. With financial support from Boston Medical Center, Partners, and BWH, in 1999, Whittier Street Health Center moved across the street and out of the Whittier Street Housing Development to its current location at 1125 Tremont Street in Lower Roxbury, where it leases three floors of Northeastern University's Renaissance Park building. WSHC serves patients from Roxbury, Dorchester, Jamaica Plain, the South End, as well as, outside Boston.

Services Provided

Whittier Street is a federally funded, JCAHO accredited community health center, which provides primary care and social services to over 12,500 children and adults who made 51,246 visits in 2008. Whittier's patients are predominantly low-income, uninsured, and underinsured. WSHC is located in Roxbury, one of Boston's neighborhoods with the majority of its members living in Boston's Empowerment Zone – an area distinguished from the rest of Boston by its higher degree of poverty, chronic illness, and high risk factors. Approximately 62 percent of patients rely on Medicaid and Medicaid HMOs, seven percent have Commonwealth Care, six percent have Medicare, and 12 percent are uninsured. Only 13 percent of patients have private insurance. Whittier has a vision to serve as the premier leader in urban health care to diverse populations by providing innovative services to improve the health of the communities served and ensuring that every resident has access to health care regardless of their ability to pay.

An International Patient Community

Nearly 65 percent of Whittier Street's patients do not speak English, so the health center offers comprehensive health and social services in 17 languages to patients representing more than 20 different countries. The health center staff reflect the diverse patient populations it serves, and when necessary it utilizes external resources for interpreter services. Whittier Street's cultural competence earned its designation as one of only ten Refugee Health Assessment Sites contracted by the Massachusetts Department of Public Health per U.S. federal regulations and one of two health centers in the city of Boston working as part of a network providing health assessment services to refugees, particularly those arriving from Africa and Latin America. Whittier is one of 45 health centers in the nation federally funded to provide primary care to public health residents. Eighty percent of the patients they care for live in public housing.

Whittier Street has an onsite pharmacy and physical therapy services that are independently owned and operated.

Public Health Priorities and Accomplishments

In May 2006, WSHC launched its Public Health Initiatives Department. Its goal is to improve the health of all patients across all clinical areas through special programs focusing on wellness, disease prevention and management. Special attention is given to several chronic illnesses including diabetes, HIV, cancer (cervical, prostate, breast, and colon), asthma, overweight, cardiovascular disease, and depression. The Public Health Initiatives Department uses a new electronic medical record for planned disease prevention and management visits.

Promoting Health Behaviors Among Children and Adolescents

Whittier has established a Healthy Weight Clinic to improve prevention, early identification, and treatment of children who are overweight, at risk for obesity, or obese. The Healthy Weight Clinic serves children ages four and up – more than 40 percent of the health center's pediatric patients qualify – with medical assessment, lab screening, goal setting, nutrition and exercise counseling, and follow-up. One hundred children have participated in the Health Weight Clinic, and 100 percent have made healthy lifestyle changes.

Complementing the Healthy Weight Clinic is the Race Around Roxbury program that targets children ages eight to 18. In two-hour, after-school sessions held five days a week, children learn healthy living strategies and begin to self-manage their weight and nutrition. Of the 44 Race Around Roxbury participants so far, more than half have made lifestyle changes, 14 percent lost more than eight pounds and 16 percent lost one to five pounds.

Improving the Health of Men

In response to racial and ethnic disparities in health among men in the Black and Latino communities, WSHC formed the Men's Health Clinic, a community-based initiative which provides innovative and comprehensive outreach, education, screening, and referrals, as well as a link to primary health care, mental health care, and related support services focused on men. To further engage the community in the importance of men's health, WSHC is mobilizing community residents through the Men's Health Ambassador Program. As part of the program, the health center trains well-known men in the community in key men's health care topics, and then sends these new ambassadors into the community to engage men in taking charge of their health and participating in men's health programming at Whittier Street. The effort has been a tremendous success; in 2006, WSHC saw a nearly 300 percent increase in the number of men of color coming to the health center for routine physical exams and cardiovascular, diabetes, and prostate cancer screening.

Improving Care for Patients with Diabetes

In 2006, Whittier Street was one of five Massachusetts health centers to receive a five-year grant, from the Richard and Susan Smith Family Foundation and the Paul and Phyllis Fireman Charitable Foundation, to improve the quality of care for Type II diabetic patients. This grant enables the health center to continue and expand its diabetes program by providing support groups, case management, patient education, and community outreach to diabetic patients. The health center's diabetic group visits have gained national recognition, and are expanding to include additional ethnic groups, such as Spanish and Somali patients. Additionally, the diabetes program provides individual home visits.

WSHC was selected as one of three health centers in the Northeast region to be a demonstration site for the Centers for Disease Control and U.S. Department of Health and Human Services-funded National Health Disparities Cancer Collaborative, which seeks to increase screenings and follow-up care for low-income women with breast, cervical, or colon cancer. Frederica Williams was selected to lead the statewide initiative.

The health center has also started a new Cancer Survivorship Clinic to reconnect cancer patients with their primary care providers after cancer treatment, so they are not left on their own. In partnership with Dana-Farber Cancer Institute, the Cancer Survivorship Clinic is providing the medical care, case management, education and emotional support needed after curative cancer therapy has ended. Whittier Street has successfully obtained a highly competitive nine-year contract with the Massachusetts WIC office to serve as the Roxbury WIC provider.

Increasing Access to Care

Whittier Street Health Center is working to create a patient-centered medical home with patients as partners in their own health and wellbeing. Some of the ways they are working to accomplish this are by having health center staff out with laptops signing people up for health insurance, tapping families in crisis to spend an afternoon a week for 12 weeks to address all of their health and personal needs, holding events like the Latino Health Fair and annual Men's Health Summit, providing patient navigation for men and women who are the least likely to see a physician or are the most susceptible to certain diseases because of their age, utilizing their electronic medical records system to coordinates patient care, offering group visits, and continually tracking their progress with focus groups and surveys to determine how the health center is measuring up to their patient's expectations and the health center goals.

WSHC is working to increase access to care at the health center to reduce the unnecessary use of local emergency room services and to help link patients without a primary care physician to a medical home. In April 2007, Whittier Street successfully opened an Urgent Care Program, through funding received from Neighborhood Health Plan, to expand the health center's hours from 9 am to 8 pm, Monday through Friday, and

from 9 am to 5 pm on Saturdays. Urgent care is open to anyone, even those who are not existing health center patients. The health center's laboratory and x-ray departments are also open during the extended hours. Since the Urgent Care Program started in April of 2007, there have been 3,801 visits. The volume was a combination of MD/NP and nurse visits.

In December 2008, WSHC took over the Veterans Benefit Clearing House HIV contract with the Boston Public Health Commission. Additionally, the health center just opened a Veterans Services Department to meet the needs of minority veterans.

Relationship with Partners and BWH

Partners and BWH have been important allies for the health center by collaborating on clinical programs and providing grant funding for new initiatives.

Concerned about the alarming rate of infant mortality caused by racial, economic, and ethnic disparities in health, BWH is committed to working closely with WSHC to address the social and medical needs of pregnant women in this community. BWH is addressing this problem in the community with certified nurse midwives who provide onsite prenatal care at the health center. WSHC is a part of BWH's Perinatal Case Manager Program (PCMP), which provides support for a case manager at the health center who provides women with comprehensive support services, in addition to the clinical care they receive through the health center's clinical relationship with BWH. This case manager ensures that culturally sensitive care continues for pregnant women through pregnancy and after giving birth. Partners and BWH also support comprehensive domestic violence services, including an on-site domestic violence advocate at WSHC.