

Whittier Street Health Center

Public Housing Healthy Weight Initiatives

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July 18th, 2008

Session Objectives

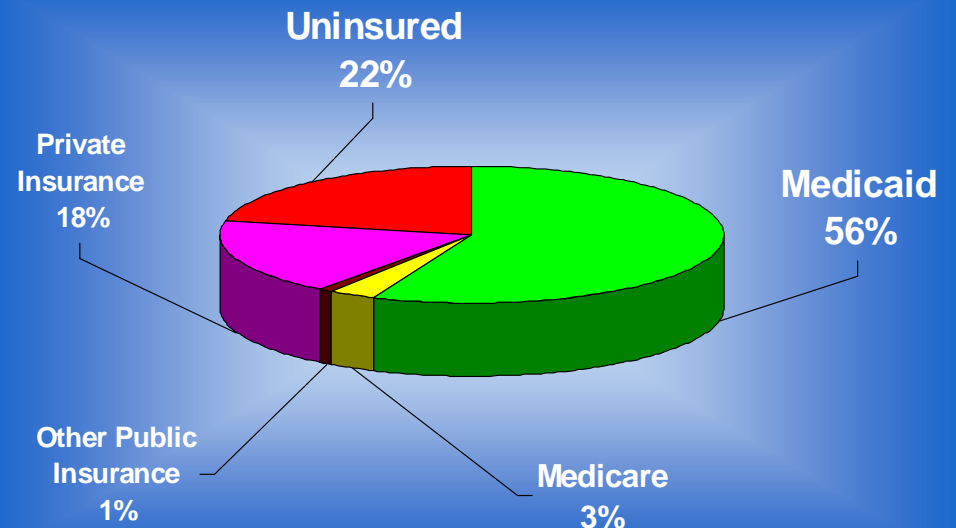
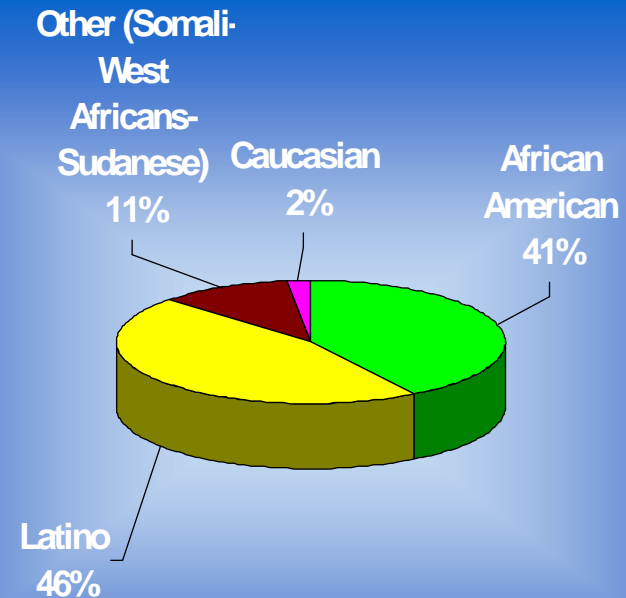
- To introduce you to Whittier Street Health Center
- To introduce you to our patient population
- To describe the connection between obesity and being publicly housed
- To describe the Care Model and Whittier's approach using the Care Model for Obesity
- To introduce Whittier's strategic interventions for both adult and childhood obesity
- To talk about lessons learned

Whittier Street Health Center

- **Urban community health Center located in the Roxbury neighborhood of Boston, MA**
- **Patient Population**
8,803 Primary Care patients
3,168 Social Services patients
- **Predominantly African American, Latino, African**

Mission

To provide high quality, reliable and accessible primary health care and support services for diverse populations to promote wellness and eliminate health and social disparities.



Whittier Street Health Center: Population served

- **The patients and clients accessing services at WSHC are predominantly low-income, uninsured and underinsured.**
- **53% of patients are children and adolescents ages 0-17; 15% are between the ages of 18-40; 32% are 40 and older. Among this population women make up 57% of those accessing care.**
- **WSHC is part of the Boston Empowerment Zone, an area distinguished by its higher degree of poverty and urban blight and whose residents are subject to considerable negative socio-economic and environmental risks to their overall health, well being and longevity.**



Whittier Street Health Center: Population served

As of the 2000 census, 29% of Roxbury's population was below the federal poverty level, compared with 20% of Boston's overall population.

WSHC attracts significant numbers of low-income individuals, including the “working poor” and unemployed, with household income levels at less than half of the federal poverty threshold (i.e \$19,350 for a family of four)

Thirty four percent of the total patient population lives well below the federal poverty and 20% of them are uninsured.



Whittier Street Health Center:

Core Services

Adult Medicine
Counseling and Behavioral Health
Eye Care and Eye Wear Dispensary
Laboratory
Radiology
Clinical Pharmacy Program
Dermatology
Orthopedics
Podiatry
Nutrition
Medical Interpreters
Obstetrics and Gynecology
Pediatrics/Adolescent Health
Geriatric Services
General Dentistry, Oral Surgery and
Orthodontics

Mission-Based Services

Post Prison Release Program
Men's Health
Family Care
HIV/AIDS
Public Housing Outreach
Prevention Education
Pregnancy and Parenting Services
Women's Infants and Children (WIC)
Whittier Youth Services and
Enrichment (WYSE) Youth Program
Wellness Programs
Advocacy and Legal Services
Refugee Health Assessment
Domestic Violence
340B Pharmacy Program



Disease Management Clinics

- Diabetes Clinic and Group Visits
- Asthma Clinic
- Pediatric Healthy Weight Clinic
- Adult Healthy Weight Clinic

HRSA Funding and Whittier's Background

- Founded in 1933 as a Well Baby Clinic**
- Incorporated in 1991 as a Federally funded Community Health Center (CHC)**
- HRSA 330 CHC**
- HRSA 330 Public Housing Grantee**
- Accredited by the Joint Commission for Accreditation of Healthcare Organizations since 2002**



What makes us Unique?

- One of 11 Refugee Health Assessment Centers in Massachusetts
- First Massachusetts health center to incorporate Arts Therapy
- Men make up 43% of those accessing care

HRSA Funding and Whittier's Background

- **Awarded a two year HRSA Expanded Medical Capacity grant to increase the number of Public Housing users by 1,000 over two years.**

We utilize this funding to expand three of our Public Housing Centers of Excellence:

- a) Pediatric Healthy Weight**
- b) Geriatrics Comprehensive Care**
- c) Men's Health**



Some of the Medical and Social Challenges experienced by our Public Housing Residents

- **Increased environmental risks – smoking, diet**
- **Violence (Youth Violence, Domestic Violence, Witness to Violence)**
- **At-risk females**
- **Men's Health**
- **Asthma**
- **Obesity**
- **Mental Health and Substance Abuse / Addiction**
- **HIV / AIDS**



Some of the Medical and Social Challenges experienced by our Public Housing Residents

- **Post Prison Re-entry and Integration**
- **Unemployment / Hopelessness / Education**
- **Significant growth in new immigrant population
needing help to navigate Health Systems**



How We Started:

Developed a five year Strategic Plan which included strategic objectives to address:

- **Health Disparities and Population Specific Issues,**
- **Health Promotion, Wellness and Community Outreach,**
- **Clinical Performance Measures and Best Practices**
- **Clinical Programs and Operations**
- **Expanded Health and Wellness Service Capacity**



How We Started:

- **Participated in the National Health Disparities Collaborative in 2003 (Diabetes)**
- **IOM Quality Chasm report guided our planning**
- **Selected by HRSA to participate in the National Cancer Dissemination Demonstration Project in 2005**
- **Established a Public Health Initiatives department in May 2006 to support the Expanded Care Model implementation**



**Health Disparities Collaborative
Guidance and principles in trying to
accomplish the same goals at Whittier:**

- **Improve Access to Health Care**
- **Improve Health Outcomes**
- **Improve the Quality of Health Care Eliminate Health Disparities**
- **Improve the Public Health Care Systems**

by

- **Generating and documenting health outcomes for underserved populations;**
- **Transforming clinical, financial, and operational practice through models of care, improvement and learning in the context of Community Oriented Primary Care;**
- **Developing infrastructure, expertise and multi-disciplinary leadership**



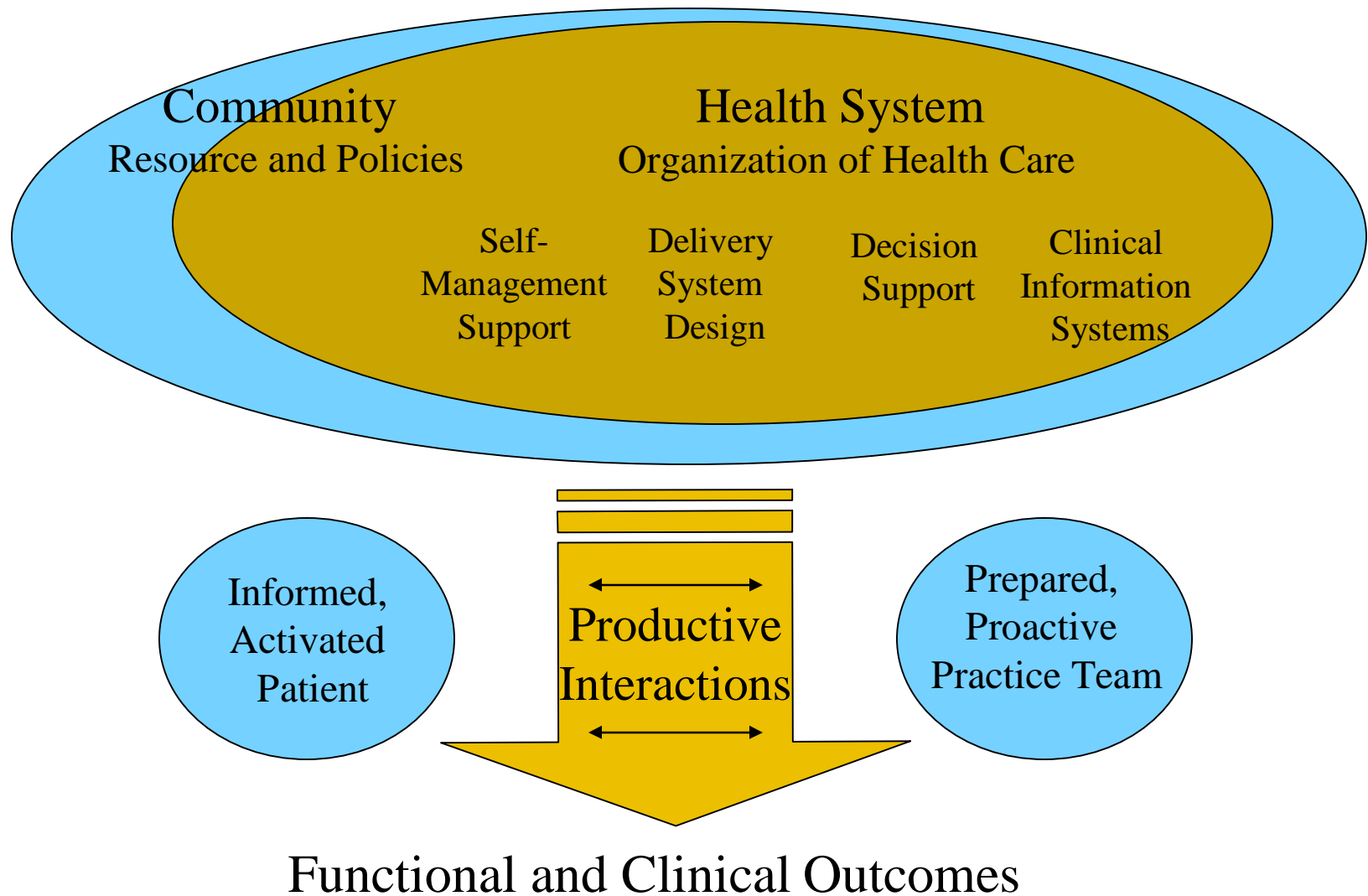
Obesity Statistics

- Massachusetts has an adult obesity rate of 18.6%
- Massachusetts is one of 31 states whose rate rose last year
- Massachusetts has a rate of 6.0 % for diabetes and 23.8 % for hypertension
- Locally, more than half (52%) of Boston residents report being overweight or obese
- 25% of Whittier's adult population have a BMI>35%
- Boston Youth Survey found 48% of youth age 9 –12 are overweight

The Connection between Obesity and Being Publicly Housed

- Few places to get a healthy meal
- Local options are fast food and/or local convenience store with primarily soda and candy
- Less than ideal facilities for exercise
- Unsafe neighborhoods for outdoor activities
- Indoor activity areas also rare
- Residents often poor and minorities. Rates of obesity are higher among poor and ethnic minorities

Chronic Care Model (Care Model)



Care Model Implementation

- **Our experience has affirmed the Care Model's ability to overcome deficiencies in the health care delivery system and to transform it from reactive to proactive care focused on wellness.**
- **We embarked on an Expanded Care Model approach to include services provided at and for our Public Housing residents.**
- **Our focus is to improve the quality of patient experience and care and to address aspects of health disparities for Public Housing residents.**



Chronic Care Model (Care Model)

Our approach is based on the recognition that the health care organization needs to be capable of meeting community needs of our public housing residents, addressing psychosocial needs of patients, providing modern, evidence-based care and coordinating care across settings through greater office efficiency, better access to care and more assured patient safety.



PHI Staff supporting Care Model

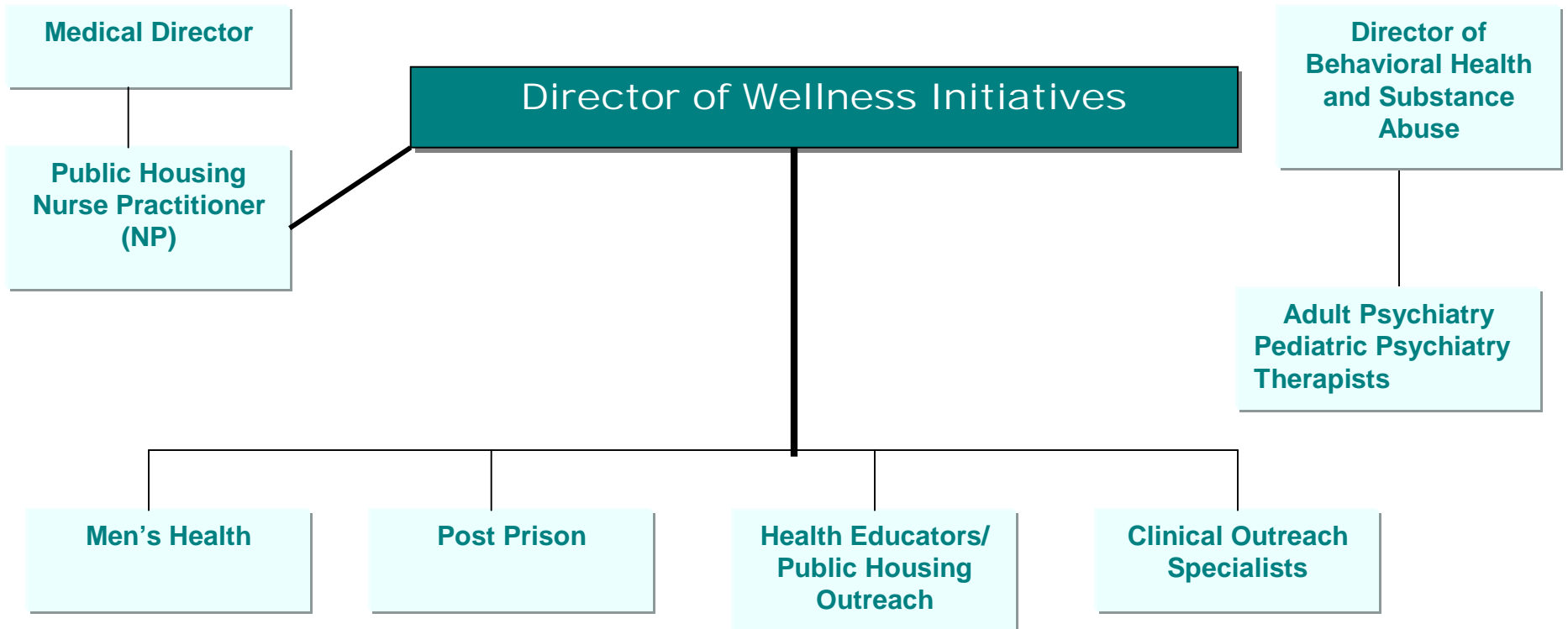
Intensive Case Management / Self Management

- **Communication with patients** – letters, follow-up phone calls and letters for patients who were overdue for an office visit
- **Self –management process** –an accurate assessment of what is truly going on with the patient. Following the assessment, the examiner and the patient can decide on a realistic goal for the patient to work on.
- **PHQ- 9 screening** - the PHQ-9 is designed to have patients assess their own level of functioning, as it is relevant to feelings of hopelessness and depression.
- **Planned visits** - The major goals of the PV are completing anything that is due for the patient during the visit time – the self management process, PHQ -9 screening, referrals, community resource information which will enable providers to spend more time on patients’ medical concerns. The patients responded favorably to the planned visit and revealed that they feel that they can express their concerns in an environment where they have individual attention.



Community Relations Staff

(Staff supporting Public Housing Residents)



Chronic Care Model (Care Model)

Community Outreach:

- Hired Public Housing Outreach staff to recruit patients – use laptops to enroll patients and insurance enrollments.
- Provide services on-site at elderly and public housing facilities.
- Support groups and educational classes run by Whittier staff.



Chronic Care Model (Care Model)

Community Outreach:

- Health Fairs and screenings involving Public housing residents
- Formed partnerships with community organizations including Tenant Associations, Boston Housing Authority, Roxbury Community Alliance for Health, Lower Roxbury Coalition, Boston Public Schools, YMCA and Churches.



Community: Weight Management

- **Outreach to agencies for additional resources:**
 - Boston Medical Center
 - Joslin Diabetes Center
 - Massachusetts Diabetes Control program
 - Drug companies (Literature, pedometers, glucometers)
- **Dana Farber Cancer Institute**
- **Brigham and Women's Hospital**
- **Children's Hospital**



Childhood Obesity

- Healthy Weight Clinic
- Race Around Roxbury

Healthy Weight Clinic

- Format
- Recruitment Activities
- Case Management
- Utilization

Healthy Weight Clinic Format

- Ages 2 – 17 at 85% or greater of weight percentile
- Weekly clinic
- Case Manager contacts family
- Average of 6 – 8 visits
- Preventative clinic
- Multidisciplinary

Recruiting Kids for the Healthy Weight Clinic

- Electronic Medical Record Search for >85% percentile (not BMI) for children between 2 and 17 years old
- Generic letter sent as if to all parents with flier
- Pediatricians suggested to patients
- Letters to greater than 95%, conversations from providers for greater than 85% - 95%

Case Management

- Full-time Case Manager in Pediatrics
- Case Manager works 10 – 6 p.m. daily
- Parents have cell phone # for Case Manager

Race Around Roxbury

- The Objective
- The Model
- The Funding
- The Utilization

Race Around Roxbury Objective

- Develop an after school program designed to encourage kids 6 – 17 to eat well, exercise regularly and have fun
- Introduce kids to a variety of physical activities
- Develop a process so kids could enter and leave at any time
- Integrate Art Therapy component
- Integrate a nutrition component

A Typical Race Around Roxbury Week

- Monday 3:30 – 4:00 – healthy snacking
- 4:00 depart for activity
- 4:15 – 5:15 – Martial Arts
- 5:30 – return to Center enter activity/mileage
- Tuesday – snack – Martial Arts
- Wednesday – snack – community walking
- Thursday – snack and Art Therapy developing personal boxes – weigh in

Recruiting Kids for R @ R

- Targeted mailing sent to families with children at or above 25% BMI
- Providers had fliers to present to appropriate families
- Posters around Center
- Positioned as an after school physical activity – fitness and fun
- All children in family can attend
- Prizes for accomplishments
- Free sneakers and MP3 players or equivalent prize

Utilization Thus Far

- Goal was 10 participants first year
- 26 kids currently participating with 35 participating to date
- Two sponsored in full-time Summer Camps and Two in free camps

Lessons Learned

- Kids love free stuff
- Kids love to compete but not lose
- Connection to parent/guardian is important
- Inviting other children from family is essential
- Older teens do not want to be around younger kids
- Celebrate regularly and include families

Adult Obesity

- Programs and Services
- Healthy Weight Clinic
- Be Fit Be Well
- Roxbury Weigh-In

Healthy Weight Clinic

- Targeted mailing sent to all patients with a BMI greater than 35% - generic presentation
- Adult Primary Provider who is gastric bypass recipient
- Primary providers referring patients
- Referrals from Be Fit Be Well
- Interdisciplinary team to support patients considering bariatric surgery (Psychologist, Nutritionist, MD and Case Manager)
- Currently one full day a month
- Began last month and 6 patients thus far have been scheduled

Be Fit Be Well

- Boston Medical Center partnership
- Part-time Case Manager
- Introduces Patients to how technology can assist their weight management goals
- Focuses on self-management goals and behavior changes/tracking
- Telephone for support and on-going encouragement

Roxbury Weigh-In

- Conducted twice a year
- Three month educational program on weight management
- Goal of 30 participants
- Guest speakers, cooking demonstrations and exercise
- Healthy meals served
- Those completing series get a month gym membership and a discounted membership after that initial month

Lessons Learned

- Adults like free things
- Having food helps
- Pay careful attention to what the program is called
- Outreach is a sensitive issue
- Engage your primary providers
- Need a provider champion

Last Enrollment

- 7 men/19 women
- 20 African American/Black
- 6 Hispanic
- For 19 of the 26 this was their first experience in a weight management program
- 7 of the 26 said they ate fruits/vegetable at least three times a day
- On average they were accessing fast food 8 times a week

Benefits of Care Model Implementation for Obesity

Community Resources and Linkages:

- ❑ The Center has established stronger linkages with community organizations that can enhance our capabilities, provide key patient services or improve care coordination as it relates to weight management
- ❑ For Whittier patients, Clinical Team have the patient information, decision support, and resources necessary to deliver high quality care



Benefits of Care Model Implementation for Obesity

- ❑ Team have defined roles, uses planned visits to support evidence based care
- ❑ Case management assures regular follow up and care coordination and program participation
- ❑ Evidence based guidelines are integrated into care, and supported by provider education
- ❑ EMR functions as a database of clinically useful data and provides timely information on all patients



Benefits of Care Model Implementation for Obesity

- ❑ Demonstrates that patients can be engaged and activated using self management and planned visits
- ❑ Organization and managers encourage and support better care using ongoing quality measurement and improvements
- ❑ Provides a measurement tool for job performance evaluation for all staff, patient satisfaction and clinical outcomes
- ❑ Demonstrated increase in Public Housing users.



Benefits of Care Model Implementation

- ❑ Ability to track disease specific outcome measures using evidence based guidelines has given the data needed to identify successes, areas requiring improvements and comparison to Best Practices
- ❑ Our Public Housing and other clients now see us as experts in a wide variety of chronic diseases and public health issues, including weight management
- ❑ Provided case for support from private and public funders



THE END



“the Best of Whittier is YOU!”