

Prevention and Wellness Advisory Board

Summary of Ranking of Health Conditions by Expected Cost Savings

At the June 27, 2013 meeting of the Prevention and Wellness Trust Advisory Board, members were asked to review materials provided by MDPH and make a ranking of health conditions and risk factors in terms of how important each was to achieve the goals of Chapter 224. The specific request is below:

Our work at MDPH has led us to look deeply at 13 specific areas where policies and interventions might help us achieve the goals of the Trust.

To move the Board's discussions forward, we've asked you to rank order 13 areas where MDPH staff thought savings could be realized. In some cases, an intervention may only work for a small portion of the population (e.g., children or older adults). In other cases, you might feel that there a particular intervention is more effective in one part of the state than another or with a particular demographic subgroup. You may also think that we've missed an area or intervention altogether. If that is the case, please add it to the list.

Thirteen of fifteen Board members submitted ranks. Below is the average rank provided by the Board members. Lowest ranks indicate greater importance in achieving the goals of Chapter 224. Higher ranks indicate lesser importance. One member added "Violence" to the list and ranked that 8th.

Health Event / Risk Factor	Average Rank
Obesity	4.85
Hypertension	5.35
Tobacco Use	5.42
Substance Abuse	5.62
Asthma	5.77
Diabetes (Type 2)	5.77
Mental Health (Depression)	5.85
Oral Health	6.38
Cholesterol Control	6.50
Congestive Heart Failure	8.96
Falls Prevention	9.58
Stroke Care	10.04
Cancer	10.62

Prevention and Wellness Advisory Board

Request for Information by August 6, 2013

Instructions: The Listening Sessions provided broad areas where we would like the Advisory Board to comment. Please respond briefly to the questions below

- 1) Should there be geographic requirements for distribution of these grants? For example, should there be a certain number of grants per region, a certain number in small vs. large communities, a certain number in rural vs. urban communities?
- 2) Should there be a certain percentage of funds that goes to innovative vs. evidence-based interventions? If so, what percentage should go to innovative interventions?
- 3) Within the clinical and community settings, which sectors should participate in these partnerships? Should the local partnerships reflect the roles of the membership of the Prevention and Wellness Advisory Board?
- 4) Listening session attendees expressed that municipalities may have different levels of capacity to take on this kind of work. What role should municipalities play in these partnerships?
- 5) Should there be a maximum time allowed for moving from the capacity building phase to the implementation phase? If so, how long?
- 6) How much weight should be given to the sustainability plan in the initial application? What kinds of benchmarks should awardees be required to meet to ensure that sustainability is a focus throughout the grant?

If you have any other comments, please direct them to Tom Land at Thomas.Land@state.ma.us.

Prevention and Wellness Advisory Board

Draft Outline of RFR

Part One: Overview

- I. Background
 - a. Chapter 224 scope and mandates
 - b. Description of each of the domains
- II. Importance of Partnerships
 - a. Required partners
 - b. Expected level of involvement of partners
 - c. Demonstrated capability of partners (Partnership Checklist)
 - d. Roles and responsibility of lead and partner organizations
 - e. Fiscal agent requirement and minimum funding expectations for partner organizations
- III. Preventable diseases /risk factors/conditions
 - a. Disease burden and risk factor prevalence
 - b. Priority diseases /risk factors/conditions
 - c. Optional diseases/ risk factors/conditions
- IV. Population impacted
 - a. Priority populations and subpopulations
 - b. Target # population reach
- V. Data collection and expectations for cost savings and health improvement within 3 years
- VI. Description of grant phases and funding levels of each
 - a. Capacity Building/Strategic Planning Phase
 - b. Implementation Phase
 - c. Sustainability Phase
- VII. Description of DPH roles and responsibilities (including support from vendors providing TA and other support)

Part Two: Descriptions of Expectations and Performance Criteria for Domains and Phases

- I. Capacity building phase
 - a. Partnership Infrastructure
 - b. Community
 - c. Clinical
 - d. Community/Clinical Linkages
 - e. Sustainability plan and funding partner(s)
 - f. Funding levels and budget criteria

- g. Process for going from Capacity to Implementation
- II. Implementation Phase impacting priority conditions
 - a. Community
 - b. Clinical
 - c. Community/Clinical Linkages
 - d. Funding levels and budget criteria
- III. Sustainability Phase
 - a. New funding partner(s) continue work in all domains based on evidence and data
 - b. Continue to attend collaborative meetings sharing best practices
 - c. Continue to share data with DPH

Part Three: Application

- I. Application directives
- II. Questions
- III. Budgets of lead and partner organizations, including budget narrative
- IV. MOUs from all participating organizations
- V. LOI requirement
- VI. DPH's review process, dollar allocations

Part Four: Appendices

- I. Demographic and disease data
- II. Sample budget
- III. Journal articles re: Evidence-based interventions
- IV. Sample responses
- V. Legal regarding data sharing
- VI. Sample BAA agreement