

# Prevention and Wellness Trust

## Executive Summary for Listening Sessions

July 22, 2013

Listening sessions were held throughout the state to give organizations an opportunity to weigh in on the process, structure, content and goals of the Prevention and Wellness Trust Fund (PWTF) application RFR. On July 17<sup>th</sup>, listening sessions were conducted in New Bedford and Boston. On July 18<sup>th</sup>, listening sessions were conducted in Holyoke and Worcester. These sessions had great attendance (approximately 300 people) and participation. Detailed notes were recorded from these sessions and can be found by searching for the prevention and wellness trust fund on the state website ([www.comm-pass.com](http://www.comm-pass.com)), in addition some written comments are posted.

Similar themes emerged from each of the four listening sessions conducted. Below is a summary of the themes and general recommendations, comments or concerns noted by the participants.

### Populations of Focus

- Need to focus on health disparities, but also the importance of a broad definition of health disparities. Suggestions included focusing on rural vs. urban health issues, people with disabilities, and smaller populations such as the transgender population, older adults and men's health.
- Attendees emphasized the importance of flexibility in defining health disparities—for example, rural vs. urban issues, health issues faced by people with disabilities, and issues among small but particularly vulnerable populations such as the transgender population.
- Many comments were made, particularly from the western and central regions, stressing the importance of setting geographic requirements to give all areas of the state an equal chance and opportunity in securing funding.
- Defining the number of people who should be in the catchment area applying for the grant would also be helpful for some potential applicants.

### Partnerships

- Vital to define specifics about the nature of the partnership in the application, such as roles and responsibilities of each partner and budget allocations to each partner to ensure equity and commitment.
- Encourage a wide variety of clinical and community-based partners among, including: schools, public housing, veterans' organizations, law enforcement, and private businesses.
- Partnerships should determine lead organization and fiscal agent—many municipalities cannot handle this role for many reasons.

- Include organizations with a history of working with vulnerable populations and to ensure that members of these populations are engaged in these partnerships in a meaningful way as equal partners.
- Fund organizations with a strong history of providing services using community health workers.
- Encourage new partnerships to get “out of the box” thinking and innovation.
- Smaller regions stressed that municipalities cannot be the lead or even a primary partner, as many in the western region do not have the capacity, expertise or even the inclination to participate in this type of program. Therefore, if municipalities are required, allowed certain areas to include them in a smaller role.
- Others expressed conviction regarding the value and importance of municipalities as a primary or lead partner (Worcester was given as an example of an effective and engaged municipality).
- Require that the clients be at the table in some way so that services are provided to them and not “at them”.
- Linking with HMOs and ACOs is important and is also linked to sustainability.
- Linking with community benefits programs in hospitals.

### **Diseases/conditions**

- Many attendees emphasized diseases or conditions they thought should be a focus of these grants. Suggestions included:
  - substance abuse,
  - mental health,
  - prevention and wellness throughout the life cycle (integrating behavioral health),
  - end-of-life, and
  - care transitions.
- Secondary and tertiary prevention were also suggested as areas of focus.
- Some issues involve statewide infrastructure improvements, such as, lack of beds for people in need of behavioral health services, and PCPs encouraging people to use the emergency department for non-emergent issues because same-day appointments are unavailable.

### **Interventions**

- Include the opportunity for innovative strategies as well as evidence-based interventions.
- There may not be evidence-based literature for vulnerable populations, so allow programs to adapt evidence-based interventions for use among these populations.
- Implementing programs, as well as, policies and environmental strategies is critical to engage consumers.
- Suggestions for particular programs included:
  - mentoring youth,
  - implementing a training entity for community health workers in the western part of the state,
  - cultural competency training for providers,

- employee leadership within worksite wellness programs, and
- wellness champions within the community.
- Important to continue to provide programs in the community, as well as, within worksites (including medical facilities and municipal offices).
- Focus on broad-based policy and advocacy, such as unifying medical and dental insurance, and broadening language around worksite wellness programs.
- Reimbursement—the potential for creating a system where partners can submit for reimbursement, the need to demonstrate sustainability in the reimbursement structure.
- Unifying dental and mental health insurance with health insurance.

### **Evaluation, Data Collection, Outcomes**

- Need for clarity in data collection expectations and outcome requirements.
- Focus on the portion of health care costs saved by patients, outcome measures adjusted according to amount awardees are funded.
- Need for interim reports and success data to make the case along the way rather than demonstrating successes at the very end.
- Focus on distal health outcomes rather than interim measures.
- Allow flexibility in outcome measures--different communities may measure different things depending on what they're implementing,
- DPH provided assistance interpreting data to make a compelling case for stakeholders
- focus on outcomes other than cost savings, such as:
  - costs of implementing a CHW program,
  - increased employability as a result of addressing chronic diseases,
  - perspectives of consumers,
  - perceptions of barriers, and
  - how barriers to accessing care are decreasing over time.

### **Funding level**

- Many applicants suggested that funders might consider offering smaller grants or tiers of grants,
- Equity in funding depending on the population size projected to be affected by these grants.
- Funding equity by region—minimum number of grants and dollars should be allocated to each region.
- Partnerships should define their region, not the state.

### **Readiness to move from capacity-building to implementation**

- Attendees suggested ways to assess whether partnerships were ready to move from capacity-building to implementation through:
  - clearly defined goals, roles, and responsibilities of each partner,
  - organizational plan framing the entire partnership,
  - meeting structure,
  - operating bylaws and principles,
  - thorough community needs assessment,
  - developing focus groups or other ways of engaging the community,

- defined process for decision-making,
  - representation from a wide variety of groups within the community,
  - clear budget with adequate staff time and equitable funding,
  - strategic plan,
  - developing a mechanism to demonstrate outcomes,
  - communications plan,
  - correlating services with other funding sources,
  - collaboration spelled out within the budget,
  - number of policies passed on prior relevant community-wide efforts, and
  - clarity in how replicable the work is in other settings.
- Attendees pointed out that 7 weeks may not be a long time to build partnerships for inexperienced applicants, but also noted that it was critical to hold applicants to a projected timeline.
  - There was general consensus in the need for capacity building as phase 1 but that some partnerships can be ready more quickly and should be able to move to implementation on their own timeline.

### **Sustainability options**

- Build awareness in the community of incremental success and create a story in the community.
- Including the clients in the community .
- Demonstrate sustainability in the initial application, including:
  - looking the budget for startup vs. ongoing costs,
  - a history of developing infrastructure to sustain programs and policies,
  - what will be left behind in the community at the end of the grant,
  - partnering with ACOs and insurance companies for reimbursement,
  - writing in changes that will be in place that do not involve program staff,
  - regulatory policies, focusing on environmental, infrastructure, and systems changes including “bricks and mortar,”
  - having a clear sustainability plan with a beginning and end included in the application,
  - returning savings to the program itself,
  - demonstrating partnerships with existing DPH programs in the community, and
  - looking for integration with health records and other data to demonstrate the long-term commitment to the partnership .

### **Process/Communication/Infrastructure**

- Grant writing time allotment is too short.
- Goal of decreased healthcare costs in less than 4 years seems unreasonable.
- Need opportunity for networking with other organizations and suggestions that this is provided by DPH.
- Need good communication with DPH to provide periodic assessment as a partnership and in comparison to other partnerships.
- Consensus with DPH goal to provide learning communities among awardees, as well as, sharing tools and data with all interested organizations—funded or non funded.

# Prevention and Wellness Trust

## Listening Session Notes

July 17, 2013, 10 am

Southeast Region – Waypoint Event Center, New Bedford, MA

Public attendance: ~50 people

Tom Land and Lea Susan Ojamaa presented an overview of Prevention and Wellness Trust Fund:

- Objectives for meeting
- Vision and Guiding Principles
- Overview of the law
- Approach to grants
- Discussion of advisory board, open meeting, and access to all documents

*Public Question and Comment Period—Questions and comments are not verbatim*

QUESTION: How many grants in total and can one geographic region receive more than one grant?

DPH: Not a definitive answer at this point. Total number of grants estimated to be between 6 and 12, so \$1-2 million per awardee per year. The quality of applications will dictate award.

QUESTION: These are multi-year awards?

DPH: Yes, up to 4 years, depending on how quickly we complete RFR process

QUESTION: Is there a timeline?

DPH: The expected timeline is that RFR will be released by the end of August, with applications due in October. Decisions then made in November or December to prepare for January awards.

QUESTION: Have you thought about using CHNAs for collaboration since they do so much collaborative prevention and wellness work already?

DPH: We support multiple models for coalitions and partnerships, and see this as one of several examples of an existing partnership that could apply, as can others.

QUESTION: If you already have state funds, such as Mass in Motion, can you still apply?

DPH: Yes, nothing precludes people who already receive funds from participating.

QUESTION: How do the unused monies roll back into the Trust?

DPH: This is a trust, so money does not roll back per se, but there are no restrictions that it has to be spent by June 30<sup>th</sup> / the end of fiscal year. We can distribute the money as needed throughout the four years.

QUESTION: Will grantees or DPH fund the creation of electronic referrals to track clients that are a part of this? And where is the boundary in terms of who and how we collect that information?

DPH: We will try to make a really clear boundary as to what DPH relative to applicants will need to do and fund. We hope we will have laid out those boundaries clear enough that you will know where you fall.

QUESTION: Are the workplace grants separate from or part of proposals?

DPH: No more than 10% of what we have in trust can go to worksite initiatives. A lot more about training and technical assistance to support worksites, but as we write RFR and build community partnerships, one of the key component is working with businesses. And we encourage community-based organizations and municipalities to think of themselves as worksites. The wellness tax credit is also in place for businesses. We envisioned that worksites / employers would be welcome partners in application for 6-12 grants we are talking about. But also envisioned that employers all over the state will look for TA. We are not permitted to spend more than 10% on TA.

QUESTION: Is there any population-based requirement?

DPH: We believe there is a lower limit and upper limit for what will be effective. A program that serves the whole state or only a very small town may not be an ideal group. We expect smaller communities to partner with those around them b/c can't provide cost effective interventions if too small. We need advice on the right size. What makes sense?

QUESTION: What about smaller suburban communities?

DPH: Many suburban communities may have more resources than urban and boundary communities, so it may make sense for those towns and communities to partner and collaborate with those around them.

QUESTION: Would applications from communities who are already collaborating be stronger than communities who have not worked together previously?

DPH: It is important to document existing partnerships with evidence of how you work together as that may present a stronger application. But that does not preclude new partnerships that can demonstrate their ability to work together with good outcome measures to be created. If we are not looking at those outcome measures, legislature not look kindly at what we are doing.

QUESTION: Some federal grants allocate funds based on the population being served. Will the Trust RFR have those guidelines in terms of a population number to reach?

DPH: DPH does not have established guidelines and will not exclude any application based on size of population served. We are advising the board and working with the commissioner to determine what the guidelines may be. As written in the law, we have to consider disease burden, geography, etc. and have to go to communities where we can save money. If MA had a community with no chronic disease and no potential for chronic disease, we would not go there.

QUESTION: How will we measure dollars saved?

DPH: Part of what we are expecting to include in the application is what clinical partners can bring to the table. We work with Mass League of Community Health Centers, which have CHIA DRVS. That gives us access to every patient, every visit. We also have the All Payer Claims database, which we can track whether or not programs, policies, services, are linked to reductions in healthcare costs to communities over time.

QUESTION: Does the fiscal agent have to be a municipality?

DPH: Some of us see that municipality is central to application, and they must be a strong partner if not the fiscal agent. We encourage them to be the fiscal agent, but understand that can be difficult.

QUESTION: How will you gauge innovative programs and ideas versus those in the evidence base? How will out of the box be viewed versus tried and true?

DPH: We are not trying to stifle innovation, but believe you have to have effective partnerships. One of the measures we are looking to address is building the evidence base. We are not entirely sure what the balance is, but looking for evidence informed application. If you can say this has been done in one area, but we want to apply it elsewhere, that makes sense.

QUESTION: We may have more than one municipality and organizations, so can there be a lead organization that covers multiple municipalities?

DPH: Yes, municipalities can work together and potentially have someone else as the fiscal agent.

COMMENT: Municipalities are a nightmare to have as a fiscal agent and some communities will prefer to not have them as the lead.

DPH: We still need agreements with all partners and still have to have resources going to them – that has to be clearly defined in applications.

QUESTION: Who is responsible for data gathering?

DPH: It will be a combination of DPH and awardees. In the RFR, we want you to spend vast majority of time defining partnerships. But the appendices will contain population data so applicants do not have to spend time looking for this information. DPH will also provide data collection instruments and will define DPH relative to community responsibilities clearly.

COMMENT: There is a concern on our part that we have to create an elaborate data-gathering mechanism to get this data for outcome measures.

DPH: It has not been fully decided yet, but the expectation is that the large data systems come from us, but smaller comes from communities. Try to combine community data with our resources. But from the clinical side, there has to be a strong clinical partner who has data and can work with you to provide that information. DPH is hoping to piggyback on federal initiatives that have funded the transition to electronic medical records to allow clinical partners to share information.

QUESTION: Are Mass in Motion communities more likely to be a good applicant or partner or less likely b/c they have those pots of money already?

DPH: Participating in MIM does not preclude someone from applying for funding. They do have demonstrated partnerships, and have policies and systems change. It is a great foundation.

COMMENT: We seem to be very ready, and are already organized and more funding will be better for communities already doing collaborative work.

QUESTION: Is there a minimum money amount? Is it \$1 million only or can a smaller community request \$100K?

DPH: Do not have any set lower or upper limit, but we have to look at outcomes measures. We will look at that and what can maximize return on investment. In early conversations, it was decided a smaller number of larger grants will get this return on investment. This is an opportunity, especially to show cost savings in a short period of time. We have to be very focused and diligent on what we are doing. It would not be as effective if we tried to do it in a broad way across the state.

QUESTION: There are obviously projects further down the path ready to move forward with partnerships, but for newer groups, 7 weeks is not a large period of time. So will part of the capacity building phase be focused on further building partnerships that are defined in the application?

DPH: Yes, we want you to come in and demonstrate partnerships you have, but we also know it will take time to make connections and build infrastructure. We also have to take into account the likelihood of success. If have a very strong partnership that works well together versus a community that may need to start from scratch, that is a consideration.

QUESTION: Is cost savings more important than the number of people served and disease prevalence?

DPH: It has to be both reducing prevalence and saving money; one is not more important than the other, but it has to evaluate both. For some health conditions, we may be preventing them 10-20 years from now, but in our 4 year window, we will not see change. We have to think about what we can do within 4 years. The Board will be advising on priority disease states, and you can find data briefs for each disease state online. The Board needs to help the Commissioner determine what those priorities are. Again, chapter 224 is about cost containment, but prevention is a key part of that.

QUESTION: One of the parts of the community that really connects with our community is churches. Is that a potential partner?

DPH: Yes, faith-based could be considered if it will reach your target population. The driver is what will work best in your community.

COMMENT: I would like to suggest you include schools and school nurses because of the data they have on their patient population and the cost savings that they can enable to prevent hospitalizations and doctor visits.

QUESTION: How will you evaluate effectiveness?

DPH: The fact that we can fund 6-12 communities does not mean that all of them will make it to implementation phase. We are trying to establish criteria that communities can use to demonstrate that they are ready to move on from capacity building, and we need to make those benchmarks clear, but there is no guarantee.

QUESTION: Do you expect these to be more than a single year grant?

DPH: It depends on how quickly we get the money out. It is a 4 year trust, but if we release funds in January, it is more like 3.5 years. Every funded applicant will get evaluated for progress. If a partnership falls apart, we are not obligated to continue funding.

QUESTION: How far out (geographically) we should go for collaborations?

DPH: There is not a concrete answer; primarily you are trying to put together the right team. Applicants should leverage existing relationships, clinical partners and think about how each partner or community will add or dilute your application. Health systems operate in multiple communities, so that could be the thread that brings different communities together. We are looking for something that is cohesive.

QUESTION: This is to enhance and not duplicate existing work?

DPH: Yes.

QUESTION: Are all populations included, including undocumented immigrants?

DPH: Nothing in the law excludes any population, including undocumented immigrants. There is a directive to address disparate populations. However, some populations might not generate medical claims because there is no official claimant, but there is basic demographic information we can get about patients who seek care.

QUESTION: In the application, do we need to demonstrate a model for how we have already reduced funds?

DPH: In the RFR, DPH will define the evidence-based intervention, priority disease and conditions with as much clear detail as possible. We are not expecting people to create something from scratch, but hope they can build upon something with evidence.

DPH QUESTION: What other partnerships and entities should we consider as priorities for applications?

- Public housing where you have a population at risk
  - DPH: effective policies and interventions do exist that could be used in this group
- YMCAs, Boys & Girls Clubs
- Schools, school nurses

DPH: We are looking for input on municipalities and clinical partnerships we should seek.

- VFW – veterans are a huge population seek care
- Community organizations that deal with immigrant populations (documented and undocumented)
- MA Association of Public Health Nurses – already placed and have chapters throughout the state
- Local for-profit businesses – going to die if we are not walking hand in hand with them
- Homeless – healthcare for homeless often go undetected and receive care.

- CHNAs – a lot of those partnerships are not just about healthcare, including things that preclude people from accessing care.
  - DPH: Mental Health is a clinical area we are looking at because it is interrelated with other diseases. “Saving two birds with one stone” would be great.
- It would be great to build on existing programs like Mass in Motion. They could be an important partner for synergy and for moving this all forward.
- Want to add something about mental health, homeless and veterans, and those that have experienced trauma
- Are you able to define sub-populations, for example a sub-population of diabetic? And you have not talked about children yet, either.

DPH: If you can present a program that is more effective when dealing with a part of the population, then absolutely the ROI and reduction in prevalence there are relevant. It does not necessarily have to be all inclusive.

- Consider police department partners because they capture a lot of data

DPH QUESTION: What are indicators of a partnership being ready to move on to implementation?

- A strategic plan so you know what partners are going to do, roles and responsibilities
- A developed mechanism to demonstrate outcomes
- A pattern where self-sufficiency can occur: correlate services with other funding sources not just grant monies. Have to have a plan by which you will make transition from this to private funding source. Start off with these funds, then taper it down.
- Spell out the roles of the collaborating partners – not just letters of support, but here is my role in the work. Maybe even indicate the amount of money needed to support that collaboration.
- Specific job tasks laid out.
- Make sure collaboration and role are in the budget
- Number of policies passed on prior efforts that are relevant that will speak to sustainability – what will stay without us or with a partner?
- Should be clear how replicable the work is to other populations and how organizations will leverage existing funding as a model to change the way they do business
- Include visiting nurses
- Another thought on valuable partnerships is someone who provides education and support to the population

QUESTION: Will there be a need for other funds secured or committed to?

- You mean matching? Not required, but if partners come to the table and say they will do in-kind time and provide services, we’ll consider it valuable.

DPH QUESTION: We’re also looking to hear from you about what is realistic to achieve in the first year and second year, passing policies and delivering services. At what point do you think it is reasonable for partnerships to say they’ve achieved some of these goals?

- QUESTION: Will we report quarterly? Will we meet as a group?
  - DPH: Yes, but we do not know the exact format this point. We know this will not be achieved in 3 or 6 months. We do not want to expect too much or wait too long. There will be close monitoring from DPH. Need to determine what the needs of the group are, but the expectation is to share information and work together.
- 6-12 months to begin to serve a number of clients and to get hard data from them. Anything less than that seems like it is pushing it and might not be doing best work. Longer might not enable us to get info you need to report back.
- For workplace improvement – if a big corporation, can take some time to get policies in place, but if smaller, can be shorter term if have enough buy-in. You could have a policy written in a year and have it ready to implement, but it may be closer to three years for some.

QUESTION: Does having more partners speed up that process?

COMMENT: Yes

COMMENT: But sometimes more partners can slow the system down.

DPH QUESTION: So is it better to have more or less?

COMMENT: More

QUESTION: Can you make that part of RFP – rather than setting a standard timeframe, see what applications are like to determine the timeline?

DPH: Yes – this is not one size fits all for anyone. Different groups may check different boxes, but we need to be able to say they can sufficiently move forward to implementation.

COMMENT: Include strong language in RFR that requires applicants say how long it will take to do leg work. And if taking too long, not fund it.

COMMENT: I'm concerned about cost containment in early years of the grant because if you are really implementing innovative strategies, may very well see an increase in service use.

DPH: Yes, some conditions may lead to increased service use, but the savings over time should be there.

COMMENT: A lot of literature says worksite wellness takes 3-5 years to see ROI, so I'm not sure how this can be short-term.

DPH: We don't want to say all small or all large and certainly don't want to say all short or long term. Want changes so long term effects will pay dividends in the future.

QUESTION: CTG was so prescriptive...will this look for similarities across grantees so can show outcome measures?

DPH: Yes and no – Yes, expectation is that there are core inventions and categories, but no in that communities can choose menu options that make sense for them

QUESTION: My experience is that smaller grants are more nimble, but have smaller impact. Larger grants take longer to get rolling, but the impact is bigger. So can we adjust? Larger grants have longer timeframe for showing implementation and results?

DPH: That is part of why we have the capacity building time built in.

QUESTION: Could there be a shorter implementation phase for smaller grants?

DPH: That may be the case, but it really depends on the individual situations to see if capable and prepared to move to next phase.

QUESTION: Would DPH consider grants more desirable if they have a clear pathway to self-sufficiency?

DPH: Yes.

Notes taken and submitted by: Bonnie Andrews, Jenna Roberts, Susan Svencer

# Prevention and Wellness Trust

## Listening Session Notes

July 17, 2013, 3 pm

Boston Region – Boston Public Library, Boston, MA

Public Attendance: ~125 people

Tom Land and Lea Susan Ojamaa presented an overview of Prevention and Wellness Trust Fund:

- Objectives for meeting
- Vision and Guiding Principles
- Overview of the law
- Approach to grants
- Discussion of advisory board, open meeting, and access to all documents

*Public Question and Comment Period—Questions and comments are not verbatim*

COMMENT: I want to make sure [the grant] provides for services to people with disabilities – not just ADA compliant. The language needs to include this population. Focus on health disparities – obesity, tobacco, lack of PA – people with disabilities have higher rates of these, so want to make sure they are addressed.

COMMENT: Health disparities are a key legislative mandate within the trust fund, so that must be one of the absolute top priorities in the RFR. Must insist on reduction of actual disparities for a given disease, not just the disease overall. Focus on reduction in that gap, not just on the population as a whole. Partnerships must work with community-based organizations and community members that are most directly affected by disparities in health. In cost savings, the RFR should award points that are reflective of the patient portion of health care costs and not just that of health care organizations. Or, that it should reflect savings outside of health care systems – within families, school, worksites. Partnerships should be based on equity. Under evaluation, that DPH should hire a private evaluator and process of hiring should be transparent. To make the cut for consideration, applicants must demonstrate how their proposal actively addresses disparities gap. Once made that cut, the intended programs should constitute 20% of funds for that focus on disparities.

COMMENT: I like the focus on municipalities and the room for innovation at the local level. Municipalities can join together for regulatory reform, which is sustainable over time, serves as a vanguard of the state and other municipalities as well.

COMMENT: I want to second the comment about the populations served and disparities. I am a member of the transgender community, and we are very small and disenfranchised, so disparities really matter. Often data collection does not allow for Trans people to be included, so when developing data collection tools, Trans populations are invisible. Please consider how to capture that and include us. Disadvantage is us.

DPH: We are trying to look broadly and deeply and are exploring opportunities to understand specific disparate groups. Can use panel surveys, which are increasing valid, to help us understand as many sub-populations as possible.

COMMENT: I'd like to recommend you broaden the language around workplace wellness. Worksites can provide education, but are also a source of hazards. Allow interventions to look inside their workplaces as well, for both psycho-social and physical issues, to address health.

COMMENT: In addition to seeing the workplace as a place for exposure, it is also a place where people can play a leadership role, as they can in the community. Don't just view the employer as the only person who could be leading the initiative.

QUESTION: Mass in Motion is very municipality-focused, and in Cape Ann there are a lot of coalitions that we are a part of. So does that speak to our readiness? And should we partner up with other communities around us – how regional should we get?

DPH: The question we've been looking at is the size. We are thinking of 6-12 grants so about \$1 million per year per awardee. We will not cover the state with that money; the impact will be greater in a small, focused area. So we don't know what that size is yet, and welcome input here. That would dictate the type of interventions we'll see. It is going to be different and will be variability. So thinking small number of grants, but a very targeted focus. \$2.50 per person, per year is not going to change lives. So we want to hear from you what is the right size and the right partnership? Also can be too large – entire state is too much, but also some that are too small. What is likely to work well – require a community of a certain size – where is the sweet spot?

COMMENT: 6-12 does not resonate with me. When I think about communities banding together, you don't need a million dollars to do that. 6 would be way too small, and I think we can do that for a lot less money than that.

DPH: I would guide you to the outcome measures. We have to show effectiveness within 3 years and some cost effective things would show savings in the long term, but we cannot focus on that as per the law. The focus is on secondary prevention as well as primary. The clinical system change, technology to link to communities will be important as well. So if can pass policy to reduce asthma rates b/c of smoke free housing, etc., primary prevention is important, there is also going to be clinical change. If we were doing policy work, that piece may not take that much money, but it has to be that in concert with other interventions.

COMMENT: How much money will be allocated to community-based organizations, people with disabilities, LGBT community? I want a line item for how much will be spent on disparate populations so make sure it is there. Reporting out should be transparent and available to the public so that we can see how people are doing within disparate populations.

DPH: There is annual reporting and b/c linked to publically reportable advisory board, it will all be accessible to the public.

COMMENT: The money should be infused into already existing programs. BSAS program is infused into every hospital to reduce sub abuse through screening and referral to treatment. Substance abuse needs to stay on the table – it is a major concern and coexists with chronic diseases.

DPH: Substance abuse is directly mentioned in the law and the specifics will be a part of the RFR.

COMMENT: Part of my issue is when working with municipalities and hospitals in my region in Medford, we have citizens going to hospitals outside our catchment area, and we don't know what is happening in Boston, Burlington, and so on.

COMMENT: I want to speak for continuity; you should look for collaborations that already exist. Do this through CHNAs and other established partnerships to see a return in a small period of time.

DPH: Partnership is key. They may already be working, or it may be an expansion or something new. MIM has partnerships; substance abuse has partnerships, so we are looking for partners that are a natural fit.

COMMENT: Regarding the partnership piece, I would encourage the RFR to include patients in that partnership. We often assume we have those rights covered, but we don't. And including them could be a key driver in lowering costs – patient activation, satisfaction.

COMMENT: There should be a component to the law that promote information beyond the law itself (e.g., a Good Samaritan law).

COMMENT: I would like to see language around community health workers as part of it. It is difficult to figure out how in the RFR to figure out equity in partnership. There was a lot about CHWs in CTG, but not really equitable partnerships and too much trickle down where partners on the bottom received little. It has to be built into the language and who is reviewing. CHW certification and others may be a good and critical component. The scope of work with a budget will show the level of partnership. And show a budget for those partners.

DPH: We do see CHWs as so integral. So that litmus test – what it might be?

COMMENT: I need to really think about that and will email it in.

QUESTION: You say you are looking for evidence-based interventions, so how can that be inclusive of populations without an evidence base, for example African immigrants? For example, there has been some very good HIV/AIDS work, but in others areas not any work at all. How will you allow for home grown or adaption of interventions?

DPH: We want to balance evidence-based with innovation, so we are focused on evidence-informed. May have something you've done with a certain population in HIV that may work for other chronic conditions. It should be based in some sort of evidence, but you can take that and build on it.

COMMENT: Also, don't think of prevention and wellness as disease specific. It is more how they live in the community in a holistic manner. How are we including other partners that are not health specific like schools, police, and other partners that we do not traditionally think of in public health? I want to second policy change so language in partnerships as to how to define that.

COMMENT: Include partnerships with gyms, alternatives like acupuncture, and thinking holistically for the mind, body, and soul.

COMMENT: I think one element of success will be behavior change, and how to affect that. There are many smaller organizations with access to populations, so I encourage you to think about including organizations that have access to many people and populations of interest.

DPH QUESTION: What are the minimum infrastructures / requirements needed for a funded applicant group to achieve outcome measures? What is essential?

- There needs to be a history with all partners of implementing policy, system and environmental change – not just programs
- Range of sectors represented – health equity, some way to address that
- Shape Up Somerville's alliance with Cambridge Health Alliance has really helped sustained it. It might be a good piece to focus on to make sure those partnerships are sound.
- There has to be a really strong consumer point for whatever the disparity is from beginning to evaluation.
- Existing partnerships are great, but disparities exist b/c of those left off of the table. I want to reiterate that having those that have not been able to be active participants involved is important.

DPH: We encourage you to look beyond boundaries and find new partners to deliver different services and partners to achieve goals. There is not a perfect partnership that already exists and smaller groups have the opportunity to be involved.

QUESTION: What about investing in entrepreneurial, smaller scale options?

DPH: Think about key partners and people you can work with. Think about partnering with municipalities as part of their application – one of the key elements is that we see municipalities as key to success. They are written in throughout the entire legislation.

DPH: There have been a couple of comments about small versus large, but what looking for is team approach. We are not trying to discourage programmatic effectiveness, but that that work should be part of broader application.

COMMENT: Bridge the gap between consumer and municipality – strong consumer-community engagement process. If you want to engage community members you are having trouble meeting, have to do some programming and provide translation and daycare and services. I encourage you to let programming be a part of it b/c our hands are so tied with MIM and if we did not have services on the side, we couldn't do what we do.

DPH QUESTION: We see municipalities and health systems as key partners. Who else should be involved?

QUESTION: When you say municipality, what are you imagining that to be? Health departments, elected officials, what?

DPH: I think all of the above – lesson learned from MIM, is that you have to have buy in from the municipal head. Where the grant is specifically housed may change, but municipalities need to be a part of it in some way. Many cities and towns are used to establishing those types of relationships with each other.

COMMENT: Hospitals and community health centers are key partners for clinical linkages.

QUESTION: What is the role of research and evaluation partners? Is DPH taking on that role or who?

DPH: It is too large for just DPH. We have good partners now and will be reaching out to other universities. We need partners to navigate the evaluation and data gathering. We are encouraging strong data collection on the local level for assessment. We will be using existing evidence-based collection tools. DPH will provide access to these materials so that communities do not have to spend time searching for these data. For example, the All Payer Claims database – we have access, but it is extraordinarily complex. Few have worked in something so complex. Have to find ways to link it and use it to inform our work.

QUESTION: Are you looking for municipalities to partner on the evaluation?

DPH: We're not sure. It is probably too large, so we're encouraging strong data collection on the local level and that will be used in evaluation, but part of DPH's responsibility is to create data collection instruments. It is part of what we'll do, but there is a lot we can do in collaboration with communities.

QUESTION: In the proposal stage, we often lay out survey tools and designs, but am I hearing right that we don't need to do that for this grant because DPH is taking the lead?

DPH: We want to use existing evidence-based data collection tools. Instead of asking communities what they want to use, we will recommend particular tools about healthy stores, safe parks, etc. – data collection tools that work well already. We will include those in RFR.

COMMENT: I'd like to suggest applicants maintain and grow partnerships they have. It is not just who is at the table, but that there is some thought going into how they are going to do that moving forward.

DPH: We mentioned the capacity-building and implementation phases; implicit in that is growth. You have to move from the starting point in October to implementation.

QUESTION: It feels like workplace wellness is a different beast. But could it be workplace and public health infrastructure? I'm trying to understand how you think about population of employers versus community in terms of putting the RFP out.

DPH: Only 10% of total funds can be dedicated to worksites and mostly for training and technical assistance in applications, we do see the importance of worksites as partners b/c of role they play in communities. We don't always address municipalities as worksites, so there is that piece, too.

QUESTION: The key partnerships with municipalities – are they the lead or can they potentially be part of a couple of different applications? I advise that they can be part of multiple applications. The municipality can be a challenge in the partnership.

DPH: There are some places and neighborhoods that are more appropriate. Municipalities do need to be involved, and play a lead role in the applications and efforts because that is what the legislation dictates. Feedback from this morning noted that municipality as the fiscal agent can be challenging.

COMMENT: It can be a challenge in larger municipalities. If stressed as lead, municipalities can be too dominating a voice to dictate equitable partnerships. So I agree to have them as a necessary sign-on partner, but having them as lead, it can squash other ideas and innovations.

COMMENT: Municipalities help direct traffic, so language in the RFR as to the direct role of municipalities is helpful. District Incentive grants are a good model. Mass in Motion or other regional grants are also helpful. Defining the base level of population or number of cities and towns would be helpful for us to figure out who will play nicely together in the sand box.

COMMENT: When you talk about 6-12 grants, that is a huge amount of money. If something doesn't go well, it is a lot of money invested without outcomes. I suggest starting small or offering small grants.

DPH: There is capacity building and planning, so if we award 6-12 grants, it could be that not all awardees advance to implementation if they cannot demonstrate the ability to move to next level. We want planning to be less than a year – some may be ready in 3 months, some may take longer. We plan on treating them individually and not making them have to conform, but if they are not getting to a certain point at a certain time, we can make the decision to not move forward.

DPH QUESTION: What defines someone as ready to move to next phase? What are the criteria for determining who should move from planning to implementation?

QUESTION: There are designated areas within the state that have higher or lower disparities. Will they be a priority?

DPH: The RFR appendices will include a lot of data around what is happening to-date. We will be looking at areas with high disease burden and prevalence. That is factor. You just have to show disparity populations if you're looking to address them.

DPH QUESTION: There needs to be evidence when grants come in of strong partnerships – so what are good indicators of a strong partnership? What should we look for? If you can't answer us now, email us at the address in the presentation.

DPH QUESTION: There are specific outcome measures in 224, so are there partners that are critical in order to achieve those goals?

- There are a number of health partners mentioned, but also having organizations at the table that are impacted. Working with those with a track record of reaching targeted populations is important.
- There should be some equity in funding, so a clear definition of what you mean by partnerships is important. Outcome measures, funding that is allocated based on size and clear expectations for what the funding should do.

DPH QUESTION: What criteria might be used to show how an organization can move from capacity building to implementation? How can partnerships demonstrate they are playing a leadership role and document that impact? What does leadership mean? Give it some thought. We struggle b/c we want to fund the right applicants, and the clearer we can make definitions of what leadership is and what readiness to move on is, the better off we'll be.

- Effect meaningful change towards your outcomes
- All partners have clarity around goals, roles and responsibilities
- Also a meeting and government structure in place
- Operating by-laws and principles
- A defined process for decision-making
- Representation from community
- In terms of budget, look at staff time. Do the partners have staff being paid through the grant? Could be full-time or FTE. That is a way to look at equity and leadership roles

DPH: It could also be in-kind staff. For example, offering a half-time position funded through this and another grant. They are saying we are a partner that can offer something from the beginning.

DPH QUESTION: What are some sustainability options? Is it attainable and how should applicants document it?

- Looking through budgets to determine initial costs versus investments that can stay in place; start up versus ongoing costs
- A history of having developed infrastructure to sustain things. Take the catalyst model for breastfeeding – sustainability is part of the evaluation plan, which helps us trying to do the work.
- Look at what capacity is left behind in the community. Can they pick up the ball and move forward?

DPH: Two of the potential groups you can partner with in the law are ACOs and insurance companies – how can you use that as sustainability?

- Have them write it in their policies how they will reimburse; write in specific changes that do not require program staff. Regulatory policies

QUESTION: Voluntary policies are more easily adapted, but mandatory policies may take years to pass. Are there any restrictions on funding groups to be involved regulatory change process?

DPH: We are doing work currently where we fund communities to do regulatory changes, and that often leads to state policy changes. Tobacco is a great example. We do not have restrictions on funding to do local policy work. CDC does have some restrictions, but we do not. Our expectation is that it will be a key component of what people will be working on.

COMMENT from Susan Servais, PWAB member: I am part of a very diverse and knowledgeable group working on this. I want you to know that nothing that was asked today has not been thought about or considered. I am just 1 of 17, but I have worked with many of you. We are aware of all of this, and are looking forward to having very positive results from the work we do. We will have incredible outcomes from the wonderful trust we've been given.

QUESTION: Is there a forum to help facilitate forming of partnerships, especially for individuals are who interested in this?

DPH: We would have to think about how to have that happen. There is the opportunity for a bidders conference to see who is applying, but other folks who can facilitate that. We said 'partnership' many, many times today. Don't wait until the RFR is posted at end of August to develop those and think about applying. We encourage everyone to think about logical partners now.

DPH: I want to reiterate that the materials put together for board are available online, and we encourage you to go onto the DPH website and find the open meeting notices.

Notes taken and submitted by: Bonnie Andrews, Jenna Roberts, Susan Svencer

# Prevention and Wellness Trust

## Listening Session Notes

July 18, 2013, 10 am

Western Region – Holyoke Community College, Holyoke, MA

Public Attendance: ~60 people

Tom Land and Lea Susan Ojamaa presented an overview of Prevention and Wellness Trust Fund:

- Objectives for meeting
- Vision and Guiding Principles
- Overview of the law
- Approach to grants
- Discussion of advisory board, open meeting, and access to all documents

*Public Question and Comment Period—Questions and comments are not verbatim*

QUESTION: In terms of data collection, is DPH developing performance indicators, expecting room for differences, are there different things they'll want to look at?

DPH: DPH will be developing common measures, for all of the funded applicants, but you can develop your own, too.

QUESTION: This is a 4-yr turnaround, so I would guess people would propose a healthy food program in schools, as in Springfield and Holyoke, with has a shorter-term turnaround. But, I would not want the cost savings to be the only driver—it would be a missed opportunity for other things.

COMMENT: I am wondering in terms of cost savings is there a preference for communities/populations who suffer from variety of risk factors or if applicants should look at multiple risk factors or single, some of them fairly costly, including substance abuse.

DPH: We do not have specifics, but the outcomes are reducing preventable conditions and reducing costs, if work with people with comorbidities is reducing simultaneously, we would not discourage that.

QUESTION: Are you looking for total population or targeted populations?

DPH: The law says we are required to look at disparities, but also a full community assessment.

DPH: In terms of number and size of grants, we are thinking 6-12 grants between \$1-2 million. The approach is to have a smaller numbers with larger funding. Though this is different from how operated in past, we need to have a high impact in a short period. We would love feedback. In terms of population, do you think it is 20K, 30K, 50K, 100K population?

DPH: If you consider \$11M annually, spread to everyone in state, you would end up with \$2 per person. This will not change a lot of lives.

COMMENT: Is rural considered a disparity? Many would recommend this as a disparity for this grant.

DPH: We have not looked at that and made specific decisions but it may be part of the evaluation. We are looking for grantees to inform us on important populations.

COMMENT: I agree with rural as a disparity, also qualifications among populations, smaller populations and comparing obesity/chronic disease rates to the overall population. We might have higher per capita than other areas. Also, some data in towns/cities can be narrowed a bit further. Think about overall county data rather than city/town specific.

DPH: Multiple towns can apply together. It does not have to be county or preexisting partners.

DPH: There is the opportunity for multiple towns to apply together. How can DPH judge if that is an effective grouping?

COMMENT: Look at past performance and see that municipalities already have partnerships in place.

COMMENT: Only looking at prior groups would preclude future partnerships and I recommend a minimum number of grants by region for equity.

Comment: The state goes on for 60 miles west of Holyoke—is there a geographic requirement in terms of grant distribution—Berkshire County has 3 distinct areas and coordinating across is not feasible in all cases.

COMMENT: I also disagree with municipal requirement. In rural communities, particular towns may have only one employee working 2 days per week. They may not have expertise, whereas CBOs or other entities would be logical. Requiring municipal participation may be like forcing a square peg into round hole.

DPH: Partnership with municipalities is throughout trust language. So, how would we satisfy the law if municipal governments are not effective?

COMMENT: Towns may not be helpful or want to be involved because they do not have the expertise or time to be effective. You can have a representative from the town at the table but not necessarily a leadership role in the application.

COMMENT: That kind of money would require you to hire people to facilitate the award. With 6-12 grants, municipalities who may have only a part-time worker would be hiring someone full-time for that money to oversee the grant. I assume someone existing would not be taking that on as additional work.

DPH: With this funding, we can assume multiple positions would be hired and we may have different size grants across state.

COMMENT: People in Boston are not considering the low capacity of health departments in the western part of the state.

COMMENT: Isn't part of this grant building capacity? We really need that capacity in this region. This grant would give us the opportunity to build some of the capacity that is missing.

COMMENT: You must support those communities in building capacity.

DPH: Yes, 1<sup>st</sup> phase is capacity-building.

COMMENT: Look at proposals from different type of entities. The MOU is important and part of the picture, but saying that the municipality has to take the funding would definitely disadvantage many towns.

COMMENT: The key is flexibility. Hampshire county may not need it as a whole but certain pockets need attention. Reserve a little bit for some smaller projects that may show results.

QUESTION: Will you be disclosing data so that we are not doing a lot of that legwork?

DPH: Yes, we will provide a large data set in the appendix. We want you to spend time on the partnerships as opposed to looking at the data. Oral health is one of the data points being considered.

QUESTION: Will oral health be included? Mental health?

DPH: Oral health and mental health are both in data briefs.

COMMENT: What is the turn around time?

DPH: We expect you will have 7 weeks to write. We anticipate that the RFR will be released in late August and then due sometime in October. We expect you to begin building your partnerships now.

COMMENT: It would be helpful to have a training entity in the Western region for community health workers.

COMMENT: Organizations with existing partnerships would have a shorter time in moving to implementation phase.

DPH: What are the key elements to determine good partnerships?

COMMENT: There are a lot of people working together but I am not sure it is as integrated as it could be and there is room for thinking outside of that box and bringing other players to the table. Look for integration with health records and other data to demonstrate the commitment to partnership.

COMMENT: Communications is a key piece. There must be good communication among organizations.

COMMENT: Look at large organizations with a track record with effective community health workers.

COMMENT: Internal wellness champions should include the community so we are doing things with them and not at them.

COMMENT: I agree. We need to consider underserved populations. Not just organizations doing things to people, but close contact with people, who are underserved. These are frequently organizations with CHWs.

DPH: Should we have a proportion requirement of agencies with community health workers?

COMMENT: Grass roots organizations that include people of color need to be at the table. The community itself should be at the table and reflected.

QUESTION: I am from a statewide organization. After community healthcare workers are trained, they often leave. Can CHW be paid through stipends?

DPH: Absolutely. They would pay anyone who is working on this grant. Our expectation is that one agency would be the fiscal lead but that all the partners would receive resources and compensation as partner organizations. There are no restrictions on how the budget can be constructed to involve partner organizations. This does bring up the sustainability issue and as you hire employees, how do you sustain these positions over the long term?

COMMENT: We need to have training for mainstream organizations to ensure people running the larger organizations understand cultural issues and the community needs and their health issues. A lot of medical providers are not familiar with cultural issues and socioeconomic issues, so there needs to be that training.

COMMENT: CHWs are a valuable component but on the community side you have to have an active and trusted relationship with the community you are serving. You cannot just make a referral connection. The winners of the grant have to have a real hand off.

DPH: What do organizations bring to the table to demonstrate collaboration? Signing MOUs, is easy to do, but what can they bring to table to demonstrate they're actually a partner? Offer a .5 time employee to work on something? Offer access to clinical data? How can they say are active participants?

COMMENT: There should be a requirement to conduct a community needs assessment initially and over time. There should also be a partnership list and potential partner list. Perhaps real partnerships would have agendas and minutes of meetings among partners. Showing projects with partners would show real collaboration.

COMMENT: I urge caution on electronic health record and security. This could be a substantial and costly exercise. Give preference to other DPH activities—Mass in Motion, WIC, etc.

COMMENT: What makes coalitions is demonstrating the willingness to change and not just sign off on an MOU. Regulatory flexibility among organizations will be important because it is hard to integrate the different data tools to truly share information. We need the opportunity to work with DPH to not just collaborate but integrate.

COMMENT: Grant deadlines are so tight that it requires a grant writer. There has to be some time for internal discussions. Is there enough time to authentically turn these grants around?

DPH: There is 7 weeks to respond and then the capacity phase gives the partners time to solidify their roles. Partnership development needs to start now, work through the application process and then continue the development during implementation. It is not assumed that everyone will move from capacity building to implementation.

COMMENT: What technical assistance will be provided? We need assistance to set appropriate local outcomes and know how to evaluate at the local level. Sometimes we are given tools but we need to really know if we are moving toward outcomes.

DPH: TA will be provided by DPH but the expectation is that the community is not the only data gathering entity. This will not fall on the community to do the final assessment. Other partners will be brought on by DPH, such as universities to help compile and assess outcomes.

COMMENT: TA can help us understand what we have accomplished. It is important for the communities to know their outcomes so they can leverage this in their community for long-term sustainability.

DPH: We want to develop a learning community. These grants will be related to much of the work that is already happening and it is important that there is collaboration among all these groups. We want our programs to share and benefit from lessons learned, successes, etc. This is not going to fall on communities to do final assessment to determine cost impact. DPH is looking to expand their local evaluation capacity at the same time with local universities and partners. It is a huge task.

COMMENT: Broad based policy can be very effective. What is the proportion? I would like to see this as an important piece, as well as advocacy. Will this be allowed?

DPH: It depends on who the grantee is advocating to--locally, certainly. We are expecting a majority PSE changes, not a lot of programming. Some programming will be involved in that, but making health systems changes is where we get sustainability. Referrals are a health systems approach, but need to figure out how it will be paid for. Referrals to CHWs can be an effective intervention, but someone needs to pay for it. We are interested in hearing about models for how that would happen. The policy and systems change will give us the long-term change needed that may be sustainable. We want to see models that will last past the grant.

COMMENT: Are you looking at other states evidence-based practices? I hope you look at Oregon.

DPH: The law requires that these grants contribute to the evidence. We do want to balance this with innovation—evidence informed strategies are encouraged, as well. Look at the data briefs. There is a great deal of information about interventions that contribute to cost savings. We also want balance and will consider something that's evidence-informed and will contribute to the evidence moving forward.

COMMENT: Challenges of long-term prevention—these interventions are not reimbursable and therefore how do you sustain this? I recommend there be an opportunity for these interventions be part of the state reimbursement system.

DPH: What people/organizations should be on local coalitions to help make the case? Can we make progress on that prior to October deadline? Can applicants find partners who will sign on and agree to do this?

COMMENT: The challenge is that so much of what is needed is tied in social case management and other factors, at CHCs, it is a really difficult thing to figure out how to sustain because it is not reimbursable. If we were to have these people in community-clinical linkage teams the opportunity to demonstrate sustainability should be included in reimbursement structure. We can also leverage HC reform. We need to include these people in case management/care system (start conversation with MassHealth as a department using this evidence).

DPH: You would want the department to urge mass health based on the success of these interventions?

COMMENT: Yes, we are constantly trying to find mechanisms to fund these important interventions.

DPH: Should there be partnerships that make this case?

COMMENT: You have to have people from all different health communities at the table to deliver. Changing the system will make it more equitable and sustainable over time. All the people in the room should be part of that conversation. I do not know if everything can be resolved in four years but these are missing elements that contribute to sustainability.

COMMENT: Deficiencies already exist. This has created issues of lack of sustainability.

DPH: Applications should focus not on deficiencies, but strengths.

COMMENT: I suggest we create a system of pseudo-reimbursement where partners can submit for reimbursement.

COMMENT: 3<sup>rd</sup> party payers are doing the same thing. You can improve care and reduce cost by improving payment models. Integration between DPH efforts and their efforts and ensuring that they're integrally involved in this conversation, it makes sense to have the 3<sup>rd</sup> party payers as part of local coalitions.

DPH: The makeup of PWTF advisory board consists of bringing entities together as well.

DPH: Local representation might want to mimic makeup of PWTF advisory board.

COMMENT: It makes sense for insurance companies to develop cost-saving initiatives, since they're the ones saving money.

COMMENT: ACOs, VNA, hospital, PCMH, CHCs—all local health systems are important to have represented.

COMMENT: There still needs to be statewide conversation among DPH, 3<sup>rd</sup> party payers in addition to having representation on local coalitions. I like the idea of tracking costs of interventions such as CHWs, because that's something that's going on among 3<sup>rd</sup> party payers. We need to establish what the true cost might look like.

COMMENT: The reimbursement model is a good one for sustainability but I would caution people, if we want community partners, where will they be at the end of this grant? Consider what reimbursement mechanism would benefit grassroots organizations as well.

DPH: Does it all get centralized to one group benefiting from the sustainability plan?

COMMENT: I am not sure but the bureaucracy in terms of who gets reimbursed and what kind of medical oversight we need in order to do this, has to be developed in terms of the partnership, with an eye to developing this partnership, that benefits continuing and strengthening the community organizations is part of the requirements of the funding.

COMMENT: For behavioral health, peer workers and families and grassroots workers, we need to be connected and engaged. We need to build relationships among people who have gone through the same thing. I would caution people against bringing all the services inside medical institutions. Third party payment is not entirely the answer, because everyone becomes medicalized and you get caught in the "medical necessity" trap—emphasizing pathology. If you want authentic community partners, where do they go and how do they stay involved with the grass roots? I am not sure how you ensure only one group does not get too much. I think it has to be developed in partnership.

DPH: Should third party payers be at the table?

COMMENT: Yes, third party payers should be partners in these grants.

COMMENT: Maybe you should not have it as a requirement but you have it as part of the menu of options of core local health organizations that people have to select from.

DPH: What minimum infrastructure needs to be in place to have a successful application?

COMMENT: If you are working with hospitals you need to be tied to community benefit programs. There should be a strong linkage.

DPH: What role do workplaces play?

COMMENT: We are not talking about a lot of large employers in W MA. In Berkshire county I can count the number of employers with 100 employees on one hand. Some may already have worksite programs.

You can have different options in the application. The focus needs to go back to disparities and what would benefit the largest numbers of people in the community.

COMMENT: Maybe networks of employers would work in smaller communities—like through the chamber of commerce.

COMMENT: Most employers are wrestling with the transition from mass health to affordable care act. This cannot be done in isolation. If an applicant wants to do worksite wellness this consideration should be part of capacity building.

COMMENT: Collaboration is key. You need to consider health programs for people who work in different organizations. Also, if the person delivering the message does not buy in, it will not work.

COMMENT: CHWs need support to be successful. They need to be healthy and model good behavior. You need a holistic program. You need a provider champion but you need healthy workers going out in the field. We need a well-funded program that pays partners equally.

DPH: How do you create an organization that is nimble and can function and change over four years?

COMMENT: We need assistance with evaluation and a system with ongoing check-ins, as well as, feedback from the community and an understanding of what's working and not working (focus groups?). This should increase as grant progresses with process evaluation planted along the way so we have continual feedback and can respond to barriers.

COMMENT: The way reporting is structured will set expectations right from beginning.

COMMENT: Allow time for organizational development and goal setting. You need to look at the skills and decision-making processes of an organization.

COMMENT: Provide funding in the grant for evaluation assistance, which will allow many organizations to be involved.

COMMENT: Consumer input is essential.

COMMENT: You need understand barriers and track over time. This should be informed by the team members, but more importantly, by the people participating. Clients need to be involved and have the opportunity to give critical feedback and advice. Formative evaluation should be along the way, such as focus groups. The focus should be on the experience and success of the service delivered.

COMMENT: DPH should help us with evaluation of targets. We need DPH guidance to determine how nimble we have to be. We do not want to go in the wrong direction.

DPH: Should we give you feedback on how to prune the tree? Is everything piloted?

COMMENT: For the evidence-based interventions it may not be necessary. These services can be altered if they are not working.

COMMENT: Consumer input—there should be a strong place for consumer input. Councils on aging have advisory boards and we should build on what organizations already have on all levels, including evaluation.

COMMENT: Dental is a separate realm for reimbursement and this does not make sense. This may be a higher level or a structural consideration. We need to unify medical and dental insurance.

DPH: Data briefs discuss oral health. These briefs will be presented to the advisory board. We tried to cover all the diseases and conditions through these briefs that will likely be targeted.

COMMENT: There should be funding for equipment, screening tools and software.

COMMENT: Awareness of the tax credit is very low. When will we see more promotion? Non-profits were left out.

DPH: The tax credit went into place in June and more promotion will be coming soon. This is a tax credit so only benefits those who pay taxes. This grant can help provide training and TA. Worksite wellness is changing the culture to change health from a holistic perspective—policy and environmental change, not just education.

QUESTION: Will there be a TA contract that will go out to bid?

DPH: We have existing contract but we may need separate providers and we have not yet figured that out. We may need to expand it. Grants will start in January.

COMMENT: What populations should we work with?

DPH: Look at the outcome measures and determine how you can best serve the communities in need based on your partnerships.

Notes taken and submitted by: Bonnie Andrews, Jenna Roberts

# Prevention and Wellness Trust

## Listening Session Notes

July 18, 2013, 3 pm

Central Region – College of the Holy Cross, Worcester, MA

Public Attendance: ~75 people

Tom Land and Lea Susan Ojamaa presented an overview of Prevention and Wellness Trust Fund:

- Objectives for meeting
- Vision and Guiding Principles
- Overview of the law
- Approach to grants
- Discussion of advisory board, open meeting, and access to all documents

*Public Question and Comment Period—Questions and comments are not verbatim*

QUESTION: What is an “RFR”?

DPH: RFR and RFP are used interchangeable. This is the application we write and you respond to.

QUESTION: What will the length requirements be for the RFR?

DPH: There is always a restriction but we do not know what it is yet

QUESTION: \$60 million, 4 years, 6-12 grants, how are you looking to divide the money?

DPH: 6-12, grants may not all be same size, will be a range, interested in getting input on what the right population size would be—50K, 100K—want these to be high-impact grants—if 12 funded, for example, that would be for duration of trust—really would be 3.5 years because it would not be awarded until Jan 2014—all get funded for planning, but then at a certain point get to implementation, and some may not be ready—could start with 12 and end with 10, for example. Will be between 1-2 million dollars. Capacity-building would not be as expensive as implementation, most likely—will most likely have bulk of \$ spent in last 3 years. Latter phases—substantial amount of \$ for each funded community. Rich intervention—not a lot of \$ on one thing, should be broad, multi-faceted, may not be the same per capita—maybe one awardee gets \$12 per person and another \$15—due to the fact that burden might be different

QUESTION: You are looking at geographic regions with high prevalence. Will you provide that?

DPH: Yes, we will provide as much information as we can in the RFR appendix so that you can spend time working on partnerships instead of data gathering.

QUESTION: Are you assuming everyone will have a 6-month planning phase or can you go right into implementation? I believe there are benefits from planning, but some organizations may have greater readiness and they should be able to move to implementation more quickly. For sustainability, we would want to focus on environmental, infrastructure changes and systems—including bricks and mortar.

DPH: Capacity-building may be brief for some communities—might do assessment, but would like to move to implementation as quickly as possible.

COMMENT: Be sure to mention infrastructure of the community and environmental issues as a requirement of the grant. It would be beneficial to look at connections and broader systems change. I am

thinking of organizations that are targeting diseases, as well as, outside forces causing those diseases (i.e. pollution causing asthma).

COMMENT: Rural communities do not have reliable government structures and we need to consider natural boundaries. Let the applications determine their regions, not at the state level.

DPH: Pre defined regions are not defined by the law.

QUESTION: Mass in Motion and other programs are already doing some work—will you measure the short-term changes?

DPH: Much work is happening both short and long— what should we look at to meet goals of trust? Many things will show long-term effects, and not discouraging work on those, but with a four year turnaround time we must show results. The goal is short term cost savings.

QUESTION: Are some communities more shovel ready and do they have an advantage or disadvantage?

DPH: Existing funding for other programs does not preclude those partners for applying for funding, nor do we expect them to be the only ones who will receive funding. 3.6% GDP in MA, this is intended to be a part of ensuring growth does not exceed that—may project for legislature what it might look like in 10 years, but must demonstrate it meets 3.6 requirement. This does not mean those communities are only type of communities who will get funding—will be looking for innovative partnerships. What infrastructure do you think should be in place to determine likelihood of it being a successful application?

COMMENT: It is difficult to look at how partnerships affect health—for evaluation, how will we measure that? Suggest looking at outputs--# meetings, #stakeholders who attend, also qualitative in addition to quantitative

COMMENT: Federal government—IRS regulation that all hospitals do 3-year needs assessment, and public health should be involved—also should be action plan, all communities within an acute care facility’s catchment area—should link with needs assessment process. Have specific, concrete areas where can reduce growth, but not based on “kumbaya” stuff—based on hard data.

QUESTION: How realistic is this based on short timeframe? Talking about ROI in terms of prevalent chronic disease—if takes until January before giving out a dime, then a year to plan, then after that, will have to show results. I get the “fast track”...room is full because talking \$60 million, but in order to pull this off, I am not getting it.

DPH: This is not going to be easy. We have been working over the last 6 months to try to lay the groundwork to try to achieve these goals. We developed the data briefings to identify short, medium and long-term interventions to achieve the requirements. We are trying to promote something that has sustainability because that will pay dividends over time. The legislature has asked us for a short-term ROI, but from public health perspective, should not just be looking at short-term ROI, but also some longer-term things that have sustainability and will pay dividends over time. This is ambitious but it is doable and exciting. Is part of healthcare reform, prevention and wellness is part of the solution. We need to be selective in who we fund so this can have significant impact. This is not only about primary prevention. We need to create the environments to promote healthy behavior but also secondary prevention.

COMMENT: With regard to reporting, you cannot put this together on the last day. We need preliminary reports and stories that show interim measures that demonstrate success through the years. The case needs to be made along the way. There must be consistent messaging to make the case to continue to invest in prevention, which will lead to real environmental changes and significant investment in infrastructure.

DPH: You are recommending is interim reports to show where there has been success.

QUESTION: Can successful short-term measure be something other than cost savings?

DPH: Assuming what you want is that we'll be looking at interim measures (for example, Mass in Motion communities—have been looking for interim measures, for example, what people are buying in grocery stores in MiM communities)—is there concrete information that's a precursor to health evidence? Yes, will be looking at these and some of the things we'll report on, but will adhere to letter of law.

COMMENT: As an example, CHWs and use of hearing aids—for example, we might be able to demonstrate use increases, but for example, longer-term health issues like dementia will be more difficult to prove—I recommend you consider and look at these things.

QUESTION: Is mental health part of the conditions? It would be great to increase data collection and standardize data collection, and then use it for improvement of the system—at the same time create objectives that are achievable—working together more between clinical and community side, something we have not been doing very well.

DPH: Yes, mental health is one of the conditions in data brief. We are interested in hearing from people about what they think of community-clinical partners applying.

DPH: We want to discuss the idea of requiring of municipality and health systems to partner.

COMMENT: Health systems and municipalities are not overlapping—for example, a lot of people living in MetroWest go to Boston for health care—used to be a free flow of information between community and clinic until HIPAA and EMRs, and also not a consistent EMR—difficult to have seamless electronic communication between community and clinical. Also, very excited that DPH will provide data collection instruments. Also, Institute for Community Living has developed software to aid in volunteer management, but only available to selected organizations—but not all CBOs have access to it. So, we are hoping that these tools will be available to everyone. I am excited that DPH will provide collection instruments because one of the weaknesses to date is that we are not all collecting common measures to understand what we are doing and what we are doing collectively. Even if we do not get funded we should all share what the grantees do collect. I would hope that these data collection be available to all players.

DPH: All data collection instruments will be posted for access for everyone, not just funded communities. Re: EMRs, MA has been funded to build open-source software to facilitate clinical to community communication, designed to allow for minimal effort on behalf of clinical and community people to talk to each other in a secure way—plan will be completed summer next year. Municipality is mentioned a lot in the law, so work is needed around cost containment that municipality and clinical partner should both be an integral part of the application.

COMMENT: Municipalities do not connect right now but there should be a designated person at the municipality. Some are more connected to the small and local healthcare facilities, not the larger ones. In terms of claims data, that is challenging to achieve over a four year period, most is over 10 years.

DPH: We are required by law to use the APCD.

COMMENT: Great work has happened because of the change from DPH over the last 5 years that required partnerships with municipalities. Engagement of a municipality can lead to a great partnership. Also, HMOs have a strong connection and this is a partner that can assist with sustainability.

COMMENT: I respectfully disagree with last comment--not all municipalities have the capacity to be good or successful partners. Though Worcester has a lot of capacity, many municipalities don't, this puts other partners in an awkward position if having the municipality to be making promises to do things they don't have the capacity to do. It simply does not always work that way in rural towns. Best in an RFR situation, to say what would be ideal, but not required—HMOs, hospital systems, should include a variety of partners. Municipalities should be at the table but they may not be able to or even want to play a significant role. The RFR should stipulate ideals but not make these partnerships a requirement. There are too many differences across the state for this to work well. Not every place is equal.

COMMENT: I agree. There are so many smaller towns that are so woefully underfunded and even if some funding was given there is no way you can sustain it. So, do not require that they take the lead role.

COMMENT: Coming from Worcester as a school nurse, sometimes large hospitals are also the largest employers in area, when considering social justice, are partnerships fair? Do they have other motives/agendas? It's difficult we realize the value of having research hospital in city, but also as the largest employer it might be putting smaller groups in a more vulnerable situation.

COMMENT: Milford has a strong community hospital—partnerships should not be forced because it may not be as successful.

COMMENT: You should have municipal schools involved, we do more than refer out but manage in conjunction with medical system—also have electronic medical record they use every day, can communicate with medical records.

COMMENT: Thank you! Thank you for mentioning the children. Please do not forget the children. School nurses work directly with students and have access to and can make short-term impact with 1.2M children. We save children from going to the ER all the time.

COMMENT: Regional public health groups funded through DPH—broaden focus and partner with existing groups that will cover multiple communities help to spread joy and work, those groups are the ones that bring smaller communities on board that don't have the capacity—people should look for these linkages that are growing—whole focus is sustainability is what we're doing anyway—if municipality piece too daunting, then broaden the scope. We are willing partners.

COMMENT: Remember we are in testing period of time, we cannot please everyone, we must be focused on long-term—imagine in some ways this is a pilot that is trying to provide better investment for state money. Be sure to consider the diversity that we have in the state. We need to find better investments for our money. Look at other styles of partnerships.

COMMENT: Good thing about requiring municipalities to be involved, the programs/interventions are out in the communities all the time rather than staying within four walls of one place—in a way that is not as natural/intuitive for larger health care organizations (like hospitals) though CHCs bridge between what hospitals and communities do. Another thing, to be very clear, specific, and strict about what a partnership really is.

DPH: What are some of the indicators to know if something is a strong, functioning partnership right from beginning, and what can we look at to see whether communities can go from capacity-building to implementation?

COMMENT: In the action plan, all the partners that are listed, they need to have detailed roles and those have to be reported out, as well. If you have a large healthcare organization and several municipalities and other community organizations, it should be clear who is doing what and who is contributing to the overall work.

COMMENT: Research shows that if a community has never rallied around an issue ever before, there will be less success. There should be some demonstration that the municipality has engaged and participated in the community.

COMMENT: Sometimes the community is not informed of an issue so they did not dedicate any attention.

COMMENT: There should be a history of working together. These need to be real and equitable.

COMMENT: Signature of support is a minimum requirement.

DPH: Should they sign an agreement or should organizations check off certain items they will do as a partner?

COMMENT: Working Cities Challenge Grant should be something you look at.

COMMENT: You should consider who is doing what but also resources are being shared throughout the grant years.

DPH: This is an expectation. The fiscal agent disperses the funds, does not keep all the funds.

COMMENT: Sustainability—how do you include that as a component of the proposal? We do not want to go back and have to drop something. This is an important issue. The community should be engaged. So, how should it be implemented as a policy? It should be developed from the beginning and anticipate and plan for how it's going to end.

DPH: Tell us how to focus on sustainability? Someone in another session commented that sustainability impossible, but we believe that is not necessarily the case.

COMMENT: Return savings to the program itself.

COMMENT: Is there a model or benchmark of success DPH is looking at as they design RFR? Consider Shape Up Somerville as an example. We may have issues with duplicative services.

DPH: With partnerships, we are considering “Who is brought to the table?” Also we will be soliciting written thoughts based on conversations.

COMMENT: Demonstrate partnering with existing DPH/MTCP programs—policy that can be sustainable and existing partnerships are important. I hope that tobacco got rolled in.

DPH: Tobacco one of 13 conditions the board is looking at.

COMMENT: Back to issue of mental health. Some of it is statewide infrastructure with a lack of beds, the statewide infrastructure key. There are lots of other ways we impact.

QUESTION: Why are municipalities so important? If we want to improve population health we need to focus on policy. How many communities are expected to put in an application?

DPH: Looking at size—places like Worcester, Boston, Springfield, may be cases where it would make more sense to look at neighborhood. What is the range low-high in terms of population? Not one municipality in all instances. In the bigger cities it may be neighborhoods. In those cases, it may make sense to have more than one application. But if the entire town is applying and has more than one application, that doesn't make sense.

COMMENT: Five recommendations: 1) Support engagement of CHWs, consider literature around it, 2) Importance of secondary and tertiary prevention 3) Prevention and wellness throughout the life cycle, older adults, end-of-life, care transitions, 4) Prevention and wellness that includes integrated behavioral health, and 5) also inclusion of men's health.

COMMENT: I think a reduction of emergency room visits for non-emergent reasons is something that partnerships could work on changing.

DPH: You're recommending that evaluation should have a way to measure reduction of non-emergent uses of ER.

COMMENT: Also, flexibility in definition of disparities.

QUESTION: What about TA? Will that be offered through DPH or bidding process?

DPH: We have not fully determined how we're going to do that. We are looking at developing a learning community that should it be engaged with the other initiatives we have: MiM, tobacco, substance abuse, CTGs working in clinical settings. Does it become part of what we're offering those, do we add onto existing structure? It is still in formative stage. Awards will be announced in early 2014. Some TA will come from DPH.

COMMENT: Grantees should involve youth and/or mentoring college students. Youth should be integral part of process and be engaged in the community process in meaningful way as time goes forward. This is the leadership for the future.

COMMENT: In looking at hospitalizations, there is a high percentage of people showing up there because the doctor told them to go there. If you call your physician at 4:45 with an ill child, the physician will tell them go to ER. Then the ER will shoot the messenger for following medical advice. We need to look at the structure. Problems include: waiting time to get to a PCP, having insurance does not necessarily give you access to care, shooting the messengers for accessing that care they were instructed to seek.

DPH: We really want to emphasize community-clinical linkages. There may be a structural problem with doctors referring to EDs, but in terms of abuse, there's a good reason why people go in many cases and why the health provider recommended it. Establishing strong community-clinical linkages may be best opportunity to make a change.

COMMENT: It is Important to involve orgs with primary responsibility for payment (health homes?), also rewards of project—not requiring them, but having them at the table.

DPH: You mentioned sharing savings...how do we know have a partnership strong at beginning that can create sustainable change? Respondent says to identify where savings are happening—those payers will be able to see a decrease by looking at claims whose rates decrease—the more we can narrow down/focus in effort with savings. What response should applicants give to say that in year 5, it's likely to lead to something sustainable?

COMMENT: Federal study of pilots: you can drive slope down, but it depends on how you define savings. Atrius is one of the organizations, some orgs did well because there was a lot of inefficiency, but some are dropping out.

COMMENT: I hope the RFR will not just address need to attend to chronic disease management to improve health, but also look at people's increased employability because they improved their health conditions and consider how this will address professional development of the workforce.

COMMENT: What about communities with high percentage of residents who are food insecure?

DPH: That's one factor we'd take into account, like high rates of hypertension or diabetes

COMMENT: Contain something in the proposal related to financial analysis. An organization may not be great at expressing things in terms of money, but in the Senate, will express things in terms of savings and orgs need to speak the language of the legislature.

DPH: Goes back to telling story (what was said earlier)—we need to find a way to translate numbers into a story (reducing something by a certain percentage equals this many individual people, etc).

COMMENT: Even applicants might need assistance translating percentages into numbers.

COMMENT: When you define the data collection piece, work with providers in terms of what that will mean beforehand. For some DPH grants it's quite a lot of work to collect data.

DPH: Expectations for grant—one will be a relationship with clinical organization with an EHR—some expectations will be laid out right from beginning, but it is good to make sure we're being clear in the application and also not being burdensome with data collection.

COMMENT: Have a little room (flexibility) because some things that will be measured may differ between funded communities.

QUESTION: At some point there was a conversation about a health economist being involved? Would that be someone at DPH providing TA?

DPH: Yes, will be hiring a health economist, and that person along with a team of people will be conducting the evaluation.

DPH: We have clearly defined slots for the advisory board and they are representatives from many different sectors. The types of people that are on that board may be useful to consider when you are pulling together your own groups.