Health Policy Commission
Community Healthcare Investment and Consumer Involvement Committee

Massachusetts Prevention and Wellness Trust Fund

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Prevention and Wellness Trust Fund: Chapter 224 Guidelines

All expenditures should serve the following purposes:

- to reduce rates of the most prevalent and preventable health conditions, and substance abuse;
- to increase healthy behaviors;
- to increase the adoption of workplace-based wellness;
- to address health disparities;
- to develop a stronger evidence-base of effective prevention programming.

Critical PWTF Design Decisions

- Selected priority conditions based on associated interventions with 3 to 5 year ROI
- Population and service area size must be matched to available resources and estimated cost of interventions
- Emphasize Community-Clinical Partnerships
- All grantees required to use **bi-directional e-Referral**
- Data driven Quality Improvement approach
- Model must be sustainable

Focus on Health Conditions that Yield Positive ROI *within 4 years*

Priority Conditions (2 of 4 are required, at minimum)	**Optional Conditions (Not Required)**	**Other Conditions (not specified)**
Tobacco use Asthma (pediatric) Hypertension Falls among older adults	Obesity Diabetes Oral health Substance abuse	Proposed by applicant

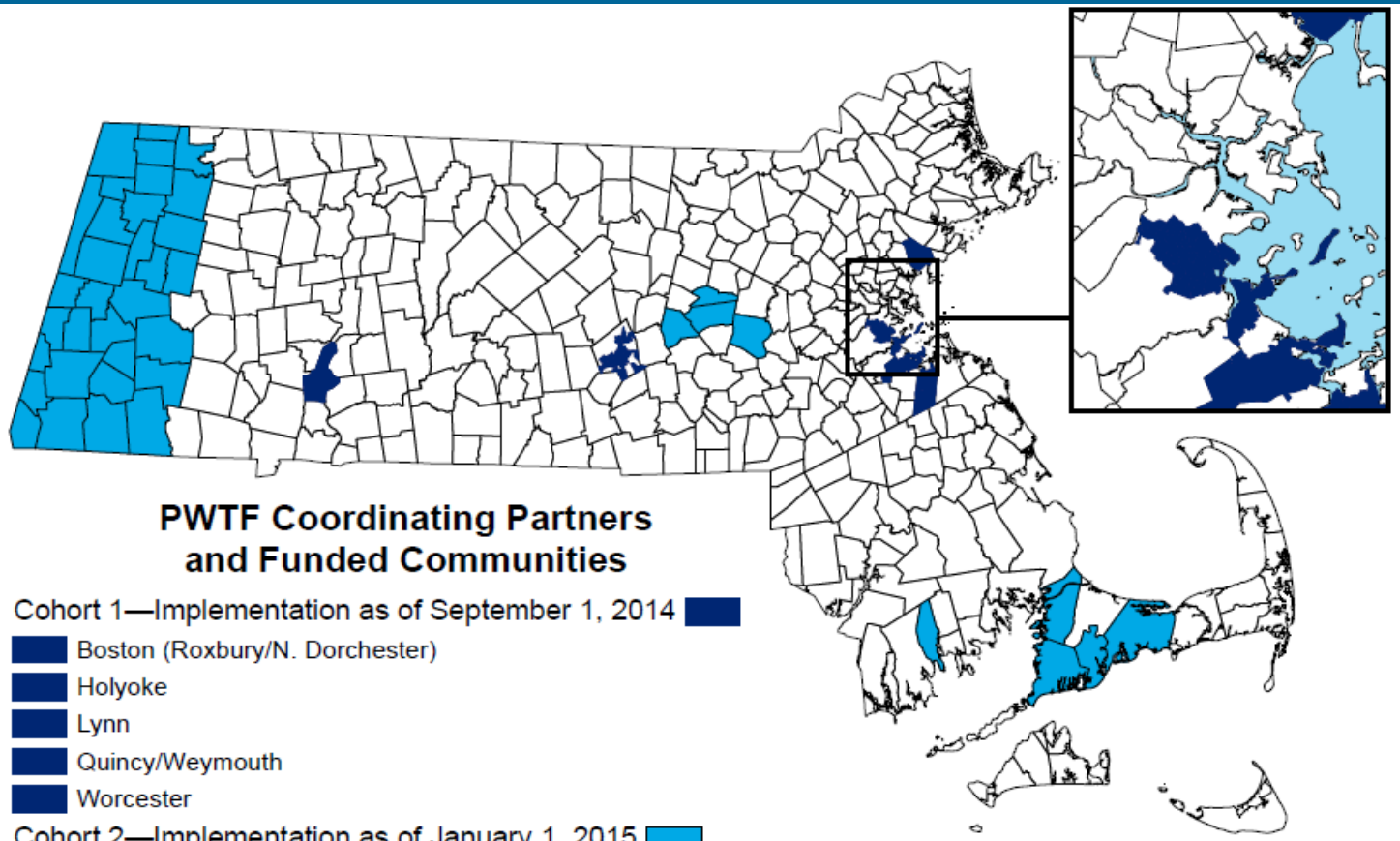
Vulnerable Populations and Co-Morbid Mental Health Conditions

Plans to address the conditions listed above should also include specific strategies to reduce disparities in the burden of these conditions (e.g., racial and ethnic disparities). Mental health conditions, such as depression, may be viewed as co-morbid to any of the above. Interventions may be proposed and tailored for populations affected by mental health conditions.

9 Selected Grantee Partnerships: Coordinating Partners

- Barnstable County Department of Human Services (Barnstable, Mashpee, Falmouth, Bourne)
- Berkshire Medical Center (Berkshire County)
- Boston Public Health Commission (North Dorchester and Roxbury)
- Holyoke Health Center, Inc.
- Town of Hudson (Framingham, Hudson, Marlborough, Northborough)
- City of Lynn
- Manet Community Health Center, Inc. (Quincy and Weymouth)
- New Bedford Health Department
- City of Worcester

Partnerships are Across the State



PWTF Coordinating Partners and Funded Communities

Cohort 1—Implementation as of September 1, 2014

- Boston (Roxbury/N. Dorchester)
- Holyoke
- Lynn
- Quincy/Weymouth
- Worcester

Cohort 2—Implementation as of January 1, 2015

- Barnstable (Barnstable, Mashpee, Falmouth, Bourne)
- Berkshire (all of Berkshire County)
- Metro West (Framingham, Hudson, Marlborough, Northborough)
- SHIFT (New Bedford)

Grantee Funding Levels

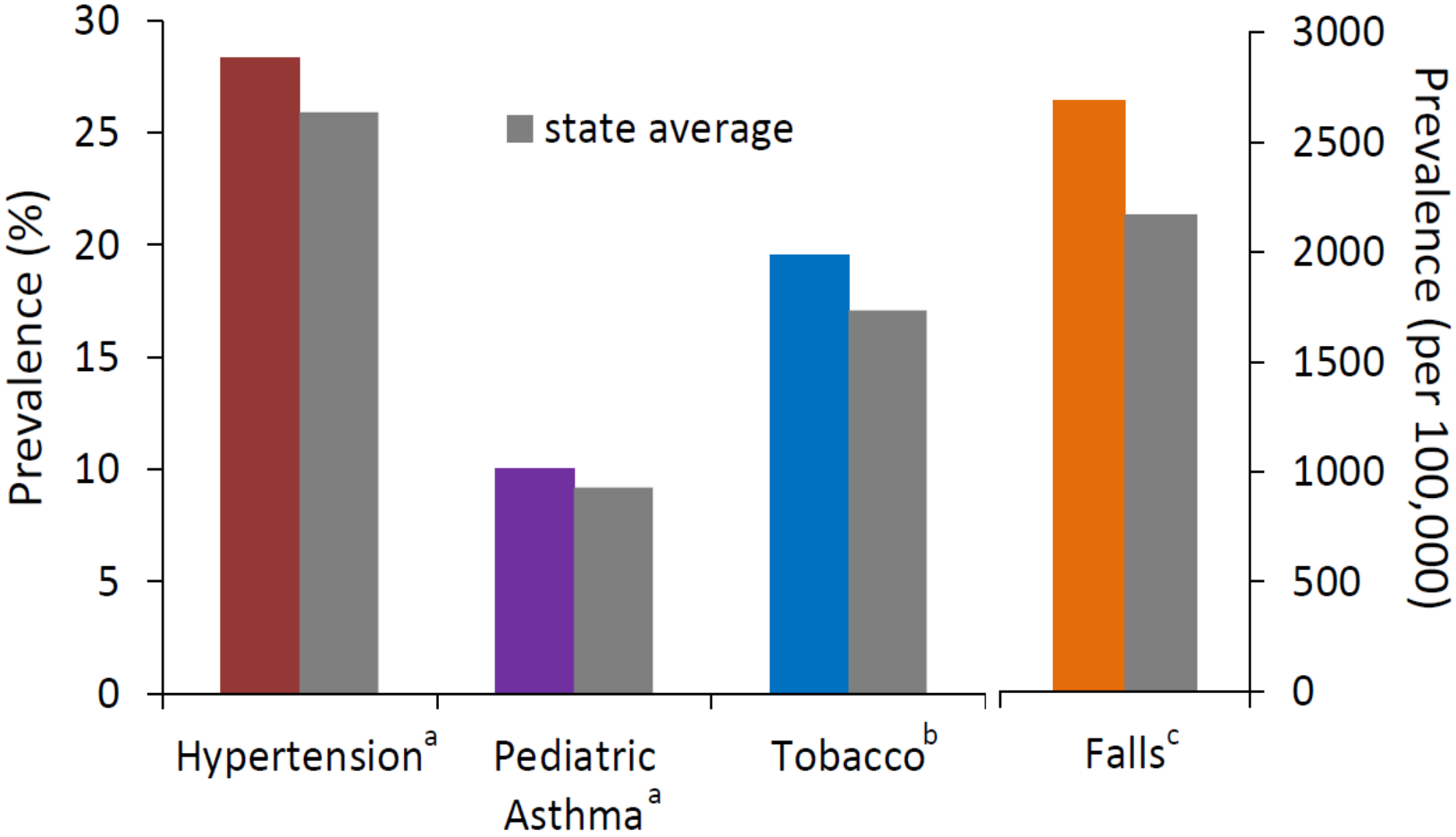
- **Capacity Building Phase**: each award up to $250,000

- **Implementation Phase**: Between $1.3M and $1.7M on an annual basis

Populations of Focus

- Total population within funded communities is 987,422 (approximately 15% of the state population)
- Some of the most racially/ethnically diverse communities in the state
- Many communities with large percentages of people living below poverty as well

Prevalence of Priority Health Conditions



Health Conditions to be Addressed

Coordinating Partner	Tobacco	Hypertension	Pediatric Asthma	Falls in Older Adults	Other Conditions
Cohort 1					
BPHC		✓	✓	✓	
Holyoke	✓	✓	✓		Obesity, Oral Health
Lynn	✓	✓	✓	✓	
Quincy/Weymouth	✓	✓		✓	Substance Use
Worcester		✓	✓	✓	
Cohort 2					
Barnstable		✓		✓	Diabetes
Berkshire	✓	✓		✓	Diabetes
Metrowest	✓	✓	✓	✓	
SHIFT		✓	✓	✓	Substance Use

Tiered Approach to Interventions

Tier 1

- Straightforward access to data
- Strong evidence base for clinical impact
- **High likelihood of producing Return on Investment (ROI)**

Tier 2

- Available data sources
- Inconsistent or emerging evidence base
- **Low to moderate likelihood of producing Return on Investment**

Tier 3

- No PWTF evaluation and little technical assistance
- Minimal budget

Tier 1 Interventions

Condition	Clinical and Community Interventions
Tobacco	• Implement USPSTF Recommendations for Tobacco Use Screening and Treatment
Pediatric Asthma	• Care Management for High-Risk Asthma Patients • Home-Based Multi-Trigger, Multi-Component Intervention
Falls	• Comprehensive Clinical Multi-Factorial Fall Risk Assessment • Home Safety Assessment and Modification for Falls Prevention
Hypertension	• Evidence-based guidelines for diagnosis and management of hypertension* • Chronic Disease Self-Management Programs

Community Health Workers

- All partnerships
- Statewide innovation
  - Varied models
  - Consistent training
  - Consistent Supervision
- Certification

Electronic Linkages – e-Referral

E-Referral Linkages are a Hallmark of the PWTF

- Bi-directional, electronic referrals between clinical and community organizations
  - Within each grantee partnership
  - Integrated into EMR for at least one clinical partner
  - Use web-based e-Referral Gateway for other partners
- State Innovation Model funding for 3 sites
  - First successful e-Referral sent June 30th!
  - Basis for PWTF e-Referral approach

E-Referral Benefits

Create

- e-Referral requires bi-directional electronic linkage as well as organizational conversation to initiate community-clinical linkages

Evaluate

- e-Referral system can provide baseline reports on # of referrals, # of services received, and other information e.g. # of pounds lost
- When integrated with the EHR, health systems can evaluate the impact of these community programs on population health

Sustain

- Once installed, the e-Referral system can be modified to add additional types of community resources
- Using the e-Referral software and EHRs, community-based organizations can make the case for clinically meaningful and cost-effective programming

Prevention and Wellness Trust Fund: Example e-Referral Flow

Outbound Transaction

Transmission from EHR

Clinical Setting

Identifies patient appropriate for community intervention

e-Referrals from Clinical Provider to Community Organization

Patient Contact Information
Referral-specific information:
(1) Parent/Guardian Information
(2) Condition status
(3) Reason for referral

Community Resource

Patient contacted by Community Organization to enroll in intervention

Inbound Transaction

Transmission to EHR

Community Resource

Community Organization provides feedback to clinical provider

Progress report from Community Organization to Clinical Provider

Sessions attended
Condition status
Next steps

Clinical Setting

Feedback reports added to EHR.
At next appt, provider sees update in the EHR and reassess status

Evaluation Goals

Outcome measures defined by Chapter 224

- Reduction in prevalence of preventable health conditions
- Reduction in health care costs and/or growth in health care cost trends
- Beneficiaries from the health care cost reduction
- Employee health, productivity and recidivism through workplace-based wellness or health management programs

Two Primary Goals

- Using evaluation to promote change (Quality Improvement)
- Using evaluation to demonstrate change

The Measurement Problem

- 4 Priority Health Conditions
- 3 Domains
- 9 Grantees
- Measures that change over time
- Incomplete data

The Sustainability Problem

- Siloed conversations
- Payment models that focus on service not health
- Comprehensive evaluations are missing
- This is all new!!

The Strategy: Amplify Effect, Sustain Momentum

- Targeting high need areas
- 3 types of partners working together
- A whole-of-life approach to health conditions: extending care into the community
- At least 2 health conditions per grantee
- Evidence-based interventions that are tiered
- Quality Improvement approach
- e-Referral aids in developing a common language and embeds new clinical practices

THANK YOU

Questions?