Boston Medical Center
Community Health Programs

Children with Medical Complexity

Family Navigation Team

Telehealth Epilepsy Care Collaborative

Housing Prescriptions as Health Care

BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Boston Medical Center Case Study

At Boston Medical Center – known locally as BMC – all are welcome and treated equally. This 514-bed academic medical center is also the largest safety net hospital and busiest trauma and emergency services center in New England.

When compared to many cities across the country, Boston is a healthy city, with numerous successes to celebrate. However, this is not uniformly the case for all neighborhoods or population groups in Boston, and specific groups consistently experience poor health outcomes. BMC serves a significantly disproportionate number of disadvantaged patients who live in the Greater Boston community. Approximately 32% of patients do not speak English as a primary language, and 59% of patients are from underserved populations, such as the low-income and elderly, who rely on government payers for their coverage.

Unwavering in its commitment to the community, BMC makes community health investments and social interventions core to their day-to-day operations. Integrating upstream interventions into BMC's clinical care models is critical to achieve equity and health in the broadest sense. The goal is to foster innovative and effective new models of care that are essential for patients and communities to thrive.

BMC's community health programs, powered by Activate Care's community health platform, have achieved:

- 40% reduction in avoidable inpatient visits, with 29% reduction in length of stay.
- Significant improvements in child health status and parental anxiety and depression.
- Increased Quality of Life scores reported by parents of medically complex children.

Community health outcomes that last

You can't create equitable health outcomes for America's communities without tackling the underlying economic and racial disparities that drive them. BMC recognizes that poor health is often caused or exacerbated by a lack of economic resources, which creates additional challenges for our patients in their day-to-day-lives. Addressing the root causes of poor health, which are largely driven by low income, allows health systems to disrupt the cycle of poor health. BMC's efforts to address social determinants of health have taken shape in several community health programs and social interventions:

- **Massachusetts Alliance for Complex Care,** provide families of children with medical complexity with integrated medical, behavioral, and social care teams, working together in an electronic shared care plan developed by Activate Care.

- **Family Navigation Team,** an evidence-based care management strategy designed to help low income and minority families access timely mental health services, with technology-assisted delivery of care coordination powered by Activate Care.

- **Telehealth Epilepsy Care Collaborative,** a telemedicine program connecting epilepsy and neurology patients and families to their specialty and community providers across 13 clinical sites across the state, incurring less wait time and fewer travel costs.

- **Housing Prescriptions as Health Care,** an innovative intervention combining services across the health, housing, social and legal service sectors in order to improve housing stability and child health outcomes among participants.

All-in-one platform for SDOH care

Imagine if our healthcare system seamlessly coordinated care around all of our physical, behavioral, and social needs. With Activate Care this is the new standard of care.

The Activate CareHub™ offers everything communities need to manage high-quality care coordination and community resource referral networks in your community. Hundreds of organizations across the country rely on Activate Care to improve community health outcomes and address the social determinants of health. **Join us.**