BCBSMA FOUNDATION 2009 AWARDS
Innovation Fund for the Uninsured – Grant Summaries

The *Innovation Fund for the Uninsured* helps Massachusetts health care delivery organizations improve the organization, continuity, and completeness of care for the uninsured. The program's ultimate goal is improved health outcomes and more cost-effective care through outreach and education, prevention, and medical management. This program area typically offers a three-year grant commitment, and the 2009 grantees include two new grants and 15 grants continuing into their second or third year. The grants range from $50,000 to $75,000 and this year they total $1,125,000.

Behavioral Health Network
Collaborators: Hampden County Sheriff's Department, Department of Mental Health, Hampden County District Attorney's Office, and Department of Probation

Springfield
$75,000
A second year of funding to implement a Jail Diversion Program that connects the mental health and court systems through a case management system for the mentally ill, developmentally disabled, and/or substance abusing individuals who have committed a minor crime. The program has established a case manager who has organized a coordinated system of mental health services, substance abuse treatment services, primary care access, and other social supports that the courts can use as an alternative to jail when appropriate.

Brookline Community Mental Health Center
Collaborators: Beth Israel Deaconess Medical Center, Brigham and Women's Primary Care Associates of Brookline, and Children's Hospital Boston

Brookline
$70,000
Funding to implement the *Mental Health Home* program, which is based on the Patient Centered Medical Home model and uses a mental health case manager and social worker team to serve uninsured adults and families. Clients will be assisted in obtaining health coverage and provided access to integrated medical and mental health care. The program will target adults with serious mental illness, homeless families or those at risk for eviction, and recently unemployed individuals and families facing economic hardships.

Boston Health Care for the Homeless

Boston
$65,000
A second year of funding to implement a program integrating the primary care and behavioral health care services offered to Greater Boston's homeless population, with the goal of ensuring that a greater proportion of homeless individuals receive timely, appropriate care.

Dimock Community Health Center

Boston
$65,000
A second year of funding to implement a *Diabetes Healthy Life Initiative* that provides patient navigator services to black and Latino diabetic patients. The program has allowed Dimock to more fully integrate its diabetes-related services so that more patients have access to all services and to ensure that uninsured individuals are supported in accessing diabetes support services.

Family Health Center of Worcester

Worcester
$75,000
A second year of funding as the health center works to convert its urgent-care center, which currently serves nearly 3,000 uninsured patients, into a walk-in primary care and social services clinic. The transition helps uninsured patients enter into a relationship with a primary care provider and offers other services that help the uninsured utilize the Family Health Center as a medical home.

Great Brook Valley Health Center
Collaborators: Central MA Area Health Education Center, YWCA of Central MA, Legal Assistance Corporation of Central MA, and Project Bread-The Walk for Hunger

Worcester
$72,500
A second year of funding to utilize a specialized, bilingual, bicultural Social Services Case Manager who works with health center patients experiencing complex barriers to care and unusually dire needs. A particular focus is placed on patients whose only form of coverage is Health Safety Net fund or those transitioning off of Refugee Medical Assistance coverage.

Greater New Bedford Community Health Center

New Bedford
$65,000
A second year of funding to revamp the health center's chronic disease management and care coordination systems. The new system is networking primary care providers so they can more easily use evidence-based patient care strategies with support from dedicated case management workers. The target population for this initiative includes uninsured patients with diabetes, hypertension, and asthma.

HealthFirst Family Care Center
Collaborators: St. Anne's Hospital Project Assert, City of Fall River Community Development Agency, and Project New Beginning

Fall River
$65,000
A second year of funding to implement a system that facilitates access to continuous and coordinated primary care for the area's homeless population, especially young mothers. The health center has adopted the role of medical home and has partnerships with other area organizations to coordinate health access and a variety of support services. The health center is also testing other innovations such as an "open access" scheduling system to accommodate appointments with homeless patients.

Hilltown Community Health Center

Worthington and Huntington
$65,000
A third and final year of funding for the creation of a medical home for those who remain uninsured in the Hilltown region post-health reform. This program is based at two community health centers and engages 300-400 individuals using additional community health worker staff and a coordinated set of activities. Those activities supportively engage uninsured patients and provide a broad array of services, including access to medical specialists and the expansion of preventive and education services.

Holyoke Health Center
Collaborators: Hampden County Correctional Facility and After Incarceration Support Services, Behavioral Health Network, and Valley Opportunity Council

Holyoke
$72,500
A second and final year of implementation funding for a set of coordinated strategies that extend care into the community and minimize disruptions to access. A care team including physicians, nurse practitioners, patient navigators and nurse case managers are working with the uninsured population of Holyoke and Chicopee to evaluate individuals referred by community partner organizations. Those patients requiring urgent care will be treated accordingly and those able to wait for a primary care appointment get support from a patient navigator so they can take charge of their health through the Health Center's various wellness and patient education programs available in the community.

Joseph M. Smith Community Health Center

Brighton and Waltham
$70,000
A second year of funding to expand care coordination services for uninsured adults aged 20-39 and those over age 65. The health center is utilizing its substantial technological infrastructure to identify eligible patients and track their progress accessing primary and preventive care. The health center is creating Preventive Service Plans to records when patients are due for follow-up and routine care. This electronic system facilitates care coordination effort so they can target, engage, and support patients in continuous care.

Justice Resource Institute

Boston
$60,000
A third and final year of funding to continue efforts focused on improving the continuity and completeness of care for an uninsured population facing numerous access barriers. The target populations include homeless youth and young adults in downtown Boston, with a special focus on those who are gay, lesbian, bisexual, or transgender. The program uses outreach/health care navigators to target high need areas of Boston. The navigators establish access for the target populations in community settings which continues seamlessly into JRI's clinical setting, the Sidney Borum Jr. Health Center.

Lowell Community Health Center
Collaborators: African Assistance Center, Massachusetts Alliance of Portuguese Speakers, and the Latin American Health Institute

Lowell
$75,000
A second year of funding to implement the *Lowell Health Compass* Program, which helps immigrant communities in Greater Lowell access the health care system. Through the program, the Lowell Community Health Center has developed a team of patient navigators and integrated them into the center's primary care delivery system. In addition, the health center is coordinating a network of organizations that facilitate access to care and education about health care issues for uninsured immigrants in the Greater Lowell area.

Partners in Life
Collaborators: Suffolk County House of Corrections, Prison Health Services, and Lemuel Shattuck Hospital's Goldfarb Ambulatory Care Center

Boston
$65,000
A second year of funding to develop the *Transition to Primary Care* program for inmates nearing release from the Suffolk County House of Correction. Prior to release, inmates receive an initial primary care visit via telemedicine and schedule an in-person appointment at Shattuck Hospital. For six months after their release, the program intensively tracks and supports patients in maintaining health coverage and assist with negotiating barriers to care. The program seeks to serve 200 people annually.

South End Community Health Center
Collaborators: Commonwealth of Massachusetts Department of Corrections, Project Place, United South End Settlements, and Boston's Health Care for the Homeless Program

Boston
$55,000
A second and final year of implementation funding for *Comp Care*, a program that provides a medical home with integrated medical and mental health services for homeless, uninsured patients; female detainees in the Suffolk County correctional system, and uninsured Latinos in the Greater Boston area. *Comp Care* utilizes a community health worker to create an access referral network with various community organizations in Greater Boston.

Volunteers in Medicine, Berkshires

Berkshires
$60,000
A second year of funding to expand case management services at its free care clinic. The clinic offers preventive services in mental health, and primary and dental care. The clinic expansion includes the development of a case management model that integrates clinical services, outreach, pharmacy services, and quality assurance. Additional efforts are focused on increasing the organization's capacity to provide culturally competent care.

Women of Means
Collaborators: Women's Lunch Place, Rosie's Place, HEARTH, HomeStart, Inc., Metropolitan Boston Housing Partnership, and the Dimock Center

Boston
$50,000
A one-year renewable grant to create a case management and health promotion system for chronically homeless women in Boston. The project will target aging women (in their forties and fifties) utilizing several homeless shelter programs based in Boston. These women are expected to need more services due to the higher rates of chronic illness and loss of function normally associated with aging and their access to those services will be coordinated and tracked among several collaborating organizations.