News Release
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FOR IMMEDIATE RELEASE

BLUE CROSS BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION AWARDS $1.5 MILLION IN GRANTS TO CONTROL COSTS AND IMPROVE QUALITY

January 3, 2012 – The Blue Cross Blue Shield of Massachusetts Foundation has awarded more than $1.5 million in grants to 13 Massachusetts organizations to develop and implement innovative cost containment initiatives as part of a new grant program, *Making Health Care Affordable*.

Moderating the growth of health care spending is critical to sustaining the gains that Massachusetts has made in access and coverage over the past five years. Each of the grants holds promise for slowing the growth or reducing public and/or private health care spending in Massachusetts while also increasing quality.

Cost containment is a national issue yet significant responsibility for identifying and implementing cost saving opportunities is expected to continue to fall to the states. Massachusetts has the opportunity to lead in these efforts and the Blue Cross Blue Shield of Massachusetts Foundation is one of the few nationwide funders to tackle this important issue.

"Our grantees will address a range of important issues including reduction of inappropriate emergency department use, chronic disease management and wellness, and children's behavioral health. Their efforts will contribute immensely to our state's practical knowledge about achieving cost containment while increasing health care quality," said Sarah Iselin, President of the Blue Cross Blue Shield of Massachusetts Foundation.

By supporting these initiatives, the Blue Cross Blue Shield of Massachusetts Foundation seeks to encourage and inform efforts of providers, purchasers, consumers and policy makers to create a health care system that rewards efficiency, improves quality and access, and enhances value.

One of the grantees is Boston Medical Center, which will implement the RED-Plus intervention. Re-Engineered Discharge (RED) is an already established process for reducing the risk of patients being readmitted to the hospital. The enhanced version will integrate a depression-screening tool into the RED protocol, and be piloted with Boston HealthNet patients across 15 community health centers affiliated with

Boston Medical Center. The initiative hopes to reduce both 90-day readmissions and the average cost of caring for these patients by 25%.

Making Health Care Affordable will provide up to three years of grant support to community health centers, hospitals, nonprofit physician groups, other safety net providers and community-based organizations in the Commonwealth. The grants announced today support a project's first year of work. Applicants were encouraged to pursue collaborations with both payers and providers to ensure that savings could be both measurable and sustainable.

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A complete listing of grantees with a brief description of their work is attached.

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 health care. It focuses on collaborating with public and private stakeholders to develop measurable and sustainable solutions that benefit uninsured, vulnerable, and low-income individuals and families in the Commonwealth. The Foundation was formed in 2001 with an endowment from Blue Cross Blue Cross Blue Shield of Massachusetts. It operates separately from the company and is governed by its own Board of Directors.

Making Health Care Affordable
2011 Grants
Brief project descriptions

Boston

1. Boston Medical Center, RED-Plus, $123,972 (first year)

From 2005 to 2007, staff at Boston Medical Center, led by Dr. Brian Jack, developed Re-Engineered Discharge (RED), an 11-step process for reducing the risk of patients being readmitted to the hospital. Results have shown that patients who receive RED are 30% less likely to be readmitted within 30 days of discharge. Because further research has shown that patients with symptoms of depression are 74% more likely than those without to be readmitted in this same 30 day window, Boston Medical Center has proposed to integrate a depression-screening tool into the RED protocol to create RED-Plus. If successful, RED-Plus will be disseminated to other hospitals in Massachusetts and nationally.

2. Judge Baker Children's Center, Modular Approach to Therapy for Children (MATCH) $94,703 (first year)

Over the last decade, Judge Baker Children's Center (JBCC) and its president Dr. John Weisz have designed the Modular Approach to Therapy for Children (MATCH). Unlike most evidence-based treatment approaches which are designed to focus on a single condition, MATCH is designed for children who have multiple complex disorders. JBCC estimates that 80% of the pediatric caseload in community clinics is made up of children with some combination of anxiety, depression, post-traumatic stress, and disruptive conduct. MATCH has

been tested and found to be effective in randomized clinical trials. This grant will help implement MATCH in four outpatient clinics in the greater Boston area as a step toward bringing the model to scale in the state.

3. Partners in Health, Prevention and Access to Care and Treatment Project (PACT) $125,000 (first year)

Partners in Health (PIH) is an organization founded by Dr. Paul Farmer and is committed to improving the health of the poor and marginalized. The Prevention and Access to Care and Treatment (PACT) project is PIH's only domestic program. PACT adapts the community health worker (CHW) approach developed in Haiti to vulnerable populations in the U.S. PACT's work in the Boston area has demonstrated how CHWs can improve the health of and reduce costs for those with HIV/AIDS. In this proposed work, PACT will embed CHWs in two community health centers, Lynn Community Health Center and North Shore Community Health in Salem. PACT will identify 2,000 high-risk, high-cost Medicaid patients and stratify them into three groups: those who will receive "maintenance" services, patients receiving telephonic care management, and a third group receiving home-based support through CHWs. The goal of the overall effort is to better understand where care management teams with CHWs are most effective.

Brockton

4. Brockton Neighborhood Health Center, Behavioral Health Initiative $125,000 (first year)

Brockton Neighborhood Health Center (BNHC) will target high risk patients, defined as those having had two or more emergency department visits and/or psychiatric hospitalizations within six months, and/or patients presenting to the urgent care department two or more times within six months without consistent follow-up with a primary care provider. BNHC's Primary Care Behavioral Health Model aims to increase patient access to behavioral health services, enhance coordination between primary care and behavioral health, and improve health outcomes. Partners include Good Samaritan Medical Center and Brockton Hospital, inpatient psychiatric units, community mental health clinics, and insurance companies.

Brookline

5. Brookline Community Mental Health Center, Healthy Lives, $124,545 (first year)

Healthy Lives is a new project designed to serve the needs of patients with co-occurring serious mental illness and multiple chronic health conditions. *Healthy Lives* will engage patients in their care and help them coordinate the services they receive, provide wellness interventions, and offer disease management programs. The program will offer home visits and individual and group counseling and wellness groups. The intent of the project is to help patients move from passive recipients to active participants in their health care and by doing so, reduce cost and improve quality.

Cambridge

6. Alliance Foundation for Community Health, Children's Health Initiative $125,000 (first year)

In its project *A Collaborative Practice Model for Improving Pediatric Mental Health Value*, the Alliance Foundation for Community Health, an affiliate of Cambridge Health Alliance, aims to develop a new method of identifying youth at risk for low quality/high cost mental health treatment. The sample for this study will be drawn from the 101,000 youth under age 20 insured by Network Health. The project will also look within diagnosis groups to compare treatments and expenditures across race/ethnicity, language, geography, and other characteristics. In the second phase of the effort, the project will identify primary care providers who have the largest number of high-expenditure youth and work with them and families to develop better more cost-effective approaches to treatment.

Fall River

7. Steppingstone, MyCare, $75,131 (first year)

Steppingstone provides residential and other programs promoting health and recovery for chemically-dependent individuals. In this project, Steppingstone will partner with Stanley Street Treatment and Resources (SSTAR) to create a new program called *MyCare*, an effort to promote a more pro-active approach to health care for those in Steppingstone's residential recovery programs. The target population for *MyCare* is persons in early recovery from chronic substance abuse and mental health disorders. Over 70% of this population has recent histories of homelessness and more than 70% have chronic conditions, in addition to their substance abuse or mental health disorders. The project will begin with residents of its Fall River women's program in year one and will incorporate the Fall River men's program in the second year, and its Stone Residence for chronically homeless individuals in the third year. The program projects to serve 465 clients over the three years.

Holyoke

8. Holyoke Health Center, Diabetes Management Initiative, $125,000 (first year)

This project will serve 300 patients of Holyoke Health Center who are at high-risk for preventable hospitalization, re-hospitalization, unnecessary emergency department visits, or adverse drug events due to diabetes. The project will begin with identifying 100 patients with diabetes with a recent hospitalization at Holyoke Medical Center, an unnecessary emergency department visit there, or eight or more prescriptions for diabetes. The project aims to develop ways to determine which groups of high-cost patients are amenable to disease and medication management programs leading to more effective, lower-cost services.

Lawrence

9. Greater Lawrence Family Health Center, Enhancing Patient Access to Primary Care $125,000 (first year)

Greater Lawrence Family Health Center (GLFHC) will target "super-utilizers" of the emergency departments of Holy Family Hospital, Lawrence General Hospital and Merrimack Hospital through its new *Enhancing Patient Access to Primary Care* program. "Super-utilizers" are identified as those who have visited the emergency department during clinical hours of operations or could have waited at least 12 hours to be seen, and have been seen at least four times within a 12-month period at one of the hospitals. A team consisting of a family physician, a behavioral health psychologist, a nurse care manager, and bilingual and bicultural health care coaches will develop care plans for these patients.

Lowell

10. VNA of Greater Lowell, Chronic Disease Management, $125,000 (first year)

This project will deliver home health care services, self-care education and coaching, and tele-monitoring to high-cost patients identified by the Lowell General Physician Hospital Organization (PHO) and Lowell Community Health Center. The project will serve 100 "high utilizers" in its first year and will triple in size by its third year. Targeted patients will be those diagnosed with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or diabetes. This project's innovation is that in-home assessment, coaching, and monitoring will be provided to patients who do not qualify for these services under current payment and benefit guidelines because they are not homebound and do not have acute conditions, but rather chronic ones. The project's goal is to demonstrate the cost-effectiveness of these services.

Lynn

11. Lynn Community Health Center, Integrated Care Project, $125,000 (first year)

Lynn Community Health Center will develop and evaluate its *Integrated Care Project*, an effort that integrates primary care and behavioral health care and develops a universal care plan supported by an electronic health record. The project will build on this integration to create new models of care management and coordination for the health center's highest-risk patients. The health center believes that more appropriate services and increased treatment compliance will result in fewer emergency room visits and inpatient hospital care, reducing overall health care costs. Over the three-year project, the health center will target 1,000 patients who have the highest rates of emergency room visits and inpatient hospital care. To serve these patients, Lynn will develop an intensive care management team in which primary and behavioral health providers will work together.

Springfield

12. Mercy Hospital, Emergency Room Utilization Project, $125,000 (first year)

Mercy Medical Center's Health Care for the Homeless program (Mercy HCH) will collaborate with hospital emergency departments in Hampden, Hampshire, and Franklin counties to "re-direct" homeless persons who are "high-end utilizers" of emergency department services to access health care services through Mercy HCH's clinical team. Mercy knows the area's homeless well and has documented cases where individuals are going to emergency rooms more than 20 times per month. Mercy HCH staff will work with these homeless individuals to obtain stable housing and resolve chronic conditions such as substance abuse and mental health issues. Over the three-year grant period, the five participating hospital emergency departments will "re-direct" 120 homeless individuals to more appropriate care through the program.

Worcester

13. Community Healthlink, MyLink, $123,741 (first year)

Community Healthlink began planning for this project by reviewing data on individuals who visited UMass Memorial Medical Center's two emergency rooms in Worcester more than 10 times per year without a resulting inpatient admission. They identified 276 individuals who in the aggregate made 5,181 ED visits, an average of 18.4 visits per person per year. In the new *MyLink* project, Healthlink and its hospital partners have proposed to identify 300 "high user" patients and provide them with a *MyLink* community support worker who will meet them in the emergency room. *MyLink* will serve 240 patients over two years. The *MyLink* workers will maintain regular telephone and in-home contact; provide assistance in meeting basic needs, help the patient anticipate crises, and connect the patient with the appropriate level of care (primary care, home health services, or behavioral healthcare). Collaborating emergency departments will put a "red flag" in the records of those served by *MyLink*, alerting staff to notify *MyLink* when an emergency department visit is made. The project expects to expand to Health Alliance Hospital in Leominster and St. Vincent Hospital in Worcester in 2013.