Section A. Background and Need

The Massachusetts Department of Public Health (MDPH) is applying for a Community Transformation Implementation Grant, our core state application, to serve all eight counties with populations less than 500,000. Massachusetts is uniquely positioned to meet the goals of this grant due to our past policy successes, including the 2006 Healthcare Reform Act, strong coalitions and readiness to ***implement*** policies, environmental changes and systems to increase tobacco-free living, active living, healthy eating, evidence-based clinical interventions and strong data collection systems. To assure maximum statewide impact on chronic disease prevention, MDPH is also submitting an application to serve Middlesex County with a population over 1.5 million and will continue to collaborate closely with the Boston Public Health Commission which is submitting a proposal to serve Suffolk County.

Signed into law in April 2006, the Massachusetts Healthcare Reform Act (Chapter 58) reforms the health care system by focusing on universal access to health care through commercial or subsidized health insurance. Specifically, barriers to purchasing health insurance were eliminated, existing government assistance was redirected from hospitals to the individual, personal responsibility is expected, and health care costs are contained.[1]With the implementation of Chapter 58, the Commonwealth has made significant progress to achieve near universal health insurance coverage (98.1%), but significant hurdles remain. The Massachusetts Department of Public Health (MDPH) has played a key role in health care reform to lower those hurdles through its historic support of community health centers and through its work on chronic disease prevention and health promotion. MDPH will continue its work to promote health care reform and to reduce health outcome disparities by racial, ethnic and linguistic minorities in a number of Massachusetts communities.

Past Policy Success: Health reform in Massachusetts included coverage for comprehensive tobacco cessation for Medicaid clients. Counseling and all FDA approved medications were included with low co-pays for services. Medical claims research from MDPH has now demonstrated that a sharp reduction in hospitalizations for heart attack and atherosclerosis occurred following use of the benefit. Medical savings from these reduced hospitalizations in the first two years was an estimated $10.2 million. The cost of tobacco treatment medications and promotion was only $5.1 million. Therefore, the net savings was $5.1 million, or $2.00 return for every dollar spent. This calculation covers a 2 year period only. The net savings is expected to increase substantially as more tobacco related illnesses show downward trends. Another aspect of Health Reform in Massachusetts is the requirement that insurers submit medical claims to the All Payers Claims Database (APCD). This database will allow MDPH and other users to directly measure changes in the health outcomes and identify ways to improve care and contain costs. Massachusetts is one of only 11 states with an APCD.

Massachusetts has a history of passing laws and regulations in towns and cities as a strategy for protecting public health when statewide entities are not prepared or able to institute needed policy changes. This strategy allows for education, building support, and evaluation on the local level before replicating the policy on a statewide level. A strong infrastructure of technical assistance and local programs is central to Massachusetts' policy-based strategy.

One example is the Commonwealth's smoke-free workplace law. Community-based programs funded by Massachusetts Tobacco Control Program (MTCP) worked in cities and towns to pass increasingly comprehensive local laws governing smoke-free workplaces, eventually including bars and restaurants. Because these communities had focused on gathering community support and monitoring post-implementation, it was much easier to build the case for

a statewide law. The capacity and infrastructure were in place to educate and enforce a statewide law. A comprehensive law went into effect in 2004 with little protest and has enjoyed public support and a 94% compliance rate. The implementation in July 2004 of the Massachusetts Smokefree Workplace Law led to rapid decrease in the number of heart attacks and heart attack deaths in the state. Deaths dropped by at least 277 per year while non-fatal heart attacks dropped by at least 485. Medical claims studies have shown that the average heart attack in Massachusetts costs over $50,000. Using this estimate, the Smokefree Workplace Law in Massachusetts has saved at least $38 million annually.

This type of local support is the basis for other statewide policy change. Local education about the importance of price in preventing young people from smoking contributed to the passage of a $1.00 cigarette tax increase in 2008. Massachusetts currently has the 8th highest cigarette tax at $2.51. Education about the role of other tobacco products (OTP), particularly by young people, led to Governor Patrick's support of a proposed OTP tax in FY 2010. Local efforts to reduce the density of tobacco retail establishments and programs to ban sales of tobacco in pharmacies at the municipal level through local MTCP and youth will be brought to statewide scale. These bans now cover over 20% of the residents of the Commonwealth, and statewide legislation has been filed that mirrors the local policies.

While Massachusetts has been a national leader in tobacco control since the early 1990s, our innovative work on healthy eating and active living began under the leadership of Commissioner John Auerbach in 2008. The Commissioner declared this a priority and has established inter-agency relationships and new coalitions that are now ready to implement this grant. A number of successes have already occurred. Massachusetts launched a major initiative, the ***Mass in Motion*** campaign, in January 2009, to promote wellness and to prevent overweight

and obesity in Massachusetts. The purpose of this multifaceted campaign is to promote the importance of healthy eating and active living at home, at work, and in communities throughout the Commonwealth. One strategy of *Mass in Motion's* multi-sectoral approach is to promote and support local initiatives to increase opportunities for better nutrition and more physical activity.

The *Mass in Motion Municipal Wellness and Leadership* grants aim to support communities in their efforts to address overweight and obesity through the implementation of policy, systems and environmental strategies to increase access to healthy eating and active living opportunities. The *Mass in Motion Municipal Wellness and Leadership program* is the first statewide health initiative to be supported by all of the Commonwealth's major health funding foundations and a major insurer. This includes Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Massachusetts Foundation, The Boston Foundation, The Harvard Pilgrim Health Care Foundation, The MetroWest Community Health Care Foundation, and The Tufts Health Plan Foundation. Currently 14 programs are funded in Massachusetts. Successes during the past two years include expansion of farmers markets, establishment of healthy dining programs, and development of regional biking/walking trails and municipal wide walking routes.

Massachusetts General Law (M.G.L.) c. 111, s. 223, adopted in July 2010, required the Department to promulgate regulations establishing standards for competitive foods and beverages sold or provided in public schools. The law specifies many of the provisions to be contained in the regulations, based on the *Institute of Medicine's Nutrition Standards for Foods in Schools* (2007). The regulations go into effect on August 1, 2012. Other statewide policies include the Executive Order 509 (EO509) mandating that state agencies that purchase or serve food will comply with nutrition guidelines established by the Department of Public Health. These guidelines govern the purchase and serving of food by state agencies, and ensure that

agencies offer a broad choice of healthy, balanced meals and snacks.

Massachusetts is on the forefront of the Patient Centered Medical Home Initiative which strengthens our ability to implement evidence-based clinical interventions. In February 2009, Massachusetts was awarded $500,000 in grants from a variety of national and local foundations to support the transformation of 14 Community Health Centers (CHCs) into patient-centered medical homes over a four-year period. In 2010 EOHHS awarded 46 practice sites throughout the Commonwealth to participate in the Massachusetts Patient Centered Medical Home Initiative (PCMHI), representing family practice, internal medicine, care for the homeless and community health centers throughout the state. [2] These practices will follow a three-year transformation plan that involves applying for medical home recognition by the National Committee for Quality Assurance (NCQA) within 18 months of the start of the Initiative.[3]

Areas to be served There are two distinct areas in our core state application: four counties in Western Massachusetts and four counties in the Southeast, including two islands. Each area has unique needs and challenges. The Western MA area consists of two rural counties: Franklin and Berkshire; Hampshire county with some rural areas and farms; and Hampden county with suburban areas and two low income cities: Springfield and Holyoke which will be the focus in Hampden county.

The Southeast area includes Plymouth county where efforts will be concentrated in the city of Brockton and the town of Plymouth on opposite ends of the county. The remainder of the Southeast includes Barnstable County and two islands, Nantucket (Nantucket County) and Martha's Vineyard (Dukes County). These areas are strongly affected by summer tourism and part-time residents. Many of the people who live and work in Barnstable and the islands struggle with low wages, high winter unemployment, and a high cost of living. For example, the average

annual wages for the two lead employment sectors, retail trade and hospitality, are $23,000 and $29,000 respectively while the annual income required to live in Barnstable County is about $64,000 for a family of two adults with two children. The unemployment rate almost doubles in winter, 12.9% in January and 6.6% in August 2010, with the most rural towns having rates as high 20% to 37%.

Massachusetts is divided into 14 counties, varying in size and population. Most counties currently exist only as geographic regions, and have no county government. In these counties, former county functions were assumed by state agencies in the late 1990's-early 2000. There is no county council or commissioner. The three counties that make up the Cape and Islands area in southeastern Massachusetts are the exception. Barnstable County has a County Health Department and each town has a local board of health. The local board of health is still responsible for promulgating regulations. While both islands have some county government, neither has a county health department.

MDPH has provided leadership and resources to encourage regionalization and the formation of new health districts. Franklin Council of Governments and Hampshire Council of Governments are two examples of areas that currently work on developing models of shared services and are exploring becoming health districts. This lack of a county health department structure means that the approach in Massachusetts is different from other states – the policy changes in this proposal need to be approved at the local municipal level. (Support letters from John Auerbach MDPH Commissioner and local health departments are included in Appendix A.)

“Despite being one of the wealthiest states in the nation, Massachusetts has fewer supermarkets per capita than almost any state in the country ranking third lowest nationwide” according to a February 2011 report “Food for every child” by the Food Trust. The report clearly

identified areas that were in "crisis" due to the lack of fresh, healthy food. In the southeast, Brockton and areas of Barnstable County are identified as high need. Key areas identified in western MA included Springfield, Holyoke, Greenfield and Orange in Franklin County, and Pittsfield and North Adams in Berkshire County. All of these communities have significant health disparities. Springfield (population approx. 153,000 and majority of residents are Latino or African American) has been identified as having a child poverty rate that is the 6th highest in the country with 44.6% of children under 18 living below the poverty line as compared to 12.4% for Massachusetts (2010 American Community Survey). According to the 2009 Youth Risk Behavior Survey, only 9% of Springfield adolescents ate a green salad more than one time in a typical week. Holyoke (pop. 40,000) has the highest proportion of Puerto Ricans in any city outside of Puerto Rico (39.5%). Public school data from 2009 shows that over 47% of children in the fourth grade are overweight or obese compared with 37.6% of children in grade 4 statewide. Policy and environmental changes are needed to make the healthy choice the easy choice for adults and children in Massachusetts. We believe we can leverage this funding to make sustainable changes in some of our communities with significant health disparities.

Summary of data and disparities Based on responses to the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), self-reported rates of smoking, obesity, and hypertension in Massachusetts have changed significantly between 2000 and 2010. Smoking prevalence decreased by 5.8% over that period. While undeniably good news, prevalence of current obesity increased by 6.8% and the rate of ever having hypertension increased by an estimated 1.4% between 2000 and 2010. Our plan for making 5% improvements in these three measures will take into account long term trends in the target counties.

Within Massachusetts, the eight targeted counties have a disproportionate burden of

smoking, obesity, and hypertension. Using 2010 BRFSS data, we find that the smoking rate is 8% higher in the target counties than the rate for the rest of Massachusetts. The obesity rate is 7% higher and the hypertension rate is 13% higher. The conditions and diseases associated with these risk factors are also higher. In 2008, hospitalization rates in the targeted counties were significantly higher for heart attack (19%), diabetes (10%), and COPD (6%). Even larger differences were found for Emergency Department (ED) visits. In 2007, ED visit rates in the targeted counties were significantly higher for heart attack (24%), diabetes (30%), and COPD (37%). Rates for hospitalization and ED visits for diabetes and COPD were especially high for minority populations. Finally, the rate of smoking during pregnancy was 86% higher in the target counties. See Appendix B for the full list of chronic disease indicators (CDI) for each county..

While Massachusetts' smoke-free workplace law has significantly reduced secondhand smoke for most of the population, people who live in multi-unit housing still face an elevated risk of exposure. Non-smokers living in multi-unit housing are twice as likely to report secondhand smoke exposure (21% reported more than 1 hour of exposure in past 7 days) compared to non-smokers living in single family homes (10%) (Source: MA BRFSS 2010). The targeted municipalities have a combined total of 108,597 units of multi-unit housing.

The gap between white and minority populations has widened over the last decade. Although smoking rates have decreased for all major subpopulations in Massachusetts, smoking prevalence decreased 10% more slowly for blacks and Hispanics than for whites. The gap between whites and Hispanics is widening at an alarming rate for both obesity and hypertension. In the past decade, the rate of obesity has increased at nearly double the rate among the Hispanic population when compared to whites in Massachusetts. The rate of increase for hypertension is nearly triple for Hispanics when compared to whites.

B. Program Infrastructure

The Community Transformation program will be an integral part of our Division of Prevention and Wellness within the Bureau of Community Health and Prevention (BCHAP) at the Massachusetts Department of Public Health. Three senior managers will devote in kind time to supporting this program as well as other staff. There will be 6 staff for 4.25 FTE paid on the grant including the full-time Project Director and full-time Evaluator. The Director of the Office of Health Equity will provide in-kind time for supervision of a 0.5 FTE. The Tobacco Cessation and Prevention Program, part of the Bureau of Substance Abuse, will provide in-kind time for contract management and program development for the tobacco-free living interventions. (Resumes and job descriptions for MDPH and contract staff are in Appendix C.)

Ms. Cheryl Bartlett, Director of BCHAP, will serve as the PI on this grant and will provide guidance to the program. Ms. Lea Susan Ojamaa, Acting Director of the Division of Prevention and Wellness, will be responsible for hiring and supervision of new staff and the over-all management of the program. She will also manage activities until a Project Director is hired. Ms. Ojamaa has worked at MDPH since 2000 and has extensive experience in managing local, regional and statewide policy promotion initiatives for tobacco control, active living and healthy eating. Dr. Thomas Land is the Director of the Office of Statistics and Evaluation for BCHAP. Dr. Land will supervise the full-time evaluator for Community Transformation as well as manage an evaluation sub-contract with University of Massachusetts Medical School. Dr. Land will spend 10% of his time in-kind on Community Transformation evaluation activities.

The Community Transformation Project Director will be a full-time position within the Division of Prevention and Wellness at BCHAP. This position will manage the overall grant deliverables and coordinate with statewide technical assistance providers and partners. This

position will be responsible for over-seeing the local *Mass in Motion Municipal Wellness and Leadership* programs in the Southeast counties. Once MDPH receives a formal notice of award, Ms. Ojamaa will work with our Human Resources department to post the job as a Program Coordinator III. The process of recruiting and hiring will take 60 days.

The Western Community Liaison is Donna Salloom. Ms. Salloom is a current employee of BCHAP and is the Community Liaison for West and Central regions of Massachusetts. Her office is in the Northampton DPH office in Hampshire County. Within 2 weeks of the award notification, Ms. Salloom's responsibilities will be shifted to solely work in the four Western counties. In addition to providing direction to the *Mass in Motion Municipal Wellness and Leadership* programs in Western counties, Ms. Salloom will coordinate the tobacco and clinical interventions in Western counties with the *Mass in Motion* programs.

The clinical component will be coordinated by Patricia Daly, MS, RN, Health Systems Specialist, Diabetes Prevention & Control Program, Division of Prevention and Wellness. She oversees all health systems and community-based interventions and serves as a clinical expert on diabetes for the Program. She is responsible for diabetes primary prevention efforts, including pre-diabetes and gestational diabetes.

Ms. Breanne Beagan is the full-time Evaluator for the grant and has been employed as a Program Evaluator/Epidemiologist II at MDPH since 2005. Her areas of evaluation expertise include: worksite wellness, community wellness, quality improvement, chronic disease primary prevention, community-based interventions, systems dynamics modeling, and statewide media campaigns. Dr. Tom Land will be her supervisor. Within 2 weeks of the award, she will be assigned to work full-time on the Community Transformation grant.

The Communications Coordinator is Alana Teilan who currently coordinates a variety of

communications projects in BCHAP. Within 2 weeks of the award, she will be assigned to work half of her time on *Mass in Motion* projects related to the Community Transformation grant. She is responsible for updating the *Mass in Motion* website and will focus on developing local information on the site in collaboration with the 11 local *Mass in Motion Municipal Wellness and Leadership* program directors. She will document and edit success stories, a key element in the required quarterly communications with legislators. The Director of Communications will supervise Ms. Teilan.

The Community Transformation Health Equity staff will be Diane Randolph who will work half-time on the grant to provide Culturally and Linguistically Appropriate Services (CLAS) trainings and instruction on the use of medical interpreters by clinicians for the programs and coalitions in the grant. The office of Health Equity is managed by Georgia May Simpson who will supervise the staff person and provide guidance on reducing health disparities.

The Contract Administrator will be 0.25 of a new position to be hired. The position will be hired within 8 weeks. The position will be responsible for administration of contract management and processing including coordinating contract plans, procurement activities, maintenance of records and reconciliation of data with MMARS monthly. The position will be supervised by Elizabeth Barry, Director of Finance and Administration for BCHAP.

MDPH's Tobacco Cessation and Prevention Program (MTCP) is part of the Bureau of Substance Abuse Services. Patricia Henley, MTCP's Manager of Community Programs, will oversee and provide direction for all programs involved in the tobacco-free living initiative. The Community Transformation Project Director and Ms. Henley will meet on a regular basis to ensure coordination and collaboration. All eight tobacco prevention programs are current MTCP programs and will be adding hours to existing staff or hiring part-time staff. The interventions in

this proposal enhance existing infrastructure. Experienced technical assistance providers are also ready to add additional hours to their contracts.

***Mass in Motion Municipal Wellness and Leadership Programs*:** *Mass in Motion* plays a key role in MDPH's effort to empower local municipalities to effect policy and environmental change to improve health outcomes. This proposal will enhance and expand that effort. Current *Mass in Motion Municipal Wellness and Leadership* programs with Program Coordinators in place include Springfield (Nicole Bourdon) and Brockton (Meghan Goloboy). The Tri-Town *Mass in Motion* program has a current vacancy which they plan to combine with an existing vacant position in their Tobacco prevention program. This staff person will also work on the Community Transformation secondhand smoke project. The Tri-Town Health Department Director estimates a staff person can be hired within 4-5 weeks. The director is committed to finalizing the workplan with partners while hiring is occurring.

Several new *Mass in Motion Municipal Wellness and Leadership* programs have existing staff who will assume the responsibilities of Program Coordinators. Rachel Stoler will become the program coordinator for Franklin County and Christine Stein will become the program coordinator for Barnstable County. The town of Plymouth's program will be managed by Jordan Hospital. The hospital is donating 25% of Vice President Andrea Holleran time as part of their community benefits. Current staff Marcia Richards (half-time) and Carol Burns (quarter-time) will also work on the *Mass in Motion Municipal Wellness and Leadership* project.

Several new *Mass in Motion* programs will hire Program Coordinators including Holyoke, Hampshire County, Northern Berkshires, Nantucket and Martha's Vineyard. All programs estimate that hiring will occur within 6 weeks. Supervisors or other key staff are prepared to begin coordinating final work plans with partners while hiring is occurring.

Clinical Interventions: The Massachusetts League of Community Health Centers (MLCHC) will manage an innovative clinical intervention for MDPH. Historically, the health centers have provided high quality health care in culturally, racially and linguistically appropriate settings and their participation is crucial to reduce disparities in health outcomes. In the project, they are also charged with working with *Mass in Motion* so that both can maximize opportunities for clients to access healthy eating and active living resources in their communities. The MLCHC has experienced staff that will begin working on the project within a week of the contract award. The MLCHC will manage sub-contracts to 7 health centers and 1 private practice in Nantucket county. They will coordinate data collection and performance measures with all sites; establish a quality improvement plan for each site based on identified areas of need related to blood pressure, cholesterol, tobacco and diabetes; establish a site level team at each site and develop practice coaching for implementation of IT system changes and policies and procedures to improve the accuracy of blood pressure measurement. Each site will also develop procedures around CLAS standards and medical interpretation training to identify and address health risks for chronic disease by population and increase access to services that are culturally and linguistically appropriate.

One health center has been selected in each county to participate in this systems change intervention. Nantucket does not have a health center, so a private practice has been invited to participate. Affirmation letters from the health centers are included in Appendix D.

CDC Required Trainings and Meetings: We have no barriers to attending CDC required trainings and institutes if the CDC sends documentation stating it is a requirement of the grant and the specific number of staff and/or partners required to attend. We require documentation at least 6 weeks in advance to process travel approval. MDPH Prevention and Wellness and

Tobacco Control staff have a history of attending required trainings and meetings and being active participants at these events. Appropriate travel funds for key staff and the Leadership Team is in our budget.

C. Fiscal Management

The Massachusetts Department of Public Health is submitting a budget request of $2,319,004 to serve a population of 1,574,922 across eight counties. Of the entire population, 60.2% (948,715) live in an area with multiple interventions planned. A total of $1,277,795 is being awarded directly to municipalities, regional government and local non-profits including community health centers. This is 55% of the entire award. An additional 5% is being awarded to small non-profit organizations that will provide workshops and trainings in the community that will build skills and knowledge of coalition members, local officials and interested community members. Examples include how to conduct walk audits, bike audits, increase farmers markets, increase physical activity during recess and plan for complete streets policies. MDPH is only using 18% of the funds for staff and administrative expenses. The Department is contributing significant in kind staff time to this program to ensure that the majority of the funds go to community awards as well as training, technical assistance and evaluation support.

FOA Appendix H stated that Massachusetts only had a rural of population of 1.6% - the islands of Martha's Vineyard and Nantucket. However, the rural areas of Berkshire and Franklin were not included. The rural areas of Berkshire and Franklin are both high need areas that are considered rural by HRSA for other federal funds. These areas share characteristics common of rural areas: lack of major highways; higher than state average poverty and unemployment; significant populations without easy access to healthcare or human services; limited opportunities for higher education, and negative health indicators. The data charts in Appendix B

clearly show the negative health status of all of our rural areas. We submitted a question in June asking for clarification but as of July 11th, an answer has not been posted on the website. We have distributed 23% of the entire award to our rural counties of Berkshire, Dukes, Franklin and Nantucket. We believe this serves the needs of the rural populations in Massachusetts.

To ensure compliance with the Affordable Care Act, the Community Transformation Grant Team will work with the Massachusetts Department of Public Health Budget, Purchase of Service and Accounting Offices under the guidance of Comptroller's office when establishing grants in MMARS, (Massachusetts Management Accounting and Reporting System). This will include reports that support the distribution, monitoring and performance verification of Affordable Care Act dollars for both the department and any subcontractors. Fiscal management is overseen by Lea Susan Ojamaa, Acting Division Director and the Division's Contract Administrator in concert with fiscal staff, Maria Arguedas and Curtis Jackson.

MDPH staff will document all decisions as they relate to the disbursement of funds. These records must support procurement and contracting, accounting and reporting efforts and document that the decision making process was fair and made in good faith, that targeted and measurable goals were established, and that funds are fiscally accountable, and - if needed - a recoupment process is in place. These records must be filed and be maintained in a way that will allow for easy retrieval so that they can be reviewed for the purposes of oversight and audit.

The Contract Administrator under the supervision of the Program Director will work closely to monitor and manage all contracts to communities and technical assistance providers. Contracts will clearly delineate roles and responsibilities and how individual scopes integrate with the overall program. All contracts will include requirements to track leveraged resources and will be reported on an annual basis and monitored in a central database.

Existing *Mass in Motion* communities already leverage resources from foundations and municipalities. New communities will be encouraged to identify leveraged resources. The Program Director will work with the local communities and the Massachusetts League for Community Health Centers to develop a "bi-directional" relationship between the health centers and *Mass in Motion* Communities to leverage local resources such as gyms, local farms, organic groceries for the benefit of patients. The Program Director will work with the Leadership Team to develop and strengthen relationships with other funders, trusts and foundations to ensure the sustainability of these interventions within Massachusetts. The Contract Administrator will centrally track all leveraged resources that our partners report to obtain a full picture of the intervention scale, impact and sustainability.

D. Leadership Team and Coalitions

Massachusetts has a strong history of innovative public health policies due to effective statewide and local coalitions. This infrastructure enables the Massachusetts Department of Public Health to leverage the resources of the Community Transformation grant to reduce heath disparities and improve health outcomes in eight key counties. Massachusetts has had a number of strong statewide coalitions such as Tobacco Free Mass, Partnership for a Heart-Healthy, Stroke-Free Massachusetts, and Massachusetts Public Health Association working on public health policy. However, until 2009 there was not a systematic mechanism to bring together statewide coalitions, local coalitions, government, private foundations, voluntary organizations, healthcare, community organizations, business and universities to promote wellness policies. MDPH Commissioner Auerbach made it a Departmental priority to form a Wellness Promotion Advisory Board with key representatives that could coordinate key policy objectives to promote wellness and reduce chronic disease and health disparities. The clear priorities and commitment

of Commissioner Auerbach and his senior managers is critical to create a cohesive force to work on effective policy and environmental change. The leadership of MDPH with local leadership on environmental and policy issues will result in sustainable changes for healthier communities.

The **Wellness Promotion Advisory Board** will serve as the primary coalition for the Community Transformation grant. The WPAB has served as the advisory council for *Mass in Motion* and the *Mass in Motion Municipal Wellness and Leadership Program* since 2009. In March 2011, Commissioner Auerbach convened this group to discuss the anticipated Community Transformation grants and advise the department on proposed strategies and objectives. This group will continue to provide guidance on implementation of the grant and partner on key objectives. A Leadership Team will be formed from members of this group to coordinate the Community Transformation grant. Since the funding is focused in two distinct regions, two regional Community Transformation partnerships will be formed with the local coalitions and funded programs in each region. This group will meet quarterly. One representative from each region on the Leadership Team will ensure any concerns of the region are addressed by the Leadership Team. Additional regional representatives serve on the Wellness Promotion Advisory Board (WPAB). This model allows groups to interact at a variety of levels – statewide, regional and local. A diagram is in Appendix E with the membership list of the WPAB and support letters from some of the key members. Commissioner Auerbach chairs the WPAB with staff support from the Division of Prevention and Wellness. Dr. Lauren Smith, Medical Director, Cheryl Bartlett, Director of the Bureau of Community Health and Prevention, and Lea Susan Ojamaa, Director of the Division of Prevention and Wellness attend and participate in WPAB meetings.

The members of the WPAB have been instrumental in many public health policies. Many of the members of the Wellness Promotion Advisory Board, first came together in 1991 to form

the Coalition for a Healthy Future which successfully advocated for a 25 cent cigarette tax as a ballot referendum. Chaired by Dr. Howard Koh, the Coalition successfully advocated for the funding to go into a health protection fund and it was used for public health and education programs for almost a decade. Tobacco Free Mass worked with the Mass Public Health Association and Health Care for All to include a comprehensive smoking cessation benefit in the landmark 2006 health care reform law. For years Tobacco Free Mass led education and advocacy efforts for the statewide smoke-free workplace law in 2004. This law built on a decade of local boards of health passing regulations to protect the public health. A partnership with labor unions and framing the issue as a worker's rights issue helped "Clean Air Works" to succeed.

In 2009, the newly formed Wellness Promotion Advisory Board prioritized improving school nutrition as a policy goal. Members led by the Massachusetts Public Health Association, the American Heart Association and the MA chapter of the Academy of Pediatricians educated lawmakers about the importance of healthy nutrition in schools and the importance of preventing obesity. The legislation successfully passed in 2010. MDPH was authorized to promulgate regulations which were approved on July 13, 2011.

The **Community Transformation Leadership Team** will provide input and guidance to the Massachusetts Department of Public Health during the five years of the Community Transformation grant. The Leadership Team will oversee the strategic direction of the project and monitor and support the organizational structure for the WPAB, regional partnerships and local coalitions. Members have been carefully chosen to connect other statewide groups previously described, local coalitions and funded programs with the WPAB, so that policy, environmental, programmatic and infrastructure changes can be coordinated. Leadership Team members will participate in local and national meetings, including quarterly meetings.

Commissioner John Auerbach will serve as the chair of the Leadership Team with support from the soon to be hired Community Transformation Project Director. Representation has been carefully chosen to include statewide coalitions/associations (MA Public Health Association and Tobacco Free Mass), healthcare (MA League of Community Health Centers), academia (Harvard Catalyst), local public health (MA Association of Health Boards and a local health department director), municipal partners (Barnstable County Department of Human Services), community organizations (Alliance of MA YMCAs) and the legislature (Rep. Jeffrey Sanchez, Co-chair of the Public Health Committee). Two additional members are the Vice President of Health Resources in Action which has been a key partner in managing the *Mass in Motion* grants funded by private foundations and one of the private foundations, Harvard Pilgrim Health Foundation. The local health department and municipal partners were chosen from different regions of the Commonwealth and have made a commitment to travel significant distances to attend Leadership Team meetings. In all cases the representatives are directors or experienced senior managers of their organizations. A complete list of the members is in Appendix F with support letters demonstrating their commitment to the Leadership Team.

The Commissioner and leadership of MDPH are active with a number of related coalitions whose work directly or indirectly determine statewide health policy and will be vehicles to channel local efforts into sustainable policy and environmental change.

- **The Prevention Caucus** convened in 2010 supports a legislative agenda to promote wellness and reduce chronic disease and healthcare costs. Commissioner Auerbach is invited to attend and present at quarterly meetings. The Prevention Caucus is co-chaired by Senator Harriet Chandler and Representative Jason Lewis.
- **The Healthy Transportation Compact** is a requirement of the transportation reform

legislation of June 2009. The inter-agency initiative will ensure that the transportation decisions of the Commonwealth balances the needs of all transportation users, expands mobility, improve public health, supports a cleaner environment and creates stronger communities. Commissioner John Auerbach serves on the Compact with the Secretary of Transportation and the Secretary of Energy and Environmental Affairs.

- The **Food Policy Council** was established by the legislature in Chapter 277 Section 6C. The 17 members are designated in the legislation and include the Commissioner of Agricultural Resources, the Commissioner of Public Health, the Commissioner of Elementary and Secondary Education, the Commissioner of Environmental Protection, The Commissioner of Transitional Assistance and the Secretary of Housing and Economic Development. WPAB member Jeff Cole, Executive Director of the Farmers Market Association, is one of the appointed members of the Food Policy Council.
- Additional statewide groups will support the goals of this grant. The **Massachusetts Grocery Access Task Force** develops policy recommendations to encourage supermarket development in underserved communities. A **Commission on School Nutrition and Childhood Obesity** was established to investigate childhood obesity and effective programs promoting nutrition and exercise for the children of the Commonwealth. **The Massachusetts Health Disparities Council** was established in 2006 as part of Massachusetts' Health Care Reform Law. The HDC Council identifies and recommends policies and actions to eliminate racial and ethnic disparities in health care and health outcomes and to achieve health equity for all Massachusetts residents. Senior members of MDPH serve on all of these groups as well as members of the WPAB.

Each of the *Mass in Motion Municipal Wellness and Leadership programs* selected for

this grant have been chosen through a competitive process. We required applicants to demonstrate an active multi-sectoral coalition willing to work to promote policies and environmental change for tobacco-free living, active living and healthy eating so that we could assure maximum attention to policy and environmental change across the counties. In some areas, there are many coalitions and we have witnessed an effort by different interests to collaborate with organizations to reach wellness and prevention goals that benefit the entire community. All of the coalitions have examples of successfully working on policy initiatives and environmental change. In Appendix G, are membership lists of the coalitions and support letters from key members of the coalitions.

- Below are just a few examples of **past policy and environmental changes by local coalitions**:
  - The **Northern Berkshire Community Coalition** has led many policy initiatives in the past 25 years. Partnering with Target Hunger and the REACH Community Health Foundation, NBCC was part of a multi-coalition effort to create a Northern Berkshire Food Policy Council Work Group.
  - The **Be Well Berkshire Working Group** in the central and south areas of Berkshire county has worked with the Lee and Lenox Housing Authorities to implement a smoke-free housing policy in their multi-unit facilities.
  - **The Springfield Wellness Leadership Council** (SWLC) was responsible for passing a city council ordinance requiring the food sold in municipal vending machines meet a high nutrition standard. Members of the SWLC are active in a multi-coalition effort to bring a grocery store to the underserved area of Mason Square.
  - **Barnstable County** made history when all 15 local municipalities on Cape Cod passed

regulations requiring all restaurants and bars to be smoke-free. This received national attention and was a major factor in the passage of the statewide smoke-free workplace law in 2004.

E. Implementation Plan

Multi-sectoral Approach: The foundation of our Community Transformation project is our *Mass in Motion* initiative launched in 2009 through a competitive grant process to municipalities to assess the health needs of their communities and develop strategies to promote wellness and to prevent overweight and obesity in Massachusetts - with a particular focus on the importance of healthy eating and physical activity - at home, at work, and in their communities. The premise of this approach is to empower local communities to make policy and environmental changes in sectors of their communities where they have the capacity to make change: schools, local planning, local boards of health and local businesses. We will expand *Mass in Motion* Municipal Wellness and Leadership programs to 2 additional municipalities and 6 counties.

Work to promote tobacco-free living builds on our strong tobacco cessation and prevention program. As described earlier, Massachusetts already has a strong comprehensive smoke-free workplace law. Existing local boards of health and Community Partnership programs that align with the *Mass in Motion* Municipal Wellness and Leadership programs will receive additional resources and technical assistance to increase the unit price of tobacco products – one of the most effective policies to reduce tobacco use – and advance smoke-free multi-unit housing. During the past four years, local areas in Massachusetts have conducted pilots to promote voluntary smoke-free policies in condos and apartments and smoke-free policies in housing authorities. Building on relationships and lessons learned, we will utilize these resources to launch a coordinated initiative to reduce exposure to secondhand smoke.

Massachusetts will use a mix of evidence-based, cost-effective communication strategies

to promote policies and environmental change at the local level. The strategies will be based on statewide websites and communication messages that can be adapted locally. Without adequate funds for a comprehensive media campaign, it is critical to have consistent messages and branding. MDPH will maintain two websites www.makesmokinghistory.org and www.mass.gov/massinmotion updating the websites frequently with local information and success stories. Local programs will use materials branded consistently with these two campaigns and utilize strategies to drive traffic to the websites. Consultants will support program staff in earning media through local newspapers, TV and radio as well as on-line strategies including twitter and facebook. Paid media funds will be available to use strategically.

The Healthy Transportation Compact, described above, the Healthy Mass Compact and the Quality Care and Cost Council provide opportunities for the Massachusetts Department of Public to collaborate with other state agencies under the authority of the Governor and his Secretary of Health and Human Services to develop policies and programs that will affect health promotion and wellness statewide. The Healthy Mass Compact is a Memorandum of Understanding coordinated by the Secretary between agencies under her jurisdiction, including MDPH, the Department of Mental Health, Medicaid, the Department of Children and Families and all other health agencies to work with the Executive Office of Administration and Finance, the Commonwealth Health Insurance Connector Authority, the Attorney General, Department of Public Safety and others to achieve five health care reform goals. They are 1) access to health care, 2) advance health care quality, 3) contain costs, 4) promote individual wellness and 5) promote healthy communities. The Health Care Quality and Cost Council was created under the 2006 universal Health Care Reform law. Its purpose is to establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in

health care as well as demonstrate progress to achieve those goals. MDPH is a participant.

Consistent with our approach to our rest-of-state CTG application, MDPH is submitting an application to serve our largest county, Middlesex County, in an innovative partnership with the Metropolitan Area Planning Council (MAPC). Since Middlesex county has no county infrastructure, we are pleased to have developed an innovative partnership with MAPC which has organized Middlesex communities and health organizations to adopt a county-wide health policy and systems approach. A number of public health advocates spearheaded by MAPC, as well as local boards of health and the health centers wanted MDPH to address the chronic disease issues of Middlesex county and encouraged us to apply. This is truly a collaborative effort of local public health that takes an active role in wellness and prevention efforts in their communities. It builds on five years of collaboration between MDPH and MAPC to ensure that regional planning for growth in the Middlesex area include plans for healthy eating, active living (walking, bicycling and public transportation as well as adequate space) and addresses health equity. This is an exciting opportunity to demonstrate and further develop an innovative approach that integrates public health planning and implementation into other county-wide and regional multidisciplinary and multi-sectoral planning efforts. This proposal focuses on urban municipalities in three areas of the county that have high rates of obesity and smoking compared to the rest of the county and state. These are also areas with significant diversity among their populations and unique challenges to reach low-income ethnic groups.

We are also supporting an application from the Boston Public Health Commission to serve Suffolk County. The Massachusetts Department of Public Health has historically had a strong relationship with Boston's Health Commission and we look forward to our continued collaboration through the Community Transformation project.

Sustainability: During the five years of the Community Transformation grant, these strategies combined will have a significant impact on the communities and improve health outcomes. Many of the policy changes will be sustained beyond the grant because they would have created a changed environment that supports healthy choices and active living. Statewide and local leadership will also work on financial sustainability of local programs by leveraging private foundation money, state dollars and hospital community benefits to fund areas that need continued support for long-term strategies such as reducing a food desert.

Local health foundations and one insurer in Massachusetts have supported *Mass in Motion*. The Boston Foundation, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care Foundation, Blue Cross Blue Shield of Massachusetts Foundation, MetroWest Community Health Care Foundation, Tufts Health Plan Foundation, and the Boston Foundation have responded with funding and support for MDPH's statewide efforts. We will continue to work closely with *Mass in Motion* communities to obtain local support, including grants to augment their work. Massachusetts is confident that with this funding, our assets, and past success at local and statewide policy that we will be able to truly transform our communities.

Clinical and Community Integration: Finally, through the Mass League of Community Health Centers, MDPH plans to implement strategies in community health centers *to increase use of high impact quality clinical preventive services* related to increasing access for screening and control of high blood pressure, high cholesterol, diabetes and tobacco cessation services. We want to build on community health centers current activities related to Patient Centered Medical Home and Meaningful Use to achieve these goals. In addition we want community health centers and the community-based *Mass in Motion* initiatives to *work together* for preventing and controlling chronic diseases by: 1) identifying and developing needed community resources, 2)

developing and implementing a bi-directional communication plan that actively links patients, primary care providers and participating community agencies, and 3) identifying a clinical champion at the health center who will work with *Mass in Motion* to change policies, systems and the environment in the community to better support healthy lifestyles. The health centers provide the project access to racial, ethnic and linguistic minorities who experience disproportionately high poor outcomes in heart disease, stroke and other chronic diseases.

The Community Transformation Implementation Plan is located in Appendix H.

F. Selection of Strategies and Performance Measures

Description of Strategies: The Massachusetts Department of Public Health has developed a Community Transformation Implementation Plan built on existing infrastructure and past policy successes. The Community Transformation plan enhances and expands our *Mass in Motion* intervention to promote healthy eating, active living and healthy and safe physical environments. The plan also enhances on our tobacco prevention strategies by adding additional resources to our existing program recognized for innovation and achievements. The clinical intervention builds on the Massachusetts healthcare reform law and the All Payers Claims Database to strengthen community health care systems to improve evidence-based clinical prevention interventions. The plan addresses strategic direction 4 by implementing effective positive youth development and risk reduction approaches to improve adolescent health. Youth are engaged in planning and promoting policy initiatives in their communities and these activities support their development into well-rounded, civically engaged young people.

Massachusetts will use the majority of its grant award on the three required strategies. When our entire budget is combined, 15% of the funds are dedicated to Strategy 1, 48% to Strategy 2, 22% of funds to Strategy 3 and 15% of the funds are dedicated to Strategy 5 (mostly

for physical activity). Strategy 4 is integrated into Strategy 1 and Strategy 2 since the goal of youth engagement is to increase policies that promote tobacco-free living, healthy eating and active living.

To achieve a 5% reduction in obesity and 5% reductions in death and disability related to tobacco use and heart disease in eight Massachusetts counties by 2016, MDPH studied the available health and health risk data for Massachusetts to ensure our work would have a realistic chance of achieving these 5% goals. The implementation plans, routine surveillance, evaluation, and midcourse corrections are all intended to maximize the probability that goals are met. For example, our plan includes a $1.25 increase in the price of cigarettes. We estimate that given the current price of cigarettes ($7.91) in the eight target counties, we project that this increase would result in a 3.16% decrease in prevalence. Our smoke-free multi-unit housing initiative would result in a 0.12% decrease in prevalence. Analysis of 2010 BRFSS data showed that an average weight loss of 9 pounds for adults in the eight target counties would produce a 5% decrease in obesity. Similarly, we computed the impact of clinical interventions that address tobacco use, obesity, hypertension, and hyperlipidemia. For the full detailed plan for achieving the 5% goals, see Appendix I1.

To reach the long term objectives of the RFR: reduce death and disability due to tobacco use by 5%; reduce the rate of obesity through nutrition and physical activity interventions by 5%; and reduce death and disability due to heart disease and stroke by 5%, the MDPH will support implementation of strategies to increase use of high impact quality clinical preventive services and reduce disparities in health outcomes in one community health center (CHCs) in each of the seven counties and a healthcare site in Nantucket County. These strategies will - 1) expand monitoring and reporting systems to improve the quality and use of clinical and other preventive

services and, 2) enhance linkages between community-based and clinical services.

Strategic Direction 1: Tobacco Free Living

The Massachusetts Tobacco Cessation and Prevention Program has been reducing smoking prevalence since 1992. The program is currently funded at approximately $6 million with state and federal dollars and focuses on five strategies: ensure access to effective cessation resources for all Massachusetts residents, protect young people from tobacco industry tactics, implement evidence-based pricing strategies, ensure that all health care visits include tobacco intervention and promote and protect a smoke-free environment for all Massachusetts residents. This work occurs throughout the state in addition to the Community Transformation resources. With CTG resources, two strategies will be enhanced at the community level – (1) increasing the amount of smoke-free multi-unit housing and (2) increasing the unit price of tobacco. These enhanced interventions will focus on the same communities as the *Mass in Motion* Municipal Wellness and Leadership programs.

Increase Smoke-free Multi-unit Housing. In addition to removing a serious health hazard, smoke-free environments motivate smokers to quit and prevent young people from starting to smoke. Massachusetts' smoke-free workplace law has a 94% compliance rate, but vulnerable adults and children living in multi-unit housing are largely unprotected. Massachusetts has begun work in education and policy change around secondhand smoke in multi-unit dwellings, but this work needs to be expanded and intensified. Local boards of health tobacco policy programs and Tobacco-Free Community Partnership programs will work to raise awareness of the risks of secondhand smoke in multi-unit housing and promote policy changes. Education of landlords and condo associations can lead to voluntary adoption of smoke-free policies. Partners in this initiative can include landlord and other professional associations, fire departments and

healthcare providers. Smoke-free policies in Housing Authorities is a newly developing policy area in the state with significant interest from housing authority staff and tenant organizations.

While Massachusetts' smoke-free workplace law has significantly reduced secondhand smoke for most of the population, people who live in multi-unit housing still face an elevated risk of exposure. Non-smokers living in multi-unit housing are twice as likely to report secondhand smoke exposure (21% reported more than 1 hour of exposure in past 7 days) compared to non-smokers living in single family homes (10%) (Source: MA BRFSS 2010). Smoke-free environments serve a protective function, motivating smokers to quit smoking and encouraging sustained quits. Smoke-free housing protects children from exposure to secondhand smoke and risks of asthma, ear infections and other health problems.

Increasing the Unit Price of Tobacco. Price increases, in strategic increments, have been proven in the past to help people in Massachusetts quit smoking and prevent our young people from starting. The price of tobacco products is clearly connected with a reduction in adult smoking and a drop in youth initiation of tobacco use. Each 10% increase in the price of cigarettes results in a 4% drop in consumption and a 7% drop in youth smoking.[4] Currently in Massachusetts, tobacco products are sold at varying price levels, from packs of premium cigarettes hovering around $8.00 each to single cigars at 25 cents. Municipalities can increase the lowest prices by implementing various pricing strategies, including implementing minimum packaging policies that eliminate the sale of single cheap cigars.

Neilsen data that looks at the retail price of tobacco products in the Boston region in 2010 shows a wide variety of tobacco products being sold at very cheap prices. Cheyenne brand small cigars, which look nearly identical to cigarettes, retail at a quarter of that price, around $2.00. Marlboro Snus 6-packs are being sold for $2.53. In addition to the Neilsen findings, MTCP-

funded local programs have reported sales of single cigars priced as low as 25 cents. To better survey the status of price and products in communities in a systematic way, MTCP has developed a new module for its Retail Data Management System (RDMS), a web-based electronic database system that allows real-time tracking of tobacco retail establishments. This information will guide local policy solutions to pricing issues.

Working with local funded health boards and Community Partnership programs, young people in chapters of The 84 will gather evidence, educate their community's stakeholders, and advocate for local policy change. One example of a local policy change is to prohibit the sale of single or mini-packs of cheap small cigars. Programs will educate stakeholders about the importance of pricing strategies and the impact of their local policy work. This will lay the groundwork for informed tobacco pricing policy change at the statewide level.

Engaging young people to help fight the tobacco industry's efforts to target them will reduce the ranks of the 7,200 Massachusetts youth who start smoking each year. MTCP's youth movement, The 84, is in nearly 100 communities across the Commonwealth. There is an immediate need for expansion to allow for young people to expose industry tactics in their communities and assist with pricing policy initiatives in key areas. Implementing evidence-based pricing strategies at the level we propose will reduce youth smoking in Massachusetts by 12.1%.

Make Smoking History has been the slogan of the MTCP since 1993 when Massachusetts became the second state to launch a comprehensive tobacco media campaign. With limited funds today, a website, social media and earned media are the primary communication materials. Comprehensive information about secondhand smoke including pages for apartment owners, condo owners and tenants are available on the website. Materials targeting parents of young children are also available on the website with the theme "Before you light up, look down" to

support tenant organizing in housing authorities. Flyers and fact sheets are available on the website with radio ads educating about the impact of secondhand smoke on young children. Local programs work with a communications consultant to earn local media stories about smoke-free multi-unit housing and promote the website link.

Free resources for quitting smoking, including information about the free quitline and QuitWorks, is available at www.makesmokinghistory.org. Community Partnerships work on an innovative strategy "Ex Smokers Hall of Fame" that identifies, documents, and celebrates the stories of ex smokers. Sharing local success stories encourages smokers to make a quit attempt. A series of short videos linked to the website and facebook page share the success stories. Many stories promote the role healthy eating and active living played in helping smokers quit allowing for connections to *Mass in Motion*.

Strategic Direction 2: Active Living and Healthy Eating: The *Mass in Motion* Municipal Wellness and Leadership Grant Program is designed to build capacity at the municipal level to create a sustained approach for active living and healthy eating. Municipalities have been funded to plan, assess, initiate, and/or expand the implementation of policy, systems, and/or environmental approaches that support healthy eating and active living. Under the leadership of city or town management (e.g., Mayor, Town Manager or the Board of Selectmen), municipalities create or expand an existing community partnership that includes municipal partners (e.g., local elected officials, local Board of Health, Planning, Recreation, Economic Development, School Superintendent) and community partners (e.g., YMCAs, faith-based organizations, legislators, hospitals/healthcare providers, health insurance providers, foundations, business owners, chambers of commerce, urban planners, and leaders from underserved and/or racial and ethnic communities) to lead this effort.

The *Mass in Motion Municipal Wellness and Leadership* communities will focus on the following healthy eating strategies: (1) increasing accessibility, availability, affordability and identification of healthy food in the community by establishing healthy dining standards, establishing healthy retail environment, reducing food deserts, establishing vending machine nutrition standards and increasing farmers markets (2) improving nutritional quality of food and beverages served in school; and (3) promoting the purchasing and availability of fruits and vegetables and other healthy food through food assistance programs.

The *Mass in Motion* communities will be working on the following active living strategies: (1) improving the quality and amount of physical education and physical activity in schools by increasing the total number of physical activity opportunities implemented at schools recess, intramurals and by increasing the safe routes to school (bicycling and/or walking) and (2) increasing opportunities for physical activity in communities and workplaces through community-wide campaigns and access to facilities and places. In Brockton and Springfield, there will be additional strategies around creating access to safe locations for physical activity.

MDPH has laid important groundwork for these active living policies by establishing a relationship with the MA Department of Transportation's Safe Routes to Schools Program. MDPH staff are on the statewide Task Force and supported a successful pilot in 2008-2010. This pilot developed a community-wide program to encourage children to walk and bike to school and to incorporate these activities into their daily lives.

The *Mass in Motion* website was established in 2009. The website features sections for the home, work and community. Twitter feed and a blog are currently established and there are pages in Spanish and Portuguese. One of the goals is to build out the community section to have information from each *Mass in Motion* program. Information about free physical activity and

healthy dining options can be linked to the website. *Mass in Motion* branding will be used on restaurant decals, walking maps and other local materials to drive traffic to the website.

Materials that can be used for a campaign include existing *Mass in Motion* materials which encourage low cost healthy eating and active living strategies. The Division of Prevention and Wellness has been working to adapt the New York City campaign: Salt Explosion. The campaign increases consumer awareness of the amount of sodium in processed foods and to create demand for processed foods with lower sodium. Materials are currently being adapted and will be available as fact sheets, posters, and public transportation ads. Campaign materials will be available in English, Spanish and Portuguese.

Local programs will work with a communications consultant to earn local media stories and promote the *Mass in Motion* website link. A limited paid media campaign will be developed by each local program. This campaign will be web-based to maximize the connection to the *Mass in Motion* website. Each program will work with their coalition and the consultant to determine the most effective placement for their media buy. Programs will also be encouraged to work with local coalitions to see if additional dollars can be found to match the campaign. Examples may include local hospital community benefits or local private foundations.

An ethnic media campaign to promote healthy eating will be coordinated in the Springfield and Holyoke area. MDPH has had success in the past reaching low income Latinos with radio campaigns. MDPH would work with local coalitions to develop a 30 second and 60 second radio script. The scripts would be read by local radio talent – in addition to saving production costs, this is an effective strategy since many Latinos turn to the local Spanish radio station as a primary information source. The radio talent are usually well known and respected members of the community. Having the ads read by familiar local people will give the campaign

additional visibility. Since these stations format includes talk shows, it is possible to develop significant earned media to complement the paid media. The local Springfield and Holyoke Spanish radio stations are inexpensive allowing limited funds to be used effectively. A 30 second ad during the 6am-10am time period is $40 on WSPR and $18 on WACM.

Strategic Direction 3: Increased Use of High Impact Quality Clinical Preventive Services

MDPH will support implementation of strategies to increase the use of high impact quality clinical preventive services and their integration into local *Mass in Motion* efforts also supported by this grant. This will have the added effect of reducing disparities in health outcomes in one community health center (CHCs) in each of the seven counties and a healthcare site in Nantucket County. These strategies will 1) expand monitoring and clinical data reporting systems to improve the quality and routine use of effective clinical and other preventive services and 2) enhance linkages between municipal wellness/*Mass in Motion* initiatives and clinical services focused on increasing the overall effectiveness of health promotion efforts in both clinical and community sites. The interventions will improve management of high blood pressure, elevated cholesterol and diabetes and tobacco cessation. These secondary prevention efforts will be linked to primary prevention efforts underway through the local community's *Mass in Motion* initiative.

To improve patient health outcomes related to screening and management of blood pressure, cholesterol and diabetes, and tobacco cessation, each CHC will have a dedicated multi-disciplinary team composed of a physician/provider champion, nurse, community health worker, information technology (IT) representative, medical assistant and a patient representative. Practice coaches, skilled in the field of evidence-based quality improvement, will assist teams in conducting baseline assessments and developing quality improvement plans for their practices based on identified site-specific gaps and needs. CHCs will enhance their electronic medical

record systems to assist with decision support, patient referrals and follow up, and assessment of individual and practice level health outcomes. Outcome data from CHCs will be collected through an existing Community Health Information Association (CHIA) Data Reporting and Visualization System (DRVS). This system collects patient level, detailed clinical data and creates a provider scorecard with actionable information for care teams. The CHIA DRVS supports the Patient Centered Medical Home (PCMH) and Meaningful Use (MU) reporting with HL7 interface for automated MDPH reporting.

A key element of this model will be designated key staff members from each CHC working with their local *Mass in Motion* coalition to - 1) identify needed community resources, 2) develop and implement a bi-directional communication plan that actively links patients, primary care providers and participating community organizations, and 3) change policies, systems and the environment in the community to better support healthy eating and active living.

The MDPH will work with the state primary care association, the Massachusetts League of Community Health Centers (MLCHC), to provide technical and IT support to the participating CHCs. The MLCHC will assist with data collection, creating templates and reports, tracking self-management goals, and developing bi-directional referral systems between CHCs and community-based organizations. MLCHC will hire and oversee the practice coach for the CHCs.

The strategy will build upon CHCs current efforts related to the Patient-Centered Medical Home (PCMH) and Meaningful Use (MU) and the MDPH's *Mass in Motion* initiative to achieve these goals. The PCMH has demonstrated success in increasing quality and reducing cost of care,[5] as well as improving patient and provider experiences[6] by organizing care around patients, working in teams and coordinating and tracking care over time. Participating CHCs will apply PCMH principles and processes to increase screening and control of high blood pressure, high

cholesterol, diabetes and tobacco cessation services.

Experience in quality improvement indicates that to improve health care quality and eliminate inequities in health outcomes, innovative changes in health care delivery systems will be required. The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality care of chronic conditions: the *community*, the *health system*, *self-management support*, *delivery system design*, *decision support* and *clinical information systems*. Evidence-based change concepts under each element in the system foster productive interactions between informed, "activated" patients who collaborate with providers who have resources and expertise.[7] The proposed strategies include using practice coaches to assist health care teams to implement and evaluate comprehensive, systematic interventions within the framework of the CCM. Teams will use instruments and a change tool that has been adapted by the MDPH for an integrated chronic disease approach to practice redesign.

Evidence for tobacco cessation interventions in healthcare is robust and even brief clinician-delivered tobacco use interventions are shown to increase overall tobacco abstinence rates.[8,9] Clinic screening systems, such as expanding vital signs to include tobacco use, or the use of other reminder systems like computer prompts significantly increase rates of clinician intervention. The Clinical Practice Guideline for Treating Tobacco Use and Dependence concludes that tobacco dependence treatments are effective across a broad range of populations and recommends that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.

The Community Prescription Plan will be used to link primary care to community resources. CHCs will develop geographic specific templates for prescriptions to community resources and work with community-based organizations to develop capacity for sending and

receiving feedback on patient follow-up like the MTCP QuitWorks program. In 2010, QuitWorks and the Massachusetts quitline was the first quitline in the United States to offer fully electronic bi-directional communication to healthcare facilities. MDPH will work community-based organization to promote fully electronic bi-directional referrals.

Provider champions at each of the CHCs will work with their *Mass in Motion* coalitions" policy, systems and environmental change efforts, such as providing expert testimony at community level hearings. CHC staff will participate in advocacy training facilitated by MDPH. The training will be adapted from the Robert Wood Johnson Foundation-funded *Be Our Voice*™ program and will include the following topics: (1) community "call to action"; (2) successful advocacy; (3) public policy and policy opportunities; and (4) media and communications advocacy. This training will link opportunities for engagement of the health center team, including the physician champion and community health workers, with *Mass in Motion* coalition activities and will add a powerful new perspective to the policy, systems and environmental change the *Mass in Motion* coalitions undertake.

These strategies link the *Mass in Motion* initiative to the five-tiered health impact pyramid[10] that delineate the factors that affect health with interventions focused on the several levels likely to have the greatest population impact. Combined CHC and *Mass in Motion* action plans will be developed to create resources and/or policies necessary to support patients with or at risk for chronic disease. The action plan will address multiple levels of the health impact pyramid: *context* (policy and environment), *long-lasting protective interventions* (change in and across systems), *clinical practice* and *counseling and education* (tobacco cessation, chronic disease self-management programs). This multi-tiered approach will have mutually reinforcing impact and contribute to generating the engagement necessary to sustainability of these efforts.

Site-specific Improvement Plans will be developed based on baseline data collection and assessments. Identified needs related to blood pressure, cholesterol, diabetes, tobacco, and disparities will be addressed in the Improvement Plan. The follow up clinical and process data will assess the extent to which the activities in the CHCs, in conjunction with environmental and policy changes in the broader community, result in patient-level improvements in obesity, blood pressure, lipid and diabetes management and smoking cessation.

CHCs will be assisted in using electronic medical record (EMR) data to identify disparities between and among populations of patients. To improve access to care, screenings and education, the improvement plan will include strategies to address barriers and engage populations experiencing health disparities. CHCs will be encouraged to include community health workers (CHWs) as essential member of the team to assist with engaging hard to reach populations. CHWs successfully engage populations who may not be seeking care. They provide services that are culturally, linguistically and socially applicable.[11,12] CHWs will be encouraged to become members of the *Mass in Motion* coalition and participate in advocacy training.

CHCs have a long history of providing comprehensive health services to underserved people and are at the leading edge of addressing some of the most vexing problems of our health care system, including facilitating access to health insurance coverage for low-income residents and eliminating health disparities between racial and ethnic populations. By sharing their expertise working with vulnerable and culturally diverse populations, CHC staff will assist *Mass in Motion* coalitions to identify and remove barriers to healthy living and quality of life for individuals and groups within the community. At the same time, participation in *Mass in Motion* coalition will help to create conditions in the community to improve health and quality outcomes for the CHC, in addition to clinical outcomes.

The focus on increasing the adoption and integration of effective evidenced-based approaches to assessing and managing high blood pressure, diabetes, elevated cholesterol and tobacco use into routine clinical practice will result in improved health status of the low-income and otherwise vulnerable populations. The non-white population in the 7 participating CHCs is approximately 50%, more than triple the percentage in the 8 target counties. Evidence suggests that evidence based approaches may diffuse more slowly into less resourced clinical sites, resulting in delayed uptake and health disparities which are preventable through effective treatment and management. This clinical intervention will serve to promote and support sustained diffusion and adoption of these effective approaches.

CHC policies will include a requirement for Culturally and Linguistically Appropriate Services (CLAS) training as well as annual courses in medical interpretation . To facilitate participation, MDPH will offer on-line Despite the Differences training. Appendix I2 graphically depicts the interdependence of the strategic directions for the Massachusetts plan. (Also, see Appendix I3 for the logic model that is the foundation of the Massachusetts plan.)

Strategic Direction 4: Social and Emotional Wellness

The focus on **social and emotional wellness** will focus on effective positive youth development and risk reduction approaches to improve adolescent health. Youth leaders will work on local strategies to increase safe physical environments and encourage young people to be physically active. Youth leaders will document the impact of tobacco, alcohol and junk food (including fast food) advertising and density in their communities and present these findings to stakeholders. Young people will participate in local policy initiatives and develop leadership skills to be engaged in making their local community a healthier community. This will occur in all of the communities with *Mass in Motion* and Tobacco Prevention initiatives.

Youth have a unique policy advocacy role that contributes to effective, comprehensive change in their communities. The CDC Best Practices for Comprehensive Tobacco Control Programs User Guide for Youth Engagement outlines the power of youth that can contribute to local policy and environmental change: advocate for policy development, project a powerful voice, exposure tobacco industry tactics, offer energy and vitality, reflect genuine concern, bring diverse representation and provide generational insight, invoke creativity and innovation and mobilize their peers. It is important to engage youth in their communities and in policy change work. Simply educating youth and empowering youth is not effective. Providing youth with the skills and opportunities to be engaged in their communities can lead to powerful local policies. This has been seen in tobacco control by youth spearheading efforts to ban the sale of tobacco in pharmacies, change zoning codes to eliminate advertising, ban the sale of loose cigarettes and ensure tobacco-free school laws are enforced. This model can be successfully transferred to *Mass in Motion* to involve young people in advocating for healthy food and active living.

Partnering with the YMCAs in Brockton and Springfield, *Mass in Motion* programs will involve youth in planning to increase safe physical environments and encourage young people to be physically active. According to the Prevention Institute "Violence and Chronic Disease" fact sheet, persons who described their neighborhoods as not at all safe were nearly three times more likely to be physically inactive than those describing their neighborhood as extremely safe. People in both of these cities worry about physical safety and some parents are reluctant to let their children play outside. Working to create safe, free spaces for physical activity is a critical change in both of these cities and we believe youth can play an important role in creating change.

During the first year of the grant, the *Mass in Motion* training institute will create a survey tool for young people to use to document the influence of tobacco, alcohol, junk food and

fast food in their neighborhoods. Over the past two decades, a variety of store front tools have been used in Massachusetts. This process will draw from lessons learned to create a new comprehensive tool that can be used to document density and advertising influences. The YMCAs in Brockton and Springfield will help pilot the survey. Holyoke, Pittsfield and Barnstable County YMCAs with other community partners will help recruit youth to be trained to do surveys once the tool is finalized. A standard tool will allow for comparisons across the state to see if there are differences in urban, suburban and/or rural communities. Youth in the city of Boston were successful in getting the city to begin to enforce zoning laws that restricted advertising on storefronts. This reduced the amount of advertising for tobacco, alcohol and junk food by simply reducing the amount of available space for any advertisements. Young people are often interested in reducing the influence of all of these issues and by taking a comprehensive look at the community influences, it may be possible to build new partnerships.

After youth document the retail environment in their community, they will do presentations to coalition members, community and stakeholders. This data will be used in planning processes to explore issues of zoning restrictions and density with the goal of at least two *Mass in Motion* programs choosing to work on zoning regulations in year 4 and 5 of the grant. The description of youth in the 84 chapters working on pricing strategies was detailed in the Strategy 1 description earlier.

Strategic Direction 5: Healthy and Safe Physical Environment

Creating healthy places is essential to protect and promote health and safety and to prevent illness and injury. The places where people live, work, learn and play are strong predictors on one's health status. Transportation policies have enormous potential to influence the development of healthy environments and healthy places. Healthy environments provide

opportunities for healthy behaviors and thus healthier people. The Massachusetts Department of Public Health has been actively working with our state partners since 2006 and the Healthy Transportation Compact is a direct result of that work. *Mass in Motion* Municipal Wellness and Leadership programs provide an opportunity for local boards of health and coalitions that care about public health to learn about transportation policies, build partnerships and influence policy at the local and regional level.

Research demonstrates links between specific community factors, such as the availability of parks, accessibility of healthy and affordable produce, and the "walkability" of neighborhoods, and the choices people make in their daily lives. These factors are heavily influenced by environmental factors. When air pollution due to traffic and industrial emissions are controlled, people can be active without getting sick. When streets are safe or clear paths wind through well-maintained parks, people are more likely to walk or bicycle. When neighborhood restaurants are in compliance with food protection regulations and offer heart-healthy food or local markets sell an abundance of fruit and vegetables, a healthy diet is easier to maintain. When schools are situated in neighborhoods with sidewalks away from major sources of air pollution, students are more likely to walk which increases physical activity. When residential areas are in close proximity to stores, jobs, schools and recreation areas, walking as a transportation mode becomes more feasible. When there is convenient, environmentally safe access to recreational facilities, people are more likely to exercise and be physically active. *Mass in Motion* can help arrest the costs of health care and promote a more active lifestyle by ensuring that public health is engaged in the land use and transportation planning processes. *Mass in Motion* communities will work with MassBike, WalkBoston, MPHA and local and regional planning agencies to ensure that public health becomes a part of community or

municipal planning. Non-traditional partners join the discussion to ensure that sidewalks are safe for the elderly and disabled. The goal is for users of all ages and abilities to be able to be active in their neighborhoods. Complete Streets trainings will be provided for local officials with walkability and bikability audits. Support will be provided for "Safe Routes to Schools".

Mass in Motion Municipal Wellness and Leadership programs will work on establishing Healthy and Safe Physical Environments: (1) establishing healthy design standards (2) establishing complete streets plans and (3) including health element in plans (master/ comprehensive, pedestrian, bicycle, open space and recreation, etc.). These elements are closely linked to the Strategic Direction 2, Active Living strategies to increase physical activity.

MDPH recognizes that making improvements to the built environment and community design necessitates the need to work with "non-traditional" partners. As a result, we have engaged regional planning agencies, municipal planners, parks and recreation, councils on aging, public safety as well as other state agencies including transportation, energy and environment, housing and community development to create healthier communities. Lessons learned over the past five years can be used to support the new *Mass in Motion Municipal Wellness and Leadership* programs.

A tool being used in some of the *Mass in Motion* Municipal Wellness and Leadership communities is the "Board of Health Resolution: Planning for a Healthier Future Through the Built Environment and Community Design." This model resolution can serve as a starting point to encourage municipal officials to work together on policies related to the health consequences of the built environment. The resolution incorporates numerous local methods available to reduce chronic disease and obesity with increased physical activity and improved nutrition through policy changes.

G. Performance Monitoring and Evaluation

1. Measuring Change in Core Measures: MDPH will collect data on the 5 core measures using the Behavioral Risk Factor Surveillance System (BRFSS). For changes in weight, we will track trends in BMI-based obesity measure. We will track responses to a question about perceived weight changes compared to the previous year. For proper nutrition, we will track the percentage of adults who eat 5 fruits and vegetables per day. For physical activity, we will track the percentage of adults who report having no daily physical activity. Tobacco use will be tracked using the core questions about "every day" and "some days" tobacco use. Emotional wellbeing and mental health will be tracked using core questions about number of days sad or depressed in the previous month. The specific tracking methodology is described below.

Small Area Estimates: **Core measures** will be assessed using responses from the annual BRFSS land line and cell telephone survey. Instead of traditional approaches that measure statewide changes, Massachusetts will use **innovative** small area estimates (SAE) methodology to focus on changing trends in *local* rates for smoking, obesity, physical activity, nutrition, hypertension, hyperlipidemia, diabetes, and emotional well-being. Since the proposed interventions are local, SAE are well-suited to demonstrate the link between process and outcome measures. Furthermore, the evaluation team has specific expertise in the area publishing significant research using SAE to prioritize public health efforts.[13,14] This innovative use of SAE for assessing trends will be **evaluated** by comparing SAE changes with changes from direct estimates whenever sample sizes permit. Each year, trends will be projected to determine when a county is likely to reach the 5% overall goals.

Using SAE, each town and county will be given targets for smoking, obesity, physical activity, nutrition, hypertension, hyperlipidemia, and diabetes. Baseline values for 2010 for each

county and partner community can be found Appendix I4. In addition, MDPH will track 3 questions added to the 2011 BRFSS that relate to awareness of the *Mass In Motion* program, understanding of program goals, and weight change.

The disease and risk factor SAE can be used to produce specific targets or reduction goals. For example, our BRFSS-based SAE for the number of adult smokers, obese adults, adults ever having hypertension in Hampden County are 70,201, 104,609, and 90,278 respectively. Five percent target reductions will be based on these estimates. Similar targets have been computed for physical activity, nutrition, hyperlipidemia, and diabetes. Separate and **higher targets will be set for disparate populations**. On a percentage basis, these disparities targets will be approximately 10% higher than those for the rest of the population since the disparate populations in these communities have disease burdens that are roughly 10% higher. See Appendix I, for a complete list of all target values for all communities.

While small area estimates have been shown to be more accurate than direct estimation methods,[15] Massachusetts will **enhance** its BRFSS sampling scheme and oversample the partner communities in order to increase the accuracy of its estimates. Some sample sizes will double. For example, the target sample for Dennis in Barnstable County will increase from 30 (in 2010) to 60 (in 2012). By increasing the sample sizes, Massachusetts will increase the probability of detecting a 5% change in the core measures. Setting a target minimum sample size of 60 for all but the smallest partner communities (i.e., <10,000 population) will ensure that the margin of error for SAE will be less than 5% for partner communities and counties. See table in Appendix I5 for the target minimum sample size of each partner community. Finally, midcourse corrections will be triggered when any SAE differs significantly from an annual milestone target.

In addition to small area estimates, MDPH evaluation staff will work with local partners

to incorporate local data. Examples of data include the local Youth Risk Behavior Surveys and Prevention Needs Assessment survey done in many of the local communities. All schools are required to collect and report BMI data. New programs have suggested that questions can be incorporated into existing surveys. For example, Barnstable County conducts an annual "human condition" survey that assesses health and social/emotional wellbeing while Franklin County conducts a survey of middle school and high school parents. In 2011, Cooley Dickinson hospital conducted a targeted Food and Fitness survey in Northampton as part of its county health assessment (conducted every three years).

2. Assessing Policy and Environmental Changes: Using the CDC's CHANGE tool: To assess local policy changes, Massachusetts will use the CDC's Community Health Assessment and Group Evaluation tool (CHANGE). On an annual basis, the policy and environment changes regarding smoke-free housing, physical activity, and nutrition will be scored using the CHANGE tool. The scores for the 5 modules will be reviewed by DPH and the partner community. The two critical components for evaluating the data developed using the CHANGE tool are defining the **criteria for success** and measuring the **impact of change**. The criteria for success will employ a measure of "constant forward motion" for policy and environmental changes. While we do not propose to measure the impact of these changes directly, we will use SAE and the data from clinical observations (described below) to track prevalence of negative health outcomes and risky behaviors in the target population. Midcourse corrections on policy goals will be triggered whenever a community score differs from a target value by 10% or more.

3. Surveillance and Evaluation: Clinical Interventions. MDPH will work the Massachusetts League of Community Health Centers to expand the number of centers using the League's clinical feedback reporting system: Community Health Information Association (CHIA) Data

Reporting and Visualization System (DRVS). On a nightly basis, encounter level patient data is updated in CHIA DRVS. This data is used to prepare feedback reports to providers on measures such as % of patients with current BMI calculation, % of patients with documented smoking status, and others. See Appendix I6 for examples of provider feedback from CHIA DRVS.

MDPH proposes to analyze the data from CHIA DRVS to add richer outcome data to the CHIA DRVS feedback reports. Specifically, MDPH analytical staff will evaluate clinical encounter data on a quarterly basis to determine the impact of provider interventions on clinical and self-reported measures. Once a full year of data has been submitted to CHIA DRVS, MHPH staff will compute **CHC-specific indices** so an individual provider can see where he/she compares to his/her peers on a range of preventive health process measures. Also, **disparities specific indices** will be developed to assess care for disparate populations. Studies have shown that feedback on clinical process measures can improve the rate at which providers adhere to clinical guidelines. Furthermore, by linking these process measures to health outcomes and peer comparison, it is expected that the rate of improvement in the process measures will increase. Although the nature and intent of feedback reports can rely on self-correction, we will recommend a midcourse correction using "performance improvement coaching" (e.g., PDSA model) whenever target process measures are missed for 3 consecutive quarters.

Data from CHIA DRVS will also be used to assess the impact of Massachusetts Executive Order 509 as it applies to school lunches and childhood obesity. With data available for school aged children through CHIA DRVS, we can compute a longitudinal trend analysis to assess the impact of EO509 on rates of youth obesity. While only a portion of school aged children will be seen at the participating CHCs, the executive order applies to the entire state. Therefore, estimates of the **impact of EO509** on youth obesity rates for CHC patients will serve

as the impact estimate for all school aged children in each county.

Assessing Impact of Community Linkage (Community Prescription Plan): The Community Prescription Plan (see Section F) will develop a "take away" report for patients who visit participating Community Health Centers. The report will be based on the "Know Your Numbers" concept promoted by the CDC and the American Heart Association. The feedback in the report will give patients information about local programs and facilities that will help them address health issues highlighted in the "Know Your Numbers" section of the report. In the second year of the grant period, MDPH will work with the Massachusetts League of Community Health Centers to develop and implement a bi-directional communication plan that actively links patients, primary care providers and participating community agencies. When sufficient data is available (year 3 or beyond), MDPH will assess the impact of the programs offered by participating community agencies on clinical outcomes. Specifically, we will **compare three groups**: patients not receiving the Community Prescription Plan, those receiving but not known to have accessed any services, and those receiving the Plan as well as services. Midcourse corrections will be triggered whenever the number of links of patients to participating community agencies falls below targets for 3 consecutive quarters.

Policy and Environmental Interventions: Partner communities will submit to MDPH information on such items as numbers of restaurants limiting portion size or offering healthy menu choices, changes to vending machine selection, farmer's markets accepting SNAP or WIC cards, towns adopting Complete Streets or Safe Routes to Schools policies, walking, bicycling and school recess plans, etc. MDPH will track progress on these measures and make comparisons to baseline on an annual basis. Midcourse corrections will be triggered whenever a community fails to meet an annual milestone.

Tobacco Measures: MDPH conducts routine surveillance on per pack cigarette prices, calls and referrals to the quitline, and numbers of youth participating in 84.org programs. MDPH also includes questions about smoke-free multi-unit housing in the annual BRFSS. Trends and changes from this surveillance work will be reviewed on an annual basis.

Communication: All communications will tag the *Mass in Motion* program. We will track awareness and understanding of the program through the annual BRFSS.

Health Outcomes: Finally and possibly most important of all, Health Reform in Massachusetts also requires that health plans submit medical claims data to the Massachusetts All Payers Claims Database (APCD). Massachusetts is one of only 11 states to have an APCD. While claims reports from insurers will lag by some months, the primary diagnoses (ICD9) associated with these medical claims can serve as concrete measure of changing health outcomes for coronary heart disease, hypertension, and diabetes. Payers are scheduled to submit claims to APCD for 2008 – 2010 later this year. Once fully operational, APCD will also allow MDPH evaluators to track use of medications for controlling hypertension, hyperlipidemia, smoking cessation, and other condition. In the interim, MDPH will prepare baseline measure for the Chronic Disease Indicators (CDI) for residents of the eight partner counties. For this work, midcourse corrections are not applicable.

For all this work, Massachusetts enthusiastically affirms its **willingness to participate in national evaluations**. Furthermore, the MDPH team has demonstrated its willingness to collaborate with local partners by co-submitting a CTG application with Middlesex County and supporting the CTG application for Suffolk County. MDPH also has a history of collaborating with research and public health departments around the country. Finally, Dr. Thomas Land, the evaluation coordinator, is a consultant to CDC on Medicaid and health systems research and has

worked extensively with American Lung Association, Partnership for Prevention, major health plans, and more than 20 state Departments of Health on health systems research.

H. Participation in Programmatic Support Activities

The Massachusetts Department of Public Health has a long history of actively participating in national meetings and trainings to share success stories and lessons learned. We have a long history of cooperating with the CDC on case studies and reports as well as presenting at meetings and conferences sponsored by the CDC. We work closely with academic and healthcare researchers in the Boston area and have recently launched an innovative partnership with Harvard through the Harvard Catalyst to involve researchers and students in a significant number of policy projects. We also work closely with private foundations in initiatives including the groundbreaking initiative to fund the original *Mass in Motion* Municipal Wellness and Leadership grants. We disseminate lessons learned through fact sheets and reports as well as research articles.

Endnotes

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[2] http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Provider&L2=Guidelines+and+Resources&L3=Guidelines+for+Services+%26+Planning&L4=Massachusetts+Patient-Centered+Medical+Home+Initiative&sid=Eeohhs2&b=terminalcontent&f=eohhs_healthcare_reform_medicalhomes_g_infosessions&csid=Eeohhs2

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