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Contact:
Julie Burns, Senior Director, Communications
Phone: 617-246-3361
Email: Julie.burns@bcbsma.com

Blue Cross Blue Shield of Massachusetts Foundation Awards $3.9 million in Three-Year Grant Program to Support Integration of Behavioral Health Care

BOSTON (December 17, 2015) – The Blue Cross Blue Shield of Massachusetts Foundation today announced the next phase of a grant program to support promising models for the integration of behavioral health and primary care for low-income and vulnerable populations.

The Foundation awarded a total of $3.9 million over three years to eight health care organizations as part of the grant program called *Fostering Effective Integration of Behavioral Health and Primary Care*. Through the grant program, the Foundation is evaluating and assessing experienced integrated care models that have the greatest likelihood of demonstrating the impact of integration on increased access, improved outcomes, and greater patient engagement and satisfaction. The diverse group of providers supported by this grant program represent community health centers, community-based mental health providers and hospital-based programs throughout Massachusetts.

"Coordinating access to both behavioral health care and primary health care is challenging, yet we've seen several innovative models that are breaking down the silos between these services and providing truly integrated care," said Audrey Shelto, President of the Blue Cross Blue Shield of Massachusetts Foundation. "We are excited to continue our work in this critical area and help sustain programs that will advance the understanding of what constitutes effective integration as well as the impact of that integration."

"Low-income elders receiving home care will be the ultimate beneficiaries of this grant as we improve the capacity of nurses and personal care attendants to identify depressive symptoms and coordinate with a depression care manager to facilitate integrated care between behavioral health and primary care providers," said Dr. Eran Metzger, Director of Psychiatry for Hebrew Senior Life.

Research shows that individuals of any age with serious mental health issues have a shorter life expectancy of as much as 25 years, as well a greater likelihood of at least one chronic medical condition. In addition, 29% of adults with a chronic medical condition have higher risk factors for depression and other behavioral health issues. During 2015, the Foundation funded and evaluated a diverse group of community-based health care providers serving primarily low-income and vulnerable patients and learned more about the factors that have the greatest potential for improving health outcomes and coordination of care.

Karen Gardner, Chief Executive Officer of the Community Health Center of Cape Cod said, "This continued support from the Foundation will enable us to expand coordinated care for substantially more low-income patients with complex behavioral health and medical needs, and to enhance training for all providers and staff to ensure quality and efficiencies."

The following organizations will receive three-year grants:

- Brookline Community Mental Health Center (BCMHC)
- Community Health Center of Cape Cod
- East Boston Neighborhood Health Center
- Hebrew Senior Life, Inc.
- Lahey Health Behavioral Services
- Lynn Community Health Center
- Pediatric Physicians' Organization at Children's
- Vinfen Corporation

Please see below for additional details about the grantees and their programs.

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 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.

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Fostering Effective Integration of Behavioral Health and Primary Care Grantees:

Brookline Community Mental Health Center (BCMHC)

BCMHC's Healthy Lives program, created in 2011, is designed to increase primary care and behavioral health access for patients with co-occurring serious mental illness and multiple chronic conditions. The patient-centered model leverages intensive care management strategies to improve access, integrates care, and helps reduce barriers to treatment for patients with complex needs. In addition to operating a community-based care management model – including home visits, and individual and group counseling – the program introduces self-care and wellness activities for patients to become increasingly more engaged in their own health. Healthy Lives, which received Foundation grant funding in 2015, serves low-income seriously mentally ill adults living in Brookline, Roxbury, Brighton, Allston, and most recently Dorchester and Mattapan, with at least two chronic medical conditions (such as diabetes, cardiovascular disease or COPD). Work to date has shown that Healthy Lives significantly improves health outcomes and reduces avoidable ED visits for participants. The goal is to serve 250 to 300 patients over three years.

Community Health Center of Cape Cod

With Foundation grant funding in 2015, CHC of Cape Cod used a combination of national best practices and center-designed strategies to develop a risk stratification tool to identify high-risk patients with significant behavioral and medical health co-morbidities, uncontrolled chronic diseases, a history of frequent hospitalization, and a history of frequent ED visits in order to implement a more comprehensive and effective model of integration. The risk stratification tool has enabled the health center to create a high-risk registry that is fully operational and key to helping the center to achieve full integration. With this three-year grant, CHC of Cape Cod will focus on patients who have screened for one or more behavioral health conditions, with the goal of improving access to ongoing behavioral health services for at least 1,000 patients who may benefit from an integrated care approach. The health center will expand complex care management and quality improvement staff, and increase family involvement with care.

East Boston Neighborhood Health Center (EBNHC)

With support from the Foundation, EBNHC will focus on expanding behavioral health services for children and adolescents (ages 5 to 21) who are seen in Pediatrics, Family Medicine and the health center's School-Based Health Center. In 2014, the Pediatric and Family Medicine Departments served a total of 15,498 patients up to age 21, and the number of child and adolescent patients served continues to increase. EBNHC's two newly hired child/adolescent psychiatrists will be able to fully treat and manage, and track and measure, the care of children and adolescents with mild to moderately severe depression and anxiety disorder, and integrate this care with a range of medical conditions. EBNHC has historically only been able to refer

pediatric patients with behavioral health issues to community providers where there are challenges associated with long wait times due to psychiatric provider shortages, as well as geographic and linguistic barriers. Expanding on-site psychiatric capacity also will help to facilitate care planning for patients following psychiatric hospital discharge.

Hebrew Senior Life, Inc. (HSL)

HSL has developed a depression services program, Making Real Progress in Emotional Health, to integrate behavioral health treatment with primary care and other health services to reduce the severity of depressive symptoms in seniors, and to improve overall health. The Foundation's grant will enable HSL to expand services to patients receiving in-home care. In 2015, HSL acquired Jewish Family and Children's Services, which expanded HSL's home care services by an additional 1,000 seniors (now totaling 2,000 older adults). In contrast to seniors in supportive housing who tend to be part of a community, seniors in home care are more likely to suffer from isolation, pain, and increased debility post-hospitalization. These stressors also increase these seniors' susceptibility to depression. HSL will take the lead in developing and monitoring individual care plans; tracking health outcomes in collaboration with primary care physicians from the practices treating the majority of patients; and developing additional community partnerships to ensure more comprehensive collaborative care for their patients.

Lahey Health Behavioral Services

Since 2012, Lahey Health Division of Primary Care and Lahey Health Behavioral Services have collaborated to embed behavioral health clinicians in five community primary care practices, sharing medical records, and using the Collaborative Care Model (CCM), a team decision-making model of care. Through this grant, Lahey Health Behavioral Services proposes a multi-faceted, multi-site expansion of its integrated CCM approach, by adding two community primary care practices (Gloucester and Beverly); introducing CCM in one Lahey Health System obstetrics practice; establishing CCM in one Lahey Health System pediatrics practice; piloting reverse integration at the Lahey Health Behavioral Services community mental health center in Salem; and expanding screenings of primary care patients across all of these sites to identify higher-risk patients and track outcomes. Lahey Health Behavioral Services will also use tele-psychiatry to enable consulting psychiatrists to serve more patients, particularly for more rural, isolated sites, such as Gloucester, where there is a lack of access to specialty services.

Lynn Community Health Center (LCHC)

LCHC has developed and implemented a fully integrated primary care and behavioral health program with co-location of services, co-management of patients by the medical and behavioral health providers through a shared care model, and utilization of shared electronic medical records through a newly-implemented Epic system. The Foundation has supported the development, growth and improvement of this very strong behavioral health integration program, with continued funding for the health center's response to the substance abuse epidemic in Lynn.

Building upon the learning and successes of its foundational behavioral health integration model, LCHC has developed an integrated primary care/mental health/addictions team of professionals who specialize in addictions and mental health disorders. The team also utilizes medication to treat addictions, including Suboxone, with plans to add Vivitrol. LCHC will expand this multi-disciplinary team by adding a psychiatrist, therapists, primary care providers, and nursing staff to serve approximately 800 patients.

Pediatric Physicians' Organization at Children's (PPOC)

The PPOC launched its Behavioral Health Integration program in 2012 and now has 41 practices participating. The focus of this initiative is to provide substance abuse prevention and treatment services to adolescents and young adults (up to age 25) and their families at PPOC practices in Lowell and Wareham. This funding will help expand PPOC's effort to help practices with high-risk populations detect, treat, and manage substance abuse issues, and make referrals to community-based substance abuse care when needed. The expansion will enhance the learning community curriculum to offer five additional hours of training on substance use, and ensure that the collaborative behavioral health integration teams have an embedded integration and clinical support specialist with substance abuse expertise via the PPOC's partnership with the Adolescent Substance Abuse Program (ASAP) at Boson Children's Hospital.

Vinfen Corporation

Vinfen has developed 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 CBHH model achieves close collaboration approaching an integrated practice by embedding Nurse Practitioners (NPs), Nurses (RNs) and Health Outreach Workers (HOWs) into existing community-based rehabilitation and recovery behavioral health teams, bringing primary care services directly to individuals with serious mental illness in their communities since 2012. Over the past three years, Vinfen has been actively evaluating and piloting health technologies in an effort to integrate behavioral and primary health care for its population. The Foundation-supported expansion program embeds two HOWs and the use of a smartphone app specifically designed to support the population into a dispersed, community-based outreach team. A dedicated Program Coordinator will manage the program, collect data and evaluate impact.