THE INNOVATORS

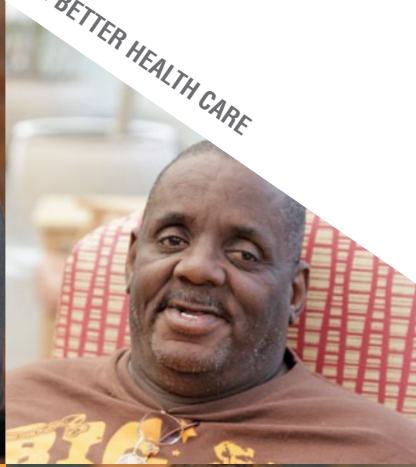
WHAT THE INNOVATION FUND FOR THE UNINSURED 2001–2010 TEACHES US ABOUT DELIVERING BETTER HEALTH CARE










FOUNDATION
MASSACHUSETTS

From 2001 to 2010, the Blue Cross Blue Shield of Massachusetts Foundation was proud to partner with health care delivery organizations that pioneered new ways to care for low-income and uninsured patients.

Through its Innovation Fund for the Uninsured grant program, the Foundation became the first philanthropy in Massachusetts to invest in this area, awarding $10.5 million to 48 organizations during a decade of health care transformation.

People who lack or are at risk for losing health coverage often delay needed treatment, seek care in more expensive settings such as emergency departments, and receive care with little continuity or coordination among providers. Together, these conditions can result in poorer health outcomes and heightened costs. The goal of the Innovation Fund was to support providers in their efforts to improve access, health outcomes, and cost-effective care for these at-risk patients.

This report shares experiences of select Innovation Fund grant recipients who improved the organization, continuity, and completeness of care for their uninsured patients. Their work—in the areas of outreach, education, preventive care, and medical management—put them on the forefront of changes recognizable in today's care delivery system. Their stories can serve as lessons for other providers, funders, and policymakers who are committed to the promise of quality, affordable care for the most vulnerable.

Sierra Arell, nurse, with Emuna Hidremicael at Family Health Center of Worcester

CONTENTS

1 THE STORY OF THE INNOVATION FUND

THE NEED FOR REFORM

To understand the lessons and legacy of the Innovation Fund, it is important to look back to 2001 when the fund was established. The health care system was, without doubt, more accessible to the uninsured in Massachusetts than it was in other states. Partially reimbursed by Massachusetts' Uncompensated Care Pool (UCP), more than 40 community health centers and a dozen disproportionate-share and teaching hospitals provided care to the uninsured in major urban areas, while physician-led initiatives and community hospitals addressed the need in other areas of the state.

Despite this limited access, uninsured individuals and families were still sicker and dying sooner than others.[1] The reasons were many: The uninsured were more likely to forgo preventive screenings and delay seeking needed care. The UCP did not cover physician office visits, many prescriptions, and most mental health services. And health care was often provided with little continuity or coordination among providers. The result was higher costs as people sought care in more expensive, less efficient settings for routine health issues.

In response to these challenges, some communities in Massachusetts began to reorganize and streamline their health care delivery systems to help patients coordinate their care, manage chronic conditions, and access all available health care services.

AN INCUBATOR FOR INNOVATION

The Foundation launched the Innovation Fund for the Uninsured in 2001 to encourage new thinking and programmatic risk-taking. The solutions proposed by grant applicants were strategic, systematic, and potentially sustainable for a population with multiple and often complex health needs. Specifically, their strategies and models:

- Improved the organization of services and addressed gaps in care;
- Reached out to adult populations that were uninsured, or had difficulty accessing and navigating the health care system;
- Strengthened health education and patients' awareness of healthy behaviors; and
- Engaged patients in preventive, coordinated, and appropriate care.

Over the course of the ten-year program, the Innovation Fund's grant criteria evolved with the changing needs of the uninsured. For example, after the implementation of Massachusetts' landmark health care reform law of 2006, grantees were challenged to design systems of care that addressed the communities that were ineligible for the law's new insurance options or were at high risk for experiencing gaps in coverage.

No single care model was appropriate for every community, and often a diverse set of strategies and tactics proved most effective. The Foundation provided the grantees with clear direction and technical support, while remaining flexible to encourage experimentation and risk-taking.

LESSONS FROM THE INNOVATION FUND

The organizations profiled in this report, along with the other Innovation Fund grantees, were at the forefront of a movement to deliver higher-quality, more cost-effective care. They honed a number of contemporary strategies that remain instructive today, including team-based care, case management, coordination of physical and behavioral health care, and the use of health coaches, patient navigators, and community health workers.

Further, the grantees played an informative role for the health care delivery and payment reform models of today. The Massachusetts Patient-Centered Medical Home Initiative, the Dual Eligible Demonstration Project, the MassHealth Primary Care Payment Reform Initiative, and accountable care organizations all encourage the same principles of care coordination, comprehensiveness, and continuity as the Innovation Fund.

Finally, there was this timeless lesson: The Innovation Fund programs demonstrated the value of human connections. This report reveals patients, providers, and other care delivery workers speaking about each other with genuine affinity and trust. As Cary Hardwick, a nurse practitioner with Holyoke Health Center, explains of her patients, "We're talking about people who are often very disenfranchised, who feel a lot of despair. You can really make a huge difference at very difficult places in their lives. That's a wonderful experience."

[1] Institute of Medicine of the National Academies (2002). *Care without Coverage: Too Little, Too Late.* Washington, DC: The National Academies Press.

Yasir Abdulqader, Sangto Nguyen and Teuta Kodra, interpreters at Family Health Center of Worcester

Grant recipients honed a number of contemporary strategies that remain instructive today, including team-based care, case management, coordination of physical and behavioral health care, and the use of health coaches, patient navigators, and community health workers.

Adapting to the Changing Face of Homelessness

HEALTHFIRST FAMILY CARE CENTER

Reginald Jackson is an upbeat, optimistic, quick-speaking man whose favorite subject is his children, ages 14, 13, and 10. "There's nothing in the world more important than my kids. To cook and clean for them, I love it. I want them to go to school, be successful in life, and be proud of themselves," he says.

One thing the divorced 52-year-old did not love—caring for his children in a homeless shelter in Fall River, a small city on the south coast of Massachusetts. Like many families, Reggie and his kids fell on hard times during the economic downturn of the late 2000s. It was part of the "changing face of homelessness," explains Dr. Uma Kolli, medical director for the city's HealthFirst Family Care Center.

"To go from having a job, a career, a home, to being homeless—there was a lot of shame involved. They didn't want to tell anyone they were homeless," Dr. Kolli says.

To help remove the stigma, Stephanie Lee, a physician assistant at HealthFirst, began making rounds at shelters, soup pantries, libraries, and schools as part of the center's Care Coordination for the Homeless Program, supported by the Innovation Fund. On Thursdays, Lee did community outreach, offering health education, introducing the health center, and encouraging people to take advantage of services. On Fridays, her schedule was open for appointments with people she had just met, including Reggie.

In addition to Lee's work, the grant program had these elements:

- **Community partnerships:** The center developed a referral system by coordinating with shelters, clergy, schools, politicians, law enforcement, and other community and government agencies.
- **Open-access slots:** Blocks were built into all providers' schedules to accommodate homeless patients within 24 hours.
- **Transportation vouchers:** Homeless patients received free transport to and from appointments.

Many achievements of the program have been sustainable. Everyone in the community knows about HealthFirst, says Lee, and open-access slots are available five days per week. "We found the program to be the type that runs itself," she says.

Lee also feels personally gratified by the ability to follow a family's health and life changes. "One of the wonderful things to see is when the people successfully move on from shelter and establish their own residence and then continue to seek health care for their family here," she explains.

That's exactly what happened to Reggie and his children. They recently moved into a three-bedroom apartment and still get their care at HealthFirst. Reggie says he is grateful to everyone who works at the health center, especially Stephanie Lee: "She's very polite, she listens to what you say, but most of all, she fights for the homeless."

190 *NUMBER OF HOMELESS PATIENTS SERVED BY HEALTHFIRST DURING THE FIRST YEAR OF ITS GRANT, EXCEEDING ITS GOAL BY 115*

Reginald Jackson

INSIGHTS FROM THE INNOVATION FUND

- Providers must minimize the stigma of homelessness by establishing face-to-face relationships before patients will feel comfortable seeking care.
- Schedules must allow for recurring open-access slots to accommodate homeless patients' unanticipated lifestyles and spotty access to transportation.
- Reaching homeless patients in non-shelter situations, improving show rates for initial appointments, and securing funds for transportation vouchers will pose long-term challenges.

"One of the wonderful things to see is when the people successfully move on from shelter and establish their own residence and then continue to seek health care for their family here."

STEPHANIE LEE
Physician Assistant, HealthFirst Family Care Center

"You can palpably feel the energy and see the smiles. Providers work as a team. There's a positive culture and climate of therapeutic healing."

DR. GREGORY A. CULLEY
Chief Medical Officer & Vice President of Medical Services, Family Health Center of Worcester

Redesigning Urgent Care for Walk-In Patients

FAMILY HEALTH CENTER OF WORCESTER

Family Health Center of Worcester (FHCW) in central Massachusetts provides medical, dental, behavioral health, and social services to more than 30,000 low-income patients each year. As a result of a sharp increase in demand for services, in 2008 the health center found itself struggling to connect walk-in patients at its urgent care clinic to a primary care medical home.

Many walk-in patients were seeking urgent care for complex health problems better addressed in a primary care setting, such as health assessments, immunizations, and attention to chronic diseases. They also needed help signing up for health insurance. The urgent care clinic, however, was designed to address the immediate care needs of patients and triage to reduce unnecessary emergency room visits, according to Noreen Johnson Smith, FHCW's vice president of development and advancement.

FHCW used a grant from the Innovation Fund to redesign its urgent care delivery model. The goals were to integrate primary care and social services into a walk-in visit to increase efficiency and connect patients to a medical home at FHCW to improve continuity of care.

First, the center conducted focus groups in English, Spanish, and Vietnamese to better understand how its patients made health care decisions when accessing care. Additional interviews with medical leadership and urgent care staff yielded insights on how best to integrate urgent care patients into primary care services.

Next, leaders restructured staffing, redesigned check-in procedures, and integrated electronic medical records to improve patient flow. Patient navigators and health benefit advisors were cross-trained to help more patients learn about the health care system, sign up for insurance, and enroll in care with a primary care provider.

The grant also allowed FHCW to dedicate a primary care nurse manager, as well as an additional full-time health benefits advisor, to provide walk-in care. In just one year after the redesign, the health benefits advisor lowered the proportion of urgent care patients lacking insurance from roughly 15 to 20 percent to approximately three percent.

Further, the grant established a foundation for subsequent capital improvements to the urgent care clinic, culminating in its 2010 reopening as the Walk-In Center for Urgent and Primary Care. Today, urgent care providers work alongside primary care providers, allowing for "instant hallway consultations," says Dr. Gregory A. Culley, chief medical officer and vice president of medical services at FHCW.

Providers also share a single common office where "the door is always open. Nurses and medical assistants can come in and out. It fosters a team approach; they can talk to each other about patients," Dr. Culley explains.

Johnson Smith says the new delivery model is "highly productive" and has supported FHCW's broader push to transform itself into a patient-centered medical home. Dr. Culley agrees. "It's been remarkably improved," he says. "You can palpably feel the energy and see the smiles. Providers work as a team. There's a positive culture and climate of therapeutic healing."

INSIGHTS FROM THE INNOVATION FUND

- Enrolling in health insurance is one hurdle; staying enrolled is another. Patients with low incomes can churn in and out of coverage for dozens of reasons, requiring specially trained staff to help them maintain insurance.
- Insurance application support, community outreach, and medical interpretation and translation of patient education materials to assure culturally and linguistically competent services are all non-reimbursable expenses incurred by providers that serve immigrants and refugees. The need for funding remains urgent and ever-present.
- Team-based care and electronic medical records are the norms for current medical students and the next generation of physicians, according to Dr. Gregory Culley, and they support efforts to assure a patient-centered medical home for every primary care patient.

363 *AVERAGE NUMBER OF PEOPLE WHO APPLIED FOR HEALTH INSURANCE EACH MONTH WITH ASSISTANCE FROM THE WALK-IN CLINIC BEFORE THE REDESIGN*

605 *AVERAGE MONTHLY APPLICATIONS SINCE THE REDESIGN*

Building Trust via Community Health Workers

LOWELL COMMUNITY HEALTH CENTER

Linguistics, international studies, and cultural psychology are not subjects generally taught in medical school classrooms. But for providers who treat patients from around the world, awareness of these subjects can make a significant difference in how patients understand and engage in their own health care.

For guidance, providers at Lowell Community Health Center (Lowell CHC) turn to their colleagues, a multicultural team of community health workers (CHWs). According to the Massachusetts Department of Public Health, CHWs are public health professionals who promote full and equal access to health and social services by applying their unique understanding of the experiences, languages, and cultures of the communities they serve.

At Lowell CHC, CHWs help clinical staff serve more than 40,000 low-income individuals per year in Lowell, the fourth largest city in Massachusetts. Half of the center's patients speak little to no English, with immigrants hailing from Latin American, African, and Asian nations. In particular, in the 1970s and '80s Lowell attracted tens of thousands of Cambodian immigrants who fled the atrocities of the Khmer Rouge regime.

Lowell CHC secured a three-year grant from the Innovation Fund to improve patients' access to care and chronic disease management. The center trained and deployed six CHWs into the community to deliver culturally and linguistically appropriate health education, build trust with residents, and promote referrals for treatment at the health center.

8,500 *RESIDENTS REACHED VIA COMMUNITY AGENCIES, BUSINESSES, FAITH-BASED ORGANIZATIONS, AND NATIVE-LANGUAGE MEDIA*

2,500 *PEOPLE GIVEN COMMUNITY HEALTH SCREENINGS*

500 *HEALTH AND HUMAN SERVICES STAFF MEMBERS TRAINED ON CULTURAL COMPETENCY*

81 *PATIENTS ENGAGED IN CHRONIC DISEASE MANAGEMENT PROGRAMS THROUGH THE INNOVATION FUND*

Community health workers wear many hats. Among other roles, they can serve as medical interpreters, community liaisons, case managers, and cultural competency trainers.

ON BUILDING TRUST

"When you see someone as a CHW helping you, it's like a familiar face. They understand you, and at the same time they can help you understand the system a little bit better."

ELISA GARIBALDI, CHW to the Latino and Brazilian Community

"We left Cambodia because we don't trust our own government. [Immigrants] see the health center as another government office, so they don't come. Even with something like nutrition counseling, they feel like it's an interrogation. As community health workers, we sit down and make sure they are not afraid."

SONITH PEOU, CHW Leader to the Cambodian Community & Lowell CHC's Metta Health Center Director

"Pastors, monks, and other respected faith-based leaders are key to our success. Most immigrants go to church before they come to the health center. We need to make sure they are well educated, so if someone asks them, say, about flu shots or how to get insurance or a primary health doctor, they know the answer."

MERCY ANAMPIU, CHW to the African Community

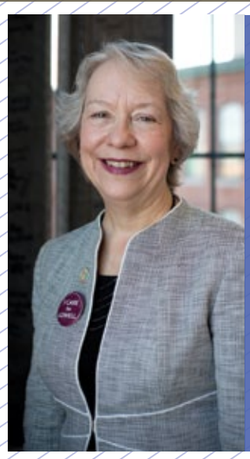
ON ADDING VALUE

"Education occurs on a daily basis between the CHWs and our providers and care teams. In many ways, our CHWs serve as cultural brokers between providers and patients. It helps the providers be more respectful and have a higher level of awareness of biases that may exist so they can better navigate a session with a patient."

SHEILA OCH, Deputy Director & Cultural Competency and Medical Interpreter Trainer

"CHWs conduct chronic-disease self-management groups and follow patients. We then enter the communication between the patient and CHW into an electronic medical record so the provider can see it."

SIDNEY LIANG, Outreach/ Education Advisor to the Cambodian Community & Media

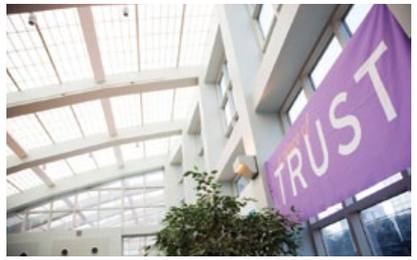


"Increasingly, CHWs are working in the clinical setting … helping do vital signs, talking to patients about their health needs, and helping them deal with their chronic diseases and get better clinical outcomes. That's going to be increasingly important as [the system] moves toward acountable care organizations and global payments."

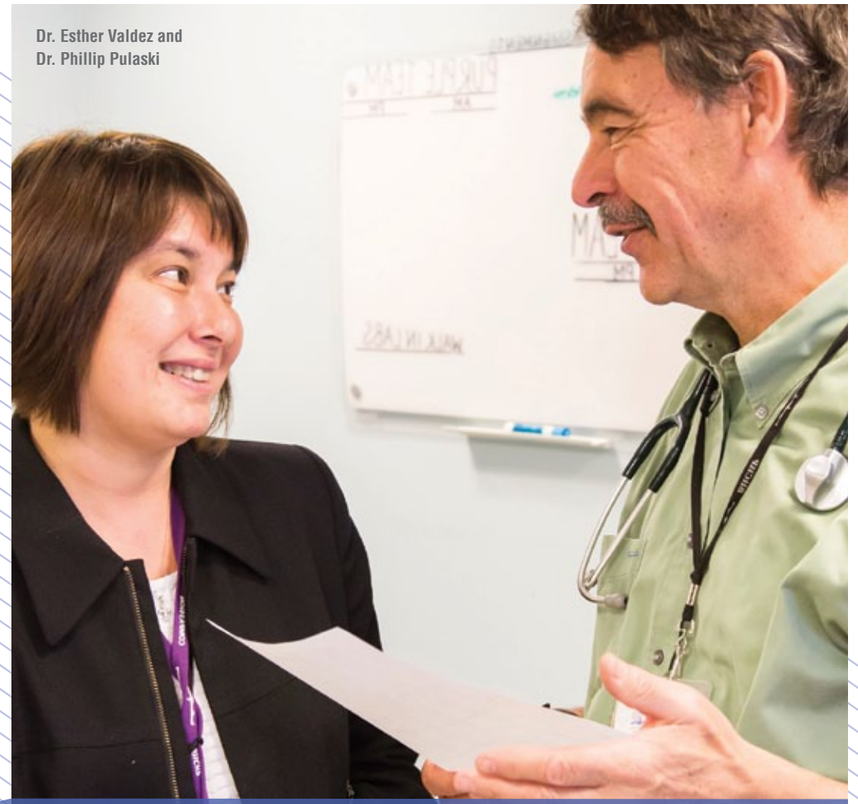
DORCAS GRIGG-SAITO, Chief Executive Officer

INSIGHTS FROM THE INNOVATION FUND

- Care coordination improves when primary care and behavioral health providers communicate with, understand, support, and make referrals to one another.
- Face-to-face meetings known as case conferences, as well as electronic medical records, are important mechanisms that help providers break down silos and collaborate on treatment.
- Behavioral health information sessions give patients an opportunity to learn about what it means to be engaged in therapy or psychiatry, gauge which types of services they would like to pursue, and understand what is expected of them for their care to be successful. Patients who attend these information sessions are more likely, later on, to keep individual appointments and follow treatment plans.



John Griffin



Dr. Esther Valdez and
Dr. Phillip Pulaski

"Our work is not a mystery anymore to primary care … and that's made all the difference in the world."

BARBARA COCCI
Director of Behavioral Health,
Boston Health Care for the Homeless Program

Integrating Behavioral Health and Primary Care

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

In the sun-drenched lobby of Boston Health Care for the Homeless Program's (BHCHP) headquarters, John Griffin drapes both palms over his cane, sits down gingerly, and looks around for familiar faces. Over the next five minutes, just about every passer-by, from patients to providers, cheerfully greets the 59-year-old by name. "This is my family," he says.

Born into poverty and abuse, John endured a hard life of addiction, homelessness, and, ultimately, a diagnosis of AIDS two decades ago. BHCHP has provided his health care ever since. "They wanted me to see a psychiatrist," he recalls of getting diagnosed. "I didn't want to, but I finally got comfortable knowing I could take medicine and hopefully live through it."

According to Barbara Cocci, director of behavioral health at BHCHP, nearly half of BHCHP's patients experience both mental illness and substance abuse, and most of them have a history of trauma. With so many cases like John's, BHCHP sought an Innovation Fund grant for its Behavioral Health Integration Project to coordinate the work of primary care and behavioral health providers. Elements of the project included:

- **An integrated staffing model:** A behavioral health clinician is embedded in each primary care team to offer consultation, assist with patients in crisis, and ensure continuity of care.
- **In-service trainings:** Psychiatrists educate primary care providers about issues like crisis management and psychiatric drugs, while behavioral health staff learn about HIV treatment, diabetes, and other frequently occurring illnesses.
- **Behavioral health information sessions:** Patients can attend seminars to learn about the benefits and expectations of psychiatry and therapy.
- **Electronic medical records:** Behavioral health providers add notes to patients' records (within appropriate privacy limits) about visits and treatment plans. Primary care staff reinforce the plans by encouraging patients, for instance, to attend group therapy meetings or keep upcoming behavioral health appointments.

"Our work is not a mystery anymore to primary care," Cocci explains. The grant has, she says, "allowed us to have better communication with primary care, and that's made all the difference in the world."

Since the integration, BHCHP is operating more efficiently and seeing more patients with fewer no-show appointments. The achievements promise to be sustainable now that integration is a standard practice at BHCHP.

As for John, he has made great progress. Today, he lives in an apartment and sits on BHCHP's board of directors and consumer advisory board, giving back to the institution that has stuck by him for nearly 20 years. "No matter how many times you walk out that door, they welcome you right back," he says.

24% *INCREASE IN PRIMARY CARE PATIENTS RECEIVING BEHAVIORAL HEALTH SERVICES*

43% *RISE IN BEHAVIORAL HEALTH VISITS OVER BHCHP'S THREE-YEAR GRANT PERIOD*

Maximizing Resources for Better Care Management

HOLYOKE HEALTH CENTER

In 2007, nearly 800 new uninsured patients sought care at Holyoke Health Center (HHC) in western Massachusetts. Most of them had been discharged recently from the hospital or moved to Massachusetts from Puerto Rico, and they were very sick. Uncontrolled diabetes, exacerbated asthma, and depression were not uncommon.

"Many of our patients come to us at a point of despair," explains Cary Hardwick, a nurse practitioner at HHC. Compounding the problem, five primary care providers had recently left the facility.

For relief, HHC sought an Innovation Fund grant to rework its same-day-care team. Hardwick partnered with a physician, a community health worker, a triage nurse, and a program manager to identify the sickest uninsured patients and funnel them into a special panel for both same-day and follow-up care.

In the initial appointments, Hardwick addressed the patients' immediate needs and referred them for specialty services, such as mammography, diabetes education, or psychiatric care. She then continued to see them weekly or biweekly over a few months until an opening came up on a primary care provider's panel.

"This [grant program] allowed me to really jump-start these patients and get them established with care," Cary explains. "Once I focused on the issues making them sick, I could also start to look at primary care screening issues."

HHC's community health worker helped patients keep appointments, get medications, and enroll in care management programs. According to Martha Fisk, assistant clinical director for HHC, this one-on-one support and continuity is critical for patients who may not speak English or are unfamiliar with the health care system.

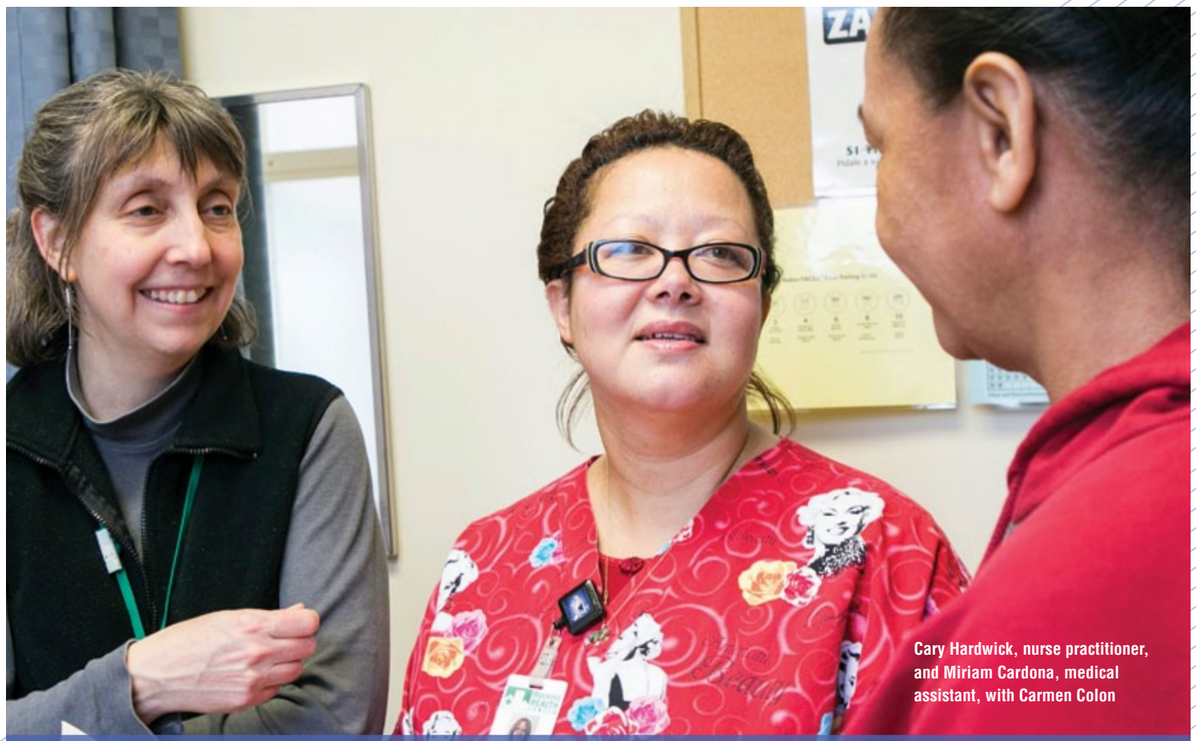
"If you see a patient and then don't see them again for a month with a primary care provider, either they're back in the hospital, or they've lost the will to persevere," Fisk says. "It's really important for them to feel that someone's paying attention to them."

Two years into the grant, the model proved much more than a temporary fix. Clinical Director Nancy DiMattio says patients were getting not just basic care but better care.

"The feedback from primary care providers was so positive because instead of getting a patient who was very ill, they were now coming to them stabilized and really put back together again with a whole plan and treatment in place. So the providers loved this," DiMattio explains.

Today, HHC has hired more primary care providers and hopes to continue the modified same-day-care program with third-party billing. "Cary paved the way for care management here at the health center," DiMattio says. "It's a beautiful, high-level care management model utilizing a mid-level provider."

748 NUMBER OF MEDICAL VISITS FOR PATIENTS WITH SEVERE HEALTH ISSUES PROVIDED BY HOLYOKE HEALTH CENTER IN JUST ONE YEAR OF THE GRANT



Cary Hardwick, nurse practitioner, and Miriam Cardona, medical assistant, with Carmen Colon

"The feedback from primary care providers was so positive because instead of getting a patient who was very ill, they were now coming to them stabilized and really put back together again with a whole plan and treatment in place."

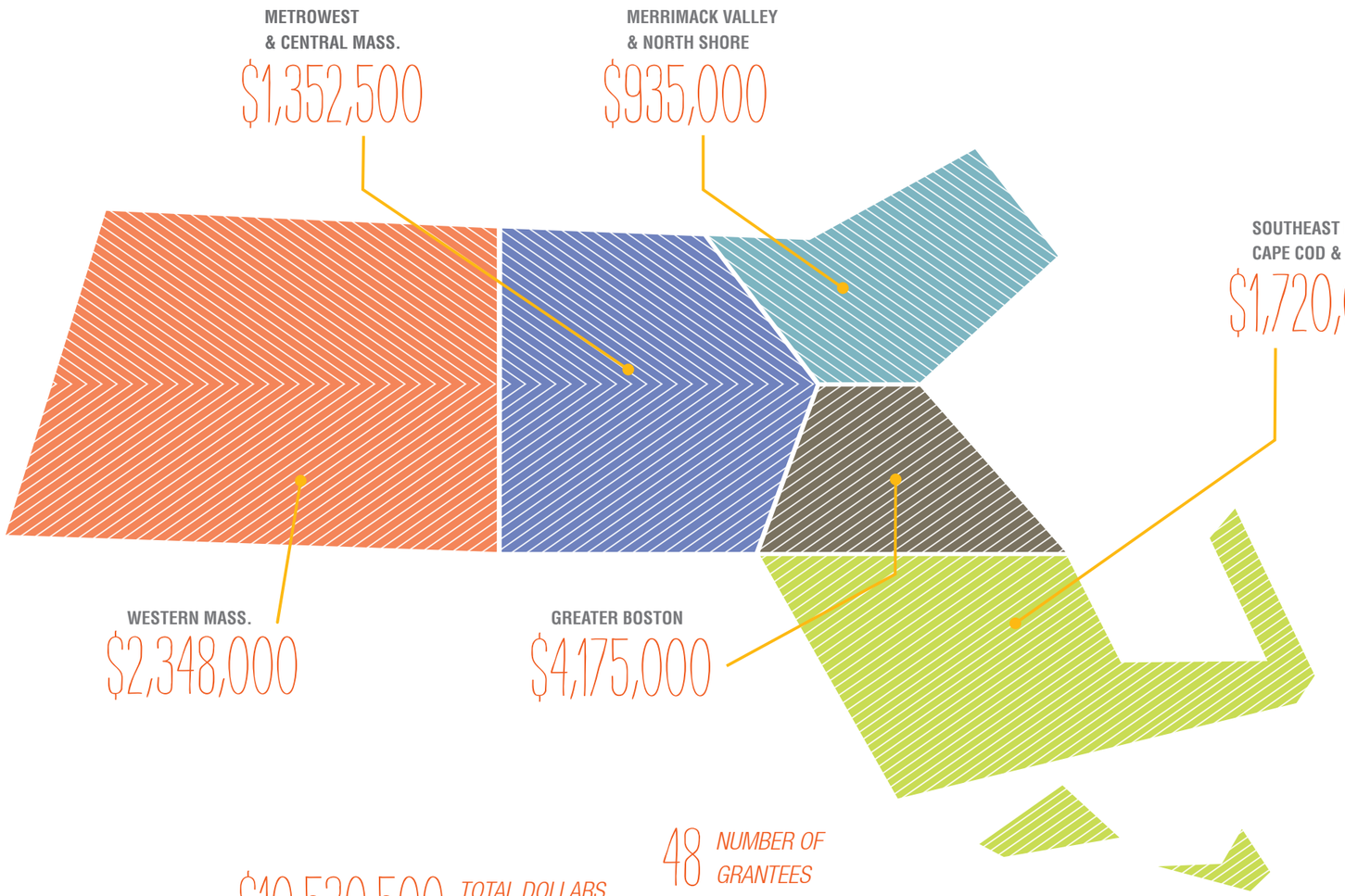
NANCY DIMATTIO
Clinical Director, Holyoke Health Center

INSIGHTS FROM THE INNOVATION FUND

- The utilization of mid-level providers, including nurse practitioners and physician assistants, can help boost primary care capacity and access.
- A team-based approach can help maximize available staff time and resources.
- With primary care providers operating at full capacity and many specialists not accepting uninsured or underinsured patients, access will continue to be a challenge in some geographic areas.

3 IMPACT AND REACH

From large health care systems to grassroots advocacy groups, in neighborhoods urban and rural, the Innovation Fund for the Uninsured touched every corner of Massachusetts.



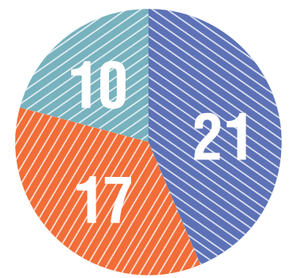
$10,530,500 *TOTAL DOLLARS AWARDED*

48 *NUMBER OF GRANTEES*

10 *YEARS OF AWARDS*

GRANTEES

- Baystate Brightwood Health Center/ Centro de Salud
- Baystate Medical Center
- Behavioral Health Network, Inc.
- Beth Israel Deaconess Medical Center
- Boston Health Care for the Homeless Program
- Boston Medical Center
- Brockton Neighborhood Health Center
- Brookline Community Mental Health Center
- Cambridge Health Alliance
- College Bound Dorchester
- Community Action Committee of Cape Cod & Islands, Inc.
- Community Health Center of Cape Cod
- Community Health Center of Franklin County
- Cooley Dickinson Hospital
- DotWell
- Ecu-Health Care, Inc.
- Edward M. Kennedy Community Health Center
- Family Health Center of Worcester, Inc.
- Geiger Gibson Community Health Center
- Greater Lawrence Family Health Center
- Greater New Bedford Community Health Center, Inc.
- Hampshire Community Action Commission
- HealthFirst Family Care Center
- Heywood Hospital
- Hilltown Community Health Centers, Inc.
- Holyoke Health Center
- Island Health, Inc.
- Joseph M. Smith Community Health Center
- Justice Resource Institute
- Lowell Community Health Center
- Lynn Community Health Center
- Lynn Health Task Force
- Morton Hospital
- Neponset Health Center
- North Shore Medical Center
- Partners for a Healthier Community
- Shattuck Partners, Inc.
- Sisters of Providence Health System
- South Cove Community Health Center
- South End Community Health Center
- Stanley Street Treatment and Resources
- St. Francis House
- The Dimock Center
- The Family Van
- UMass Memorial Health Care
- Volunteers in Medicine Berkshires
- Whittier Street Health Center
- Women of Means, Inc.



AWARDS BY ORGANIZATION TYPE

- Community Health Centers
- Community-Based Organizations
- Hospitals or Hospital Systems

4 A LOOK AHEAD: ADDRESSING AFFORDABILITY

In Massachusetts and nationwide, the health care landscape has evolved dramatically since the Innovation Fund began in 2001. Today, the state's insured rate is the highest in the nation at 96.9 percent,[1] and more uninsured Americans across the country will secure coverage upon implementation of the Affordable Care Act of 2010 (ACA).

With greater access, attention now shifts to cost control, value, and efficiency. Rising health care costs, independent of reform, threaten the sustainability of the entire health care system. Per-capita health care spending in Massachusetts was projected to nearly double between 2010 and 2020 without interventions.[2] The state's Chapter 224 of the Acts of 2012[3] and the ACA both aim to improve affordability over time by promoting efficiencies in health care.

Years before terms like "patient-centered medical homes" and "accountable care organizations" entered the lexicon of health care reformers, the Innovation Fund grantees were already developing health care delivery models to further high-quality, cost-effective care. Their forward-thinking work to integrate primary and behavioral health care, promote disease management, and utilize mid-level providers and community health workers is instructive to reform efforts happening today.

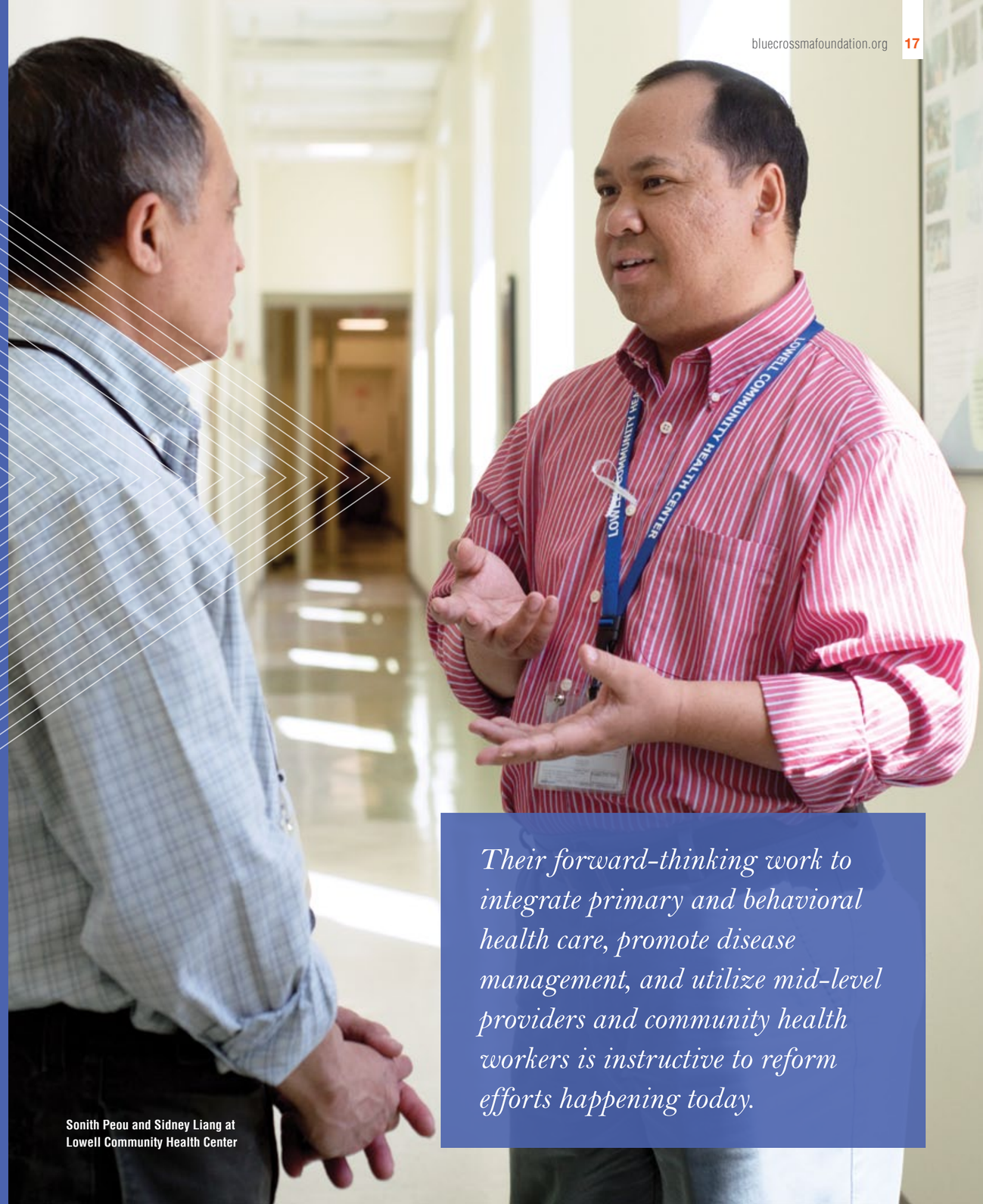
In 2010, the Foundation successfully concluded the Innovation Fund and developed a new grant-making program that builds upon lessons learned. Making Health Care Affordable: Preserving Access and Improving Value provides funding for cost-containment initiatives that maintain and improve access and quality of care with a specific focus on managing scarce resources more efficiently. The first cohort of grant recipients is working to lower costs by reducing utilization (such as preventable emergency department visits and inpatient admissions) while maintaining quality of care.

The challenge presented by rising health care costs is formidable, but previous successes give reason for optimism. The Foundation looks forward to once again serving as a catalyst, a neutral convener, and a non-partisan source of expert analysis to further meaningful and positive change.

[1] Source: Massachusetts Division of Health Care Finance and Policy and the Center for Health Information and Analysis, Massachusetts Household and Employer Insurance Surveys: Results from 2011, January 2013.
[2] Source: Massachusetts Health Care Quality and Cost Council, Roadmap to Cost Containment, October 21, 2009.
[3] An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation.

This report was printed on Mohawk Options paper, which is made with 100% postconsumer recycled fiber and wind-generated electricity.

CREATIVE: CIAMPA CREATIVE LLC
WRITING: VIBRANCY COMMUNICATIONS
PHOTOGRAPHY: MARILYN HUMPHRIES/ KELLY CREEDON (pages 9 and 17)
LINE EDITING: BARBARA WALLRAFF



Sonith Peou and Sidney Liang at Lowell Community Health Center

Their forward-thinking work to integrate primary and behavioral health care, promote disease management, and utilize mid-level providers and community health workers is instructive to reform efforts happening today.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION | Landmark Center, 401 Park Drive, Boston, MA 02215 | 617.246.3744 | bluecrossmafoundation.org

FOUNDATION
MASSACHUSETTS