



For Immediate Release

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**Blue Cross Blue Shield of Massachusetts Foundation
Awards \$1.3 Million in Grants
To Support Integrated Behavioral Health and Primary Care
For Low-Income & Vulnerable Populations**

Boston - December 18 – Individuals with behavioral health and other medical issues are among the highest need, most complex patients in the health care system but rarely receive care that integrates both aspects of treatment. The National Co-morbidity Survey Replication (NCS-R) shows that 68% of adults with a severe behavioral health disorder had at least one chronic medical condition, and 29% of adults with a chronic medical condition have serious mental illness. Moreover, those with a mental illness live far shorter lives than those without, partly due to treatable medical conditions and inadequate access to medical care.

Better coordination of primary care and behavioral health – including early identification, timely and regular treatment, and rehabilitation and recovery supports – is important to improving health care outcomes and potentially controlling costs for people with behavioral health needs. “We believe the time is now to invest in and evaluate programs that have experience providing primary care and also treating mental health and substance use disorders to help define what truly constitutes an effective integrated model of care,” said Audrey Shelto, President of the Blue Cross Blue Shield of Massachusetts Foundation.

The Blue Cross Blue Shield of Massachusetts Foundation’s new grant program called **Fostering Effective Integration of Behavioral Health and Primary Care** will support ten organizations that are currently implementing collaborative, co-located and integrated service models for patients with a range of medical and behavioral health needs, including support for their families. The grantee organizations represent a variety of provider types – community health centers, community-based behavioral health centers and hospital-based programs – located throughout the entire state. “We are thrilled to be working with some of the most experienced health care providers in the Commonwealth and look forward to sharing information and collaborating on this critical issue,” said Shelto.

The focus of these one-year grants is the evaluation and assessment of integrated care programs that demonstrate the greatest likelihood of effectiveness across a range of domains such as increased access, improved outcomes, greater patient engagement and reduced costs. The Foundation will document the success factors, barriers and challenges faced by grantees with the intent of making a longer-term investment in promising, replicable models in the future.

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A complete listing of the Fostering Effective Integration grantees with a brief description of their program is below. For additional information on the Foundation, please visit our website at www.bluecrossmafoundation.org

ABOUT THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION:

The mission of the Blue Cross Blue Shield of Massachusetts Foundation is to expand access to healthcare for low-income and vulnerable individuals and families in the Commonwealth. The Foundation was founded in 2001 with an initial endowment from Blue Cross Blue Shield of Massachusetts. It operates separately from the company and is governed by its own Board of Directors.

Fostering Effective Integration of Behavioral Health and Primary Care Grantees:

Boston Health Care for the Homeless Program (BHCHP)

The Boston Medical Center (BMC) Campus Clinic of the BHCHP opened in 2008 and serves more than 4000 patients each year; 72% of whom had at least one mental health diagnosis and 77% of whom had either a diagnosis of substance use disorder or a history of overdose. Since opening this site, BHCHP has focused on coordinated care across disciplines and has co-located primary care and behavioral health services. Behavioral health clinicians and psychiatrists are embedded in primary care to promote ease of access for patients, reduce stigmatization, and enhance the level of consultations across disciplines. Behavioral health clinicians have created dedicated "open access" appointments to accommodate referrals from primary care, same-day appointments, and walk-ins.

Brookline Community Mental Health Center (BCMHC)

Healthy Lives (HL) is a BCMHC program created in 2011 designed to reduce mortality, improve health outcomes and increase primary care and behavioral health access for patients with co-occurring serious mental illness and multiple chronic conditions. Healthy Lives is a patient-centered model that leverages intensive care management strategies to improve access, integrate care, and help reduce barriers to treatment for patients with complex needs. In addition to operating a community-based care management model – that includes home visits, and individual and group counseling – the program introduces self-care and wellness activities for patients to become more engaged in their own health. HL serves low-income adults living in Brookline, Roxbury, Brighton and Allston, who present with serious mental illness (schizophrenia, bipolar disorder, major depression, severe anxiety or PTSD) and at least two chronic medical conditions (including diabetes, cardiovascular disease, or COPD), and is implemented in partnership with primary care physician groups at Beth Israel Deaconess Medical Center and with Bowdoin Street Community Health Center in Roxbury.

Cambridge Health Alliance/Windsor Street Clinic (CHA)

The CHA Collaborative Practice Model was developed in 2011 to support children with mental health and substance abuse treatment needs at the Windsor Street Clinic to test the concept that greater and earlier integration of care would improve their physical health. The program is focused on: improving behavioral health services for at-risk children and adolescents by providing timely access to culturally competent evaluation and treatment; enhancing integrated

care between pediatricians and mental health providers, including increased understanding of unique family cultures and social dynamics that impact the child's health; improving family engagement in behavioral health treatment, and building better communication between providers and parents; providing greater outreach and follow-up processes with the children and their parents, through outreach from and involvement of two tri-lingual family support specialists; reducing unnecessary expense associated with treatment delays or poor quality of care; and, expanding the integrated care model throughout other clinics in the CHA system.

Center for Human Development (CHD)

CHD has created a project in partnership with two health centers to provide integrated care to seriously mentally ill adults and individuals with substance use disorders. The health centers – Caring Health Center of Springfield and Holyoke Health Center – provide integrated primary care, care management and wellness services, and the Western MA Recovery Learning Community provides peer-guided wellness groups and peer specialists. The largest cluster of patients is within the Department of Mental Health funded Community-Based Flexible Supports (CBFS) program, identified as 'super-utilizers' with high rates of avoidable ED visits. The program provides primary care services to people with serious mental illness on site at a CHD community mental health center, with a focus on patients with diabetes, pre-metabolic syndrome, and high-risk for cardio-vascular disease. Chronic disease management and wellness programs are provided by primary care nurses and peer specialists, and patients involved with the integrated care program experience reduced wait-times when seeking medical care at the respective health centers.

Community Health Center of Cape Cod (CHC)

CHC of Cape Cod is a patient-centered medical home that has organized its 15,000 patients into primary care teams consisting of physicians, nurse practitioners, nurses, behavioral health counselors, and non-clinical support personnel for the purposes of providing comprehensive integrated care. The health center is implementing a center-wide risk stratification system to identify the most at-risk patients. They are utilizing a combination of national best practices and center-designed tools to identify patients with significant behavioral and medical health co-morbidities, uncontrolled chronic diseases, increased risk for hospitalization, and a history of frequent ED visits. This grant will help support the full implementation of the risk stratification process, and a Complex Care Management program, which a RN has recently been hired to lead. Patients with such indicators as CVD malignancies, positive M3 screens (screens for depression, PTSD, anxiety, bipolar disorder, suicidal thinking, and functionality), a positive SBIRT screen, active drug or alcohol dependency, frequent hospitalizations, difficulty with medication management, and other issues will be treated through the Complex Care Management program. Other patients with lower risk indicators will receive individualized care management from their usual providers and the integration teams, as described above. Integrated care teams will design care plans with the active involvement of the patient and their family members; progress and follow-up plans will be documented. When a patient with complex behavioral health needs is referred to another community partner (e.g. Gosnold, Bayview, Falmouth Hospital, Cape Cod Behavioral Health), the health center tracks to see if the patient schedules an appointment, and requests a 'release of information' to include in the patient's EHR for better continuity of care.

Community Healthlink, Inc. (CHL)

CHL is the largest provider of mental health, substance use disorders and homeless services in Central MA, serving more than 19,000 unique individuals each year. In October 2010, CHL received a four-year SAMHSA grant to implement the Primary and Behavioral Health Care Integration (PBHCI) program to improve access to and engagement in primary care and wellness services for more than 400 adults seeking mental health and substance abuse treatment at CHL. To meet these service needs, the Wellness Center was developed at CHL wherein primary care physicians, nurses, nurse case managers and peer specialists delivered medical care and a variety of wellness interventions for adult consumers between the ages of 18 and 72 with behavioral health needs. Key goals of the initiative are to continue to enhance (a) care coordination and communication between the providers at the Wellness Center, the CHL outpatient clinic, and those in the community who provide other types of services to CHL consumers, and (b) electronic health record infrastructure and processes.

Dimock Community Health Center (Dimock)

Dimock's approach to delivering integrated care is to focus on interventions designed for specific patient segments – pediatrics, adult medicine, and OB/GYN. Integrated care practices are at different levels of maturity, with pediatric integration having begun in 2011, adult medicine in 2012, and OB/GYN in October 2013. The health center has more 14,000 patients, and expansion of integrated care to adult medicine and OB/GYN marks the launch of routine screening for depression of all patients with the PHQ-9 instrument. As part of universal prevention protocols, patients with no initial behavioral health symptoms will have periodic screenings during medical appointments. Those at risk will receive appropriate behavioral health approaches through co-management with primary care providers (PCPs) and resource coordinators (RCs). Others will require basic interventions, such as peer specialist-led groups for brief episodic interventions from the behavioral health team. Those patients with a mental health disorder will receive treatment from the full behavioral health team (Medical Social Worker, psychiatrist, therapist, and/or substance use clinicians), in partnership with PCPs and RCs. The integrated team will coordinate care with external specialists for patients with severe mental illness who require subspecialty, intensive or home-based care.

Lynn Community Health Center (LCHC)

LCHC has developed and implemented a fully integrated primary care and behavioral health program with (a) the co-location of services, (b) co-management of patients by the medical and behavioral health providers through a 'shared care' model, and (c) utilization of a shared EHR. There are five integrated health teams, each with five to nine primary care providers of various types (i.e. family medicine, internists, nurse practitioners, etc.), two to three licensed behavioral health therapists, a psychiatrist or advanced practice psychiatric nurse practitioner to work with the PCPs in prescribing psychotropic medications, and clinical assistants and nurse case managers for care coordination and management of complex patients with multiple co-morbidities and high ED utilization. The health center has a fully integrated EHR with complete patient information available to all providers involved in a patient's care. Screening tools, including PHQ-2, PHQ-9 and SF-36 are templates in the system. This allows for tracking a patient's screening scores, and data reporting for quality improvement and evaluation. LCHC utilizes the Quality Improvement (QI) process to identify issues and opportunity for improvements, which are presented and discussed at Integration Team meetings. A team is then designated to undertake a QI project to clarify the problem, utilize the available data to measure

the impact of proposed changes, and test the changes using Plan-Do-Study-Act (PDSA) cycles. Successful solutions are then spread throughout the other Integration Teams for adoption as a best practice. This model allows patients to access behavioral health services through their primary care team, effectively reducing the barrier of stigma and ensuring timely access to appropriate care.

UMass Memorial Health Care, Inc.

The Department of Family Medicine and Community Health (FMCH), operates primary care practices in which Family Medicine residents are trained alongside clinical health psychology trainees. The development of the integrated behavioral health curriculum and clinical practice has been guided by Alexander Blount, EdD, a nationally recognized leader in advancing integrated primary care. The Center for Integrated Primary Care (CIPC), which he established and runs, is a resource that most of the applicants for this grant have utilized for training their team members.

This grant supports integrated care in two of the three family practice residency sites – Hahnemann Family Health Center in Worcester and Barre Family Health Center in the East Quabbin region – and the efforts to use data to assess and improve the role of behavioral health in these practices. Both clinics screen for depression using the PHQ-9, as well as a ten item audit for screening for anxiety, PTSD and physical pain. The centers have had behavioral health clinicians practicing in the clinics for the past 20 years. In the past four years, these practices have coalesced into more organized integrated models that are leveraging their co-located services to deliver patient-centered care. Each center has NCQA recognition as Level 3 Patient Centered Medical Homes, and both are participants in the state's Primary Care Payment Reform Initiative (PCPR).

Vinfen Corporation

Vinfen is two years into a three-year Center for Medicare & Medicaid Innovation (CMMI) grant to develop Community-Based Health Homes (CBHH) for individuals with serious mental illness to integrate their primary care and behavioral health and address the disparities experienced by the population. The Vinfen CBHH model achieves close collaboration approaching an integrated practice by embedding nurse practitioners (NPs) – provided by Commonwealth Care Alliance (CCA) and backed by their primary and specialty medical care – into established Community-Based Flexible Support (CBFS) and outreach teams, funded by the Department of Mental Health. Vinfen has partnered with Bay Cove, North Suffolk and Brookline Community Mental Health Center to create the CBFS teams where the embedded NPs carry a caseload of up to 40 very medically complex adult patients. The NPs are supervised by CCA's clinical director and behavioral health is provided by the above-mentioned partners with Vinfen also serving as the overall project coordinator for this integrated care model.

The teams all include Health Outreach Workers (HOWs) that are employed by each of the community behavioral health providers. They assist the NPs with care coordination and wellness management. The use of an innovative telehealth technology system called Health Buddies allows remote monitoring of psychiatric and medical conditions, and increases the efficiency of the NPs. The HOWs train and support the clients in the use of the telehealth system and assistance with self-management. The program utilizes the Integrated Illness Management and Recovery (IIMR), a health self-management program that incorporates evidence-based health and wellness practices with psychiatric recovery interventions.