

CARE BEYOND COVERAGE

THE NEXT GENERATION OF HEALTH REFORM



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FINANCIAL INFORMATION

THE MISSION OF THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION IS TO EXPAND ACCESS TO HEALTH CARE FOR LOW-INCOME AND VULNERABLE RESIDENTS OF MASSACHUSETTS. IT WAS CREATED IN 2001 WITH AN INITIAL ENDOWMENT OF \$55 MILLION FROM BLUE CROSS BLUE SHIELD OF MASSACHUSETTS. IT OPERATES SEPARATELY FROM THE COMPANY AND IS GOVERNED BY ITS OWN 18-MEMBER BOARD OF DIRECTORS. THROUGH ITS ROADMAP TO COVERAGE POLICY INITIATIVE, THE FOUNDATION SERVED AS A CATALYST FOR THE LANDMARK MASSACHUSETTS HEALTH CARE REFORM LAW PASSED IN 2006, WHICH HAS RESULTED IN HEALTH INSURANCE COVERAGE FOR MORE THAN 97 PERCENT OF STATE RESIDENTS. IN 2007, THE FOUNDATION WAS AWARDED THE PAUL YLVISAKER AWARD FOR PUBLIC POLICY ENGAGEMENT BY THE COUNCIL ON FOUNDATIONS FOR ITS WORK ON HEALTH REFORM IN MASSACHUSETTS.

In 2008, the Foundation

- Launched Care Beyond Coverage, a planned, multi-year policy initiative that will identify barriers to health care access for consumers with health insurance and propose evidence-based policy solutions.
- Revamped its Health Care Disparities grant program area to focus on a more holistic approach to dealing with disparities rooted in the complex interplay of social determinants, such as poverty, racism, homophobia, physical environment, and education.
- Introduced the Community Partnerships Leaders Program (CoPaLS) to strengthen the basic leadership skills of emerging community leaders and activists. CoPaLS is a five-session program that complements the Foundation’s Massachusetts Institute for Community Health Leadership, an intensive program that takes place over the course of nine months.

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A MESSAGE TO OUR
COMMUNITY PARTNERS

This past year has challenged all of us in ways few could have predicted: a global financial crisis decimated the stock market and precipitated the collapse of multi-billion dollar corporations. The economic downturn affected the Foundation and many of you, our community partners.

Despite these difficulties, there are also new opportunities for public and private innovation taking place around health care reform. As the nation looks to improve its health care system, many are looking to Massachusetts for examples of how to enact reform by building upon existing systems of care and coverage.

Here in the Commonwealth, where more than 97 percent of state residents now have health insurance coverage thanks to the state’s 2006 health care reform law, policymakers have moved on to the next generation of reform: breaking down barriers to access that persist even when individuals have coverage. Massachusetts is a veritable incubator of these reforms with public and private initiatives in place to study issues of cost, quality, and disparities in access to health care.

The Foundation has embarked on this next generation of health care reform with Care Beyond Coverage, a multi-year policy initiative designed to identify barriers to access and propose potential evidence-based policy solutions. The Foundation has also revamped its Closing the Gap on Health Care Disparities grant program area to better address the factors that contribute to inequities in care. We continue to support outreach and enrollment work around health care reform and have partnered with the state, Bank of America®, and Partners HealthCare on an innovative loan forgiveness program that will make it easier for physicians to work at community health centers.

As we move ahead, the Foundation is committed to expanding access to care for vulnerable and low-income individuals and families in the Commonwealth through grants, policy initiatives, and innovative programming. Expanding access to care is a long-term endeavor. The Foundation intends to continue that work with you for many years to come.

With best wishes,



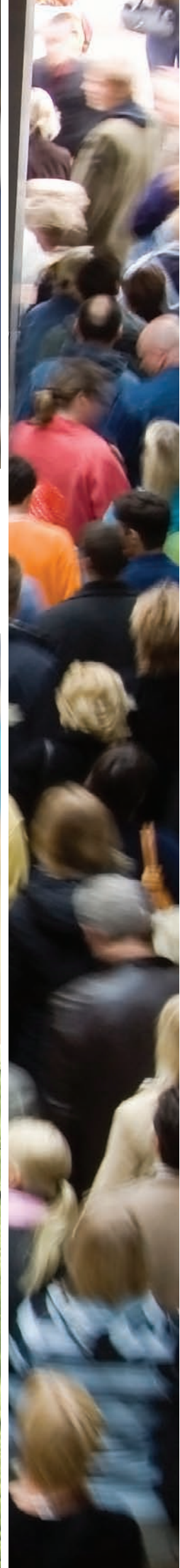
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CLOCKWISE FROM TOP ➤ JARRETT T. BARRIOS, PRESIDENT, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION ➤ FOUNDATION DIRECTOR, BARBARA FERRER, PH.D., M.P.H., M.ED., EXECUTIVE DIRECTOR, BOSTON PUBLIC HEALTH COMMISSION ➤ FOUNDATION BOARD CHAIR, PHILIP W. JOHNSTON, PRESIDENT, PHILIP W. JOHNSTON ASSOCIATES ➤ FOUNDATION DIRECTOR, CHARLOTTE S. YEH, M.D., FACEP, CHIEF MEDICAL OFFICER, AARP



POLICY INITIATIVE: CARE BEYOND COVERAGE

FOUNDATION LEADERSHIP REFLECTS ON WHERE WE'VE BEEN, WHAT WE'VE ACCOMPLISHED ... AND WHERE WE GO FROM HERE

“On to our next miracle!” exclaims Dr. Charlotte S. Yeh, Board member of the Blue Cross Blue Shield of Massachusetts Foundation. In fact, Dr. Yeh isn’t going anywhere; she’s actually just returned to the Foundation office from a few days of business travel. Rather, she is simply waxing enthusiastic on the Foundation having reached a particularly divine destination: providing the framework for what eventually would become the Massachusetts health care reform law, or Chapter 58.

Foundation Board chair Phil Johnston, president of Philip W. Johnston Associates, a health and human services consulting firm, agrees: “I don’t know if it will be the principal legacy, but certainly in the few years we’ve existed it’s by far the most important accomplishment.” Sitting on the desk of Johnston’s Boston office are commemorative remembrances from President Barack Obama’s inauguration, a reminder of the national influence wielded by Johnston and his fellow board members. Indeed, the very success of health care reform in Massachusetts, as led by the Foundation’s work, is achieving its own level of national renown.

“I’m in Washington a lot ... and it’s all about Massachusetts, Massachusetts, Massachusetts,” says Johnston. Formerly the New England director for the

U.S. Department of Health and Human Services under President Clinton, Johnston keeps another office in D.C., and has spoken with President Obama about the reform process. “Everyone in Washington is very focused on Massachusetts,” he adds. “If we had failed, it would have been catastrophic for the future of health reform. The fact that it succeeded showed people it could be done.”

Done, yes. But the work isn’t over.

“We are in an extraordinarily unique position,” says Yeh. “For the first time, we’ll have a population where essentially everyone has coverage. That will allow us to dissect the question: If you have coverage do you get care? ... What are the other barriers? Is it still economic? Is it really race, ethnic, culture, and language? Is workforce the barrier, or consumer engagement and understanding?”

These are the very notions the Blue Cross Blue Shield of Massachusetts Foundation intends to address with its present Care Beyond Coverage policy push. There is no doubt that the Foundation’s policy work informed discussions around Chapter 58 and was a major success, but Foundation leaders recognize the need to maintain forward momentum in addressing health care disparities by identifying and eliminating those barriers that continue to afflict vulnerable populations.

“The goal of this was not to get people health insurance; the goal was to improve health,” says board member

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Foundation board member Charlotte S. Yeh M.D., FACEP, chief medical officer, AARP

Barbara Ferrer, Ph.D., M.P.H., M.Ed. While she believes that health care reform is a step toward that ultimate goal, as executive director of the Boston Public Health Commission, Ferrer feels strongly about applying policy work to address other issues like social determinants. Now that nearly all Massachusetts residents have access to insurance, Ferrer says she believes that there is an opportunity for the state to take the financial resources that once went to care for the uninsured, and reallocate those funds to services that are lacking. She also hopes that future policy pushes will encourage focusing on preventive notions of care.

“There has to be a health equity agenda; we have to pay a lot of attention to what we know are the causes of inequities, and what are the strategies for promoting equity,” says Ferrer. “We [also] need to flip the paradigm and focus resources on prevention. Some of that is clinically oriented, and I think a lot of it will require really sound partnerships with non-traditional partners.”

“I think the day you have the hospital executive sitting down with the transportation department is a very important day,” she adds. “The day where you have building designers sitting down with the public health department is a very important day.”

It is exactly for orchestrating these kind of collaborative partnerships—those welded together by a common goal of addressing health care disparities—that the Blue Cross Blue Shield of Massachusetts Foundation is uniquely positioned to perform.

“I do think we are in a position where we can bring together the key players in the community to deal with very difficult issues,” says Johnston, when asked what makes the Foundation unique in its mission and approach. “I don’t mean just power brokers ... I’m more interested in bringing to the table ... people who don’t have power.”

“So if you’re representing the homeless, representing people with HIV, or representing the mentally ill ... those are the people we’re interested in. They need a voice. They need some representation in the circles of power.”

And with Care Beyond Coverage, those circles of power will grow to encompass new—and yes, miraculous—accomplishments.

POLICY INITIATIVE: CHILDREN'S BEHAVIORAL HEALTH

SPEAKING OUT AND GIVING VOICE

As she prepared to graduate high school in May 2008, Brianna was one of many teenagers across the Commonwealth planning to deliver a very important speech. But her's wouldn't be addressed to classmates assembled in caps and gowns; rather, in one of several forums organized throughout the year, Brianna was speaking to a roomful of legislators and health care advocates about the importance of the Children's Mental Health Campaign and her experience as an adolescent who had difficulty accessing support for her own mental health issues. The teenage years aren't an easy time to share such intimate details, but Brianna knew she had something important to say—a story that needed to be told.

“I don’t want people to struggle anymore,” says Brianna about why she spoke on behalf of the Children's Mental Health Campaign, an initiative funded in part by a

AROUND THE CHILDREN'S MENTAL HEALTH
CAMPAIGN, I THINK ONE OF OUR GREAT
OPPORTUNITIES WAS THE FACT THAT WE
CAME ON THE HEELS OF HEALTH CARE
REFORM IN MASSACHUSETTS. BEFORE,
I WOULD SIT WITH A LEGISLATOR OR
POTENTIAL FUNDER AND YOU COULD SEE
PEOPLE SAY, 'HONESTLY, MENTAL HEALTH IS
SO BIG, IT'S COMPLICATED!' WE CAME UP
WITH THE RESPONSE THAT, IF WE CAN PASS
UNIVERSAL HEALTH CARE, WE CAN DO THIS.
IT MADE IT A MANAGEABLE ISSUE, RATHER
THAN AN OVERWHELMING ONE.

Marylou Sudders, president and CEO, Massachusetts Society for the Prevention of Cruelty to Children

\$150,000 donation from the Blue Cross Blue Shield of Massachusetts Foundation in 2007. The coalition, led by Health Care for All, Children's Hospital Boston, the Massachusetts Society for the Prevention of Cruelty to Children, Health Law Advocates, and the Parent Professional Advocacy League, impacted policy in

enviable time, culminating in the passage of Chapter 321—An Act Relative to Children's Mental Health. When the Act was signed into law by Gov. Deval Patrick on August 21, 2008, it removed serious barriers to mental health care for young people.

“If someone had done this while I was in school, it would have been a lot easier,” reflects Brianna. Her experience was an all too common one: Brianna's symptoms of bipolar disorder and depression were misunderstood as behavioral issues in school because of poor access to appropriate mental health professionals in school settings. A competitive student, Brianna saw her academics and her social relationships suffer, and she recalls feeling starkly “alone” in her problems.

Chapter 321 facilitates the early identification of mental health concerns by promoting behavioral health screenings by pediatricians and consultations for children in preschool settings. Schools are encouraged—and provided with the resources—to identify and treat students' mental health needs. The bill also streamlines the coordination of services for children and families by public agencies and establishes a children's behavioral health research center.

Tragically, the vital necessity of the Children's Mental Health Campaign may have been most poignantly underscored by the death of 16-year-old Yolanda Torres, yet another young person who willingly testified before the legislature about her experiences with mental illness. Yolanda was not able to see the success of her work; she committed suicide before the enactment of Chapter 321, now often referred to as “Yolanda's Law.”

A year after her high school graduation, Brianna has found medications that work for her and she says she feels healthier than she has in a long time. She is now working full-time while she considers her options, and hopes to apply to college soon to study biochemistry. But today, the most valuable certificate of accomplishment she has in mind isn't her diploma—it's Chapter 321.

“I used to hide it,” says Brianna of her mental health struggles. “Now, I'm more open about it. I let people know what I've gone through and what I'm still struggling with today.”

THEY RECOGNIZE THAT I LOOK LIKE THEM,
IDENTIFY WITH THEM, AND CAN SPEAK TO THEM
IN THEIR LANGUAGE.

Sue Ponte, RN, MS, NP, director of the Asian Pediatric and Adolescent Clinical Services Program at Tufts Medical Center

BREATHING EASY

TUFTS MEDICAL CENTER ADDRESSES ASIANS WITH ASTHMA

Sue Ponte isn't just a nurse; she's a part of the community.

"The kids identify with me, they go home and imitate me," laughs Ponte. In her work as director of the Asian Pediatric and Adolescent Clinical Services Program at Tufts Medical Center, Ponte forms relationships with every child she treats. Walking down the hallway of the pediatrics department, where 47 percent of patients are of Asian ethnicity, Ponte hears a 12 year-old patient call out her name and quickly responds in Cantonese. "They recognize that I look like them, identify with them, and can speak to them in their language," she says.

Recognition of culture is paramount to the program's work, and the evidence is everywhere. "Notice a difference?" smiles May Chin, program manager of Tuft's Asthma Prevention and Management Initiative (APMI). This effort, funded by a three-year grant given through the Blue Cross Blue Shield of Massachusetts Foundation's Closing the Gap on Health Care Disparities program area, is designed to coordinate care, promote self management, and develop educational tools to address disparities around asthma rates in young patients in nearby

Chinatown. To her right, Chin motions to a hallway decorated with cartoon pictures of American fairy tale characters like Cinderella and Sleeping Beauty; to her left, another hallway is filled with Asian-inspired art featuring dragons, bamboo, chrysanthemums, and a series of murals depicting the Chinese horoscope.

These small markers of cultural competency are purely symbolic, compared to the Initiative's very practical intent to address high rates of asthma in the Asian community. Health issues related to asthma constitute 20 percent of the pediatric department's visits, and in local Chinatown schools, Asians are disproportionately represented among those with asthma. The reasons are many and not always clear, though Ponte and Chin can indicate a few that bear significant weight: air quality in an extremely congested, downtown environment; and old, urban housing that can be rife with asthma triggers.

"One issue in Chinatown and other immigrant communities is that you may not have one family [living in a unit]," says Chin. "You may have 15 people living under the same roof. It's old housing—dusty, mildewy and moldy." Chin recalls the story of one young asthma patient who was adhering to treatment quite well, but kept coming back with breathing issues that wouldn't dissipate. "We couldn't figure out why this kid kept cycling through the door," says Chin.

GRANTEE

TUFTS MEDICAL CENTER

AMOUNT

\$300,000 OVER THREE YEARS

PURPOSE

PARTNER WITH TWO BOSTON PUBLIC SCHOOLS IN CHINATOWN TO CREATE AN INITIATIVE THAT ADDRESSES THE HIGH INCIDENCE OF ASTHMA AMONG ASIAN AMERICAN CHILDREN.

Then a home visit from the Boston Public Health Commission’s Healthy Homes initiative uncovered “mold all across the ceiling,” says Chin. “And there was a leak in the roof, so the mold would come right back again.” When the mold was cleaned up, the young patient’s asthma improved.

Education is vital to helping parents identify triggers like this, eradicating stigma and alleviating fear so that children and families feel comfortable seeking service. Under the Foundation grant, APMI collaborated with two local schools neighborhood centers, and street fairs to provide outreach, conduct forums, and teach asthma classes. These were also opportunities to disseminate bilingual educational

resistant to the stigma associated with asthma. “Teenagers are embarrassed,” she says. “I would give them inhalers to use at school ... they would balk at the idea of [using them] and suffer.”

Despite these challenges, AMPI yielded tangible results: over the three years of the program, days absent from school by students with asthma decreased even as overall average absent days increased; documented patients with prescribed asthma controllers increased from 47 percent to 78 percent; and Chin says that the number of children now coming to the emergency room for asthma has been dramatically reduced to well below state averages.

WHEN IT COMES TO [EXAMINING] HEALTH
DISPARITIES, WHEREVER I LOOK IT’S WHITE, BLACK—
[STUDIES] ADD LATINOS AND VERY FEW ADD
ASIANS. ... PEOPLE DON’T WANT TO TAKE THE EXTRA
STEP TO GET THAT DATA.

Sherry Dong, associate director of Community Health Programs at Tufts Medical Center

materials developed by AMPI: *Jimmy’s Asthma Diary*, a bilingual illustrated children’s book and a DVD with language options in English, Cantonese, Mandarin, and Vietnamese. Research with parents and students helped identify the kind of information that was needed, including the need to demystify asthma as a condition. For example, in a 2008 phone survey of parent and child participants, 50 percent of respondents stated that they did not have asthma despite having at least two asthma-related hospital visits in the last 12 months.

“At first when you say the word asthma, [parents] get frightened,” says Ponte. For many in the community, the diagnosis can feel culturally charged, and parents don’t want to label their children. By focusing terminology on asthma symptoms, like coughing and wheezing, the door to conversations about the condition is opened. Young people, meanwhile, are

Moving forward, these clinicians hope that more attention will be paid to the prevalence of asthma in the Asian community. They say there is precious little literature available.

“At a gut clinician level, you say, ‘Something is going on here,’” says Chin.

“But there isn’t a lot of data out there,” adds Sherry Dong, associate director of Community Health Programs. “When it comes to [examining] health disparities, wherever I look it’s white, black—[studies] add Latinos, and very few add Asian. ... People don’t want to take the extra step to get that data.”

Back in the pediatrics department, Ponte proves that these clinicians have no problem going the extra mile.

“They have my phone number, they can call me anytime,” she says of her patients. And for that, most of them will breathe much easier.

CLOCKWISE FROM TOP ➡ SUE PONTE, CPNP, DIRECTOR OF ASIAN CLINICAL SERVICES AT TUFTS MEDICAL CENTER TEACHING TANISHA LIANG AND HER GRANDMOTHER, YU TIEN LIANG, ABOUT A PRESCRIBED CHANGE IN TANISHA’S MEDICATIONS ➡ LISA HUNG, RN, REVIEWING AN ASTHMA ACTION PLAN WITH JASON MAI AND HIS FATHER, CHANG WEN MAI ➡ JENNY MAI RECEIVES A NEBULIZER TREATMENT FROM HER MOTHER, XIU QIONG CHEN ➡ LISA HUNG, RN, TEACHING TANISHA LIANG HOW TO USE A PEAK FLOW METER TO MONITOR HER ASTHMA



OUR HALLS ARE SO CALM. WE DON'T
HAVE DIFFERENT CHILDREN NOW, BUT WE HAVE
A DIFFERENT SCHOOL ENVIRONMENT.

Debra Socia, principal of the Lilla G. Frederick Pilot Middle School in Dorchester, on the impact that Connecting With Care has on her students

GRANTEE

ALLIANCE FOR INCLUSION AND PREVENTION

AMOUNT

\$300,000 OVER THREE YEARS

PURPOSE

ADDRESS UNTREATED MENTAL HEALTH PROBLEMS AND THE PRESENCE OF TRAUMATIC STRESS AMONG AFRICAN AMERICAN, LATINO, AND SOMALI YOUTH IN THE GROVE HALL NEIGHBORHOOD OF DORCHESTER.

BEYOND BEHAVIOR

ALLIANCE FOR INCLUSION AND PREVENTION'S CONNECTING WITH CARE INITIATIVE HELPS SCHOOLS UNDERSTAND STUDENT MENTAL HEALTH

Being a parent isn't easy. Being a single parent is much less so. But when you have a support system in place to better understand your child's mental health experiences, at least you've found an ally in the parenting process.

"We talk, and we're close ... but there are always going to be things they don't show me," says Henry Barboza, referring to his 8-year-old son and 5-year-old daughter. Besides working a full-time job, Barboza is raising both children on his own following a difficult separation from their mother. The loss of that maternal relationship has impacted his children's behavior, but thanks to ongoing sessions with a mental health clinician at the John P. Holland Elementary School, his children are finding an outlet to express their experiences and Barboza is learning more about them.

Because he is learning and understanding the root of his children's behavior, Barboza is better able to address it. And it's especially helpful to parents like him that mental health clinicians are available in public school settings, a core accomplishment of the Alliance for Inclusion and Prevention (AIP) and its Connecting With Care (CWC) initiative, which was funded with a three-year grant from the Foundation's Closing the Gap on Health Care

Disparities program area. CWC has collaborated with several social service agencies as clinical partners—The Home for Little Wanderers, the Massachusetts Society for the Prevention of Cruelty to Children, Family Service of Greater Boston, and Children's Hospital Boston—to make mental health clinicians available to five schools in Boston's Dorchester and Roxbury neighborhoods. In 2008, clinicians logged nearly 1,500 hours of direct service to children and families.

By placing full-time, licensed clinicians directly in a school setting, CWC hopes to alleviate some of the barriers, including transportation and unpaid time off work, that can make it difficult for parents to provide their children with mental health services—even when behavior warrants it. Placing clinicians in schools also alleviates stigma among students and parents, allowing them to perceive mental health care as a simple, natural extension of the educational environment. In time, students seem to learn how to articulate their experiences beyond acting out through negative behavior.

"Children are learning the language," says Lisa Baron, CWC program director. "We've had children actually go up to [clinicians] and say, 'You know that I have anger management issues. I think I need to see you!'"

Finally, care at schools—where a great deal of childhood experiential learning and development takes place—allows clinicians to understand the climate of the school and its students, observe behavior firsthand, and interpret mental health sessions in their full context.

The latter is particularly important when it comes to addressing issues of trauma, a major issue at the schools selected for the CWC program. In addition to training CWC staff, the initiative also trains school social workers and other agency staff in the Trauma Systems Therapy model.

“When you look at disparities and trauma, a piece of that is that you have a really high incidence of trauma

bus. And then [the children] were afraid to have that information. Their parents were telling them, ‘Don’t talk about it, don’t tell anyone.’ They don’t want to be subpoenaed or have to testify.”

But talking about trauma is exactly what’s necessary. Otherwise, “sometimes you’ll see a numbing [reaction],” says Bob Kilkenny, AIP executive director. “It’s a concern when kids become blasé to this. It becomes normative, like kids who live in war zones and become numb to the emotions.”

“It’s not always the children who are loud that we worry about,” agrees Socia. Though she says that CWC has also helped the school staff understand the

WHEN YOU LOOK AT DISPARITIES AND TRAUMA,
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INCIDENCE OF TRAUMA IN NEIGHBORHOODS
WITH LOW INCIDENCE OF MENTAL HEALTH SERVICES.

Nechama Katz, planning coordinator for the Connecting With Care initiative

in neighborhoods with low incidence of mental health services,” says Nechama Katz, CWC planning coordinator.

At the Lilla G. Frederick Pilot Middle School in Dorchester, a school identified by the state as a Trauma Sensitive School, CWC provides clinical support and runs an evening mental health clinic for families, including those who attend other partnership schools, to meet with mental health providers after traditional work hours. “The neighborhood is considered to be one of the most dangerous in Boston, and [many] of our children know someone who has been murdered,” says Debra Socia, the school’s founding principal, on the troubles facing the local community.

“[Following an after-school program], there was a shooting, a murder that happened literally right next to the late bus,” recalls Susan Lovett, director of out-of-school time programs. “The victim ended up dying up against the

root cause of student behavior that might otherwise be labeled as simple discipline issues. “We have students who are self-injurious, quick to anger, lose control, and with the slightest provocation can go over the top,” says Socia. “We made assumptions that [negative] behavior had developed, as opposed to realizing it was them reliving a trauma because a trigger had occurred.”

Socia says that she has seen major changes in student behavior since the implementation of CWC. For example, by March 2009 the school had seen a 50 percent reduction in suspensions since the start of the school year as compared with the same period for the previous academic year. But beyond numbers, she believes that the tone of the student body has changed in ways that can’t be measured:

“Our halls are so calm ... We don’t have different children now, but we have a different school environment.”

CLOCKWISE FROM TOP ➤ JASMINE GRAHAM (AIP ASPIRE) ASSISTS A STUDENT WITH ACADEMICS ON A COMPUTER ➤ LISA BARON, ED.D., SUSAN LOVETT, LICSW (BOTH OF AIP), AND JOHN CROFFETT, LICSW (FAMILY SERVICE OF GREATER BOSTON) PARTICIPATE IN A TEAM MEETING ➤ GLENN SAXE, M.D., CREATOR OF TRAUMA SYSTEMS THERAPY, PROVIDES CONSULTATION TO CWC’S CLINICAL TEAM ➤ CHILDREN IN AIP ASPIRE’S THERAPEUTIC AFTER-SCHOOL PROGRAM COLLABORATE ON AN ASSIGNMENT USING LAPTOP COMPUTERS ➤ ANA ORTIZ, PH.D., AND IMANI SEUNARINE, M.S., (THE HOME FOR LITTLE WANDERERS), ATTEND A MEETING OF CWC AGENCY PARTNERS





GRANTEE

HOLYOKE HEALTH CENTER

AMOUNT

\$300,000 OVER THREE YEARS

PURPOSE

DEVISE INTERVENTIONS TAILORED TO THE PSYCHOSOCIAL AND CULTURAL NEEDS OF HOLYOKE LATINOS WHO HAVE OR ARE AT HIGH RISK FOR DEVELOPING CARDIOVASCULAR DISEASE.

I DIDN'T KNOW HOW TO EAT PROPERLY. IT WAS

A CHALLENGE TO LEARN, BUT NOW I FEEL GREAT.

Healthy Weight Healthy Heart participant Esperanza Marquez, 70, who has dropped 30 pounds since starting the program

WITH FLYING COLORS

HOLYOKE HEALTH CENTER BEARS HUES OF SUCCESS

“Eat your colors every day.” A simple, friendly reminder, these words adorn a poster that hangs on a wall inside the Holyoke Health Center (HHC). And in this room, on this Tuesday morning, colors are everywhere: orange tangerines sitting out in a fruit bowl; blue, pink, and green aprons worn by community health workers cooking breakfast in a small kitchenette; and yellow omelets for the dozen clients, all members of Holyoke’s large Latino community, assembled to eat them at long tables. At the front of the room is Maria Fessia, HHC’s Healthy Weight Healthy Heart program manager. Dressed in sharp red, she holds in her hand small plastic cups—orange, green, and yellow—and uses them to teach those in attendance about appropriate portion control. Gesturing to a series of posters, she guides this morning’s nutrition class through the tiers of the food pyramid and the colors of foodstuffs—green veggies, white rice, and brown bread—contained within.

“We teach them about choosing the right foods ... but that you don’t have to give up culturally important items,” says Fessia, in between fielding questions about diet, exercise, and smoking cessation from those in attendance. Fessia is enthusiastic about the mission of the Healthy Weight Healthy Heart program, which has been expanded and sustained over the last three years

thanks to the Foundation’s Closing the Gap on Health Care Disparities grant.

Disparities surrounding weight issues and the resultant health consequences—especially cardiovascular disease and diabetes—have been a problem for HHC’s Latino clients, many of whom come from low-income households and have difficulty accessing or affording the fresh foods and produce that promote healthy weight. Language barriers and low literacy rates are another obstacle, so Fessia incorporates a supermarket tour as part of the program’s 10-week curriculum: she brings participants to a local grocery store to teach them how to read important nutrition facts; memorize options by site and color if not language (red bottle caps for skim milk, for example); and identify important logos, like that of the American Heart Association, that indicate a healthy choice. Part of the program’s expansion also includes a daily exercise class where participants gather for aerobics and light weights, and to support each other in maintaining a healthier lifestyle.

The program is yielding great results for its participants, young and old.

“It wasn’t easy, but I feel better and healthier,” says Wanda Estrada, 35. The Holyoke resident has lost nearly 30 pounds since she began participating in the program, which she joined when a routine health screening

➤ ESPERANZA MARQUEZ, LEFT, AND WANDA ESTRADA ➤ MARQUEZ AND ESTRADA ARE WORKING OUT IN THE HEALTHY WEIGHT HEALTH HEART PROGRAM

indicated that her blood pressure was high. Like many of Holyoke’s Latino clients, Estrada was accustomed to a diet that emphasized skipping breakfast and lunch for a large dinner that consisted of high-fat foods. She says she makes more moderate choices now, which has resulted in weight loss, improved blood pressure, and progress around issues of depression. Fessia says that a high incidence of mental health issues in HHC clients are another problem compounding healthy choices.

“I didn’t know how to eat properly,” admits Esperanza Marquez. “It was a challenge to learn, but now I feel great.” At age 70, Marquez has also dropped nearly 30 pounds and improved her health since starting the program.

or a nutritionist ... It's about, how do you support the whole system? You collect enough data to figure out who's having trouble, and you provide them services that are the whole package.”

To that end, HHC has also implemented a smoking cessation program that assesses the smoking status of each adult patient at every clinic visit, and is prepared with stage-based educational material and intervention services to treat clients wherever they are in the cessation process. Development and implementation of a bilingual Chronic Disease Self-Management program has also allowed HHC to give patients the tools to monitor and care for their health outside the center’s four walls; in 2008, 85 percent of patients were enrolled in programs

IT’S NOT JUST ABOUT PAYING FOR AN EXERCISE CLASS OR A NUTRITIONIST ... IT’S ABOUT, HOW DO YOU SUPPORT THE WHOLE SYSTEM? YOU COLLECT ENOUGH DATA TO FIGURE OUT WHO’S HAVING TROUBLE, AND YOU PROVIDE THEM SERVICES THAT ARE THE WHOLE PACKAGE.

Jon Liebman, nurse practitioner at Holyoke Health Center

“She has had perfect attendance, every day for a year!” gushes Fessia as Marquez smiles, flushed but satisfied after another exercise class.

Healthy Weight Healthy Heart isn’t the only program supported by the Foundation’s three-year grant, although, as Diabetes Program Manager Dawn Heffernan says, “[the grant] was critical in the sustainability of that program.” She says that the grant also helped HHC integrate its healthy weight services and Community Health Worker staff with existing diabetes-specific activities.

“We needed to rethink and reintegrate all these programs,” says Jon Liebman, nurse practitioner at HHC. “There has been a history of disease-specific funding ... but the solutions are broader than that,” he adds, citing the flexibility of the Foundation’s grant in allowing HHC to address more comprehensive notions of care. “It’s not just about paying for an exercise class

with self-management goals compared to 50 percent in 2007. “The big programmatic success is [developing] supportive services for people with chronic diseases and integrating [that success] into primary care,” says Liebman. “That doesn’t often happen. You go to support groups and get education, but it’s not usually integrated into primary care.”

In these ways, the grant period has allowed HHC to integrate multiple levels of care into a single system, as if balancing the tiers of the food pyramid.

“The issue with patients is always: Where can you put in resources to make a big impact?” says Liebman. Dollar for dollar, and pound for pound, HHC has inspired a colorful impact, indeed.

CLOCKWISE FROM TOP ➡ JON LIEBMAN, FNP ➡ MARIA FESSIA, RD, LDN, PROVIDING NUTRITIONAL EDUCATION TO JOSE HERNANDEZ ➡ VOLUNTEER PERLA ALVAREZ PREPARES A SNACK ➡ FESSIA TALKS ABOUT PORTION SIZES WITH HEALTHY WEIGHT HEALTHY HEART PARTICIPANTS ➡ HOLYOKE HEALTH CENTER PROGRAMS DIRECTOR DAWN HEFFERNAN, MSN, RN





GRANTEE

COMMUNITY HEALTH CENTER OF CAPE COD

AMOUNT

\$300,000 OVER THREE YEARS

PURPOSE

COORDINATE CARE FOR AFRICAN AMERICAN, LATIN AMERICAN, AND NATIVE AMERICAN RESIDENTS THAT HAVE UNTREATED AND/OR POORLY-CONTROLLED DIABETES.

I THINK THAT WITH MANY MORE YEARS AND MORE CONTROLLED STUDIES, WE WILL BE ABLE TO SEE WHAT WORKS. BUT ANECDOTALLY, WE DEFINITELY FEEL LIKE PROGRESS IS BEING MADE.

Lee Wotherspoon, program director of the Cape and Island Diabetes Disparities Collaborative

COMMUNITY RELATIONS

COMMUNITY HEATH CENTER OF CAPE COD REACHES OUT TO ADDRESS DIABETES

There is no shortage of vital responsibilities entrusted to community health workers, but foremost among them is providing patients with the tools they need to care for their health. Sometimes, it's surprising how simple those tools can be.

"You don't know what it is that might make the difference," says Sandy Reichel, a community health worker at Community Health Center of Cape Cod (CHC of Cape Cod).

Using the Foundation's three-year Closing the Gap on Health Care Disparities grant, CHC of Cape Cod hired and retained community health workers like Reichel through the efforts of the Cape and Island Diabetes Disparities Collaborative (CIDDC), an initiative created to address disparities around diabetes rates and treatment for the region's Brazilian, Latino, Native American, and black populations. Though the issues responsible for these disparities are complex, Reichel recalls one instance that proved how providing even simple tools can make a big impact.

"I was doing nutrition education, and talking in cups and half cups," says Reichel, who often works with clients around issues of portion control, especially as they relate to cultural diets of rice, beans, and other starchy foods that can compound diabetes with weight gain. But in this class, she soon realized that one of the clients in attendance simply wasn't able to understand the units of measurement. "At the end of our meeting, I said, 'I would like you to take these with you,'" recalls Reichel of handing over a set of measuring cups. "He was thrilled ... He said that he was moving back to Brazil, and now he would be able to measure."

Implementing a community health worker model has been extremely important to the work of CHC of Cape Cod and CIDDC in addressing disparities among minority populations, many of whom are low-income, work multiple jobs, and have difficulty accessing the Cape's limited public transportation resources. For these reasons, actual face time with clinicians is often at a premium. Community health workers at each of the five health center locations are able to go out into the community—at grocery stores, for example—to conduct screenings and book subsequent appointments

➤ MARTY HOPKINS, LEFT, COMMUNITY HEALTH WORKER SANDY REICHEL, AND JOAN MARTIN ➤ REICHEL IS TEACHING THEM HOW TO CONTROL DIABETES

at the health center for diagnostic exams. During the grant period, CHC of Cape Cod also streamlined its operations so that community health workers would be notified whenever diabetic patients are coming in for an appointment; that way, they can take the opportunity to check in, evaluate progress, set new self-management goals, and, of course, follow up again later.

Day and evening support groups have also been helpful in reaching members of the affected populations, and encouraging social bonds that help reinforce the systems of care. “The social connections are really powerful,” says Reichel. For example, she

health care reform] went into effect, they would have to apply for coverage and that would require they have IDs and Social Security numbers.”

On the other hand, health care reform has also helped community health workers do some parts of their job more easily. “[Massachusetts health care reform] generally brought to the forefront some of the work we were doing,” says Karen Gardner, CHC of Cape Cod’s CEO. “It helped things happen a little more naturally, because when people are in a rush to sign up for health insurance we can say, ‘Why don’t you screen for diabetes while you’re at it!’”

[MASSACHUSETTS HEALTH CARE REFORM] GENERALLY BROUGHT TO THE FOREFRONT SOME OF THE WORK WE WERE DOING. IT HELPED THINGS HAPPEN A LITTLE MORE NATURALLY, BECAUSE WHEN PEOPLE ARE IN A RUSH TO SIGN UP FOR HEALTH INSURANCE WE CAN SAY, ‘WHY DON’T YOU SCREEN FOR DIABETES WHILE YOU’RE AT IT!’

Karen Gardner, CEO of Community Health Center of Cape Cod

knows of insulin-dependent patients who have formed carpools to help each other attend support groups. According to Melonie Kelly, director of clinical services at CHC of Cape Cod, support groups and staff trainings in cultural competency have also been particularly helpful in reaching out to Native American patients. “They are one of our most difficult populations to get into the health center,” says Kelly. “There is a huge issue of trust for the tribal populations.”

Trust also continues to be a barrier to accessing populations of undocumented immigrants. “Immigration [status] has been a number-one issue,” says Kelly. “People were afraid that when [Massachusetts

To guide future work, CIDDC has prepared a manual so that each health center site can hire and train new community health workers, and gather data on the disparity of diabetes, depression, and eye and dental health between minority and white populations.

“I think that with many more years and more controlled studies, we will be able to see what works with the communities and what their outcomes are,” adds Lee Wotherspoon, CIDDC program coordinator. “But anecdotally, we definitely feel like progress is being made.”

CLOCKWISE FROM TOP ➡ MALIQUA GOMES GETS AN EYE EXAM FROM JEANNY WISHINGSTONE, ANCC ➡ COMMUNITY HEALTH WORKER SANDY REICHEL DISCUSSES SELF-CARE TECHNIQUES FOR DIABETICS ➡ DAVID TAGER, M.D., CONDUCTS A DIABETIC FOOT SCREEN ➡ A CLINICIAN MONITORS BLOOD SUGAR LEVELS



CLOSING THE GAP ON HEALTH CARE DISPARITIES

RETHINKING, RETOOLING, AND RENEWING OUR APPROACH TO DISPARITIES GRANTS

The Blue Cross Blue Shield of Massachusetts Foundation has always emphasized the need for its grantees to carefully examine their systems and processes, identify areas for development or improvement, and maintain a steady vision of establishing best practices. It’s no different for the Foundation when it comes to evaluating its own programs. And that’s why the Foundation revamped its guidelines for the Closing the Gap on Racial and Ethnic Health Care Disparities program area after just one cycle of grantmaking.

In December, 2008, the Foundation awarded \$768,387 to 11 grantees in the Disparities program area after spending nearly a year revamping its program guidelines to focus on a more holistic approach to dealing with health care disparities. The three-year grant cycle begins with a year of planning and continues with two years of implementation. The program area began in 2005, with three years of grants to 10 organizations.

“We know that even with health coverage, care can be unequal,” says Foundation Associate Director of Grantmaking and Evaluation Miriam Messinger. “As a Foundation, we’re continuing to fund changes within health care systems, but we’re aware and able to relate these to bigger societal issues including poverty, racism, physical environment, and education.”

As in the past, the approach to closing gaps in health care disparities is rooted in policy reports and literature—most notably the 2002 Institute of Medicine report, “Unequal Treatment: Confronting Health Care Disparities”—that identify inconsistencies in the availability, accessibility, and quality of health care based on the complex interplay of social determinants. But in retooling the grantmaking process in 2008, the Foundation is “explicitly talking about social determinants of health,” says Messinger. “We’re asking [grantees] to understand them ... and think about broader conversations in the community around the notion of inequity.”

In addition to the added emphasis on social determinants, 2008 Disparities grantees are expected to engage with community stakeholders. “Whatever community you decide to address, you need to be at the table talking with them,” explains Messinger. This approach is designed to help the grantees best identify successful areas of change and improvement at three levels: systems, clinicians/staff, and individual patients. In the end, grantees should be able to answer three questions, says Mesinger: What did we do? How well did we do it? And, what impact did it have?

TOM BARDWELL

Tom Bardwell understands that clients will get better care in an environment in which they are comfortable. That’s why, upon entering the office of Cambridge Cares About AIDS (CCAA), a friendly receptionist pushes forward a plate of home-baked cookies as a welcome. Offices are adorned with prints of pop culture icons Beyoncé Knowles and Marilyn Monroe, and the needle exchange program is obscured with a heart-patterned curtain. CCAA also works with the P.U.M.P. Boys, a volunteer group of harm reduction educators and HIV counselors who visit gay bars and community venues to distribute material and information.

“A major barrier that has come up for men [seeking HIV/AIDS education and treatment] is having to leave their community or neighborhood to access health care,” explains Bardwell. “When you live and grow up in a predominantly black or African-American neighborhood, and you need to go to a place that is unfamiliar, filled with men who don’t look like you who then ask you questions about your sexuality that make you feel uncomfortable ... [the reaction is,] ‘I just don’t want to deal with it.’”

Bardwell has heard many stories from clients who have delayed seeking HIV/AIDS education, testing, and treatment for a variety of reasons: systemic distrust and fear of racism within the health care system, compromised confidentiality, and sexual stigma. Many clients of color have sex with men but do not identify as gay, says Bardwell, and they may avoid providers who try to “redefine their identity.”

To identify other barriers to care and bring them to the attention of clinicians, CCAA will engage 75 men directly from its client community to participate in a series of theatrical workshops. These workshops, culminating in a stage production to be recorded for future educational use, will allow community participants to communicate their experiences and concerns with an unusual level of candor, capturing integral research that could not be gleaned through simple surveying.

“Our agency’s mission is not only about the principal of harm reduction, but also a commitment toward eliminating social inequities,” says Bardwell. “It’s our philosophy and approach to how we work with all the populations we serve.”

A MAJOR BARRIER FOR MEN [SEEKING HIV/AIDS EDUCATION AND TREATMENT] IS HAVING TO LEAVE THEIR COMMUNITY TO ACCESS HEALTH CARE.

Tom Bardwell

WHERE
CAMBRIDGE CARES ABOUT AIDS

WHAT
AWARDED \$70,000 TO ADDRESS DISPARITIES IN HEALTH CARE FOR HIV-POSITIVE MEN OF COLOR WHO HAVE SEX WITH MEN.

JAMIE FLORES

Rows of flags suspended from the ceiling flutter over the community swimming pool at the YWCA of Central Massachusetts in Worcester. Nearly every nationality is represented: Irish, Italian, French, Japanese, the list goes on. But Jaime Flores has joined the YWCA to focus on those flags that represent the Latino community, a diverse array of cultural backgrounds united—at least in the Worcester area—by a common health problem: high rates of obesity.

“In my work, I always saw overweight and obese people [in the Latino communities],” says Flores, who was a social worker before joining the YWCA team as community wellness director. There are a number of social factors suspected of contributing to high rates of obesity: diets high in fat and multiple job households that leave little time for exercise or the creating of nutritious meals, to name two. “We don’t have [specific] facts, we only have ideas,” says Flores, adding that the Foundation’s grant will go a long way toward involving community members and city stakeholders in discussions that can shed greater light on the roots of these disparities.

One thing is certain: despite the array of exercise equipment available at the YWCA—swimming pool, basketball court, fully outfitted weight room, treadmills, and aerobic classes, among other offerings—the facility isn’t getting a workout from members of the Latino community. Things are quiet on a typical weekday, and when clients do show up, the resources are limited if English is not their first language.

Whether the answer is more bilingual trainers, increased transportation options, literature in multiple languages, or something entirely different remains to be seen. But Flores says he is looking forward to the planning period and to hearing directly from members of the Latino community about how they articulate their needs, their obstacles, and their ideas for solutions.

“There’s a lot we need to find out,” he admits. But the message to spread, he says, is quite clear: “We need to connect with them ... [and tell them that] health is the number-one priority.”

WHERE

YWCA OF CENTRAL MASSACHUSETTS

WHAT

AWARDED \$69,996 TO ADDRESS HEALTH CARE DISPARITIES THAT RESULT IN HIGHER RATES OF OBESITY AMONG LATINOS IN THE WORCESTER AREA.

Jaime Flores

ISMAEL RIVERA

Talk about progress: it was only January 2008 when the Metrowest Mental Health/Substance Abuse Task Force partnered with Central Massachusetts Area Health Education Center to begin studying disparities related to Brazilian and Latinos accessing and utilizing mental health and substance abuse treatment services. By the end of the year, the partnership had already resulted in the creation of the Framingham Mental Health & Substance Abuse Disparities Project, a pilot program that will put the Foundation’s grant to use by addressing these very issues.

Ismael Rivera, co-chair of the Project, says his group will identify barriers to health care. These disparities are well documented in industry literature; for example, Rivera cites a 2005 white paper from the Institute for Hispanic Health that states that only one percent of licensed psychologists in the American Psychological Association are Hispanic, resulting in a ratio of approximately 20 Latino psychologists for every 100,000 Latinos in the U.S. But Rivera can identify many other barriers from anecdotal experience: language, insurance coverage, and immigration status. More importantly, he says, some of the greatest obstacles have deeper roots that require a greater fluency in cultural competency to address.

“It’s not just about providing linguistic services for clients, but more for staff to be able to understand [their] belief and health systems,” explains Rivera. For example, he says, mental health services are stigmatized within Latino communities. “Clients believe that mental health services are for ‘crazy’ people and do not understand that mental health professionals can provide a service for a variety of emotional needs.”

To identify and assess some of these lesser examined causes of health disparities, the Project has collaborated with additional partner agencies to form a committee of stakeholders from within the affected communities, and focus groups will be conducted in Spanish and Portuguese to gather information. As with all the grantees, collaboration and planning are the keys to success. “What we want to accomplish is to gain a better understanding of the service needs for the target populations,” says Rivera. “[Then we can] develop strategies to address systemic and policy issues.”

IT’S NOT JUST ABOUT PROVIDING LINGUISTIC SERVICES FOR CLIENTS, BUT MORE FOR STAFF TO BE ABLE TO UNDERSTAND [THEIR] BELIEF AND HEALTH SYSTEMS.

Ismael Rivera

WHERE

CENTRAL MASSACHUSETTS AREA HEALTH EDUCATION CENTER

WHAT

AWARDED \$69,956 TO STUDY THE REASONS WHY BRAZILIANS AND LATINOS IN FRAMINGHAM EXPERIENCE DISPARITIES IN ACCESSING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, AND PROPOSE AN INTERVENTION PLAN TO REDUCE THOSE DISPARITIES.

HEALTH COVERAGE FELLOWSHIP

As a former medical writer for the *Boston Globe* (from 1986 to 2001) and the author of numerous books, Larry Tye, director of the Health Coverage Fellowship, knows that the state of the news industry is in flux. That is why the Fellowship, which celebrated its eighth year in 2008 and is largely supported by the Blue Cross Blue Shield of Massachusetts Foundation, focuses not only on bringing together the finest medical journalists from across New England—and increasingly, the nation—but on sending them back to their newspapers, radio stations, and television outlets with story lists and practical notions on how to craft their ideas into quality, and, at times, prize-winning journalistic gems.

“It’s not as though we go off, think big thoughts, and then there’s a disconnect between what you do when you go back to work,” explains Tye. “This is designed to translate [the experience of the Fellowship] into concrete stories ... and we refine those story ideas... to sell them to editors and the general public.”

The nine-day Fellowship gives its participants a private audience with experts in the medical, government, and policy-making sectors. Fellows are also provided with observational opportunities that deepen their understanding of the complex variables in health care; in 2008, fellows watched live robot-assisted coronary surgery, took a ride with crews of Boston EMS, scoured the streets of Boston looking for the homeless with health care outreach workers, and toured a psychiatric facility that employs skin-shock therapy.

“This Fellowship started with the idea that health care journalists are a very important way to bring attention to issues,” says Tye. “Back then [at the program’s inception], the big issue was insuring the uninsured, and extraordinarily important allies in that effort were journalists. They were the link between policy makers and the public.”

With the Foundation turning its attention to care beyond health insurance coverage, that link continues. “The Fellowship started out already addressing a broad range of issues that the Foundation is expanding into,” says Tye, speaking of health care disparities. “There’s a convergence between our priorities and the Foundation.”

NOW MORE THAN EVER, HEALTH CARE ISSUES DEPEND ON QUALITY MEDIA COVERAGE



EDUARDO DE OLIVEIRA

It’s no secret that immigrants can face challenging barriers when accessing health care, but for Eduardo de Oliveira (pictured left), the obstacles had to do with accessing the information necessary to write about it.

“Because I’m a foreigner, it’s harder for me to access sources,” says de Oliveira, who came to America from Brazil in 2000. He’s amassed extensive journalistic experience over the years, from working as a stringer for the *Boston Globe*, editing Portuguese-language community newspapers, and writing his own column on immigration issues for the *Nashua Telegraph*. Still, de Oliveira says that with most topics on immigration concerning issues of law and politics, health care issues are less familiar territory.

That certainly wasn’t the case after he participated in the Health Coverage Fellowship.

“If I hadn’t gone through this experience ... I don’t know if I would be a good health reporter. It would take me at least three years to learn what I learned in nine days,” says de Oliveira. “We would wake up and have breakfast with [an expert in their field], lunch with Michael Dukakis, and dinner with Thomas Menino,” he continues, adding that the quality of speakers and guests were paramount to the Fellowship’s value. “It was a great opportunity.”

He recalls meeting a group of Iraq war veterans and observing robot-assisted heart surgery as two particularly compelling experiences. Since the Fellowship, de Oliveira worked on stories inspired by his observation of the robot-assisted heart surgery, and conversations about racism experienced by doctors. Through it all, he maintains a focus on synthesizing his Fellowship experience with his professional goals.

“The thing about my work, and the Fellowship helped me define it, is that I cannot do everything,” says de Oliveira. “I can’t talk about everything in health. I need to [address health topics] within my niche: immigrants.”

IT WOULD HAVE TAKEN ME AT LEAST

THREE YEARS TO LEARN WHAT I LEARNED

IN NINE DAYS.

Eduardo de Oliveira, 2008 Fellow

WHERE

NEW ENGLAND ETHNIC NEWSWIRE

DR. DIANE SHANNON

It’s no wonder that Dr. Diane Shannon was attracted to the Health Coverage Fellowship. She’s always looking to improve.

“Part of the reason I left was that I felt like the system was broken,” says Dr. Shannon. She practiced internal medicine for years, but grew disheartened by critical flaws in the health care system’s safety net. So 10 years ago, she pursued her Master’s in Public Health to “look at the big picture,” and began overseeing the accuracy of medical documents for a communications company. She now works as a medical writer focusing on performance and quality improvements, examining best practices, and crafting white papers to help clients replicate those systems.

“I decided that the topic area of improving the health care system—what people are doing for improvement for safety, quality, and care—that’s all I wanted to write about,” she says.

Dr. Shannon says she found the Fellowship an extremely valuable personal experience, and that she was struck by how the learning opportunities rounded out her understanding of health care issues. As a former physician, she says she was most affected by a conversation about medical mistakes. The fellows were joined at dinner by a doctor who shared his experience of making a mistake during a simple medical procedure that nearly resulted in the loss of his patient’s life. At the end of the conversation, the fellows learned that the doctor’s dining companion was that very patient, and that the two had come to terms with the experience, forged a strong bond, and now work together helping other physicians overcome the personal angst and trauma of committing medical mistakes.

When it comes to preparing future stories, Dr. Shannon says that part of her attraction to the Fellowship was to feel out her burgeoning interest in other styles of writing. While she rarely writes for lay audiences, she found herself increasingly interested in pursuing journalism to reach a mass audience with her work. “[The Fellowship] helped me learn to ask more pointed questions in interviews,” says Shannon, adding that the camaraderie between fellows has also yielded informal relationships that open the door to advice, sources, and inspiration. “It really has [had] a dramatic effect.”

IT REALLY HAS
A DRAMATIC EFFECT.

Dr. Diane Shannon , M.D., M.P.H., 2008 Fellow

WHERE

ACADEMIC MEDICAL PUBLICATIONS

MARTHA BEBINGER

At this point in her career, Martha Bebinger could probably teach a class on journalism herself, but she’s not above being one of the discipline’s most eager students.

“I don’t think you could ever really underestimate how complicated health care is,” says Bebinger. Despite her wealth of experience covering health care issues, from the steps of the State House to the scene in D.C., Bebinger says there is always more to know. That’s why she decided to participate in the Fellowship, her enthusiasm buoyed by positive recommendations from colleagues and past fellows.

“There are subjects within health policy that I feel I might know pretty well,” she says, “but I’m still pretty surprised to learn a new angle or dimension.”

For example, Bebinger was particularly impressed by how the Fellowship’s speakers drew connections between seemingly unrelated issues and demonstrated how they intersected with health care. “I really hadn’t read very much about how something like global warming affects things like infection rates, the transmission of disease, and the dire public health implications,” she says.

For a reporter used to daily deadlines, Bebinger appreciated the opportunity the Fellowship provided to probe deeply into issues. “I think it made it easier to just ask questions I might not normally take the time to ask if it didn’t directly impact the story I’m working on,” she explains. “I could put that aside for now, and do it. And you don’t often get to interview people in a group setting where you benefit from everyone’s input.”

Nor do you normally benefit from simply connecting with individuals who are on the front lines of the health care system. “It was great to have the opportunity to talk to people who live [the health care industry] on a daily basis—dig into the details of their personal experiences and the sense of how they fit into the larger health care system,” says Bebinger.

Moving forward, Bebinger is working on story ideas she formulated during the Fellowship, including one on the Human Genome Project, and another that examines the premedical preparation for runners in the Boston Marathon. But what she learned most from the Fellowship was something she didn’t necessarily expect: “I was impressed by how much I got out of it,” she says of the Fellowship. “It was amazing, a really invaluable experience.”

I DON’T THINK YOU COULD EVER

REALLY UNDERESTIMATE HOW COMPLICATED

HEALTH CARE IS.

Martha Bebinger, 2008 Fellow

WHERE

WBUR

MASSACHUSETTS INSTITUTE FOR COMMUNITY HEALTH LEADERSHIP

Since it was created by the Blue Cross Blue Shield of Massachusetts Foundation in October 2005, the Massachusetts Institute for Community Health Leadership (MICHL) has helped close to 100 health care professionals develop their leadership skills and hone their talents for collaborative work. While the goal of the program is to develop the next generation of leaders in Massachusetts to effectively address the future opportunities and challenges in community-based low-income and uninsured health care, the program also helps its students evolve in deeply personal, meaningful ways that go beyond the workplace.

In 2008, though, MICHL itself underwent a transformation. Michael McCormack, program director of the Institute since its inception, transitioned to a new position at the Harvard School of Public Health.

Though last year was his final as program director, the Institute remains a cornerstone of the Foundation's work under the new leadership of Jean Weinberg, who also helms the newly developed Community Partnerships Leaders Program (CoPaLS).

For Weinberg, it's that same level of trust established between MICHL colleagues that allows them to grow throughout the program. "Where else do you get to stand in front of people in a safe environment and try [new leadership skills] out?" she says. "If it doesn't work, it's okay. There's a way in which the group forms that is pretty powerful, because it has to feel safe for them to try."

And that's as it should be. The experiential nine-month Institute—which includes sections on facilitative leadership, cultural competence, understanding systems, working with stakeholders, a practicum addressing a real world health issue, and culminates with a Thompson Island Outward Bound challenge—has the ability to change lives.



FOUNDATION STRONGLY COMMITTED TO MICHL



DEREK BRINDISI

Many people find that their work demands too much; Derek Brindisi (pictured left) has always wanted it to demand more.

"I was always trying to go the extra mile," says Brindisi, reflecting on when he first began working for the City of Worcester's health department in 2000. "I was always thinking, 'What can we be doing differently? How can we change our business model?' I wanted to take a proactive approach, and it wasn't always accepted by the individuals I work with."

Punch in, punch out, lunch breaks, and water cooler chats: that's the impression Brindisi, who has been the acting director of the department since 2007, first received of his work environment, and it was one he wanted to transform. "I always thought that there was more we could do for the public ... But I found myself in the position of having to change [other colleagues'] mindsets. It was difficult to do, and at some point you think, 'Am I the only one who thinks this way?'"

The answer, of course, is no. Brindisi said he participated in MICHL because he thought it would be an opportunity to meet other community health leaders who have similar attitudes and ambitions for the work they do. "So many of us had the same types of values as one another," he says of his cohort. "You get into a program like MICHL, and you sit in a circle with other people like you, who share your thought process and are always trying to learn something different to apply [to their work]."

By learning from and alongside those that he believes share his values, Brindisi says he has been able to work better with those who initially may not. He says that MICHL's focus on bringing independent parties to a common table has helped him rally the city's public health divisions to shared goals, and foster mutual collaboration where there was once bureaucratic territorialism. "There have been contentious moments," he admits. "But I think I've been able to get [divisions] to not lose sight of overarching departmental missions."

"I have to attribute some of my learning and success to the MICHL program," says Brindisi, who recently learned that he will be honored this spring with the Massachusetts Public Health Association's Alfred Frechette Award for outstanding service in public health. "I [have] a better sense of security [knowing] that there are others out there who believe what [I] believe."

HOW I MAKE DECISIONS TODAY HAS

A LOT TO DO WITH MICHL.

Derek Brindisi, 2008 program participant

WHERE

CITY OF WORCESTER PUBLIC HEALTH DIVISION

I LEARNED A LOT

ABOUT MODELING LEADERSHIP.

Lindsey Tucker, 2008 program participant

LINDSEY TUCKER

What are the qualities associated with someone who would sign up for a nine-month leadership program on cultural competence and the inner view of leadership? Empathy? Check. Compassion? Check. Openness? Not so fast.

“I’m not a touchy-feely person,” Lindsay Tucker admits. “It took me a number of months to feel comfortable.”

She was surprised, and struck with a sense of disconnect, when she first encountered the Institute’s approach to leadership training—one that encouraged a type of free sharing and open disclosure not always found in your usual managerial seminars.

It also didn’t help that at 28, Tucker was one of the youngest members of the group. “I was having trouble connecting, and it takes me a long time to feel comfortable opening up. I didn’t know who to engage ... and I wasn’t sure if it was right for me at the time.”

But over the course of the program, she found herself more receptive to MICHL’s approach. “I learned a lot about modeling leadership in the way MICHL has you look at it, which is ‘holding the work instead of doing the work,’” she explains. “That’s been really useful. I have a fairly manipulative approach with what needs to happen in meetings, what voices need to be heard. It’s been good for me to commingle that with just letting things happen more ... setting things up and letting them evolve.”

And yet, in other ways, MICHL also helped Tucker become more assertive as a leader. “I lead lots of meetings and until recently I felt like I was just [facilitating], and that my voice and my opinion didn’t matter as much as the rest of the folks’,” she admits. “I gained self-confidence, that even though I am young I’ve been doing this work as long as many people in the health reform world and that my voice is equally important.”

Knowing when to hold, and when to delegate—when to speak up, and when to let others have their say—it’s a delicate balancing act, but Tucker says MICHL helped her find some amount of compromise in her personal and professional life.

“It was great for me,” she says. “I had a terrible work-life balance ... and wasn’t feeling as happy and fulfilled as I would have liked to. Having MICHL there, with these people working through similar issues who were able to support me has helped me make a [positive] shift.”

WHERE

HEALTH CARE FOR ALL

JOSEPH IANELLI

“I don’t think you could understand the possibility of the internal journey.”

That’s how Joseph Ianelli recalls his expectations of MICHL. He learned of the Institute through Massachusetts General Hospital colleagues who had participated in previous groups and would only describe it to him as a “life-changing experience” with few other details. “I think they wanted me to experience it for myself,” he laughs.

What he experienced, he says, was beyond what he expected. As he got to know his fellow group members at the first MICHL meeting, he was impressed by the openness and candor with which participants approached the process. “Everyone made themselves vulnerable, but in an appropriate way,” he recalls.

Ianelli says one of the most valuable lessons he learned had to do with another delicate mix: being a supportive team member and a leading role model. He recalls a challenging exercise on a ropes course during the Thompson Island excursion: “I was one of the lucky ones who got to the top,” he recalls. “Those who do that tend to get all the attention, whereas others might feel like, ‘Here I am, holding the rope so you don’t die, and no one’s noticing.’ People have a lot of feelings about what it means to be a supportive player and I think we truly processed what that means in collaborations and how we all contribute to an overall process.”

The lesson of keeping everyone involved has stuck with Ianelli, who says that it has helped him collaborate with colleagues to cope with a recent overhaul in the MassHealth reimbursement system. “Believe me when I tell you that for a place like Partners, this is a huge deal,” says Ianelli. “I’m bringing these challenges to the people who do the work, and coming up with a great process because of it. Linking people and communicating early, making all those connections. I don’t know that I would have handled it as well [before MICHL].”

“It’s true that some projects require expediency,” he adds, “but for a really good, clean process you need to include as many voices as possible.”

FOR A REALLY GOOD, CLEAN PROCESS

YOU NEED TO INCLUDE AS MANY VOICES

AS POSSIBLE.

Joseph Ianelli, 2008 program participant

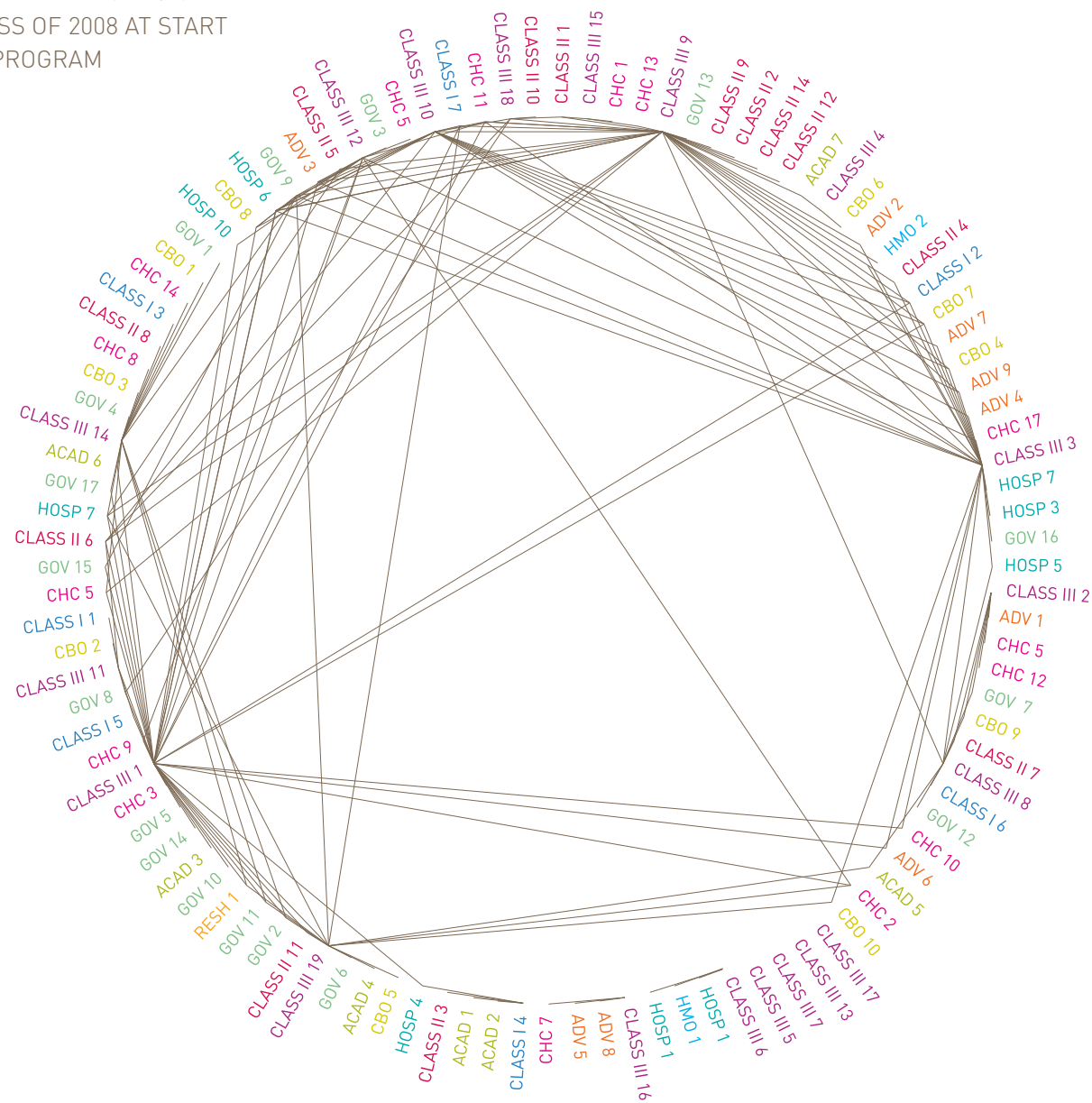
WHERE

MASSACHUSETTS GENERAL HOSPITAL

MASSACHUSETTS INSTITUTE FOR COMMUNITY HEALTH LEADERSHIP

One measure of a leader's potential to impact policy, effect organizational change, and marshal resources is that person's connections and collaborations with others. These graphics illustrate the networks within academia, advocacy, community-based organizations, policy, philanthropy, and health care provider organizations that members of the 2008 class of the Massachusetts Institute for Community Health Leadership brought with them to the program and the connections they had when they left. A color key to the various social networks is at the bottom of this page. The evaluation was completed by Bruce Hoppe Ph.D., of Boston University and Connective Associates, and Claire Reinelt, Ph.D., of the Leadership Learning Community.

SOCIAL NETWORKS OF
CLASS OF 2008 AT START
OF PROGRAM

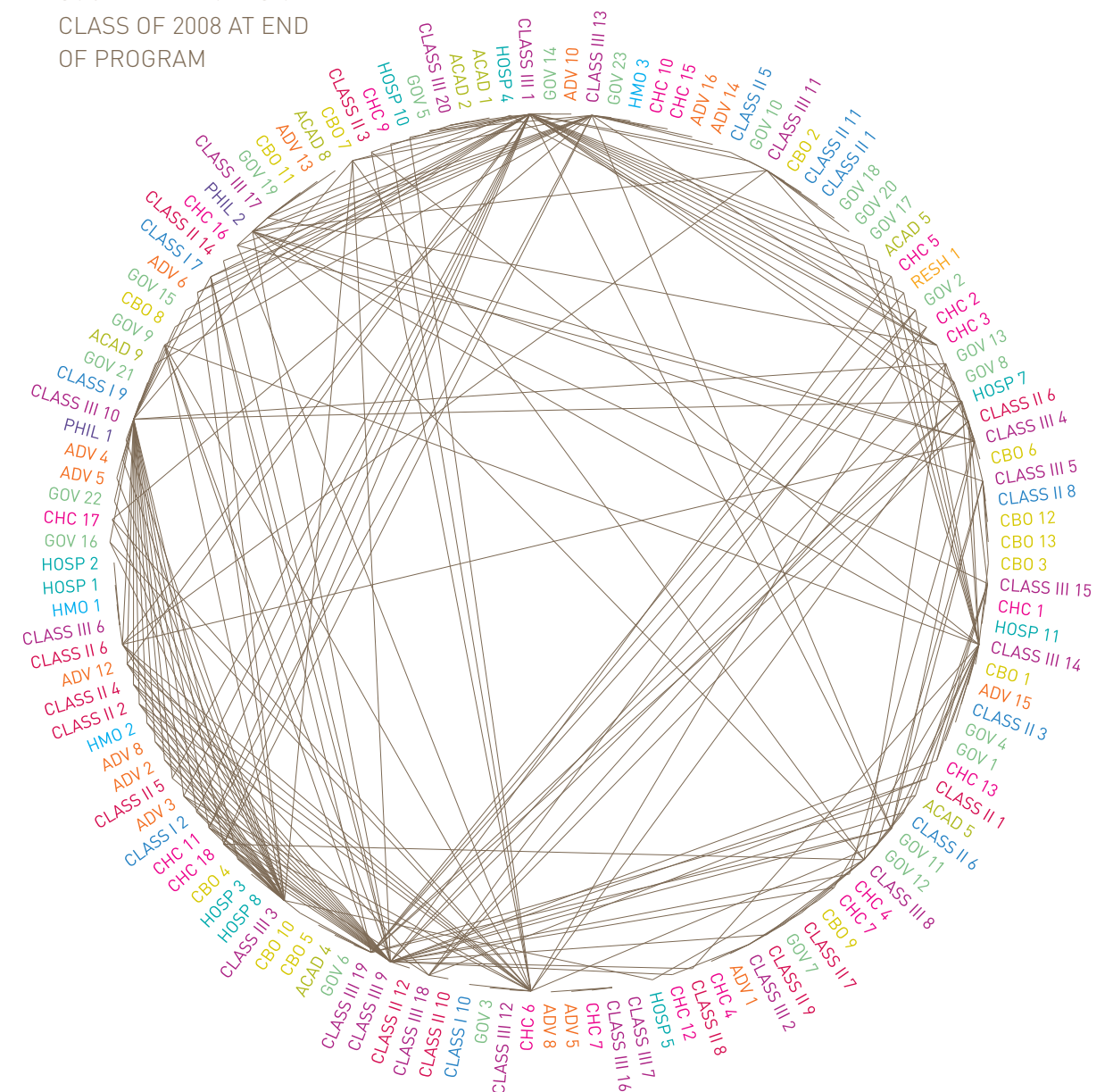


CLASS I 2006 MICHL PARTICIPANT
CLASS II 2007 MICHL PARTICIPANT
CLASS III 2008 MICHL PARTICIPANT
ACAD ACADEMIA
ADV ADVOCACY
CBO COMMUNITY-BASED ORGANIZATION
CHC COMMUNITY HEALTH CENTER
GOV GOVERNMENT OFFICIAL
HMO HEALTH MAINTENANCE ORGANIZATION EMPLOYEE
HOSP HOSPITAL EMPLOYEE
PHIL PHILANTHROPY
RESH HEALTH CARE POLICY WORK

LINKING PEOPLE AND COMMUNICATING EARLY, MAKING ALL THOSE CONNECTIONS. MICHL HELPED.

Joseph Ianneli, member of the 2008 class of the Massachusetts Institute for Community Health Leadership

SOCIAL NETWORKS OF
CLASS OF 2008 AT END
OF PROGRAM



COMMUNITY PARTNERSHIPS LEADERS PROGRAM

“I’m not the President [of the United States], but I have the same training.”

So laughs Jean Weinberg. Granted, the training she refers to has nothing to do with international diplomacy or budgetary balancing acts; instead, Weinberg is referring to over 30 years of experience in Alinsky-style community organizing.

“It’s funny,” she says. “A few years ago I could have told you I was an Alinsky-style organizer and you might not have known what that is. Now, having a President who is an Alinsky-style organizer—[people are more aware].”

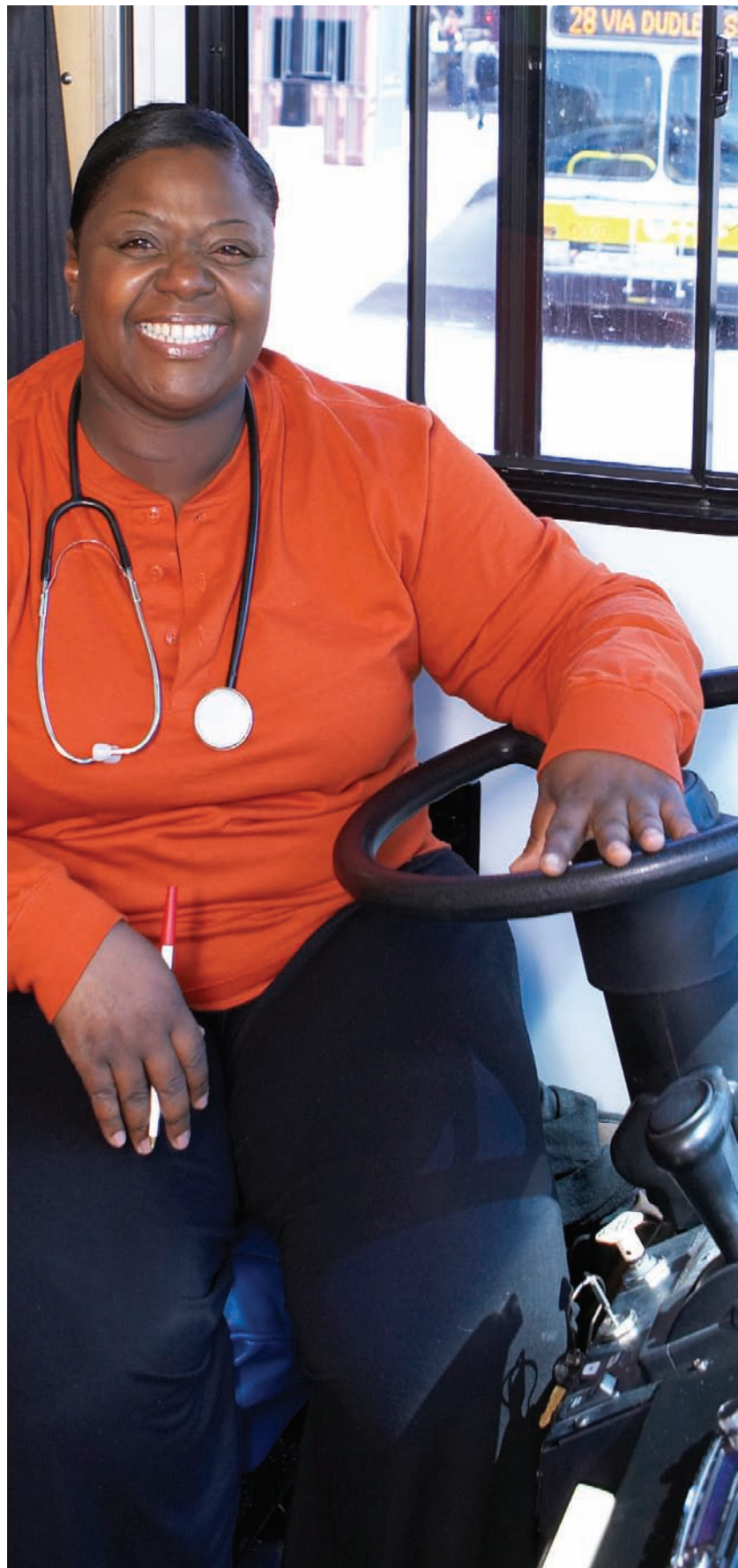
Weinberg is putting those skills to work leading the Foundation’s new Community Partnerships Leaders Program (CoPaLS), an initiative designed to strengthen the basic leadership skills of emerging community leaders and activists.

In 2008, the inaugural CoPaLS program brought together 16 participants for five weekly evening sessions. Each three-and-a-half-hour module featured a guest speaker, participatory activity (ranging from role-playing exercises to collaborative tasks), and conversation and debriefing sessions addressing five topics vital to the growth of emerging leaders: organizing successful campaigns on issues, dealing with conflict, communicating effectively, building collaborative meetings, and understanding how to impact policy.

In many ways, says Weinberg, CoPaLS was developed as a scaled-down version of the Foundation’s long-running Massachusetts Institute for Community Health Leadership, and set its sights not on the personal and professional development of established health care management, but on fostering the growth of those engaged on the ground level and front lines.

So even if CoPaLS participants aren’t at the helm of their respective agencies, they’re entitled to the same kind of training: training that builds a foundation for future growth.

BUILDING A FOUNDATION



DAVETTE ROUNDTREE

With her kind eyes and friendly smile, it’s easy to talk with Davette Roundtree (pictured left). Good thing, because starting conversations is probably the most important part of her job.

“You need to make sure you refill your prescription today. Do you need me to make a call?” says Roundtree, addressing a client who has stopped by The Family Van, a mobile health clinic program of Harvard Medical School. The van travels to seven different sites four days a week to provide cardiovascular disease and diabetes screenings, pregnancy testing, and access to sexually transmitted disease education and testing.

“He has very, very high blood pressure,” explains Roundtree of the client, one of dozens who has stepped inside the van today. Like much of the low-income population that utilizes its services, this patient was unaware of his condition until Roundtree first hustled him inside for a screening several months ago.

To do that, she starts conversations. “He was very uncomfortable,” she recalls of the first time the man stepped inside the van. “He didn’t want us to take his blood pressure, so I said, ‘Let me just talk to you.’ So we talked. Well, after about an hour he said, ‘Okay, you can take my blood pressure now.’”

Now the man has become so accustomed to The Family Van’s regularly scheduled stops, that he makes a point to visit and monitor his health on an ongoing basis.

“Young lady, the only thing raising my blood pressure is every time you flash me those eyes,” he laughs as Roundtree checks his blood pressure.

While she may seem like a natural conversationalist with patients, Roundtree says it was only recently that she became equally adept at talking to her colleagues in the health care industry. “Before [CoPaLS], I would get nervous and talk fast so that I could sit down again ... The program taught me to slow down and really think about what I wanted to say and how to choose my words.”

The success of CoPaLS can be found in the skills that help their graduates strengthen their communities, and in conversations large and small.

THE PROGRAM TAUGHT ME TO
SLOW DOWN, AND REALLY THINK ABOUT
WHAT I WANTED TO SAY.

Davette Roundtree, 2008 CoPaLS participant

WHERE
THE FAMILY VAN, DRIVER/HEALTH EDUCATOR

JENNIFER MOLINA

Jennifer Molina, a former professional soccer player who represented Mexico at the 2004 Olympic Games, is grateful for the unique perch from which she can observe and engage in health advocacy. “Not many people are able to speak from this platform to talk about other issues of health advocacy,” says Molina.

She’s been making the most of the opportunities her past has given her. Molina is interested in the social determinants that shape access to sports opportunities, and is inspired by her travels with her team, years spent living in her father’s home in Mexico City, and her observations of urban life here in the States.

“Growing up, my parents involved me in anything I wanted to try,” says Molina. “My parents understood it was important for me to be active socially and physically ... I was lucky to have those values.”

As program coordinator at Sport in Society at Northeastern University, an initiative that encourages healthy living, combats violence, and fosters notions of diversity among urban youth, Molina is putting those values to work by exploring the intersection of sport with society.

Molina participated in CoPaLS to network, and to learn more about what others were doing in positions similar to hers. She explains, “We sometimes forget about the little worker bees in health care ... I wanted to meet people who had similar passions about health, what’s going on, what bothers them and how they want to fix it. I wanted to learn from the skills of those people.”

On that front, Molina achieved her goal. Among other things, she’s currently working to re-launch a youth soccer program in East Boston, and says that CoPaLS gave her the skills to “bring [coaches, local businesses, parents, and other stakeholders] to the table to facilitate that.”

She adds that the program also allowed her to finally see herself as a leader in her work off the field. “Going into CoPaLS, I was nervous,” she admits. “I didn’t even think of myself as a leader. ... Leaving, I felt more like I was a leader with what I was doing, and feeling a lot more confident.”

PHILLOMIN LAPTISTE

Phillomin Laptiste found an innovative way to give back to the agency that saved her daughter’s life: she started working there.

“I thought, ‘This is too good to be true,’” says Laptiste of when she first learned of an open position at Bowdoin Street Health Center. In May 2007, her 14-month-old daughter was rushed to the Health Center in a precarious, lethargic state, and though Laptiste was born and raised on Bowdoin Street in Dorchester, she had never visited the facility until that dramatic day.

Her daughter’s doctor determined that the toddler had accidentally ingested her grandfather’s blood pressure medication. She recovered fully, but Laptiste says that she will never forget the compassionate care of the medical staff that attended to her daughter and called multiple times to check on her progress once she was transferred to a nearby hospital—even though Laptiste’s daughter wasn’t even one of their patients.

“That experience played a major role in my life, not just because my daughter is my everything ... [but also] because I experienced firsthand the quality of care here,” says Laptiste.

She’s now been working at Bowdoin Street Health Center for a year, promoting violence prevention, implementing farmers’ markets, and organizing sports programming to combat youth obesity.

“Because I live in this community, I believe the work I do impacts me personally,” she says.

To improve her work, she says she enrolled in CoPaLS to discover more about the community organizing aspect of health care work, get a firmer grasp on how to impact policy, and develop her understanding of how to work with the media to spread information about the health center’s work and programs. She was particularly struck by role-playing activities that helped her understand other points of view, and was grateful for the lasting network of colleagues she took away from CoPaLS. “There was great diversity,” she says. “It introduced all of us to so many people who work in the industry.”

For Laptiste, the impact of the CoPaLS program has been significant. “I was looking for tools to help me with community outreach. To engage people, empower them ... and make [my work] more impactful.” And, she says, she found them.

I WAS LOOKING FOR TOOLS TO HELP ME
WITH COMMUNITY OUTREACH. TO ENGAGE
PEOPLE, EMPOWER THEM ... AND MAKE
[MY WORK] MORE IMPACTFUL.

Phillomin Laptiste, 2008 CoPaLS participant

WHERE
BOWDOIN STREET HEALTH CENTER

I WANTED TO MEET PEOPLE WHO HAD
SIMILAR PASSIONS ABOUT HEALTH.

Jennifer Molina, 2008 CoPaLS participant

WHERE
SPORT IN SOCIETY AT NORTHEASTERN UNIVERSITY

2008 GRANT AWARDS

THESE GRANTS SUPPORT THE FOUNDATION’S MISSION OF EXPANDING ACCESS TO HEALTH CARE FOR THE COMMONWEALTH’S LOW-INCOME AND VULNERABLE POPULATIONS. IN 2008, THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION APPROVED 76 GRANTS IN 5 PROGRAM AREAS TOTALING \$3.7 MILLION.

THESE GRANTS SUPPORT MASSACHUSETTS COMMUNITY-BASED ORGANIZATIONS, COMMUNITY HEALTH CENTERS, AND SELECT HOSPITAL-BASED PROGRAMS THAT PROVIDE SERVICES TO HELP LOW-INCOME CONSUMERS ENROLL IN PUBLIC AND PRIVATE HEALTH ACCESS PROGRAMS, NAVIGATE THE HEALTH CARE SYSTEM, AND CONNECT WITH PROVIDERS. IN 2008, THE FOUNDATION AWARDED \$485,000 TO 22 GRANTEES. ➤➤

CONNECTING CONSUMERS WITH CARE

AFRICAN COMMUNITY HEALTH INITIATIVES
\$25,000 › To support the Early Intervention/Community Referral program that provides triage services to African immigrants and refugees.

BERKSHIRE HEALTH SYSTEMS › \$20,000
To support a health care specialist in the Advocacy for Access program focusing on the inpatient substance abuse and psychiatric units of Berkshire Medical Center and the Berkshire County House of Corrections and the Community Corrections Department.

BOSTON PUBLIC HEALTH COMMISSION › \$25,000 › To support the Health Care Access Project, which serves Vietnamese, black, and Latino low-income and immigrant populations. Outreach will be conducted in auto body shops, nail salons, and Earned Income Tax Credit tax preparation sites.

BROCKTON NEIGHBORHOOD HEALTH CENTER › \$25,000 › To support the continuation of a train-the-trainer model whereby community leaders receive information about applying for and maintaining health care coverage.

CAMBODIAN MUTUAL ASSISTANCE OF GREATER LOWELL › \$20,000 › To support outreach and community education via Khmer radio, public-access cable television, and community forums to inform clients of health care reform and available public health coverage programs.

CHILD CARE RESOURCE CENTER, INC.
\$20,000 › To support a health access specialist who assists families and

individuals with young children seeking referrals to child care providers.

COMMUNITY ACTION COMMITTEE OF CAPE COD & ISLANDS › \$25,000 › To support a health outreach educator targeting Brazilian and Hispanic communities, as well as Asian, Native American, and seasonal and immigrant workers from Jamaica, Pakistan, Russia, and Bulgaria.

COMMUNITY ACTION OF FRANKLIN, HAMPSHIRE, AND NORTH QUABBIN REGIONS › \$20,000 › To support the Healthy Connections program, which works to meet the health care needs of residents in the North Quabbin region.

COMMUNITY HEALTH CONNECTIONS
\$20,000 › To support a bilingual/bicultural outreach and enrollment coordinator, who will provide outreach and enrollment assistance to individuals and families. Outreach will be conducted in restaurants, businesses, public schools, and child care programs.

DUFFY HEALTH CENTER › \$20,000
To support the health center’s Benefit Coordinator, who serves individuals experiencing homelessness or at risk of homelessness and enrolls them into state programs.

DUKES COUNTY/VINEYARD HEALTH CARE ACCESS PROGRAM › \$20,000 › To support a health access specialist and a bilingual community health outreach educator in the Vineyard Health Care Access Program who will provide enrollment services to the

Island’s low- and moderate-income residents, and work to minimize gaps in coverage.

ECU-HEALTH CARE, INC. › \$25,000
To maintain its comprehensive public health insurance outreach and enrollment with one-on-one assistance and follow-up, and the institution of a broadcast and print media outreach campaign to inform the public of available health coverage programs.

JOINT COMMITTEE FOR CHILDREN’S HEALTH CARE IN EVERETT › \$25,000
To support outreach to the Latino population, as well as expanding the organization’s efforts to the African-American population. The Joint Committee will collaborate with 30 organizational partners to conduct a series of educational forums.

MANET COMMUNITY HEALTH CENTER
\$20,000 › To support the Community Outreach Program, which provides services to diverse populations including Asian, Arabic, and Brazilian communities. Services are provided in ways that ensure linguistic and cultural competence.

MASSACHUSETTS ALLIANCE OF PORTUGUESE SPEAKERS › \$20,000
To support efforts connecting the Brazilian and Cape Verdean communities to health care services through the provision of culturally and linguistically appropriate assistance.

CONNECTING CONSUMERS WITH CARE (CONT.)

MERCY HOSPITAL, INC. › \$20,000 › To assist at least 200 uninsured homeless and Vietnamese individuals with enrollment in health insurance coverage and post-enrollment services.

METROWEST LEGAL SERVICES › \$25,000
To support a project paralegal who works with clients from the application through appeal processes.

OUTER CAPE HEALTH SERVICES, INC.
\$25,000 › To support Healthy Connections, the only enrollment agency for individuals and families on the Lower and Outer regions of Cape Cod.

PEOPLE ACTING IN COMMUNITY ENDEAVORS, INC. › \$20,000 › To support outreach and enrollment assistance services, and the documentation of health plan selection processes of clients, ensuring that connections are made between clients and physicians.

STANLEY STREET TREATMENT & RESOURCE, INC. › \$25,000 › To support the Health Access Program, which provides outreach, eligibility determinations, and navigation assistance to individuals in Fall River and surrounding communities.

STEPPINGSTONE, INC. › \$20,000 › To support Project ACCTION, which assists low- and moderate-income clients obtain health insurance and access primary care services.

TAPESTRY HEALTH › \$20,000 › To support the implementation of various strategies to assist and enroll eligible and uninsured Western Massachusetts residents into health coverage programs, including MassHealth, Commonwealth Care, the Women’s Health Network, and Commonwealth Choice.

THESE GRANTS SUPPORT MASSACHUSETTS COMMUNITY HEALTH ORGANIZATIONS WORKING TO ADDRESS HEALTH CARE DISPARITIES ON THE BASIS OF RACE, ETHNICITY, IMMIGRATION STATUS, AGE, MENTAL ILLNESS, AND SEXUAL ORIENTATION. IN 2008, THE FOUNDATION AWARDED \$768,387 TO 11 GRANTEES. THE 2008 GRANTS ARE THE FIRST OF AN INTENDED THREE-YEAR AWARD SCHEDULE; THE FIRST-YEAR GRANTS WILL SUPPORT PROGRAM PLANNING AND THE SECOND-AND THIRD-YEAR GRANTS WILL SUPPORT PROGRAM IMPLEMENTATION. ➤➤

CLOSING THE GAP ON HEALTH CARE DISPARITIES

AIDS ACTION COMMITTEE › \$70,000
To support the efforts of a group of 20 women of color with AIDS and two clinical HIV/AIDS doctors at Massachusetts General Hospital to define barriers to care and develop proposed system changes to eliminate disparities in the delivery of health care to women of color with AIDS.

CAMBRIDGE CARES ABOUT AIDS
\$70,000 › To develop a Community Advisory Group to address the disparities in health care for HIV-positive men of color who have sex with men.

CASA LATINA › \$70,000 › To develop an action plan to reduce disparities in health care access among Latinos in Hampshire County.

CENTRAL MASSACHUSETTS AREA HEALTH EDUCATION CENTER › \$69,956
To develop an intervention plan to

reduce disparities experienced by Brazilians and Latinos in Framingham in accessing mental health and substance abuse services, and establish the Framingham Mental Health and Substance Abuse Health Disparities Project to oversee the initiative.

COMMUNITY HEALTH CENTER OF CAPE COD › \$70,000 › To study and plan interventions to address the higher rates of diabetes among African, Asian, Latino, and Brazilian immigrants on Cape Cod.

LOWELL COMMUNITY HEALTH CENTER
\$70,000 › To address the disparities experienced by Cambodian, African, Brazilian, and Latino immigrants in accessing mental health services.

MOUNT AUBURN HOSPITAL › \$70,000
To address the higher rates of diabetes experienced by Latinos in the Waltham community.

PARTNERS FOR A HEALTHIER COMMUNITY
\$70,000 › To address the higher rates of diabetes experienced by Latinos and African-Americans in Springfield and Western Massachusetts.

SERVICENET, INC. › \$70,000 › To address the health and wellness needs of the chronically mentally ill and developmentally disabled adults in Northampton and Western Massachusetts.

TAPESTRY HEALTH › \$68,435 › To address the high rates of teen pregnancy among Latina teens in Northampton and Western Massachusetts.

THE YWCA OF CENTRAL MASSACHUSETTS
\$69,996 › To address the health care disparities that result in higher rates of obesity among Latinos in the Worcester area.

THESE GRANTS GO TO HEALTH CARE DELIVERY ORGANIZATIONS IN MASSACHUSETTS WORKING TO IMPLEMENT MORE COST-EFFECTIVE CARE FOR THE UNINSURED THROUGH OUTREACH AND EDUCATION, PREVENTION, AND MEDICAL MANAGEMENT. IN 2008 THE FOUNDATION AWARDED \$1.95 MILLION TO 17 GRANTEES. ➡➡

INNOVATION FUND FOR THE UNINSURED

BEHAVIORAL HEALTH NETWORKS
\$75,000 › To implement a Jail Diversion Program to connect 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.

BOSTON HEALTH CARE FOR THE HOMELESS › \$65,000 › 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
\$65,000 › To implement a Diabetes Health Life Initiative that will provide patient navigator services to black and Latino diabetic patients.

DOTWELL › \$90,000 › To continue its case management infrastructure that assists uninsured patients and ensures they have continual contact with the health center through case managers who monitor their health status.

FAMILY HEALTH CENTER OF WORCESTER
\$75,000 › To convert its urgent-care center, which currently serves nearly 3,000 uninsured patients, into a walk-in primary care and social services clinic.

GREAT BROOK VALLEY HEALTH CENTER
\$72,500 › To fund a specialized, bilingual, bicultural social services case manager to assist patients on the Health Safety Net and those transitioning off of Refugee Medical Assistance.

GREATER NEW BEDFORD COMMUNITY HEALTH CENTER › \$65,000 › To revamp its chronic disease management and care coordination systems for uninsured patients with diabetes, hypertension, and asthma.

HEALTHFIRST FAMILY CARE CENTER › \$65,000 › To implement a system that will facilitate access to continual and coordinated primary care for the area’s homeless population.

HILLTOWN COMMUNITY HEALTH CENTER
\$65,000 › To create a medical home for those residing in the Hilltown region and who remain uninsured.

HOLYOKE HEALTH CENTER › \$72,500 › To extend care to the uninsured population of Holyoke and Chicopee and evaluate individuals referred by community partner organizations.

JOSEPH M. SMITH COMMUNITY HEALTH CENTER › \$70,000 › To expand care coordination services for uninsured adults aged 20–39 and those over age 65.

JUSTICE RESOURCE INSTITUTE
\$60,000 › To improve the continuity and completeness of care for homeless youth and young adults in downtown Boston, with a special focus on those who are gay, lesbian, bisexual, or transgender.

LOWELL COMMUNITY HEALTH CENTER
\$75,000 › To facilitate access to care and education about health care issues for uninsured immigrants in the Greater Lowell area.

LYNN COMMUNITY HEALTH CENTER
\$95,000 › To continue implementing a case management model for uninsured adults with serious chronic disease.

PARTNERS IN LIFE › \$65,000 › To develop a Transition to Primary Care program for inmates nearing release from the Suffolk County House of Correction.

SOUTH END COMMUNITY HEALTH CENTER
\$55,000 › To provide a medical home for homeless, uninsured patients, female detainees in the Suffolk County correctional system, and uninsured Latinos in the Greater Boston area.

VOLUNTEERS IN MEDICINE, BERKSHIRES
\$60,000 › To offer preventive services in mental health, primary, and dental care.

THESE GRANTS GO TO HEALTH CARE DELIVERY ORGANIZATIONS WORKING TO EXPAND ACCESS TO HEALTH CARE IN CULTURALLY APPROPRIATE AND COMPETENT WAYS FOR IMMIGRANT AND NON-ENGLISH SPEAKING CONSUMERS. IN 2008, THE FOUNDATION AWARDED \$637,894 TO 10 GRANTEES. THESE GRANTS WERE THE SECOND OF A TWO-YEAR COMMITMENT FROM THE FOUNDATION. THE FIRST YEAR OF THE GRANT WAS SPENT ON PROGRAM PLANNING; THE SECOND SUPPORTED PROGRAM IMPLEMENTATION. ➡➡

PATHWAYS TO CULTURALLY COMPETENT CARE

CHILDREN’S HOSPITAL BOSTON
\$65,000 › To support the hospital’s efforts to administer the Picker Survey in a more culturally-competent way. The Picker Survey measures pediatric inpatient satisfaction.

GREAT BROOK VALLEY HEALTH CENTER
\$65,000 › To address the complex mental health needs of refugees and immigrants suffering from post-traumatic stress disorder, depression, and other disorders brought on by torture, emotional and physical violence, forced relocation, and severe living conditions.

GREATER LAWRENCE FAMILY HEALTH CENTER › \$52,894 › To implement a culturally-appropriate interpreter training program for all health center staff.

GREATER NEW BEDFORD COMMUNITY HEALTH CENTER › \$65,000 › To improve providers’ abilities to identify and treat occupational health issues in low-income and immigrant populations.

HALLMARK HEALTH SYSTEM, INC.
\$65,000 › To implement hospital-wide anti-bias training programs.

HEALTHALLIANCE HOSPITAL › \$65,000 › To establish systems that meet the needs of the Fitchburg/Leominster area’s increasingly diverse patient population, which now includes Hmong, Vietnamese, and African immigrants.

JOSEPH M. SMITH COMMUNITY HEALTH CENTER › \$65,000 › To analyze data from their electronic record to quantify health disparities in patient care.

JOSLIN DIABETES CENTER › \$65,000 › To better serve the 1,000 patients who utilize the Joslin Diabetes Center’s Asian Clinic.

MATTAPAN COMMUNITY HEALTH CENTER
\$65,000 › To better serve its growing patient population of Caribbean immigrants from English-, French-, Haitian-Creole-, and Spanish-speaking islands.

NEW ENGLAND EYE INSTITUTE › \$65,000 › To train providers, staff, and students on how to better serve its diverse patient population.

CATALYST FUND

THE CATALYST FUND IS SUPPORTED ENTIRELY WITH DONATIONS FROM EMPLOYEES OF BLUE CROSS BLUE SHIELD OF MASSACHUSETTS. IT IS ADMINISTERED BY THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION. CATALYST FUND GRANTS OF UP TO \$3,500 ARE AWARDED EVERY MONTH, EXCEPT JUNE AND JULY. THEY ASSIST WITH ONE-TIME CAPACITY-BUILDING EXPENSES NEEDED TO STRENGTHEN AN ORGANIZATION'S ABILITY TO EXPAND ACCESS TO HEALTH CARE IN MASSACHUSETTS. SINCE 2002, THE CATALYST FUND HAS DISTRIBUTED MORE THAN \$540,000 TO COMMUNITY-BASED ORGANIZATIONS, HEALTH CENTERS, CLINICS, AND HEALTH ADVOCACY GROUPS.

THESE GRANTS PROVIDE CORE OPERATING SUPPORT TO MASSACHUSETTS ORGANIZATIONS WHOSE MISSION AND ACTIVITIES FOCUS ON PROMOTING THE HEALTH CARE INTERESTS OF UNINSURED AND LOW-INCOME RESIDENTS. IN 2008, THE FOUNDATION AWARDED \$635,000 TO 16 GRANTEES. ➡➡

STRENGTHENING THE VOICE FOR ACCESS

COMMUNITY PARTNERS, INC. › \$50,000
To continue its work with the Health Access Network, and advocate around outreach and enrollment issues in Massachusetts.

THE DISABILITY POLICY CONSORTIUM › \$30,000 › To continue its work as one of the few statewide, cross-disability organizations active in the Massachusetts policy arena.

THE GREATER BOSTON INTERFAITH ORGANIZATION › \$50,000 › To continue its work with 70 religious congregations and organizations in the Greater Boston area to promote social justice in the area of health care access.

HEALTH CARE FOR ALL › \$50,000
To continue its work building a movement of empowered people and organizations to create a health care system that is responsive to the needs of all people, including those who are most vulnerable.

HEALTH LAW ADVOCATES › \$40,000
To continue its legal representation of vulnerable residents who have been denied access to health care.

THE MASSACHUSETTS ASSOCIATION OF COMMUNITY HEALTH WORKERS › \$40,000 › To continue its work organizing community health workers around the state.

THE MASSACHUSETTS COALITION OF SCHOOL-BASED HEALTH CENTERS › \$30,000 › To continue improving children's access to health care through school-based health centers partnered with hospitals, community health centers, and public health departments.

MASSACHUSETTS CORRECTIONAL LEGAL SERVICES › \$35,000
To continue its work as the only organization in the state advocating for the health care needs of the Commonwealth's prisoners.

THE MASSACHUSETTS HOUSING & SHELTER ALLIANCE › \$30,000 › To continue its work advocating for the health care needs of homeless adults.

THE MASSACHUSETTS IMMIGRANT & REFUGEE ADVOCACY COALITION › \$50,000 › To continue its advocacy for immigrants and refugees across the Commonwealth.

THE MASSACHUSETTS LAW REFORM INSTITUTE › \$45,000 › To continue its work preparing legal analyses and promoting policy education around the implementation of health reform, regulating the Safety Net Trust Fund, and improving the operations of MassHealth, the state's Medicaid program.

THE MASS. LEAGUE OF COMMUNITY HEALTH CENTERS › \$45,000 › To continue its advocacy and organizing on behalf of the state's 52 community health centers.

THE MASSACHUSETTS SENIOR ACTION COUNCIL › \$40,000 › To continue to protect, reform, and increase the enrollment of seniors in Medicare and Prescription Advantage.

NEIGHBOR TO NEIGHBOR › \$35,000
To continue its work advocating for and organizing low-income residents, especially around health access issues.

THE PRO-CHOICE MASSACHUSETTS FOUNDATION › \$25,000 › To continue its work eliminating barriers to reproductive health care services.

THE VOICE AND FUTURE FUND › \$40,000 › To continue its work educating low-wage workers, particularly immigrants, about their health access rights and responsibilities.

BEHAVIORAL HEALTH NETWORK › \$3,160 › To develop a mental health resource website.

BOSTON COALITION FOR ADULT IMMUNIZATION › \$3,500 › To hire a contracted grant writer to research funding opportunities and submit proposals.

BOYS & GIRLS CLUB OF TAUNTON › \$3,350 › To purchase two Automated External Defibrillators and train staff on their use.

BRIDGE, INC. › \$3,000 › To hire a professional consultant to develop an 18-month strategic plan.

BROOKLINE COMMUNITY MENTAL HEALTH CENTER › \$3,500 › To offset the cost of hiring a consultant to develop and implement a database that integrates the health center's electronic billing and medical records system.

CONCILIO HISPANO, INC. › \$3,500 › To hire a consultant to help Concilio Hispano's board of directors explore options for a potential merger.

CROSSROADS FOR KIDS › \$2,250 › To purchase an Automated External Defibrillator and train staff on its use.

FAMILY HEALTH CENTER OF WORCESTER, INC. › \$3,000 › To contract with the faculty at The College of the Holy Cross to conduct a preliminary assessment of the language proficiency of its 25 bilingual Medical Assistants.

FRIENDS OF THE SHREWSBURY SENIOR CENTER › \$2,000 › To purchase an Automated External Defibrillator and train staff on its use.

GEIGER GIBSON COMMUNITY HEALTH CENTER › \$3,300 › To hire a consultant to help refine its strategic plan.

GREATER BOSTON GUILD FOR THE BLIND › \$3,500 › To design a low vision manual and print 600 copies of the manual to be distributed to its participants in the SightCare Vision Loss Education program.

HOPE RESTORED HUMAN SERVICES, INC. › \$3,400 › To hire a consultant to begin the first phase of its three-phase infrastructure-improvement project.

MASSACHUSETTS ALLIANCE OF PORTUGUESE SPEAKERS › \$3,400
To purchase three new computers and software.

MASSACHUSETTS SENIOR ACTION COUNCIL › \$3,500 › To hire a consultant to develop a five-year strategic plan.

METROWEST FREE MEDICAL PROGRAM › \$3,500 › To support start-up costs for the opening of a second clinic.

NATIONAL ALLIANCE ON MENTAL ILLNESS OF MASSACHUSETTS › \$3,500 › To hire a consultant that will develop a needs assessment around statewide mental health information and referrals.

NEIGHBOR TO NEIGHBOR MASSACHUSETTS EDUCATION FUND › \$3,500 › To hire a consultant for cultural competency staff training.

NEW ENGLAND HEMOPHILIA ASSOCIATION › \$3,500 › To organize and conduct a two-day Board of Directors retreat.

PARTNERS IN HEALTH › \$3,500 › To translate its training curriculum and patient workbook to accommodate its Spanish-speaking patients.

RESPOND, INC. › \$3,500 › To hire a management and resource development consultant to conduct strategic fundraising planning and research.

SPAN, INC. › \$3,500 › To contract with a fundraiser to research funding opportunities, submit proposals, develop a strategy to increase the number of individual donors, and train staff to identify potential private funding sources and to write proposals.

STAVROS CENTER FOR INDEPENDENT LIVING › \$3,500 › To hire a grant writer to prepare and submit proposals to foundations and corporations in order to secure funds for its Home Sweet Home program.

THE ARC OF NORTHERN BRISTOL COUNTY › \$2,250 › To purchase an Automated External Defibrillator and train staff on its use.

VNA OF SOUTHEASTERN MASSACHUSETTS › \$3,000 › To purchase two laptops for its home care clinical staff.

VOLUNTEERS IN MEDICINE BERKSHIRES › \$3,500 › To hire a consultant with database management and analysis experience to evaluate its current database and develop new reporting systems for its medical and dental office.

WACHUSETT REGIONAL HIGH SCHOOL › \$2,250 › To purchase an Automated External Defibrillator and train staff on its use.

YWCA OF SOUTHEASTERN MASSACHUSETTS › \$3,425 › To recruit and train four women from faith-based communities on how to conduct cancer and cardiovascular education curriculums.

FINANCIAL INFORMATION

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION, INC.
FOR EXPANDING HEALTHCARE ACCESS. YEARS ENDED DECEMBER 31, 2008 & 2007

FROM THE FINANCE AND AUDIT COMMITTEE

The Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access (the Foundation) distributed grants totaling \$4.6 million in 2008. These grants were made possible by contributions from Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (the Company), including a \$10.4 million cash contribution to the Foundation's endowment and in-kind contributions totaling \$1.4 million. The Company's in-kind contributions represent a significant amount of the Foundation's operating costs, including investment expenses, facility costs, and other operating expenses.

In addition, reflecting its continuing support of the Foundation, the Company has committed to a contribution of \$2.1 million in 2009 based on the Company's 2008 year-end results.

The Foundation ended the year with \$75 million in net assets. The decline in market value over last year is mainly attributable to the change in the unrealized/realized losses on investments of \$31.5 million due to the recent market volatility resulting from the global financial crisis. This unrealized/realized loss was partially offset by \$3.0 million in investment income for the year. For the one-year ended December 31, 2008, the portfolio generated a total return of (26.6%). During the year, the Foundation was invested approximately 44 percent in equities, 37 percent in fixed income and cash equivalents, and 19 percent in alternative investments. We continue to believe that a well-diversified portfolio is appropriate for the Foundation's investments.

The Foundation's Board of Directors voted to add two new directors to the Finance and Audit Committee for 2009: Matt Fishman and Robert Restuccia.

Our thanks to the hardworking members of the Finance and Audit Committee, Blue Cross Blue Shield of Massachusetts and its finance staff, and our investment consultants, New England Pension Consultants.

Submitted by,

Milton Glass
Chair
Finance and Audit Committee

Finance and Audit Committee:
Milton Glass, Rick Lord, James Hunt, Matt Fishman, Robert Restuccia

REPORT OF INDEPENDENT AUDITORS

*The Board of Directors
Blue Cross Blue Shield of Massachusetts Foundation,
Inc. for Expanding Healthcare Access*

We have audited the accompanying combined statements of financial position of Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access (the Foundation) as of December 31, 2008 and 2007, and the related combined statements of activities and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Foundation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Foundation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the combined financial position of Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access at December 31, 2008 and 2007, and its combined activities and changes in its net assets, and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

Boston, Massachusetts
March 27, 2009

COMBINED STATEMENTS OF FINANCIAL POSITION

(Dollars in thousands)

	DECEMBER 31	
	2008	2007
ASSETS		
Cash, cash equivalents and investments	\$76,225	\$101,545
Pledges and investments receivable	216	64
Contributions due from affiliates	2,093	10,436
Total assets	\$78,534	\$112,045
LIABILITIES AND NET ASSETS		
Grants payable	\$ 2,666	\$ 2,529
Accounts payable and accrued expenses	594	375
Due to Blue Cross and Blue Shield of Massachusetts, Inc.	304	618
Federal excise tax liability	59	117
Total liabilities	3,623	3,639
Net assets - unrestricted	74,911	108,406
Total liabilities and net assets	\$78,534	\$112,045

➤ SEE ACCOMPANYING NOTES

COMBINED STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS

(Dollars in thousands)

	YEARS ENDED DECEMBER 31	
	2008	2007
REVENUES AND OTHER SUPPORT		
Contributions	\$ 2,433	\$ 10,736
Contributions in-kind	1,438	1,089
Investment income	2,959	4,219
Net unrealized and realized (losses) gains on investments	(31,454)	539
Total (losses) revenues and other support	(24,624)	16,583
EXPENSES		
Grants	4,615	5,077
Professional services	2,233	1,881
Salaries and benefits	1,553	1,323
Conferences, conventions, and meetings	271	244
Occupancy and equipment maintenance	132	116
Federal excise tax expense	59	117
Other administrative expenses	8	108
Total expenses	8,871	8,866
(Deficiency) excess of revenues and other support over expenses and change in net assets	(33,495)	7,717
Net assets at the beginning of year	108,406	100,689
Net assets at the end of year	\$74,911	\$108,406

➤ SEE ACCOMPANYING NOTES

COMBINED STATEMENTS OF CASH FLOWS

(Dollars in thousands)

	YEARS ENDED DECEMBER 31	
	2008	2007
OPERATING ACTIVITY		
(Deficiency) excess of revenues and other support over expenses and change in net assets	\$(33,495)	\$ 7,717
Changes in net assets and liabilities:		
· Pledges and investments receivable	(152)	6
· Contributions due from affiliates	8,343	578
· Due to Blue Cross and Blue Shield of Massachusetts, Inc.	(314)	(87)
· Grants payable	137	978
· Accounts payable	219	(114)
· Federal excise tax liability	(58)	117
Net unrealized and realized losses (gains) on investments	31,454	(539)
Net cash provided by operating activities	6,134	8,656

INVESTING ACTIVITIES

Proceeds from sales of long-term investment securities	15,812	10,507
Purchases of long-term investment securities	(13,823)	(21,337)
Net cash provided by (used in) investing activities	1,989	(10,830)
FINANCING ACTIVITIES		
Net change in cash and cash equivalents	8,123	(2,174)
Cash and cash equivalents at the beginning of year	1,574	3,748
Cash and cash equivalents at the end of year	\$ 9,697	\$ 1,574

➤ SEE ACCOMPANYING NOTES

NOTES TO COMBINED FINANCIAL STATEMENTS

December 31, 2008 (Dollars in thousands)

1. ORGANIZATION

The accompanying combined financial statements of Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access (BCBSF) and Massachusetts Medicaid Policy Institute, Inc. (MMPI) present the combined financial position and results of activities and changes in net assets and cash flows of BCBSF and MMPI (collectively referred to as the Foundation).

BCBSF was incorporated in March 1992, and is a not-for-profit, charitable organization. BCBSF’s mission is to provide and support education and research, foster health care innovation and reform, and develop, promote, and support programs to improve the quality of health care access.

Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA) is the sole member of BCBSF. Several board members of BCBSMA are board members of BCBSF. BCBSF will achieve its goals through support for a combination of grants, social research, demonstration projects, and advocacy, rather than financing the direct purchase of coverage.

In July 2003, BCBSF formed MMPI to provide and support education and research, to promote programs to improve the quality of health care access and delivery, and to foster health care innovation reform and development including, but not limited to, research and distribution of information seeking to enhance the development of effective Medicaid policy approaches and solutions. BCBSF is the sole corporate member of MMPI, and as such, has a variety of powers, including appointment and approval of board members.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and disclosures of contingent assets and liabilities, at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Reclassification

Certain amounts for the year ended December 31, 2007 have been reclassified to be consistent with the presentation of the amounts for the year ended December 31, 2008.

Cash and Investments

The Foundation considers all highly liquid debt instruments purchased with a maturity date of three months or less to be cash equivalents.

Included in the financial statements are certain financial instruments carried at fair value. Fair values are based on quoted market prices when available. When market prices are not available, fair value is generally estimated by incorporating current market inputs for similar financial instruments. In instances where there is little or no market activity for the same or similar instruments, BCBSF estimates fair value using methods, models and assumptions that management believes market participants would use to determine a current transaction price.

BCBSF’s financial assets carried at fair value have been classified, for disclosure purposes, based on a hierarchy defined by Statement of Financial Accounting Standards No. 157, Fair Value Measurements (SFAS 157). The levels of the fair value hierarchy are as follows:

Level 1 Values are unadjusted quoted prices for identical assets and liabilities in active markets accessible at the measurement date.

Level 2 Inputs include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are observable or can be corroborated by market data for the term of the instrument. Such inputs include market interest rates and volatilities, spreads and yield curves.

Level 3 Certain inputs are unobservable (supported by little or no market activity) and significant to the fair value measurement. Unobservable inputs reflect BCBSF’s best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.

Investments in partnerships and similar investments are recorded using the equity method of accounting and are recorded in the statements of financial position with the changes in the fair value of the investments included in net unrealized and realized (losses) gains on investments. These investments are not included under the scope for presentation required under SFAS 157.

Investments in mutual funds are carried at estimated fair value based on quoted market prices and are recorded in the statements of financial position as common stocks with unrealized gains or losses included in net unrealized and realized (losses) gains on investments. These investments are included within the scope of SFAS 157 and a summary is included below:

Level 1 financial assets of \$20,061 These assets include actively-traded exchange-listed mutual funds identified as common stocks. Unadjusted quoted prices for these securities are provided to BCBSF by independent pricing services.

Level 2 financial assets None.

Level 3 financial assets None.

The amortized cost, gross unrealized gains (losses), and estimated fair value of cash, cash equivalents and investments as of December 31, 2008 and 2007 are as follows:

	DECEMBER 31, 2008			
	AMORTIZED COST	GROSS UNREALIZED GAINS	LOSSES	FAIR VALUE
Cash, cash equivalents	\$ 9,697	\$ –	\$ –	\$ 9,697
Other invested assets	59,818	156	(13,507)	46,467
Common stocks	26,428	28	(6,395)	20,061
Total cash, cash equivalents and investments	\$95,943	\$184	\$(19,902)	\$76,225
	DECEMBER 31, 2007			
	AMORTIZED COST	GROSS UNREALIZED GAINS	LOSSES	FAIR VALUE
Cash, cash equivalents	\$ 1,574	\$ –	\$ –	\$ 1,574
Other invested assets	65,174	12,280	(1,715)	75,739
Common stocks	24,844	169	(781)	24,232
Total cash, cash equivalents and investments	\$91,592	\$12,449	\$(2,496)	\$101,545

Realized gains or losses on dispositions on investments are determined on the basis of specific identification of the investment sold. Investment income is recognized as revenue when earned.

Gross realized gains and losses included in net unrealized and realized (losses) gains of investments for 2008 and 2007 are as follows:

	2008	2007
Gross gains	\$ –	\$1,927
Gross losses	(1,783)	(264)
Net realized investment (losses) gains	<u><u>\$(1,783)</u></u>	<u><u>\$1,663</u></u>

Income Taxes

BCBSF and MMPI are not-for-profit organizations established under Internal Revenue Code Section 501(c)(3). BCBSF is classified as a private foundation under Section 509(a) of the Internal Revenue Code and is subject to federal excise taxes. BCBSF files as a private foundation subject to a 2% tax on net investment income.

MMPI is exempt on related income from both federal and state income taxes.

Contributions In-Kind

The Foundation recognizes contribution revenue and related expenses for certain services received at the fair value of those services.

Contributions

A contribution in the form of an unconditional promise to give is recognized as revenue by the Foundation in the period in which the promise is received. Contributions are comprised of cash received from various sources, including affiliates (BCBSMA and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.), individuals, businesses, and civic and service organizations.

The grants payable amount represents approved community grants which were awaiting final grant agreements from recipients.

3. RELATED-PARTY TRANSACTIONS

BCBSMA provided the Foundation funding of \$3,531 and \$11,525, comprised of contributions in-cash and contributions in-kind, in 2008 and 2007, respectively. BCBSMA contributions in-kind represent salaries and benefits, facility costs, and other operating expenses. Total operating costs charged by BCBSMA to the Foundation were \$2,884 and \$2,592 for the years ended December 31, 2008 and 2007, respectively.

BCBSF donated \$300 and \$150 in cash to MMPI in 2008 and 2007, respectively.

4. FUNCTIONAL EXPENSES

Expenses were incurred for the following in the years ended December 31:

	2008	2007
Program services	\$8,653	\$8,506
General and administrative	218	360
Total Expenses	<u><u>\$8,871</u></u>	<u><u>\$8,866</u></u>

REPORT OF INDEPENDENT
AUDITORS ON OTHER
FINANCIAL INFORMATION

The Board of Directors

Blue Cross Blue Shield of Massachusetts Foundation,
Inc. for Expanding Healthcare Access

Our audit was conducted for the purpose of forming an opinion on the combined financial statements taken as a whole. The details of combination appearing in conjunction with the combined financial statements are presented for purposes of additional analysis and are not a required part of the combined financial statements. Such information has been subjected to the auditing procedures applied in our audit of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the combined financial statements taken as a whole.

Boston, Massachusetts
March 27, 2009

COMBINING STATEMENT OF FINANCIAL POSITION

December 31,2008 (Dollars in thousands)

	BCBSF	MMPI	TOTAL
ASSETS			
Cash, cash equivalents and investments	\$75,579	\$646	\$76,225
Pledges and investments receivable	216	–	216
Contributions due from affiliates	2,093	–	2,093
Total assets	\$77,888	\$646	\$78,534
LIABILITIES AND NET ASSETS			
Grants payable	\$ 2,666	\$ –	\$ 2,666
Accounts payable and accrued expenses	571	23	594
Due to Blue Cross Blue Shield of Massachusetts, Inc.	286	18	304
Federal excise tax liability	59	–	59
Total liabilities	3,582	41	3,623
Total net assets – unrestricted	74,306	605	74,911
Total liabilities and net assets	\$77,888	\$646	\$78,534

COMBINING STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS

For the Year Ended December 31, 2008 (Dollars in thousands)

	BCBSF	MMPI	ELIMINATIONS	TOTAL
REVENUES AND OTHER SUPPORT				
Contributions	\$ 2,363	\$370	\$(300)	\$ 2,433
Contributions in-kind	1,424	14	–	1,438
Investment income	2,958	1	–	2,959
Net unrealized and realized (losses) on investments	(31,454)	–	–	(31,454)
Total (losses) revenues and other support	(24,709)	385	(300)	(24,624)
EXPENSES				
Grants	4,915	–	(300)	4,615
Professional services	2,164	69	–	2,233
Salaries and benefits	1,424	129	–	1,553
Conferences, conventions, and meetings	267	4	–	271
Occupancy and equipment maintenance	132	–	–	132
Federal excise tax expense	59	–	–	59
Other administrative expenses	1	7	–	8
Total expenses	8,962	209	(300)	8,871
(Deficiency) excess of revenues and other support over expenses and change in net assets	(33,671)	176	–	(33,495)
Net assets at the beginning of year	107,977	429	–	108,406
Net assets at the end of year	\$74,306	\$605	\$ –	\$74,911

THIS ANNUAL REPORT WAS PRINTED ON MOHAWK OPTIONS PAPER, WHICH IS MADE WITH 100 PERCENT POSTCONSUMER RECYCLED FIBER AND WIND-GENERATED ELECTRICITY. PRINTING OF THIS REPORT USED 3,607 POUNDS OF PAPER.

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- 35 TREES PRESERVED FOR THE FUTURE
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- 14,709 GALLONS WASTEWATER FLOW SAVED
- 1,627 POUNDS SOLID WASTE NOT GENERATED
- 3,204 POUNDS NET GREENHOUSE GASES PREVENTED
- 24,527,600 BTUS ENERGY NOT CONSUMED

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COVER IMAGE TANISHA LIANG PRACTICES WITH A PEAK FLOW METER TO MONITOR HER ASTHMA AT TUFTS MEDICAL CENTER.

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