BAYWELL HEALTH

Improving Health Outcomes for Black Residents Through Community-Based Care

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ABOUT BAYWELL HEALTH

Baywell Health (formerly West Oakland Health) exists to be a trusted health care partner to the Bay Area's Black communities. With a 200-person staff serving over 1,000 patients across its East and West Oakland locations, Baywell offers comprehensive care spanning gynecology and women's reproductive health, adult medicine, pediatrics, optometry, behavioral health, oral health, pharmacy services, and more.

The Baywell team enhances its patients' well-being and dignity by providing compassionate care that values and supports every individual and family. Baywell Health is a patient-centered medical home with deep roots in the Bay Area and a strong commitment to community since 1967. In addition to accepting Medi-Cal, Medicare, and other insurance types, Baywell offers a sliding scale payment option so that no one is turned away due to cost of care.

A CASE STUDY OF BAYWELL HEALTH'S WORK TO IMPROVE ENGAGEMENT WITH PREVENTIVE HEALTH SERVICES

Baywell Health's Pulse of Change project, Bridging the Gap, is designed to address health inequities experienced by Black communities in Oakland. Baywell Health will provide culturally concordant patient navigation and social interventions to 100 Black patients with uncontrolled hypertension and diabetes. Patients will receive home and community-based screening and education coupled with in-clinic care to control chronic conditions and prevent infectious diseases. Each patient encounter is a step towards a healthier Oakland.

WHY THIS FOCUS?

Black communities in Oakland face persistent and disproportionate health inequities, including lower life expectancy and higher rates of chronic disease. Targeting uncontrolled hypertension and diabetes with early detection and consistent care can save lives, build confidence among Black Oakland residents, and empower them to take charge of their health.

GOALS

- Patients feel an increased sense of trust, understanding, and overall satisfaction with their relationships with Baywell providers.
- Patients gain more access to effective social interventions and community-based resources.
- Patients experience improvements in management of chronic conditions.
- Patients have the knowledge and resources to take control of their health.

STRATEGIES

- Identify and engage 100 Black residents with uncontrolled hypertension and diabetes.
- Provide cultural concordance training to Baywell staff.
- Leverage three-step intervention to ensure holistic continuum of care: home/community visits, clinic appointments, and post-clinic follow-ups.
- Connect patients to social services, such as housing, food assistance, and transportation assistance.
- Gauge effectiveness of care and programming with patient surveys, focus groups, and data analysis.

IMPACT METRICS

- Track six HEDIS (Healthcare Effectiveness Data and Information Set) measures:
  1. Diabetes control
  2. Hypertension control
  3. Breast cancer screening
  4. Cervical cancer screening
  5. Colorectal cancer screening
  6. Vaccination uptake
- 30% increase in patient satisfaction.
- 30% improvement in chronic condition rates.
- 90% of Baywell providers undergo cultural concordance training.
- 100% of targeted patients receive transportation assistance to health care visits.
- 25% increase in use of community-based services by targeted patients.

SUPPORTED BY CHCF'S PULSE OF CHANGE INITIATIVE

In late 2023, California Health Care Foundation put out a call for projects that would improve clinical quality of care for Black Californians. Of the many community clinics, hospitals, and technology start-ups from across the state that responded to the call, CHCF awarded grants to eight organizations using a variety of strategies to create a safer, stronger, and fairer health system for Black Californians. Funded projects focus on topics ranging from culturally responsive prenatal care to hypertension management and colorectal cancer screening.