

AFFILIATED HEALTH CENTERS

Throughout the Greater Boston area, 21 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 15 affiliated health centers¹. **The five community health centers operating under the licenses of Brigham and Women’s Hospital (BWH) and Massachusetts General Hospital (MGH), and North End Waterfront Health, which operates under its own license but has a unique affiliation agreement with MGH, are discussed within the separate sections for those hospitals.**

An Overview of Community Health Centers in Massachusetts

History

Massachusetts’ commitment to community health centers dates back more than 47 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 (Mass. League), each year 49 Massachusetts community health centers in 280 locations provide high quality, cost effective care close to home for more than 800,000 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). Ninety percent of health center patients have incomes below 200 percent of the federal poverty level (or \$41,300 in annual income for a family of four). Community health center patients represent all ages, incomes, races, and ethnicities, but 67 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

¹ Boston Health Care for the Homeless Program (BHCHP) is described in the MGH section.

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
Dental Care	Mental Health	Social Services
Dermatology	Podiatry	Acupuncture
Elder Services	Hospitalization	Home Care
Nutrition/WIC	Specialty Referrals	Public Health Programs
School Based Services	Pharmacy Services	Eye Care
Smoking Cessation	Immunizations	Fitness Programs
Substance Abuse Counseling & Treatment		Youth Peer Counseling
HIV/AIDS Screening, Counseling & Treatment		

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 that help minimize emergency department visits and prevent hospitalizations.

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. For the most recent year which data is available, Massachusetts health centers contributed \$722 million to the state's economy, generating \$505 million in household income and supported more than 10,000 jobs.

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, Carney Hospital, Massachusetts General Hospital, New England Medical Center, Children's Hospital Boston 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 women receive mammograms and Pap tests annually.
- **Improving the health of children.** From childhood immunizations to nutrition programs like WIC, to help managing asthma, and addressing obesity, 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 or teen clinics at the community health center. 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 HealthCare

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 opened in 1970. Today, there are five licensed health centers operating within the overall Partners system: three of which operate through the license of MGH in Charlestown, Chelsea, and Revere; and two of which operate under the license of BWH in Jamaica Plain -- Brookside and Southern Jamaica Plain. More than 74,959 children and adults made almost 492,953 visits to these health centers in 2012. In addition, Partners is affiliated with 16 community health centers in Dorchester, East Boston, Jamaica Plain, Lynn, Mattapan, North End, Peabody, Roxbury, Salem, South Boston, and the South End. Since 1996, Partners and its hospitals have invested over \$84 million to rebuild, relocate, or modernize aging facilities. Annually, an average of \$27 million in operating support 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. Gynecologists and nurse midwives from BWH provide clinical care at affiliated community health centers in Dorchester, Jamaica Plain, Mattapan, Roxbury, and the South End. MGH oncologists provide treatment for breast cancer patients from Chelsea, Dorchester, and Mattapan. North Shore Medical Center cardiologists, endocrinologists, pulmonologists, gastroenterologists, general surgeons and ophthalmologists provide treatment for patients in Lynn. Health centers have or are working toward establishing connectivity with Partners information systems so clinical information about care their patients receive at Partners hospitals 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 underserved women (the Avon MGH Breast Care Program), and substance abuse prevention and treatment. 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, an epidemic, or a bad flu season, and 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 supporting 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 Mass. League and other policy advocates to ensure that health reform works for everyone and that insured patients have access to primary care close to home. Toward that end, Partners, the Mass. League, Bank of America, the Commonwealth of Massachusetts, Neighborhood Health Plan, and Blue Cross and Blue Shield Foundation collaboratively support an education loan repayment plan to expand the state's supply of primary care providers at community health centers. Through 2012, 133 primary care providers have committed 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 close to 240,000 patients at community health centers. In an effort to retain providers, the program also provides small grants to individual providers to pursue a special project of interest to the provider and the health center. Since 2009, 32 Special Projects grants have been awarded to providers at Massachusetts community health centers.

The Kraft Center for Community Health

The Kraft Family National Center for Leadership and Training in Community Health (the Kraft Center) was established in 2011 by a generous gift from the Kraft family to Partners

HealthCare. Its purpose is to expand access to high-quality health care for low-income and vulnerable populations by building a strong workforce of talented physicians and nurses dedicated to community health. The Kraft Center accomplishes this goal by working closely with both community health centers and academic medicine to develop the next generation of leaders in community health. Community health centers are selected annually from throughout Massachusetts to participate as sites of clinical learning and mentorship for all Kraft Center program participants to expand access to high quality, cost effective health care for low-and moderate-income individuals and families. The Kraft Center programs include:

- Kraft Fellowship Program – a two-year post-residency program offered to 5 young physicians each year. It is anticipated that each Kraft Fellow will go on to become a recognized physician-leader committed to tackling health inequality at the patient care, policy, management and/or research level.
- Kraft Practitioner Program – a two-year program that aims to recruit and retain talented physicians and masters-prepared nurses in community health centers. Up to 16 Kraft Practitioners are selected annually from a pool of clinicians nominated by participating community health centers. It is anticipated that Kraft Practitioners will remain in active clinical practice at community health centers as they grow into leadership positions within their organizations and ultimately go on to serve as role models for subsequent generations of physicians and nurses engaged in community health.

Fourteen community health centers across the state have been sites of clinical learning and mentorship for Kraft Center Fellows and Practitioners.

Partnership for Community Health

Partnership for Community Health is an initiative of Neighborhood Health Plan (NHP), Partners HealthCare and the Mass. League to support the state's community health centers in their continued efforts to reduce barriers to access, promote health equity and organize care for patients in their communities. As part of both NHP's and Partners' deep commitment to CHCs, Partnership for Community Health will provide grant funding for projects that will enhance and further support infrastructure improvements at CHCs. Over the next 15 years, the Partnership for Community Health will provide up to \$90 million in grant funding to community health centers to develop and launch measurable programs that enhance health outcomes, services, efficiencies and quality of care. In the first round of grants, Partnership for Community Health provided \$4.25 million to 49 CHCs that are

members of the Mass. League for projects that will help prepare CHCs for patient centered medical home, state payment reform and federal health reform requirements.

Patient Centered Medical Homes

Partners is providing support for a Performance Improvement Practitioner Development Program in collaboration with the Mass. League and GE Healthcare for the licensed and affiliated health centers to help move them towards becoming certified medical homes. Twelve community health centers have sent teams to participate in this five-month long training program that includes four days of off-site training and ongoing coaching as teams learn and utilize quality improvement tools to address a specific project in their work area. Additionally, to assist mid-level managers and senior managers two training programs are being offered: Essentials of Leadership Excellence (a four-day training for mid-level managers including coaching) and Performance Improvement (two half day training sessions for senior management) designed to enhance their skills in utilizing performance improvement concepts and tools and their ability to drive change at the community health center.

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Codman Square Health Center

Dorchester House Multi-Service Center

DotWell

<i>Codman Square Health Center</i>		<i>Dorchester House Multi-Service Center</i>	
<i>At a Glance</i>		<i>At a Glance</i>	
<i>Year Founded</i>	1979	<i>Year Founded</i>	1887
<i>Community Served</i>	Dorchester/Mattapan	<i>Community Served</i>	Dorchester
<i>Number of Patients</i>	21,037	<i>Number of Patients</i>	20,714
<i>Patients Profile:</i>		<i>Patients Profile:</i>	
<i>Black</i>	83%	<i>Black</i>	27%
<i>Latino</i>	7%	<i>Latino</i>	13%
<i>White</i>	11%	<i>White</i>	29%
		<i>Asian/Pacific Islander</i>	33%
		<i>Other</i>	0%

Relationship with Partners and BWH

In 1998, Partners provided Codman Square and Dorchester House critical funding to build state-of-the-art facilities that exist today. Partners funding also helped begin and sustain DotWell, a management service organization between Codman Square and Dorchester House.

Helping At-Risk Pregnant Women to Have Healthy Babies

BWH is addressing infant mortality and low birth weight in the community with midwives, who provide onsite prenatal care for women at Codman Square and Dorchester House. To address the impact lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients.

Creating a Patient Centered Medical Home

Partners is working with Codman Square and Dorchester House on a Performance Improvement Practitioner Development Program in collaboration with the Mass. League to help move health centers towards becoming certified medical homes. One team from Dorchester House and two teams from Codman Square have participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams

learned and used quality improvement tools to address a specific project in their work area. Staff from Codman Square also participated in two trainings: Essentials of Leadership Excellence (a four-day training for mid-level managers including coaching) and Performance Improvement (two half day training sessions for senior management) designed to enhance their skills in utilizing performance improvement concepts and tools and their ability to drive change at the community health center.

East Boston Neighborhood Health Center (EBNHC)

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

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.

In 2010, EBNHC received a waiver from the state which now recognizes the urgent care department at the health center as an Emergency Department. The 24/7/365 emergency department has continued to play a significant role in addressing the problem of overcrowded hospital emergency rooms and the attendant surge in emergency room diversions. By employing emergency medicine physicians along with family medicine practitioners, internists, and pediatricians, EBNHC has captured well over 90% of the emergency room encounters in their community, sending only three to four percent of patients seen in urgent care to an acute hospital. By the use of rapid point-of-care testing and CT scans from EBNHC's affiliated hospitals (MGH and BMC) as part of the urgent care encounter, EBNHC is able to thoroughly evaluate patients to determine whether they should be discharged, monitored, or admitted to a hospital. Today there are 41,584 emergency department visits per year.

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.

Partners and MGH provide support to a number of public health programs and other key initiatives at EBNHC, including:

- Interpreter services
- Patient access to health coverage
- Emergency Department (formerly urgent care)
- Education and Training Institute
- Mental health/social services
- Let's Get Movin' (a pediatric obesity program)
- Chronic disease education and management program (working to manage asthma, obesity, and other chronic disease issues that affect patients)

Creating a Patient Centered Medical Home

Partners is working with East Boston Neighborhood Health Center on a Performance Improvement Practitioner Development Program in collaboration with the Mass. League to help move health centers towards becoming certified medical homes. A team from the health center participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area.

Harbor Health Services, Inc. (HHSI)
Neponset Health Center
Geiger-Gibson Community Health Center
Harbor Community Health Center - Hyannis
Elder Service Plan of Harbor Health

<i>Harbor Health Services, Inc.</i>	
<i>At a Glance</i>	
<i>Year Founded</i>	<i>1965</i>
<i>Community Served</i>	<i>North Dorchester, South Dorchester, South Boston, South Shore, Cape Cod</i>
<i>Number of Patients</i>	<i>27,053</i>
<i>Patients Profile:</i>	
<i>Black</i>	<i>14%</i>
<i>Latino</i>	<i>11%</i>
<i>Asian</i>	<i>15%</i>
<i>Other</i>	<i>60%</i>

Relationship with Partners and BWH

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 Program of All Inclusive Care for the Elderly (PACE) called the Elder Service Plan of Harbor Health. This program has been successful in helping medically frail elderly patients remain independent in their own homes. Today, the program serves more than 420 patients, and has moved 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 also provided funding to assist with space costs at Geiger-Gibson.

Helping At-Risk Pregnant Women to Have Healthy Babies

BWH is addressing infant mortality and low birth weight in the community with midwives, who provide onsite prenatal care for patients at Neponset Health Center who choose to deliver at BWH. To address the impact lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA

Charlie Cards and/or taxi vouchers to eligible patients.

Geiger-Gibson, Neponset, and the Mid Upper Cape health centers participate in the MGH AVON Breast Health Program, which provides funding for a patient navigator to assist patients in following up on abnormal findings and, if diagnosed, accessing treatment. Since the program began in 2002, 3257 patients have been served by the program and 32 patients have been diagnosed with breast cancer.

Creating a Patient Centered Medical Home

Partners is working with Harbor Health Services, Inc. on a Performance Improvement Practitioner Development Program in collaboration with the Mass. League to help move health centers towards becoming certified medical homes. A team from Neponset Health Center and Harbor Community Health Center - Hyannis participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area. Staff from HHSI also participated in two trainings: Essentials of Leadership Excellence (a four-day training for mid-level managers including coaching) and Performance Improvement (two half day training sessions for senior management) designed to enhance their skills in utilizing performance improvement concepts and tools and their ability to drive change at the community health center.

Lynn Community Health Center (LCHC)

<i>Lynn Community Health Center At a Glance</i>	
<i>Year Founded</i>	1971
<i>Community Served</i>	Lynn
<i>Number of Patients</i>	36,483
<i>Patient Profile:</i>	
<i>Latino</i>	57%
<i>White</i>	17%
<i>Black/African American</i>	10%
<i>Asian</i>	5%
<i>Other</i>	11%

Relationship with Partners and NSMC

Through grant funding and program support, Partners and North Shore Medical Center (NSMC) have played a critical role in the development of the Lynn Community Health Center, helping to address challenges and community health priorities. Between 1999 and 2004, 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 the development of the Market Square and Western Avenue sites, which offer primary care and behavioral health services.

In 2009, Partners provided financial support for the development of a new eye clinic at LCHC in collaboration with the New England Eye Institute and the New England College of Optometry. The new eye clinic has improved the care that LCHC provides to patients at risk for retinopathy and glaucoma. Additionally, LCHC provides preventative screenings in the Lynn Public Schools and has improved access to eye care and eyewear for children in Lynn. Partners also supported the addition of four new behavioral health providers at LCHC, greatly improving access to behavioral health services as demonstrated by the continued growth in behavioral health visits.

In 2010, Partners provided three million dollars to support the construction of a new two-story addition to the existing health center at 269 Union Street. The first floor of the new addition, completed fall 2011, includes a new Urgent Care Center with 10 new examination rooms, an isolation unit, and nursing triage station. The first floor also includes a central registration area, and improved laboratory, radiology, and service facilities. The second floor (primary care and dentistry) and basement (Wellness Center with Teaching Kitchen and administration) were completed in February 2012, and the entire building opened for services on March 1, 2012. As a result of the addition, LCHC will have the capacity to provide health care to an additional 7,000 patients.

In December 2012, Partners provided \$250,000 to support the renovation and redesign of existing space at the 269 Union Street building for LCHC’s Innovation Team to provide

Integrated Health Care, with co-location of services and active co-management of patients by medical and behavioral health providers. The renovation will increase access to primary care by adding four new exam rooms, three new behavioral health rooms, and an open plan provider office to facilitate collaboration and consultation. NSMC also awarded LCHC \$50,000 over five years to increase services for behavioral health and substance abuse prevention and treatment.

340B Pharmacy

NSMC and Partners were instrumental in LCHC's successful effort to make prescription drugs available to uninsured and underinsured patients with the opening of a 340B pharmacy through a contract with Eaton Apothecary. For FY 2012, LCHC's two pharmacy sites (298 Union Street and 12 Market Square) provided 158,575 prescriptions to patients, 52,210 were for patients who are uninsured. The number of prescriptions filled through this program has increased every quarter since the program began in 2000.

Patient Centered Medical Home Initiative

Partners is working with LCHC on a Performance Improvement Practitioner Development Program in collaboration with the Mass League to help move health centers towards becoming certified medical homes. A team from the health center participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area. Staff from LCHC also participated in two trainings: Essentials of Leadership Excellence (a four-day training for mid-level managers including coaching) and Performance Improvement (two half day training sessions for senior management) designed to enhance their skills in utilizing performance improvement concepts and tools and their ability to drive change at the community health center.

As a result of extensive effort by health center staff to document the ways it assures that patients get clinically indicated care, and that there are electronic systems in place for coordinating, tracking, and following up, LCHC submitted an application to the National Committee for Quality Assurance for recognition as a Level 3 Patient-Centered Medical Home with a preliminary score of 92.75 out of 100 points. LCHC was also certified by the Joint Commission as a Primary Care Medical Home in December 2012.

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. LCHC staff meets with the ED staff regularly to identify

ways to reduce the no-show rate and now have a well developed nurse case management group working with the nurse care managers at the hospitals to follow up on patients who did not show up for their primary care appointments, and contacting LCHC patients who have had ED visits. The project began in 2004 and the number of referrals from the ED has been steady over the past several years.

During FY12, 1,050 patients were referred by the two hospital EDs for follow up primary care appointments at LCHC's three primary care sites and 642 of these patients were seen (61%). This is a successful joint effort by the health center and NSMC to engage patients in primary care to prevent unnecessary ER utilization.

OB Text Messaging Project

Since 2010, Partners Community Health and Partners Center for Connected Health have worked with LCHC to support and ensure that their pregnant patients are receiving appropriate prenatal care through an OB Text Messaging Project. Pregnant women are sent text messages throughout their pregnancy and two months post partum. These text messages include helpful reminders like whom to contact at the health center with questions and concerns, drinking enough water, taking a prenatal vitamin, counting the babies' kicks, buying a car seat, and many more.

Based on positive participant experience and an increase in the number of women who kept their prenatal appointments, this project has been expanded to Brookside Community Health Center.

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 has been renamed CCP (Care Coordination Program) and also provides case management and linkage to free or low-cost treatment.

As the Massachusetts Refugee and Immigrant Health Program's health assessment service for the North Shore, LCHC has served over 300 new arrivals this past year from Iraq, Burma, Bhutan, Somalia, and many other countries. For the most recent three month period, LCHC served 88 newly arrived refugees, mostly from Iraq, but also from Sudan, Eritrea, Kenya, Somalia, Congo, Bhutan, and a few other countries of origin.

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.

Since 2008, Partners has provided funding to LCHC for a community health worker to support and improve ongoing health promotion activities, and help manage the social services cases in the Cambodian community. The community health worker has also organized a very successful teen group, KAYA (the Khmer American Youth Association) in collaboration with the Lynn YMCA and Catholic Charities North. The youth, many of whom would otherwise be in gangs, meet after school at the YMCA to do homework, exercise, organize, and publicize community events, like the annual Cambodian New Year Celebration in Lynn. KAYA is now based at the Lynn YMCA, with continued collaboration with LCHC and Partners.

Martha Eliot Health Center (MEHC)

<i>Martha Eliot Health Center At a Glance</i>	
<i>Year Founded</i>	1966
<i>Community Served</i>	Jamaica Plain
<i>Number of Patients</i>	10,409
<i>Patient Profile:</i>	
<i>Other</i>	76.6%
<i>Black</i>	16.4%
<i>White</i>	5.0%
<i>Asian</i>	.50%
<i>Unknown</i>	1.5%

Relationship with Partners and BWH

Brigham and Women's Hospital (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. MEHC and BWH health centers, Brookside Community Health Center and Southern Jamaica Plain Health Center, provide cross physician coverage for each other as well.

In 2007, because of 13 shootings in a 15-week period, the Jamaica Plain Violence Intervention and Prevention Collaborative (JP VIP Collaborative) was started. The JP VIP Collaborative is composed of 15 community agencies, including four health centers (Southern Jamaica Plain Health Center, Brookside Community Health Center, Martha Eliot Health Center, and The Dimock Center) and three public housing developments, working together to address violence in Jamaica Plain. The mission of the JP VIP Collaborative is to help youth and families of Jamaica Plain and neighboring communities to live safe and healthy lives by collaboratively providing access to and education about mental health services, identifying available resources and responding to families affected by violence.

The goals and services for the JP VIP Collaborative include:

- Providing education, information, and resources related to mental health to youth and families in Jamaica Plain and Roxbury
- Develop a relationship around Trauma Response prevention, and intervention with Boston Public Schools in the Jamaica Plain community
- Support strategies that will engage youth in the JP VIP Collaborative's work and empower them to reach out to other youth.

Helping At-Risk Pregnant Women to Have Healthy Babies

BWH works with MEHC to address the social and medical needs of pregnant women in the community, infant mortality, and low birth weight. Midwives from BWH provide onsite prenatal care at MEHC. The health center is part of the BWH's Perinatal Case Manager Program (PCMP), a program that provides comprehensive support services for at-risk pregnant women. To address the impact lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients.

Mattapan Community Health Center (MCHC)

<i>Mattapan Community Health Center At a Glance</i>	
<i>Year Founded</i>	<i>1972</i>
<i>Community Served</i>	<i>Mattapan, Hyde Park, and Surrounding communities</i>
<i>Number of Patients</i>	<i>7,500</i>
<i>Patients Profile:</i>	
<i>African-American, including Caribbean immigrants</i>	<i>96%</i>
<i>Others</i>	<i>4%</i>

Relationship with Partners and BWH

Mattapan moved into their new four-story, almost 50,000 square foot building to 1575 Blue Hill Avenue, in the heart of Mattapan Square on August 1, 2012. The new facility will allow Mattapan to provide new medical and dental services for their patients including behavioral health and on-site mammography services, and expand their public health programs for the community. Partners worked with leadership throughout Mattapan’s capital campaign including being an active member of Mattapan’s Capital Campaign Steering Committee, and provided financial support towards the completion of the building. Partners also provided support for essential infrastructure during this phase.

Partners, BWH and MGH, have worked closely with MCHC since 1998 to address a number of key community health challenges, including infant mortality and breast and cervical cancer. A 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. To address the impact lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). The P-TAP provides cost-effective and reliable transportation for pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients.

MCHC participates in the MGH AVON Breast Health Program, which provides funding for patient navigators to ensure that all women access screening and they follow up quickly on abnormal findings. These navigators support patients who are diagnosed with breast cancer

throughout treatment. Since beginning this outreach program in June 2001, MCHC's patient navigators have assisted 2595 patients. Of those, 34 patients have been diagnosed with breast cancer and have received follow up support and treatment.

North Shore Community Health, Inc. (NSCHI)

<i>North Shore Community Health Center At a Glance</i>	
<i>Year Founded</i>	1977
<i>Communities Served</i>	Peabody, Salem, Gloucester
<i>Number of Patients</i>	13,004
<i>Patient Profile:</i>	
<i>Latino</i>	17%
<i>White</i>	61%
<i>Unidentified</i>	22%

NSCHI has a 35 year history of service to the communities of Peabody, Salem and, most recently, Gloucester, all located in Essex County. Nearly 95% of NSCHI patients live at or below 200% of poverty.

Relationship with Partners and NSMC

Grant support from Partners and North Shore Medical Center (NSMC) has helped NSCHI reach its clinical and financial goals. NSCHI, Lynn Community Health Center (LCHC), and NSMC developed a strong collaboration to provide high quality, comprehensive care to the North Shore communities they serve.

More specifically, NSCHI has been a key contributor to ensuring the success of health care reform by ensuring that patients get the right care in the right place at the right time. The health center currently operates the following programs with NSMC and LCHC:

- **The Emergency Department Primary Care Connection Program:** This past year NSCHI expanded the program to include pediatric ED patients, in-patient discharges and appointments at its Peabody site. Through the program, adult and pediatric patients who seek care from the NSMC ED and/or who are discharged from in-patient care and do not have a relationship with a primary care provider are provided with an appointment at NSCH (next day or within 72 hours of in-patient discharge). 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 to follow-up. Several hundred patients now receive primary care through this program.
- NSCHI works closely with NSMC and LCHC on a Massachusetts Department of Public Health-funded program for uninsured or HSN-eligible women between the ages of 40-64 years old. They can be enrolled in the Care Coordination Program, which provides them with access to local providers for breast and gastrointestinal screenings and problems.

NSCHI has participated in the following clinical performance improvement projects with support from Partners:

- NSCHI clinical leadership worked closely with the Mass. League to create and implement a robust training curriculum for Medical Assistants in June, 2012. This

training was the formal launch of NSCHI's journey to becoming an NCQA certified Patient Centered Medical Home.

- NSCHI also participated in the Performance Improvement Practitioner Development Program in collaboration with the Mass. League. A "LEAN" team from Salem Family Health Center and Gloucester Family Health Center participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area. NSCHI has spread two new LEAN teams at two of its sites. Staff from NSCHI also participated in the Performance Improvement Training (two half day training sessions for senior management) designed to enhance their skills in utilizing performance improvement concepts and tools and their ability to drive change at the community health center.

South Boston Community Health Center (SBCHC)

<i>South Boston Community Health Center At a Glance</i>	
<i>Year Founded</i>	<i>1970</i>
<i>Community Served</i>	<i>South Boston</i>
<i>Number of Patients</i>	<i>14,297</i>
<i>Patients Profile:</i>	
<i>White</i>	<i>81%</i>
<i>Latino</i>	<i>8%</i>
<i>Asian</i>	<i>1%</i>
<i>Black</i>	<i>5%</i>
<i>Other</i>	<i>5%</i>

Relationship with Partners and MGH

Throughout its affiliation, Partners has worked closely with SBCHC to address many community health issues including substance abuse.

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.

Tackling the Problem of Substance Abuse

For more than 9 years, Partners has provided financial support to SBCHC's adolescent substance abuse prevention work through programs like *Young at Arts*. *Young at Arts* is an arts-infused substance abuse prevention model targeting at-risk youth, ages 12 to 18, 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. In 2012, 48 youth participated in the Young At Arts program including attending weekly meetings. Additionally, adult mentors regularly attend the weekly meetings, most of them young professionals who reside in South Boston.

Creating a Patient Centered Medical Home

South Boston has been actively preparing for practice transformation for the past several years. Partners has provided funding to support their work to move toward becoming a medical home. Partners is working with South Boston Community Health Center on a Performance Improvement Practitioner Development Program in collaboration with the Mass. League to help move health centers towards becoming certified medical homes. A team from the health center participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area.

340B Pharmacy

In October 2011, SBCHC opened a 340B Pharmacy in partnership with Eaton Apothecary with funding support from Partners. Having a pharmacy located inside the health center benefits patients as well as the community of South Boston providing fast service and affordable prescriptions at a convenient location.

Providing Food Security in South Boston

In 2010, SBCHC, working with the Greater Boston Food Bank, opened a food pantry inside the health center, as a result of the medical director determining that her pediatric patient's parents were going without food so they could feed their children. Partners provides support towards this emergency food shelter to help fill the gaps in funding. More than 400 people visit the food pantry each month.

South End Community Health Center (SECHC)

<i>South End Community Health Center At a Glance</i>	
<i>Year Founded</i>	<i>1969</i>
<i>Community Served</i>	<i>South End</i>
<i>Number of Patients</i>	17,300
Patient Profile:	
Latino	58%
African-American	25%
Other	17%

Relationship with Partners and BWH

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. More than a decade ago, 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.

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 commitment to the development and implementation of a pediatric asthma program. In 2007, SECHC recruited a Spanish speaking pediatric pulmonologist to lead this program. Approximately 150 pediatric patients are served by this program on an annual basis. MGH also collaborates with SECHC on podiatry. 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. In 2009, SECHC received a Department of Mental Health grant to hire additional staff to care for 300 seriously ill mental health patients, and help reduce hospitalization among these patients.

Helping At-Risk Pregnant Women to Have Healthy Babies

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

SECHC participates in 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. To address the impact lack of

transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients.

Creating a Patient Centered Medical Home

Partners is working with SECHC on a Performance Improvement Practitioner Development Program in collaboration with the Mass. League to help move health centers towards becoming certified medical homes. A team from the health center participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area.

Upham's Corner Health Center (UCHC)

<i>Upham's Corner Health Center</i>	
<i>At a Glance</i>	
<i>Year Founded</i>	<i>1973</i>
<i>Community Served</i>	<i>North Dorchester</i>
<i>Number of Patients</i>	<i>15,721</i>
<i>Patients Profile:</i>	
<i>Spanish</i>	<i>25%</i>
<i>Hispanic/Latino</i>	<i>15%</i>
<i>Cape Verdean</i>	<i>18%</i>
<i>Black</i>	<i>24%</i>
<i>Asian</i>	<i>4%</i>
<i>White</i>	<i>5%</i>
<i>Other</i>	<i>9%</i>

Relationship with Partners and BWH

Although UCHC's primary relationship is with Boston Medical Center, Partners and BWH have provided significant grant funding to assist UCHC in creating a facility that provides quality medical care that is accessible to thousands of area residents. Partners is providing significant support as UCHC moves to a new practice management system, electronic medical record, and IS network infrastructure.

Helping At-Risk Pregnant Women to Have Healthy Babies

BWH is addressing infant mortality and low birth weight in the community by providing prenatal care on site, including the services of a midwife. To address the impact lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients.

Partners is working with UCHC to build a home visiting program that complements the robust services provided to elders at the health center. In FY12, 11 patients were followed through this program resulting in 48 home visits.

Partners provides funding for several key public health initiatives at UCHC including:

- A full-time nurse case manager who works with patients to manage their asthma or diabetes; in FY12 served 182 patients
- An adolescent health clinic
- Community health advocates that serve the Cape Verdean and Haitian communities; in

FY12 served over 12,000 patients

Creating a Patient Centered Medical Home

Partners is working with UCHC on a Performance Improvement Practitioner Development Program in collaboration with the Mass League to help move health centers towards becoming certified medical homes. A team from the health center participated in a five-month long training program that included four days of off-site training and ongoing coaching as teams learned and used quality improvement tools to address a specific project in their work area. Staff from UCHC also participated in two trainings: Essentials of Leadership Excellence (a four-day training for mid-level managers including coaching) and Performance Improvement (two half day training sessions for senior management) designed to enhance their skills in utilizing performance improvement concepts and tools and their ability to drive change at the community health center.

Whittier Street Health Center (WSHC)

<i>Whittier Street Health Center At a Glance</i>	
<i>Year Founded</i>	1933
<i>Community Served</i>	Roxbury
<i>Number of Patients</i>	13,920
<i>Patients Profile:</i>	
<i>Hispanic/Latino</i>	44%
<i>Black/African American</i>	43%
<i>White</i>	5%
<i>Other</i>	7%
<i>Asian</i>	1%

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. In 2010, BWH provided significant support for Whittier Street Health Center's new six-story facility on Tremont Street, which opened on January 3, 2012. This new facility will provide much needed space for WSHC to care for their existing and growing patient population. The new health center building offers primary care, dental services, a pharmacy, a physical therapy clinic, and community space for educational programs and resources. Additionally, WSHC is collaborating with Dana-Farber Cancer Institute to provide mammography and cancer screenings onsite.

Helping At-Risk Pregnant Women to Have Healthy Babies

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 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. To address the impact that lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, the Center for Community Health and Health Equity (CCHHE) at BWH has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients. Partners and BWH also support comprehensive domestic violence advocacy services, including an on-site domestic violence advocate at WSHC.