

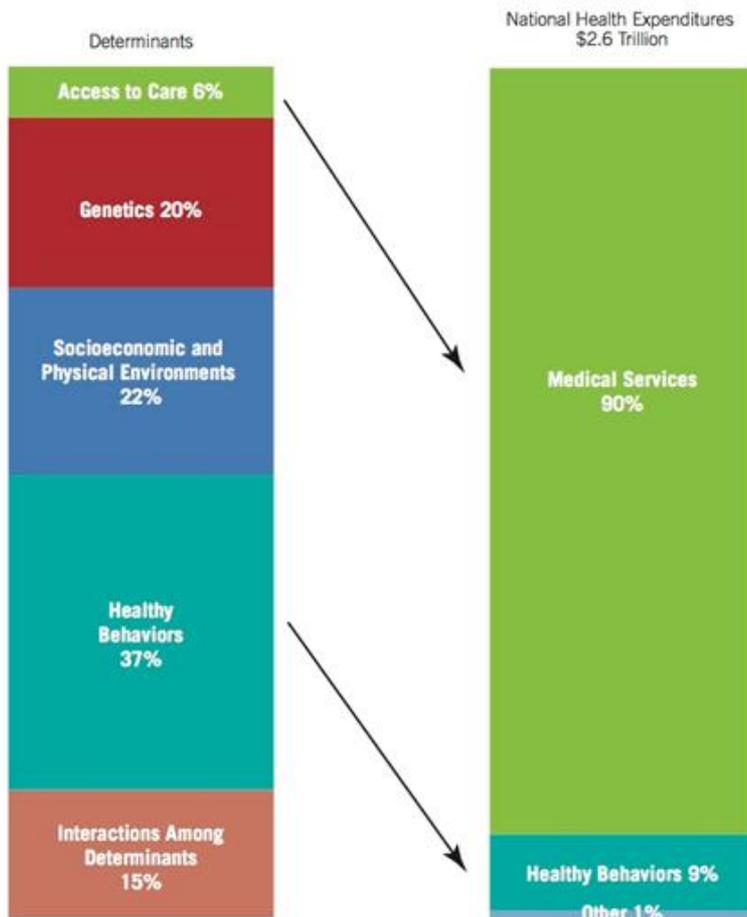
Massachusetts Prevention and Wellness Trust Fund Grantee Program

Quick Overview

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Prevention/Spending Mismatch

The Spending Mismatch: Health Determinants vs. Health Expenditures



- Drivers of medical spending are overwhelmingly behavioral, environmental, socioeconomic - and *preventable*
- 90% of national health spending goes to medical services
- **Hypothesis** – Investing in prevention will improve health outcomes and save money by reducing downstream spending on medical services.

Legislative Action

In 2012, the Legislature acted on this hypothesis with Chapter 224 of the Acts of

- Second phase of health care reform with an emphasis on cost containment
- Addressed additional components of access to primary care and strategies to address health disparities
- Unprecedented investment in a prevention strategy to link improvements in health outcomes to the containment of healthcare spending

How the Prevention and Wellness Trust funds are allocated:

- First-in-the nation prevention program (currently 2 years into 4 year program)
- \$57 million in trust for 4 years
- Up to 10% on worksite wellness programs
- No more than 15% on administration through MDPH
- At least 75% must be spent on a **grantee program**
- No requirement for spending equal amounts annually

Prevention and Wellness Trust Fund: Chapter 224 Guidelines

All expenditures should serve the following purposes:

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

How will these goals be met?

- Priority health conditions selected that have strong evidence-based interventions with a return on investment in 3 to 5 years
- Population and service area size must be matched to available resources and estimated cost of interventions
- Emphasize Community-Clinical Partnerships
- All grantees required to use bi-directional e-Referral
- Data-driven Quality Improvement approach
- Model must be sustainable

Selecting Health Conditions

- Expert board reviewed chronic diseases for ROI over 4 year time frame of the PWTF
- Conditions that have prevention strategies that have been proven to be:
 - Efficacious – improve health outcomes
 - Cost-effective – have a return on investment
 - Timely – work within timeframe of PWTF
 - Equitable – reduce health disparities

Priority and Optional Health Conditions

Priority Conditions (Required)	Optional Conditions (Not Required)
Tobacco use Pediatric Asthma Hypertension Falls in adults 65 and over	Obesity Diabetes Oral health Substance abuse



Disparate Populations and Co-Morbid Mental Health Conditions

Grantees are encouraged to develop strategies to reduce disparities in the burden of these conditions (e.g., racial and ethnic disparities).

Mental health conditions, such as depression, may be viewed as co-morbid to any of the above and interventions may be proposed and tailored for populations affected by mental health conditions.

Promoting Strong Partnerships

Grantees are required to have three types of organizations within their partnership:

- Clinical (healthcare providers, clinics, hospitals)
 - At least one clinical partner must use and be able to share Electronic Medical Records
- Community (schools, fitness centers, non-profits, and multi-service organizations)
- Municipalities or regional planning agencies,

Promoting Sustainable Linkages

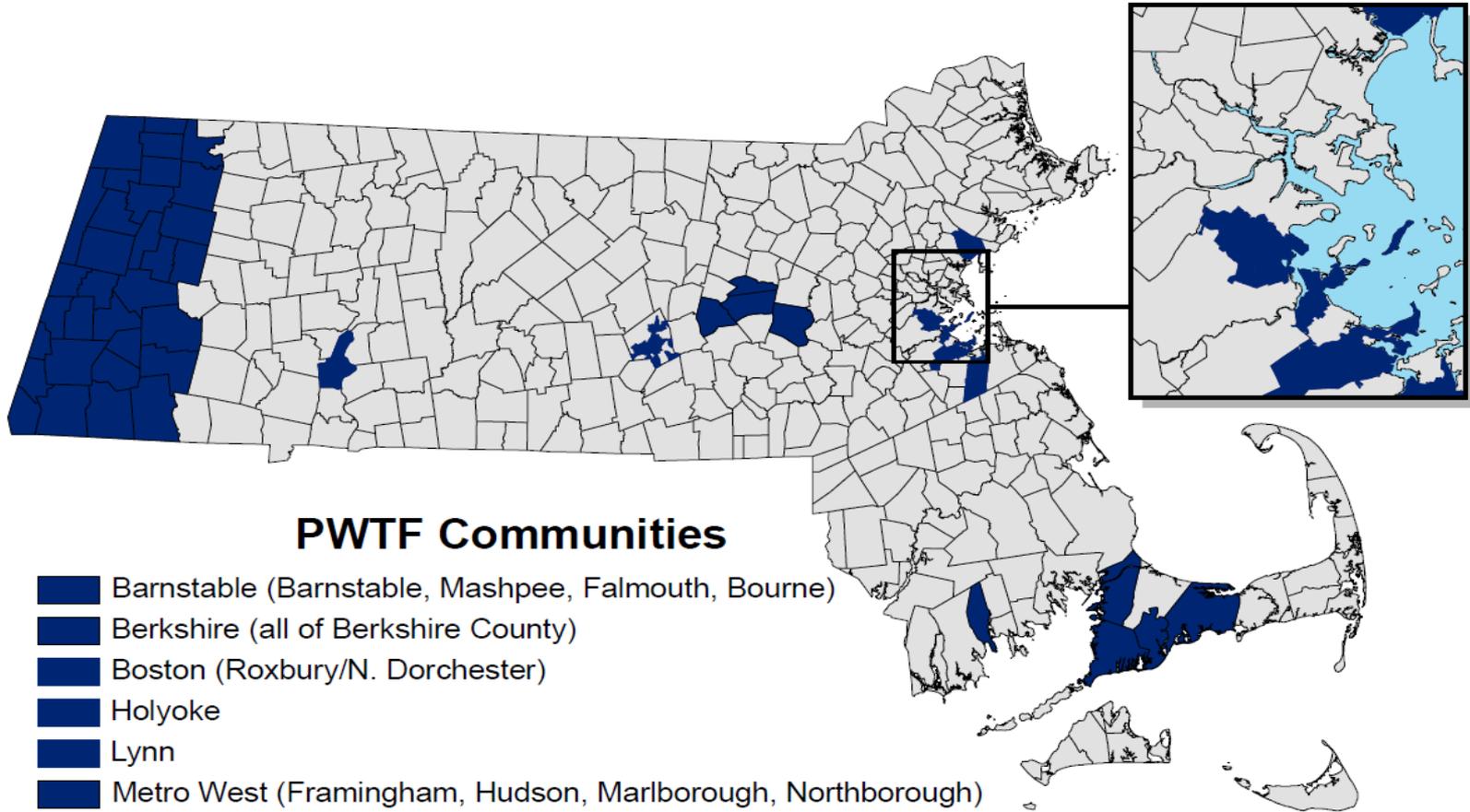
For any condition being addressed, grantees are required to include interventions in each of 3 domains:

- Community – Supports behavioral change to improve health through individual, social and physical environments where people live and work
- Clinical – Improves clinical environment – delivery and access
- Community-Clinical Linkages – Strengthens connection between community-based services and healthcare providers
 - **Including a requirement to participate in bi-directional e-referral**

Grantee Selection

- Geared to both rural and urban communities
- Prioritized high need communities with documented disparities
- *Targeted* investment strategy with fewer, larger, grants that can reach a significant percent of the Commonwealth's population to support the evaluation

Grantee Partnerships: A Diverse Array of Communities



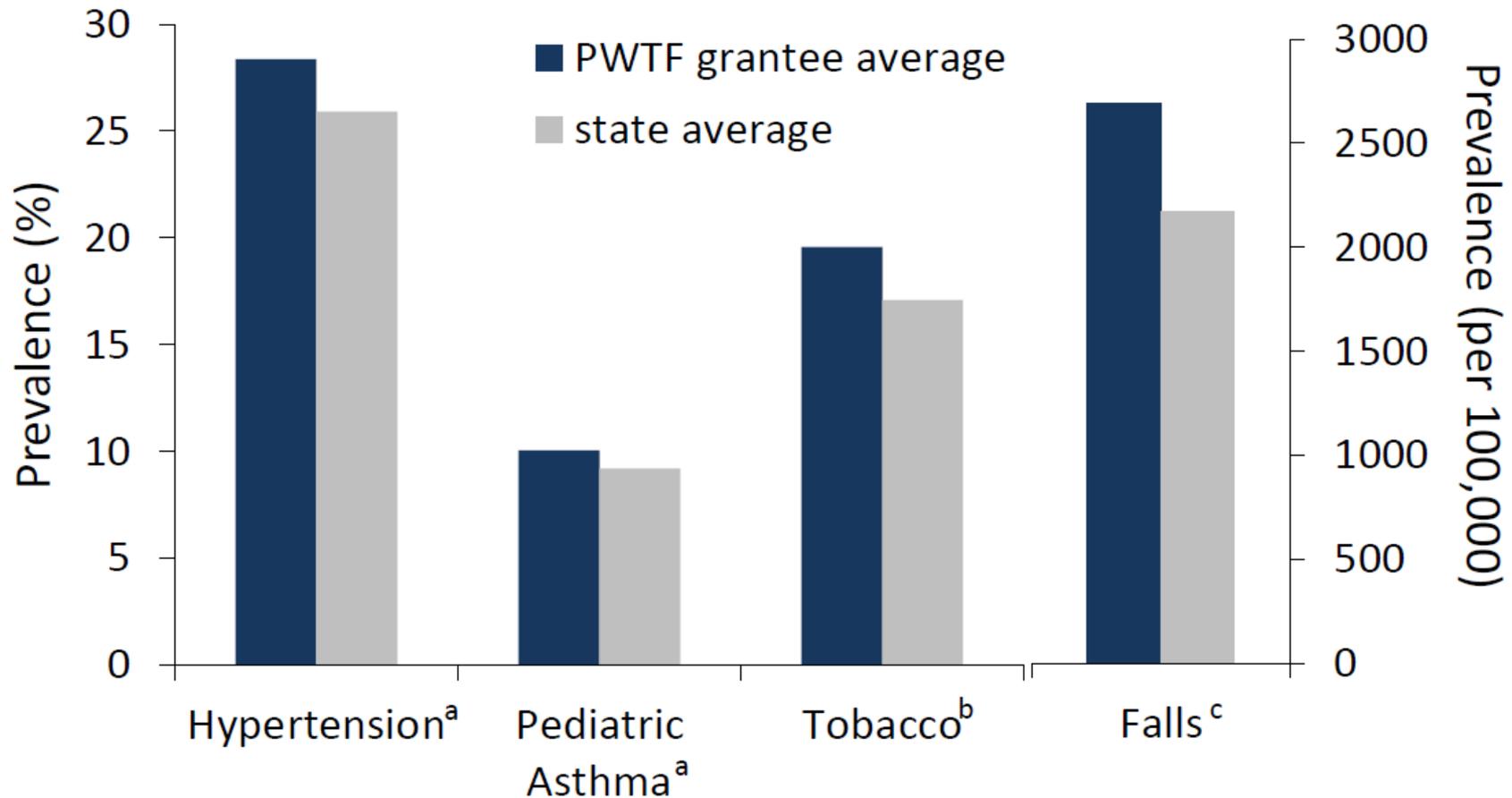
Coordinating Partners

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

Populations of Focus

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

Prevalence of Priority Health Conditions



Data sources are (a) All Payer Claims Database (APCD, 2012), (b) Behavioral Risk Factor Surveillance System (BRFSS, 2011-2013), and (c) Acute Hospital Case Mix Databases (Case Mix, 2010-2012)

Grantee Funding Levels

- **Capacity Building Phase:** each award up to \$250,000
- **Implementation Phase:** Between \$1.3M and \$1.7M on an annual basis

Tiered Approach to Interventions

Tier 1

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

Tier 2

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

Tier 3

- No PWTF evaluation and little technical assistance
- Minimal budget

Innovative Linkage Strategies

Community Health Workers

Bi-directional E-Referral

Community Health Workers

- All partnerships are using CHWs (expanding evidence base)
- DPH is requiring (and in some cases providing)
 - Consistent training
 - Consistent supervision
- Supporting certification and payment efforts

Electronic Linkages – e-Referral

E-Referral Linkages are a Hallmark of the PWTF

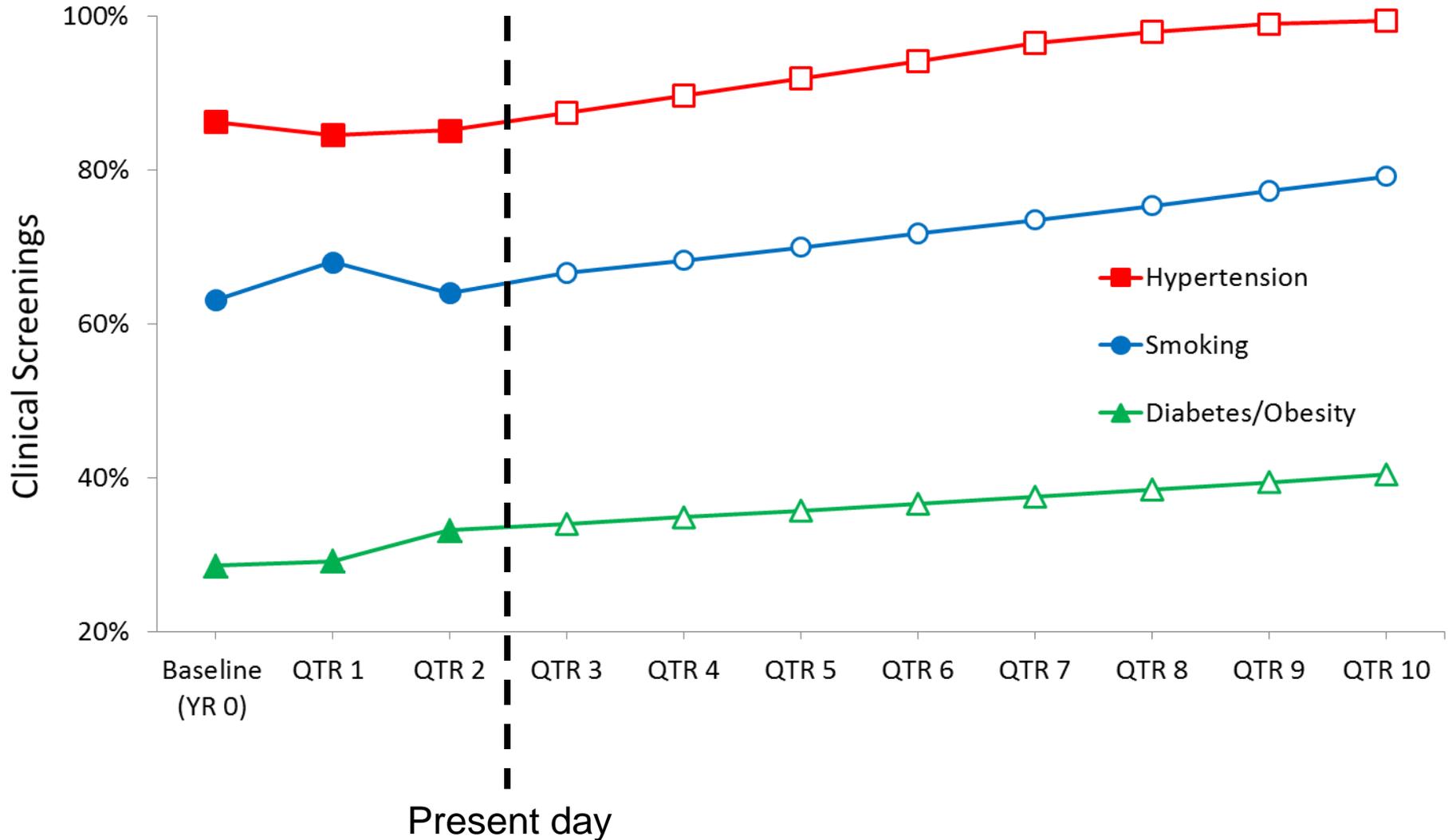
- Bi-directional, electronic referrals between clinical and community organizations
 - Required for each grantee partnership
 - Integrated into EMR for at least one clinical partner
- State Innovation Model funding
 - Basis for PWTF e-Referral approach

Evaluation to Promote Change

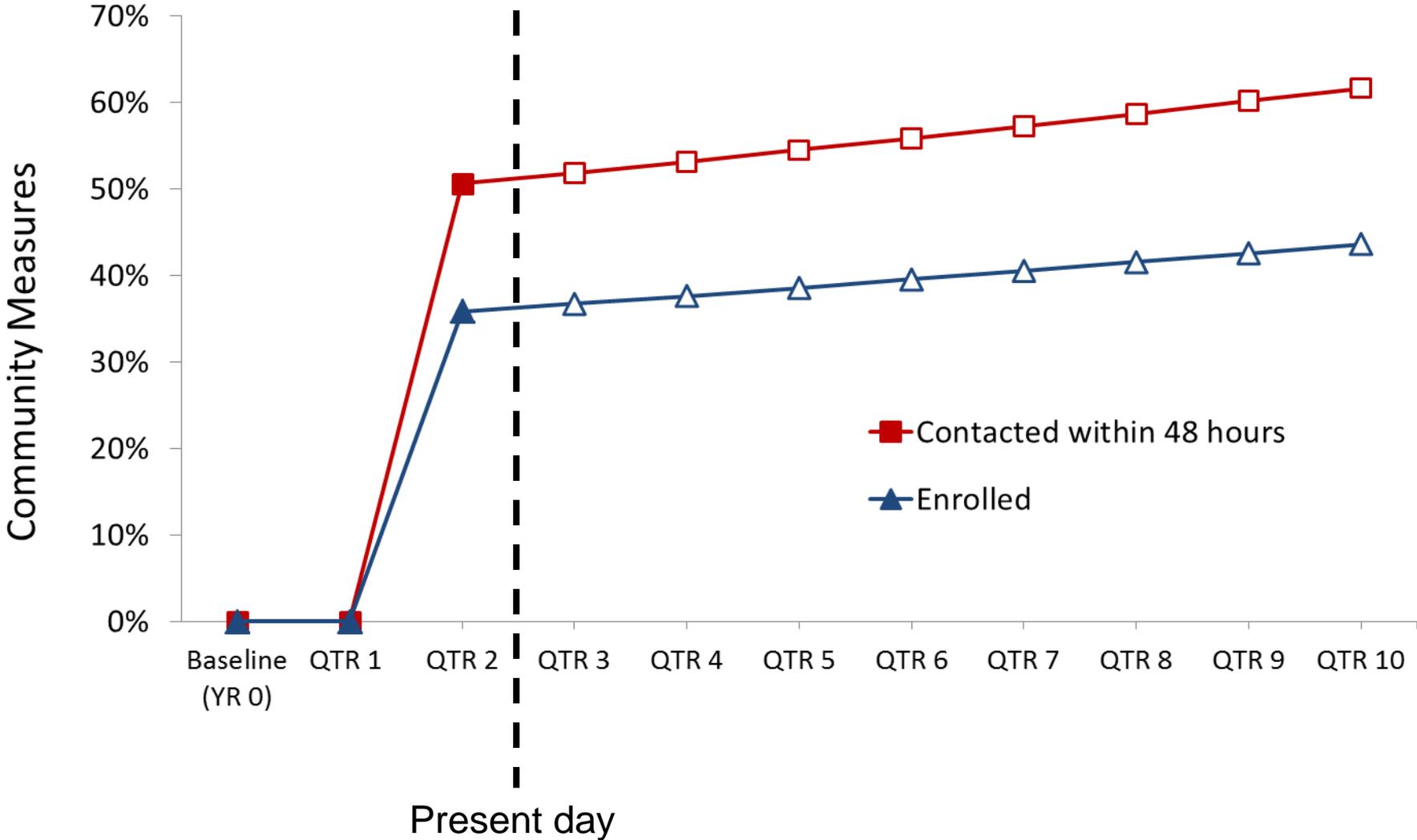
Two Primary Goals

- 1) Using data to promote change (Quality Improvement)
- 2) Using evaluation measures in Ch. 224 to demonstrate change
 - Reduction in prevalence of preventable health conditions
 - Reduction in health care costs and/or growth in health care cost trends
 - Beneficiaries from the health care cost reduction
 - Employee health, productivity and recidivism through workplace-based wellness or health management programs

Baseline Data: Clinical



Baseline Data: Community



Breaking New Ground

- Extending care into the community
 - Clinical sites and community organizations linked together
 - Use of community health workers
- Bi-directional Electronic Referrals can track patient progress
- Changing provider practice and community environments to impact the health of populations
- Setting the stage to expand to other health conditions that drive costs

Beyond PWTF

- Expand how health data can be accessed and utilized to measure and improve population health and identify and address disparities across MA
 - Leveraging data warehousing technology at DPH and health data partners to target future interventions and to measure effectiveness
- Use PWTF-generated provider infrastructure to continue improvement/expansion of public health prevention
- Adapt and expand successful interventions to improve health and save costs
- Better connect public health and medical system to work together on health outcome improvement