

The Massachusetts Prevention and Wellness Trust

An Innovative Approach to Prevention as
a Component of Health Care Reform





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“The bill is truly groundbreaking and keeps Massachusetts at the forefront of health policy. We are taking a major step away from a costly sick care system and toward an integrated approach focused on keeping people healthy”

– Maddie Ribble, *Policy Director at the Massachusetts Public Health Association on Chapter 224 and its creation of a Prevention and Wellness Trust*

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Overview

These are challenging times for public health. Funding at the Centers for Disease Control is being dramatically cut. The Prevention and Public Health Fund of the Affordable Care Act has been cut almost in half. Around the nation, state and local public health department budgets are significantly smaller than they were before the recession, and additional cuts are likely. There is no escaping it. The traditional approach to supporting public health activities – namely, with government funds for disease-specific programs – is not doing well, and is unlikely to improve any time soon.

Fortunately, several innovative experiments around the country are under way to determine whether alternative approaches can support public health activities. Some involve moving from the prevailing fee-for-service reimbursement system to one that gives financial incentives to providers to keep patients healthy by a wide variety of means, including changing the conditions at the community, school, and workplace.



Massachusetts is famous for being the first state to enact health care reform

This White Paper focuses on one alternative approach: the Prevention and Wellness Trust in Massachusetts, whose purpose is to gather evidence of the cost-saving power of disease prevention. Passed in 2012, this first-in-the-nation trust is a four-year, \$60 million commitment to population-based health promotion efforts. Its goals are ambitious, and other states might well regard them as breathtaking: nothing less than ensuring that all residents live in communities that promote health and have seamless access to community and clinical services.

Massachusetts is famous for being the first state to enact health care reform: it is seen as the leader in expanding health

insurance to virtually its entire population, as well as laying the groundwork for the Affordable Care Act. Most of the attention stops, however, at the 2006 legislation that led to the rapid expansion of insurance coverage, which is known as Chapter 58. In fact, every two years since 2006 a new health-oriented bill has been passed that has built upon and expanded the original vision of that legislation. These new iterations are a view of the future of health care for the rest of the country—a health care system that, building upon the landmark advances of the ACA, will finally focus as much on preventing illness and promoting wellness as on treating illness and conditions that could and should have been prevented.

Overview

The bill firmly supports for the first time the promotion of wellness as an integral part of health reform

Of the new iterations passed after 2006, the most significant was the 2012 cost containment bill, which had the ambitious title of “Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation.” (To the officials and policy workers who wrote and are implementing it, the bill is most often referred to as Chapter 224.) As the full title makes plain, the bill’s main goal was to contain and reduce costs: it aimed to save \$200 billion over the following 15 years by linking health care cost increases to the growth of the state’s economy.

In addition to its focus on controlling costs, the bill also firmly supports for the first time the promotion of wellness as an integral part of health reform, by creating the Prevention and Wellness Trust.

This funding is unlike traditional prevention efforts within a state public health department’s budget in three ways. First, it does not require annual approval through an appropriations process – the Trust established a unique commitment of at least four years. Second, the funding source is not taxpayers but instead a one-time assessment on the state’s large insurers and large hospitals. Finally, it is unique in including in its focus the opportunity to link public health activities with the provision of clinical care – opportunities for new collaborations that address patients’ needs not just in the doctor’s office but also in the patients’ neighborhoods and workplaces.

Originally envisioned as a steady, annual stream of new funding for primary, community-based prevention activities, the Trust as it passed was a kind of demonstration experiment whose immediate but not exclusive focus was on demonstrating a relatively rapid return on investment, leading to an emphasis on secondary prevention efforts. (Primary prevention aims to prevent a disease or injury from occurring, for example providing healthy foods and exercise opportunities for all children in school, to reduce diabetes

rates; secondary prevention helps patients after a disease or injury occurs but before the patient develops symptoms, for example specialized diets and exercise programs for pre-diabetic teenagers; tertiary prevention targets patients who are already symptomatic with the aim of slowing progression and further damage, for example giving medication and regular nutritional counseling to diabetic patients.) The final language of the bill also included a focus on workplace wellness.

By the beginning of 2014, the Trust will have distributed millions of dollars to innovative collaborative teams who want to improve health outcomes through community change and linking clinical providers with community partners. If it is successful in meeting those goals, the Trust will provide a model for the rest of the nation. The Massachusetts state legislature will most likely revisit the Trust in 2017 or 2018 to determine whether it should be continued.

By understanding the funding, structure, and priorities of the Trust, other states can identify places in their own budgets and health-care infrastructure that will allow them to form similar initiatives. Just as the first state-run insurance exchange in the country, called “The Health Connector,” formed the Obama Administration’s model for the rest of the country, the Massachusetts Prevention and Wellness Trust can be a template for how other states can achieve durable long-term reduction of health care costs.

The implications go far beyond reduced costs. The Trust provides a framework for marshaling a state’s multitude of resources—hospitals, doctors, community health-care centers, universities, local schools, and food-assistance organizations—to improve the long-term health of the entire population. As the potential of the Trust begins to be realized, a closer look at the key policy makers and officials making it work can suggest a plan for the rest of the country.

Overview

We will highlight here the model and promise of the Trust in Massachusetts, and examine the evolution of this model from the longshot idea of a group of progressive advocates to its legislative passage and implementation in what in state house terms is light-year speed. Along the way we will highlight some of the extraordinary leaders who made the Trust possible.

The completion of this paper involved a thorough review of six years of health care and payment reform legislation in Massachusetts, including numerous other prevention-oriented endeavors that have been put in place since the 2006 passage of Chapter 58; multiple interviews conducted with the diverse set of key players in the passage of both the initial bill and the bill creating the Trust; and close monitoring of the implementation of both the legislation and the Trust.

Chronology of Prevention in Health Care Laws

2006 - 2007

2006: Chapter 58 - Massachusetts Initial Health Care Reform bill is passed. Expands insurance to 98% of the population. It includes limited prevention components including Medicaid tobacco control benefits.

2007: Health Care Reform is implemented, 420,000 residents gain insurance.

2008 - 2009

2008: Chapter 305, An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care, is passed. It includes investments in the primary care workforce and creation of a payment reform commission.

2009: Various planning activities focus on cost and quality. Such work includes reports from two legislatively mandated groups and hearing on cost, quality, and access.

2010 - 2011

2010: An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses, is passed. It includes workplace wellness pilots and creates a commission on falls prevention for older adults.

Stand-alone legislation for a prevention trust is filed by the co-chairs of the Legislative Prevention Caucus.

Summer/Fall, 2011: Campaign Urban Institute report is released on cost savings associated with prevention; an open letter of support is signed by more than 300 leaders of diverse sectors; 49 legislators sign a letter of support.

2012

July: Legislature passes bill creating the Prevention and Wellness Trust Fund, funded at \$60 million after resolving differing House/Senate amounts.

August: Governor Deval Patrick signs Chapter 224 into law.

Snapshot | The Massachusetts Prevention and Wellness Trust

VISION “All Massachusetts residents live in communities that promote health and have seamless access to all community and clinical services needed to prevent and control chronic diseases”

Sixty millions dollars in funding is designated for a four-year period to support prevention and health promotion activities. At least 75% of it will be awarded in grants for local community-wide, comprehensive initiatives. Up to 10% of the funding will be spent on workplace wellness efforts, and up to 15% will be spent on grant administration. A formal evaluation will be conducted examining both cost impact and health outcomes.

Mandated Outcome Measures

The legislation requires the following measures:

- Reduction of preventable health conditions
- Reduction in health care costs
- If cost reduction, explanation of who benefits
- Employee health impact of workplace wellness or health programs

Average Size of Awards

- Year 1: Capacity building grants of \$250,000
- Year 2-4: Implementation grants of \$1,100,000 - \$2,500,000 (implementation phase with focus on sustainability process in year 4)

Fundable Projects

The Trust will fund a small number (6-12) of collaborative initiatives. The collaborations are likely to include municipalities, community based organizations, healthcare providers, health plans, regional planning agencies and/or worksites. Fundable activities include:

- Enhancing community-clinical relationships
- Addressing community members' barriers to optimal health
- Identifying health-related community resources
- Tracking referrals to and use of of such community resources in clinical records
- Using quality improvement to strengthen community-clinical process and linkage

Focus Areas

PRIORITIES:

- Tobacco use
- Childhood asthma
- Hypertension
- Elder falls prevention

OPTIONAL:

- Obesity
- Diabetes
- Oral Health
- Substance Abuse

In addition, the Trust calls for attention to the reduction of health disparities and the consideration of mental health co-occurring conditions in the prioritized areas.

Oversight

The Department of Public Health (DPH) oversees the fund, in consultation with a new Prevention and Wellness Trust Advisory Board and guided by legislative language. The funding is separate and distinct from DPH's budget. DPH will provide the awardees with a connective data system (with both clinical and community indicators) with performance indicators and provide technical assistance and opportunities for grants to learn from each other.

Advisory Board

17 members with a variety of legislatively mandated skills and perspectives. They include representatives from the insurance, clinical, public health, business, and consumer sectors as well as the Secretary of Health and Human Services and the Commissioner of Public Health.

Time Line

The Board has met monthly since June, 2013 to set priorities for the first year's grants. DPH released the Trust Request for Proposals in August 2013. Decisions will be made in December, 2013 with grants to begin in 2014.

Public Participation

Four well-attended public comment meetings were held in July, 2013. Members of the public can and do attend the Board's meetings.

Groundwork

GROUNDWORK FOR THE BILL How did the Prevention and Wellness Trust pass? This question is particularly relevant as public health officials and advocates around the country consider the feasibility of such an approach in their own states. While certain contributing factors are in fact specific to Massachusetts, others are possible in any environment. In assessing the factors contributing to the creation of the Trust, the people involved with its creation identify seven of particular note:

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1. A recognition that repeated cuts to public health cause harm
 2. An innovative precedent, the Pediatric Immunization Trust, which points to a new approach
 3. An effort to sustain public health even when state funding is not available
 4. A recognition that new approaches are needed to control costs
 5. An appreciation of promising population-based chronic disease initiatives
 6. A broad-based coalition that cut its teeth in the fight for health care reform
 7. An unusual collection of leaders from diverse fields
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Groundwork

1. Repeated cuts to public health cause harm

The years following the 2006 passage of Chapter 58, the country's first bill expanding statewide health insurance expansion, were challenging ones for those interested in public health, for two main reasons. The first is the most obvious: the recession. It hit Massachusetts hard. There were layoffs and cutbacks in virtually every area of work. The public health budget was hit particularly hard after losing almost 20 percent of its funding. From 2007 through 2012, the Department went through eight rounds of layoffs. Hundreds of jobs were lost. And some of the public health programs that were hardest hit, such as tobacco, were prevention-oriented. The prospect of funding for new prevention-related efforts was unlikely.

Unexpectedly, health care reform itself was the second reason that prevention efforts were vulnerable. The timing of the recession soon after significant expansion of coverage led to even more pressure on the rest of the state budget. Furthermore, there was considerable uncertainty about whether certain public health programs would still be needed after the expansion of insurance-funded access to care. As payment shifted to insurers, legislators and the governor's staff worked under enormous financial pressure to predict what, if any, safety-net services could be scaled back without excessive harm. This resulted in cuts not only to tobacco control but also to chronic disease prevention and control, family planning services, and public health clinical services. As it turned out, most of these program cuts involved activities that were not offset by insurance expansion.

2. An innovative precedent that points to a new approach

Some of the assumptions behind the Legislative program cuts made sense – on the surface. For example, Massachusetts is what is known as a universal childhood vaccination state. The state legislature annually gave the Department \$50 million to cover the cost of needed vaccines for all children, regardless of income and insurance coverage. This supplemented federal funding for vaccines for low-income children. It was logical to conclude that such funding could be cut: after all, those children would now have health insurance that could pay for their vaccines.

It turned out to be more complicated than that. Health insurance companies had come to rely on state funding, and weren't prepared to work through the billing procedures and rate determination for the vaccinations. Pediatricians much preferred the ease of receipt of the vaccines from the state, eliminating the need for them to bill insurers and to develop distinct storage and inventory procedures that would separate vaccines by payers. The cost of vaccines was lower when the Department purchased them, because of special discounts allowed to government agencies: the overall cost to the health care system would be higher if pediatricians bought the vaccine and billed insurers. Some pediatricians raised the prospect of providing fewer vaccines to their patients, because they could not absorb the added costs to their practices. This was not good news just as primary care doctors throughout the state were being asked to take on heavier patient loads because of the influx of previously uninsured patients.

Out of the alarm felt by pediatricians, public health advocates, insurers, and a coalition of organizations including insurers, hospitals, state agencies, the Massachusetts chapter

Groundwork



State legislature passed a school nutrition bill in 2010 that banned junk food in vending machines and Fryolators in schools

“Health and economic development are inextricably linked.”

– The Alliance for Business Leadership

of the American Academy of Pediatrics and public-health advocates proposed an innovative approach that would prove to make it easier to propose the Prevention and Wellness Trust: a plan to assess each insurer for its fair share of the cost of childhood vaccines and deposit the combined funds in a trust to be allocated by the legislature to the Department of Public Health. That would allow the continuation of the historical Department-run universal vaccine model while eliminating the new burden to pediatricians. Insurers, not the state, would pay the \$50 million annual purchase of vaccines.

3. An effort to focus on public health even when state funding is not available

During this period, public health advocates worked hard to make the case that the deep public health cuts were dangerous and had the potential to sabotage health care reform; they held rallies, visited legislators, testified at hearings, and talked to the media. Some cuts were minimized, but restorations were not forthcoming. Public health remained one of the hardest hit government agencies.

The recession, combined with increased health care costs and a legislature averse to raising revenue, made it challenging to provide government funding for public health programs. So prevention advocates also approached elected officials about other no-cost action steps they might take to promote wellness. These efforts created an environment in which it was later possible to make the case for the Prevention and Wellness Trust.

The state legislature passed a school nutrition bill in 2010 that banned junk food in vending machines and Fryolators in schools, while guaranteeing access to low-fat options and fresh fruit and vegetables. And it created a Prevention Caucus in 2010 headed by a knowledgeable and well-respected veteran senator, Harriette Chandler, and a smart, newly elected hard-working representative, Jason Lewis. The two co-chairs used the Caucus forum to organize a series of compelling and well-attended educational sessions on public health and prevention. In the forums, they highlighted the work occurring around the state, including the Mass in Motion campaign, which began in 2009. They came to understand and appreciate the importance of prevention with a fervor and commitment that reverberated through the State House. They were well-positioned to become the co-sponsors of the bill to create a Prevention and Wellness Trust.

4. A recognition that new approaches are needed to control costs: preventing chronic disease

Even if Massachusetts leaders were proud of their accomplishment in providing health insurance to all residents, they were dismayed at the continuing inability to control costs. Before the 2006 passage of Chapter 58, Massachusetts had the unfortunate distinction of having the highest health care costs in the nation. While expanding health insurance did not significantly increase those costs per capita, it also did not appear to be helping bend the cost curve in the short run. And the state was spending significantly more money on health care as a result of the sheer increase in numbers of insured.

Groundwork

A Council was established in 2007 to control costs and promote quality.

Chapter 58, however, did put in place a number of focused efforts to begin to address costs. With concerns about access no longer as worrisome, much more attention could go into the analysis of cost.

As part of Chapter 58, a Cost and Quality Council was established in 2007 to control costs and promote quality. The state's Medicaid program applied for federal waivers to help it innovate. Public hearings were held annually to consider alternative policy approaches. The Attorney General released a study indicating that quality of care was not associated with cost. The legislature held many public forums to solicit input into the proper approaches.

At many of the public forums, individuals and groups testified about the value of considering prevention and wellness as a strategy for reducing costs. Members of the coalition that had worked effectively to pass Chapter 58 continued their deliberations in the years that followed in order to actively participate in the debate about cost and to ensure continued access, affordability—and increasingly, health—for consumers.

A general consensus arose from these activities: There is no single solution. Historically, costs had often been controlled by reducing access to care. In the post-reform era, that was not a possibility. It was the atmosphere of genuine openness to creative approaches that made it possible for prevention to be seriously considered. Two additional bills, Chapter 305 and Chapter 288, tackled portions of the unfinished business of health care reform, including development of the primary-care work force and increased transparency and rate review for insurance companies.

Both follow-up bills addressed prevention and wellness in ways that were modest but pointed to the rising star of prevention. The

cost of unmanaged and preventable chronic disease was receiving increasing attention from advocates, in health policy literature and the media.

Senator Richard Moore, the chairman of the Senate Health Care Finance Committee and a driving force behind the passage of Chapter 58, declared he would make it his cause to ensure that public health and prevention be considered in the state's "payment reform" bill, Chapter 224. He repeatedly warned of the negative consequences of the state's annual public health cuts. His support increased the likelihood that a proposal to create a trust would be taken seriously.

5. An appreciation of promising population-based chronic disease prevention initiatives

In Massachusetts as in the rest of the nation, the rates of overweight and obesity had been steadily increasing for decades, and with them a disturbing rise in the rates of diabetes and other chronic diseases. But just at the moment that there was growing consensus that something had to be done, the recession hit and the public health budget took a nosedive.

In response, the Department of Public Health led efforts to establish a unique public-private partnership to mount a campaign against obesity. The Department convened a working group of more than 50 individuals and organizations. Out of that effort, Mass in Motion (MiM) began in 2009. This comprehensive effort led to regulations that required Body Mass Index (BMI) testing in schools and an executive order requiring that large state agencies include healthy options in their food purchase contracts. The cornerstone of MiM was the distribution of grants to local cities and towns to change policies so that the

Groundwork

Many leaders from very different sectors voiced their support for the new, ground-breaking bill

healthier behavior would be the easier one. Funding came from five foundations and an insurance company, pooled in coordination with DPH.

Scores of mayors applied for funding. Within a few years, the grants had resulted in the mobilization of diverse sectors in each funded city and town and visible health-promoting policy changes. Later, when the CDC's Community Transformation Grant funding became available, Massachusetts was able to demonstrate that it already had an effective model in place. The federal funding supported an expansion of MiM, and many more cities and towns became involved.

Massachusetts legislators took notice. They liked what they heard from their constituents about MiM-related local efforts to create urban gardens, and recreational activities for children, and from enthusiastic coalitions that linked high schools students and elders with health care facilities. This created an atmosphere in the legislature that was receptive to expanding similar work, with constituents in legislative districts across the state who understood and had a stake in prevention funding. Advocates were able to explain to legislators that the Trust proposal would expand programs like Mass in Motion.

6. A broad-based coalition that cut its teeth in the fight for health care reform

Chapter 58, which was designed to extend access to coverage, was the result of effective mobilization and support facilitated by Affordable Care Today! (ACT!) – an unusual coalition of public health and health access advocacy groups including Health Care For All (the lead agency of the coalition), the Massachusetts Public Health Association

(MPHA), the Boston Public Health Commission (the city's health department), and the Greater Boston Interfaith Organization (GBIO).

Many leaders from very different sectors also voiced their support for the new, ground-breaking bill. For example, senior leaders at Partners HealthCare, the largest hospital system in the state, had a strong commitment to expand insurance coverage to the poorest and most vulnerable people in the state, and were allies and strategists with the coalition. Other key but informal allies included Nancy Turnbull, now at the Harvard School of Public Health and the former president of the Blue Cross Blue Shield of Massachusetts Foundation, and Christie Hager, who had helped formulate Chapter 58 while a legislative policy director for the Speaker of the House, and who later became the Region 1 Director of the United States Health and Human Services Department.

After the passage of Chapter 58, the natural inclination of the coalitions – both formal and informal – was to disband. Their goal had been accomplished. But wisely, the group stayed together and met regularly, to focus on making sure the bill was successfully implemented. Funding from the Robert Wood Johnson Foundation helped continue the activities of the ACT coalition. A more informal group mounted a media campaign to encourage support for expanded coverage.

Importantly, even once the bill was successfully implemented, state leaders did not consider the work done. There were still issues that had not been fully addressed, related to the cost and quality of care. Health Care For All decided to form a new coalition on the successful model. This coalition would focus on quality care and payment reform.

Groundwork

Public health advocates also wanted prevention added to the list of unfinished business. But they didn't have a vision for what an actual proposal to implement prevention should be. It was crucial that public health advocates stay at the table with the health care access advocates, pushing for prevention: when the access coalition was ready to support a prevention "ask" in the next bill, public health advocates could take the lead in developing the proposal.

Public health advocates knew what was needed: stable financing.

The Massachusetts Public Health Association (MPHA) convened a small coalition to support a new, stable source of funding for primary prevention. The original core group convened by MPHA included Health Care for All, Health Resources in Action, the Greater Boston Interfaith Organization, and the Boston Public Health Commission. Playing major roles in the passage of Chapter 58; the experience, understanding, and relationships these groups had gained were invaluable to the credibility and effectiveness of the Prevention Trust campaign.

7. An unusual collection of leaders from diverse fields

The conditions in Massachusetts were ripe for the consideration of a proposal to promote prevention and wellness. But that didn't mean there was going to be new funding or an innovative way to do the work. The passage of the bill establishing the Prevention and Wellness Trust was the result of an extraordinary set of individuals who developed a wise and strategic plan to gain wide support for its creation.

“Successful Reform Depends on Prevention”

– The Campaign for Prevention in Payment Reform

People Who Made the Difference

Nancy Turnbull – the Trusted Expert



Turnbull encouraged the advocates to pursue fixes, and, importantly, concurred with them that an assessment on insurers was a reasonable strategy for funding.

As the early group of core advocates brainstormed ideas for a prevention trust, they knew they had to go speak with Nancy Turnbull, now the associate dean for educational programs at the Harvard School of Public Health, who has long been a trusted, no-nonsense, independent thinker in health care finance. Like many key players in Massachusetts health and health care policy, her roots extend back to the Governor Dukakis Administration, in which she served as the deputy commissioner of the Division of Insurance. She played a key role drafting portions of Chapter 58, and then, once she became president of the Blue Cross Blue Shield Foundation, in furthering the public discussion that led its final passage.

In 2008 and 2009, Turnbull was concerned that major cuts to public health were at the same time that the state's key health care policy players were lauding the success of expanded health insurance and health care institutions were only accumulating resources. The intention of health care reform had never been gut public health, she told the core group—but as a result of the recession and stronger pressure to protect the new health insurance expansions, that was just what was happening.

Turnbull encouraged the advocates to pursue fixes, and, importantly, concurred with them that an assessment on insurers was a reasonable strategy for funding. She offered to help analyze several different financing scenarios, including assessing the significant reserves of some insurers and hospitals. She stayed in touch with the advocates, answering questions as needed, signing onto letters supporting the Trust, and giving public support and credibility for the idea in high-level health policy circles.

In Turnbull's opinion, once key players agreed on the idea of a trust for prevention, the question became how to fund it—and how to make that amount as big as possible. "There are billions of dollars in the system that aren't being spent on what could really make people healthy," she says. "I would have supported putting much more money into the Trust" than the amount the state finally voted.

Turnbull says that the annual surveys and reports on health insurance and access to health care and released by the Massachusetts Division of Health Care Finance and Policy helped illuminate progress and gaps. These reports captured baseline information before Chapter 58 went into effect, and then updated it to show the impact of reform. Turnbull recently reflected that it was a mistake not to include health indicators in those reports alongside indicators of access and coverage. "Massachusetts was very focused on health insurance and access," she says. "Yet we know that health insurance alone is insufficient to better health."

People Who Made the Difference

Cheri Andes – The Faith-Based Grassroots Powerhouse



GBIO played an important role in building broader grassroots awareness and support, expanding the strength and power of the campaign

Cheri Andes and her family have lived through many preventable health and health care nightmares, including her father's death at age 60 from stage 5 lung cancer, complicated by undiagnosed bipolar disease. A longtime smoker, his instability led to frequent moves – and the inability to follow up on a suspicious chest x-ray several years earlier. Andes carried these and other experiences into her organizing work, motivating her to create better conditions for other poor and working people.

Until recently, Andes was the executive director and lead organizer for the Greater Boston Interfaith Organization (GBIO), which was founded in 1996 and includes among its members scores of churches, synagogues, and mosques. The diversity of its members and its ability to mobilize diverse religious congregations at the grassroots level has made GBIO a respected participant in statewide and local policy discussions. Under Andes's leadership, GBIO became involved in the debate about health care access, and ultimately engaged its members in support for the Massachusetts' universal health care law in 2006.

After that fight was won, GBIO turned its attention to the quest for more affordable and high-quality care. The group knew that payment reform was the next big thing, and sought and received grants to take a year to study the complicated issues. It surveyed its members and was surprised to find that most churches, mosques, and synagogues had already developed programs related to healthy living: walking groups, diabetes management, healthy eating, and more. GBIO leaders believed that health care should address nutrition, behavioral health, and social needs. So when they developed GBIO's list of priorities for any cost and quality reform, it included prevention.

GBIO held a conference entitled "Bringing it Home" at which numerous congregations shared their public health programs with each other. Many of them heard for the first time about the idea of the Prevention and Wellness Trust. GBIO leaders and the congregations liked the strength and clarity of proposals to provide funding for healthy food for poor people, bike paths in communities that needed them, and safe, enjoyable parks.

GBIO played an important role in building broader grassroots awareness and support, expanding the strength and power of the campaign—including mobilizing its many members to make constituent legislative visits. The involvement of so many faith-based state residents helped tip the balance on the support for the trust in the legislature.

Andes is hopeful the partnership between the GBIO and the public health community continues as the trust is implemented, "It holds great potential," she says. "But it will require continued vision and leadership."

People Who Made the Difference

Valerie Bassett – the Advocate



“I planted the seed of this idea and believed in it against the odds, watering and feeding it to a healthy viability. Then it took so many others to make the Prevention and Wellness Trust a reality.”

Even though happy with the passage of health care reform in Massachusetts, Valerie Bassett was frustrated, too. She had been a strong supporter of its passage in her role as director of intergovernmental affairs at the Boston Public Health Commission, and was an active participant in the coalition that had mobilized consumers, advocates, and public health officials to insure its passage. Yet after it passed, she regretted the limited role for public health in the health reform process.

When she became the executive director of the Massachusetts Public Health Association (MPHA), Bassett was prepared to be more actively involved in the continuing reform-related legislative process. She successfully advocated for the inclusion of prevention as a priority of the coalition of organizations advocating for a new round of reform-related laws. And through MPHA, she convened a handful of advocates to strategize and draft legislation to tie financing for primary prevention to the payment reform bill.

It was Bassett’s idea to create a Prevention and Wellness Trust. It came to her in part because a trust had worked successfully to solve recent cuts in the state’s pediatric immunization program. The important point the advocates wanted to make was that public health and prevention are directly related to health care costs. By funding expanded insurance while cutting budgets for public health, the state had been missing this piece of the puzzle.

In the fall of 2009, using contacts from her days working at the Blue Cross/Blue Shield Foundation, Bassett floated various ideas to insurers and hospital groups, and was pleased to discover that there was indeed support for expanded prevention efforts, particularly if they could be funded by a tobacco or soda tax. But new tobacco and soda tax proposals had not been well received by the legislature when the state’s governor proposed them, and were unlikely to pass. So the advocates aimed for financing that was hard-wired to health care payments rather than a Department of Public Health budget appropriation—which, as she and others had witnessed, would be vulnerable to continued cuts. Taking a cue from the success of the Pediatric Immunization Trust, which had been the way she and other advocates had remedied cuts to the state immunization program, she proposed an assessment on hospitals and insurers.

No one—including her—thought it had much of a chance of passing. But she used her skills and contacts to push the idea. And much to her surprise, it was taken seriously. “Legislators were hungry for solutions to control medical costs,” she says. While it was difficult to find a sponsor, the advocates finally found one in a young and idealistic, newly elected legislator, Rep. Jason Lewis (see profile, page 16), who had been recently appointed to the Joint Public Health Committee and was House Chair of a newly developing Public Health Caucus.

MPHA and other advocates visited legislative leaders one by one and asked for their support. More grassroots advocates joined the cause, and the coalition built momentum for a trust, delivering a strong message about the dangers of public health cuts and the power of prevention to reduce medical costs.

Coalition

THE PREVENTION IN PAYMENT REFORM COALITION

The many groups who came together to create the Prevention and Wellness Trust found ways to turn a strong but idealistic vision into practical, funded reality.

Led by the Massachusetts Public Health Association, advocates developed a bill creating the trust that would be introduced separately from payment reform legislation. At the same time, they met with legislative leaders to include language creating the trust in drafts for the payment reform bill. The goal was to have the trust included in payment reform, which was the “moving vehicle” of that legislative session—a bill they knew would pass. But payment reform brought with it its own set of controversies. So while those were discussed and settled, the advocates could build momentum separately.

A core group of advocates calling itself Prevention in Payment Reform Coalition developed a list of possible funding mechanisms. They suggested the formation of an oversight body that would include public health leaders as well as leaders from hospitals and health insurance providers—a committee that was eventually appointed. They wanted the work of grantees to be data-driven, with significant evaluation and measurement of impact. Funding would be based on an assessment of the main preventable and most expensive conditions in Massachusetts—and a compendium of proven strategies to address them. Using a proven model, advocates wanted the trust to give prevention grants to community groups.

An assessment on insurers would be the best approach, the coalition members agreed. Insurers, after all, stood to gain the most if patients were healthy. Because the members also wanted to stay flexible, they decided to consider other funding options for the trust, with a set of criteria for potential funding sources: political viability; administrative

simplicity; structural connection to the health care financing system; and sustainability, meaning that funds would be unlikely to be diverted to other uses.

The coalition found natural allies in groups already grappling with the impact of poor health on underserved populations. One, the Greater Boston Interfaith Organization (GBIO), had already formed walking and healthy-eating groups, and organized diabetes-education and other activities to promote wellness. Another, the Jewish Alliance for Law and Social Justice (JALSA) joined the campaign. Like GBIO, it wanted people of all incomes to be able to live in healthy communities and have access to healthy food.

Importantly, the coalition found allies in business, including the Alliance for Business Leadership, which was active in its support of the goals of a trust—if not the funding mechanism. To attract more business leaders in a similar position, the coalition planned a campaign on two tracks. A broad campaign encouraged people to sign onto letters of support for the trust without identifying a particular funding mechanism. This eased the way for hundreds of groups and individuals to sign letters of support.

In a second, inside campaign, core members of the coalition met with legislators to press the case for prevention’s return on investment (ROI). Advocates presented budgetary analyses that made the case that money would be saved if rates for widespread diseases like hypertension and diabetes were lowered. The message resonated with many policymakers. But because of limited research on the efficacy of primary prevention, there was no

Coalition

precise formula for how much to invest in specific public health interventions in order to lower disease prevalence. Based on economic modeling done by the Urban Institute, the coalition proposed that an investment of \$10 per person would yield significant cost savings.

As the legislation advanced, there were compromises and changes to address the concerns of different interests. The total amount of the trust was reduced from the originally proposed annual \$75 million to \$60 million over the course of four years; lawmakers were ultimately unwilling to establish a fund in perpetuity without proof of its effectiveness. Rather than an annual assessment on hospitals and insurers, the assessment was changed to occur just one time—and only on insurers and the better-resourced hospitals that served primarily privately insured patients. The assessment would also fund costs for health information technology and support struggling community hospitals.

In August 2012, the governor signed Chapter 224, the Payment Reform Bill, into law, creating the Prevention and Wellness Trust Fund. Now public health leaders are working to implement the trust, and advocates have shifted their role. The Prevention in Payment Reform Coalition dissolved. Now MPHA's Act

FRESH coalition, which includes many of the same members, is monitoring the process, maintaining the engagement of stakeholders and laying the foundation for the reauthorization of funding.

Because the program has a four-year sunset unless it can prove cost-savings, the pressure is high to accomplish short-term savings. "We intend to show that public health can save money," the new Massachusetts Department of Public Health commissioner, Cheryl Bartlett, says. "Initially our focus is on secondary prevention, because that is where there is room to show real savings" in the short term. "We are supporting limited primary prevention work now," Bartlett says. But "the real support" for the primary prevention efforts the trust wants to support will be "down the road," she adds, "after we show that our funded models work."

The next moment of truth, to show those results and keep the Prevention and Wellness Trust funded will be in 2017 and 2018. The advocates are already planning their next campaign.

People Who Made the Difference

Jason Lewis – the Legislator



When Jason Lewis started paying attention to health and prevention, he noted that there was an inconsistency between legislators' verbal support for prevention and their actual votes on the state budget.

When Representative Jason Lewis was elected for the first time, in 2008, he didn't expect to be working on health issues. He had an unusual background for a legislator. His family had emigrated from South Africa when he was twelve. As an adult, he had already had a successful career as a manager of software companies. He entered the legislature with two issues in mind—education and human rights. He was elected after the passage of the state's health care reform bill, and he thought the big issues had largely been resolved.

But he found himself appointed to the both the Health Care Finance and Public Health Committees in the legislature—and that meant he heard more and more about health. Describing himself as naïve and idealistic, Lewis kept an open mind as he began to hear about the issue of health prevention. Once he started paying attention to health and prevention, he says, he found an inconsistency between legislators' verbal support for prevention and their actual votes on the state budget—votes that consistently involved cutting the DPH line items focused on prevention.

In spite of his growing interest, he was initially wary of the idea of supporting a bill with the provocative proposal to create a prevention trust—especially given his rookie status as a legislator. The advocates for the bill agreed with him that he wasn't the ideal lead on the bill. He just wasn't senior enough.

But that changed over time. First of all, the advocates for the Trust couldn't find a more senior legislator in the House willing to file the bill. In addition, Lewis became more interested in the idea as he learned more about the Affordable Care Act and its inclusion of a Public Health and Prevention Trust. And he was impressed by Mass in Motion and the early indications that it was making a difference. "Mass in Motion had a good buzz in the State House," he says. "The legislators liked the idea of that type of activity in their districts."

In drafting the language of the bill, the big uncertainty was the funding mechanism. The proposal called for the insurers to pay. Needless to say, insurers didn't like that language in the draft. Lewis reached out to insurers and told them that this was not necessarily the way the Trust had to be funded, even if it was in the initial bill. After all, he told them, payment reform was coming: that would create new opportunities to work on the source of funding before the final bill was voted on.

The patient and easygoing Lewis was philosophical about the legislative process. His approach, he says, was to "Be flexible about the legislative language and be willing to broaden it to appeal to more legislators and interest groups." This won him allies who found he was open to discussion and amendment. He also bent over backward to be respectful of other legislative leaders so they wouldn't feel it was all about him or other particular legislators.

Lewis was soon approached by the Massachusetts Health Council about taking one additional step: forming the legislature's Prevention for Health Caucus. The Council had been promoting the idea of such a caucus for years, searching for a legislator who would support it. Lewis was ultimately convinced that this, like the Trust, made sense particularly after learning that a strong and well-respected leader in the Senate, Harriette Chandler, wanted to join him as co-chair of the caucus. Lewis and Chandler organized regular educational sessions at the State House with the continuing support of the Council. By the time Chapter 224 came up for votes, the two had built solid support for the idea of the Trust.

People Who Made the Difference

The Senate Leaders



The Massachusetts Prevention and Wellness Trust needed support in the state legislature to pass. And it got it in the Massachusetts Senate. Senate President Therese Murray indicated early on that she viewed the idea favorably. When Prevention Trust advocates met with her chief health policy director, David Seltz, about their proposal, Seltz said that Murray already wanted prevention to be a signal component of her payment reform proposal.

Murray indicated that she considered public health strategies a necessary part of the arsenal against preventable medical costs. “Chapter 224 takes the first steps to reduce costs tied to diseases like diabetes, obesity, and asthma and includes several wellness efforts including the Prevention and Wellness Trust Fund,” she says.

The support of a leader at the highest level who was part of all of the critical discussions about payment reform legislation helped assure that negotiations included the trust. And other Senate leaders also played critical roles. Senator Harriette Chandler, Assistant Majority Leader, was the Senate sponsor of the bill as well as the Senate chair of the new Prevention for Health Caucus. Along with Representative Lewis, the House sponsor of the bill and co-chair of the Prevention Trust, Chandler was out front talking to her colleagues about the bill and the importance of prevention. The caucus held sessions that highlighted the types of community-level programs the trust might support. “Through the caucus,” Chandler says, “we were able to raise awareness, broaden outreach, and inspire legislative initiatives for prevention strategies.”



Longtime public health leader Senator Richard Moore, the Senate chair of the Health Care Financing Committee, was also determined that prevention play a notable role in payment reform. As a senior Senate leader and the go-to State House leader on health issues among his peers, Moore used his influence to advocate for preventive approaches while chairing legislative hearings on cost controls around the state. “Part of our goal to contain and ultimately reduce health care costs,” he said, “involves helping people to get and stay healthy.”

With the solid leadership of Murray and backed by two of her high-level leaders, the Trust was positioned for passage in the Senate. Because the Senate version proposed \$100 million over five years for the trust, compared to \$20 million over four years in the House version, it was possible to reach the final level of \$60 million over four years.



“Part of our goal to contain and ultimately reduce health care costs involves helping people to get and stay healthy”

– Senator Richard Moore, *Senate Chair of the Health Care Financing Committee*

top: Senator Harriette Chandler
center: Senate President Therese Murray
bottom: Senator Richard Moore

What Other States Can Learn

The Challenge to Come: What Other States Can Learn From Massachusetts

While the Prevention and Wellness Trust is an exciting leap forward, Massachusetts still spends the vast majority of its health dollars on “sick care” versus primary or secondary prevention. There is a long road ahead to better distribute health dollars toward actual health. In addition to diligence and persistence in Massachusetts, this will take innovations around the country to build new models, evidence, and popular and political support for expanded prevention.

Other states will make their own path, based on local opportunities. But the Massachusetts experience may provide lessons that suggest some of the ingredients for successful efforts to dedicate funds traditionally restricted to health care to prevention. Champions are needed who believe in the rightness of this approach, despite long odds, low expectations in public health, and opposition from groups opposed to any redistribution of funds.

A strategic campaign will also be built on a foundation of advocates’ understanding of the landscape of health and payment reform—and relevant opportunities and policy levers. Advocates should have credibility and relationships in the world of health care policy as well as public health. The ideal coalition will bring together health access advocates with public health advocates for a common cause of better health for all and preventing avoidable medical costs. A strong grassroots advocacy organization is a critical ingredient. And advocates should actively convene and stay in conversation with the private sector of employers, especially hospitals and insurers.

An important precondition is to establish a baseline of understanding among policy-makers and the health care sector about what primary prevention looks like—specifically, what kinds of programs could and should receive investments. And advocates should be able to clearly convey a strong message about what is being spent on preventable health conditions and what kind of savings can result from increased total population health investments to prevent as well as manage chronic disease and other avoidable health problems.

Public health needs to bridge its research and knowledge to the framework of actuarial analysis and return on investment. For this kind of initiative, evidence-based public health interventions should be targeted to preventable and costly problems. In the area of primary prevention, data are still emerging about the impact of policy changes and interventions like healthier food in schools and “complete streets” policies that make walking and biking easier. Because it will be months or years before the data come in, it will be difficult in the short term to demonstrate the impact of these changes.

But persistence is essential. Linking increased prevention investments, however they are funded, to the mission to reduce medical costs will require a strong focus on the evidence base—and a commitment to collecting additional high quality evidence, especially for primary prevention.

Finally, a lesson from the Massachusetts experience was the value in steadily building a framework for a prevention-oriented

What Other States Can Learn

health system by seeking funding—sometimes in a piecemeal manner—whenever the opportunity arises. For example, in 2011, the CDC's Community Transformation Grant (CTG) Request for Proposals required a clinical component, which encouraged the Department of Public Health to focus on community-clinical linkages in ways not previously explored.

DPH discussions went beyond promoting coalitions and fostering dialogues between providers and community-based organizations and moved toward nuts and bolts conversations about how to develop a genuine collaborative system of care. The CTG funding that the department received later that year supported initial work to create electronic bi-directional referrals between primary care providers at community health centers and community-based agencies.

The next step in building a new framework came with the application for a CMS State Innovation Model grant in 2013 to develop open-source referral software, which could make the community-clinical partnership a reality. These grants laid the groundwork upon which the Trust could build and fund collaborative grants.

Policy Players

Massachusetts Health Care Policy Players: the role of major insurer and hospital group leaders

One of the oft-discussed elements of Massachusetts health care reform's success was the cooperation among key health care leaders and advocates. Bound in many cases by decades-long relationships, these individuals shared a belief in the importance of expanding health care access. A foundation of mutual respect and creative and intelligent problem-solving combined with willingness to compromise made possible collaboration of passionate advocates, business leaders, hospitals, and insurers. Groups were willing to support policies that did not obviously serve their self-interest for the sake of the larger shared goal.

Through the convening activities of the state's largest hospital system, these leaders continued to meet after the successful passage of health reform and to play a role in supporting implementation. However, according to one leader, after health reform was a few years into its implementation, the group did not stay as tightly unified. For example, there were no longer standing meetings at which various proposals and issues could be vetted and discussed.

Many of the same key leaders in advocacy for Chapter 58 played key roles in Chapter 224. And as in the case of Chapter 58, the initial expansion of health-care coverage, they shared a similar sense that everyone would have to give up something to achieve a common goal, in this case reigning in costs. But what about the idea of a Prevention and Wellness Trust? Were they willing to compromise on something for the sake of that goal?

Hospitals and insurers and their associations supported the need to do something about prevention and wellness, and even the idea of a trust. However, there was not the sense of shared responsibility for prevention that there was for health insurance expansion. Yet in the opinion of Nancy Turnbull, Associate Dean for Educational Programs at the Harvard School of Public Health, once the idea of a trust for prevention was out there, key players agreed on it. The question was just how to fund it.

Steven Bradley, MPHA Board President and Vice President, Government & Community Relations and Public Affairs for Baystate Health, preferred a trust that would be funded differently from what occurred. "The best chance to fund public health programs might be to earmark funding off the top of the state's total health care expenditure or a percentage of every Accountable Care Organization (ACO)'s contract dollars and have it controlled and managed by public health experts." Other approaches were also floated.

The Blue Cross Blue Shield of Massachusetts Foundation (BCBSMA) gave a grant to the Massachusetts Public Health Association for its work to convene advocates to give voice to the need for public health and prevention in payment reform. Former BC/BS Foundation president Sarah Iselin explains, "It was so clear, the critical role that public health plays in making communities healthier and health care more affordable. Investing in advocacy and deepening the consumer voice and engagement in critical policy issues of the day is a core part of the Foundation's mission."

Policy Players

“The passage and implementation of health care reform should be viewed not as an end in itself but rather as part of an important process to improve health”

– Matt Fishman, *Vice President of Community Health for Partners HealthCare*

However, insurers and hospital groups did not support the assessment on their sector as a means to fund the trust. Business groups expressed concern that another assessment on insurers would result in even higher insurance premiums for businesses. This could have been an insurmountable opposition. Why wasn't it?

Certainly, the assessment for the Trust was not as burdensome to hospitals and insurers as other measures the legislature might have passed. And perhaps it was seen as small change compared to other proposals to cut costs, such as setting hospital rates or capping or tapping into reserves. The insistence of the Senate President's office that there would be some kind of Trust and strong champions in the House and pressure by advocates also created pressure to negotiate.

As the payment reform bill progressed through the legislative process, a few health care leaders acted as communication liaisons with other leaders, proposing solutions and identifying resources, quietly helping to get to final agreement. However, because of delicate institutional politics, these people wouldn't want to take credit publicly for something that, on the surface, was against their institutional interests. Others just chose not to actively oppose it: this was a small piece of a complicated bill with more at stake for them, and it would not look good for them to be against it.

As with every piece of legislation, all parties negotiated inevitable changes in the language in order to address concerns of their sectors. For example, the final bill significantly reduced the amount of funding from what drafters proposed, and created a trust for only four years rather than in perpetuity, as an experiment to test if it had the power to affect medical costs. Health care leaders will be closely watching the impact of the grants and are looking for evidence of return on investment.

Health care leaders offered guidance for similar future efforts: Don't overlook the role of the private sector. Invest more time in convening and facilitating meetings with key sectors. They can play a critical role.

People who Made the Difference



Massachusetts Health Commissioner Cheryl Bartlett

Cheryl Bartlett is the person at the center of the implementation of the Prevention and Wellness Trust. She leads the Trust's Advisory Board and oversaw the writing and release of the Trust's first Request for Proposal (RFP). She was interviewed the week the RFP was released.

What is special and different about the Trust as contrasted with other work MDPH is doing?

"First of all, the Trust provides us with a large amount of funding, more than usual for a new public health effort. This offers us the possibility of demonstrating a measurable impact in a relatively short amount of time.

In addition, because the Trust funding is not part of a regular annual budget allocation, we have more flexibility. Any unspent money carries forward into the next year. So our contracted agencies won't be constrained by having to spend their budgets by the end of a fiscal year.

The Trust is unusual in that it requires a collaboration of municipalities, community-based organizations and clinical care providers. We will be supporting important partnerships that are likely to get results."

It also seems different in that it doesn't have a strict and limited categorical focus.

"True. But it is somewhat prescriptive because there are certain conditions that have to be met. We give the grant applicants the option of choosing from a list of four priority areas selected because they were ones where we believed we could demonstrate cost savings and health improvements in a relatively short time period. We intend to show that public health can save money. From prior work we know that falls prevention in the elderly and pediatric asthma interventions can make a measurable difference quickly. And because we have a short list of health issues we will be able to examine the varying efficacy of different approaches to addressing the same problem.

Initially our focus is on secondary prevention because that is where there is room to show real savings. We are supporting certain limited primary prevention work but the real support for that will be down the road after we show that our funded models work."

Do you think the Trust offers the opportunity to fund activities not funded with other grants? What is that?

"Communities never get enough money to make a noticeable difference in a short amount of time. This is different because it is large enough to result in policy and systems change. And it offers community-based-agencies and municipalities the opportunity to connect to the emerging reimbursement systems with global payments.

This is our chance to demonstrate to the clinical world that a population health management approach will yield health improvements and cost reductions. We believe we can demonstrate that there are ways to keep people healthy and to avoid expensive hospital settings.

We have a unique element in our new e-referral system, which is funded in part by our federal State Innovation Model grant. The system will provide a communication link between a primary care practice and the near-by community-based organizations (CBO). Using their electronic medical record, the clinical provider will alert a CBO of a patient's need for services such as tobacco cessation support, a home visit by a community health worker or chronic disease self-management training. Once a CBO gets the electronic referral it will contact the client, monitor his or her participation and provide updates to the primary care provider that feed right back into the Electronic Health Record.

We believe this will support care coordination and allow for more targeted follow-up for patients that need extra health promoting services. We will be testing it at different sites and with different types of community organizations that might get those referrals – VNAs, YMCAs and senior centers, for instance."

Do you believe that the funding for the Trust will be long-term – beyond the first four years?

"The role of the Trust is to pilot efforts that show the cost savings of different clinical-community partnership models in different settings. If we can establish the beneficial health and cost outcomes, global payment systems may see the value of care coordination and offer support for these efforts."

What advice would you offer other states regarding the consideration of this approach?

"There is a fair amount of the country that may not be supportive of expanding prevention efforts or of health care reform. Nonetheless, my experience is that we can find allies anywhere if we pay attention to their interests and show them how public health can address those interests. For example, businessmen have an interest in the resources of their business. If we can show that we can save them money by improving health outcomes and reducing expensive health care utilization, we can win them over. We've included workplace wellness in the RFP. We want to link the businesses and the employers in the area to our efforts. That is why we are focusing on some of the more costly patients first. Demonstrating a return on investment is so vital for public health. And that approach can work anywhere." ●

case study

MASS IN MOTION

WHAT A MASS IN MOTION COMMUNITY LOOKS LIKE

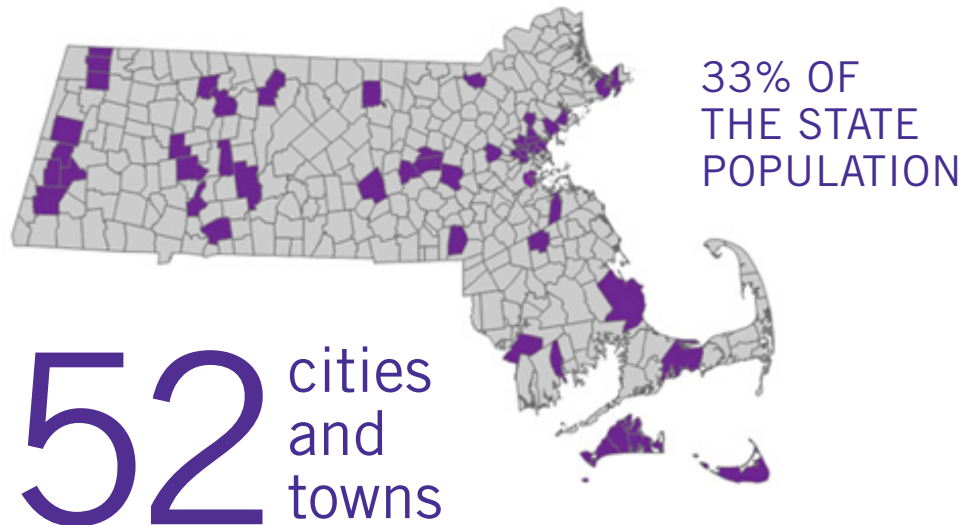
The passage of the Prevention and Wellness Trust was made possible in part because of the Mass In Motion Program. It was launched in 2009 as the Commonwealth’s effort to combat obesity and promote healthy eating and physical activity.

It had established a strong and positive reputation among a broad array of community and health care organizations as well as among elected officials. As a result they were more inclined to support the intended purpose of the Trust. They had observed in Mass in Motion the type of work if might support.

At the heart of the initiative was the distribution of grants to local coalitions led by the highest elected official/s in the community. The purpose of this funding was to change the conditions in the cities and town of the state so that the healthier behavior was the easier behavior.

While spearheaded by the leadership of the Massachusetts Department of Public Health, Mass in Motion was always a public-private partnership, a broad-based collaborative effort with many organizations playing important roles. The funding for the grants initially came from a unique set of organizations including five local foundations, an insurance company, a hospital chain and the state public health department. There had never been a public health program in state funded from such diverse sources. Later two large CDC Community Transformation Grants supplemented the Mass in Motion effort. From these diverse sources annual funding exceeded \$6 million and reached communities with more than one third of the state’s population. There are now 52 Mass in Motion cities and towns affecting 33% of the state’s residents.

Examples of Mass in Motion include:



case study

MASS IN MOTION

NEW BEDFORD is one of the original communities awarded the Mass in Motion (MiM) grants. This city of almost 100,000 is the sixth largest municipality in the state. A long time shipping and blue-collar community, New Bedford has large Portuguese and Cape Verdean populations.

With strong support from the mayor and a broad local coalition, the Mass in Motion funding was used to develop a community action plan that affected school, worksite, and community settings. Mass in Motion New Bedford increased walking and biking by creating a Southcoast Regional Bikeway, organizing adult supervised walking routes to schools and establishing a community-wide bicycle committee. The city developed healthy food vending machine policies to limit access to junk food, a children's public vegetable garden, and a healthy dining program with 14 participating restaurants.

New Bedford MiM has incorporated evidence-based health promotion interventions in primary health care, child care and schools or after-school programs. The local community health centers offer families on-site customized coaching about eating and exercise with a Childhood Obesity Learning Collaborative to ensure that clinic employees are knowledgeable and well trained in promoting wellness. Schools and day care centers in the city have adopted wellness policies and anti-obesity activities.

www.massinmotionnewbedford.org



case study

MASS IN MOTION

FITCHBURG, Massachusetts is a city of 40,000 people in the northern central section of the state. A blue-collar city with a growing Latino population and a relatively high unemployment rate, in 2009, Fitchburg had the second-highest body mass index (BMI) in MA.

In reaction, a coalition of organizations and the city's mayor, Lisa Wong, successfully applied for a Mass in Motion grant. With that support the coalition has started making positive changes for health by building community gardens, expanding access to local farmer's markets, creating an Adopt-A-Park program with 16 parks to promote safe and accessible recreation, and setting healthy vendor guidelines for park vendors. Mayor Wong personally was involved in the MiM efforts, at time strapping on roller blades and leading city employees in a lunchtime exercise regime.

The city's Planning Department has proposed the adoption of a "Complete Streets" resolution that would prioritize the development of safe walking and biking routes to parks and schools. Fitchburg is incorporating evidence-based interventions in primary health care, child care, and schools/after-school programs.

Today, Fitchburg no longer has the second highest BMI, having reduced its BMI obesity levels by 10% improvement since 2009.

<http://www.ci.fitchburg.ma.us/residents/fun-n-fitchburg>



Chronology of Process to Pass Prevention Trust Language

March 2009	MPHA develops recommendations to the Payment Reform Commission to include prevention in any proposal
April 2009	<p>MPHA signs on to support the Campaign For Better Care (CBC) coalition's principles for payment reform. (CBC was organized by Health Care For All to lead consumer support for comprehensive health care cost and quality reforms. It included many organizations that were active in earlier health access reforms.)</p> <p>MPHA submits recommendations to Payment Reform Commission that include support for CBC principles as well as calling for prevention</p>
Summer 2009	CBC coalition agrees to include prevention as one of its goals for payment reform
September 2009	MPHA submits testimony to the Health Care Quality and Cost Council about the need for prevention in payment reform
March 2010	MPHA submits testimony to the Division of Health Care Finance and Policy on the need for prevention in payment reform
October 2010	MPHA submits testimony and testified at Massachusetts Joint Committee on Health Care Financing (legislative) hearings about the need for prevention in payment reform
Spring 2010	<p>MPHA convenes core group of advocates to develop proposal for Prevention Trust, became Prevention in Payment Reform coalition (First outline of proposal is from May 5, 2010)</p> <p>Advocates consult with key stakeholders in government, hospitals, insurance, and business about the proposal and possible funding ideas</p> <p>Advocates meet with key legislators and staff to discuss the proposal, assess and build support, and identify sponsors: the Public Health Committee, Health Financing Committee, Speaker of the House, Senate President, and the emerging Prevention in Health Caucus</p>
January 2011	<p>Legislators file an Act to Promote Prevention and Wellness Through a Public Health Trust, co-sponsors Rep. Jason Lewis and Sen. Harriette Chandler</p> <p>MPHA signs on to the Better Care Campaign's principles for payment reform, which include a call for "promotion of public and community health."</p>

Chronology *continued*

May 2011	<p>Advocates host a State House briefing and press conference, and it is standing room only. “The Need for Prevention in Payment Reform: Evidence for Reducing Costs & Improving Health Outcomes” features Philip Edmundson, CEO of William Gallagher Associates, Christina Economos, PhD, Tufts University, Mary Giannetti, Fitchburg Mass in Motion, and Brenda Spillman, PhD of the Urban Institute’s Health Policy Center, who speaks on the cost savings to health care payers in Massachusetts if the state can reduce rates of hypertension and diabetes by 5%. Legislators who speak include the bill sponsors and Health Care Financing Chairman Richard Moore.</p> <p>Legislative hearing before Joint Committee on Public Health. Advocates organize a panel to testify</p>
July 2011	<p>Joint Committee on Public Health favorably reports the bill to Joint Committee on Health Care Financing</p>
September 2011	<p>Prevention in Payment Reform coalition delivers letter supporting Prevention Trust to the State House. Over 300 people and organizations sign, including business, religious, and municipal leaders.</p>
November 2013	<p>GBIO holds first Public Health Conference with members of 47 congregations to educate them about public health. A special session is included to educate and mobilize members in support of the Prevention Trust proposal, led by MPHA and HCFA.</p>
January 2012	<p>Coalition releases “Dear Colleague” letter signed by 49 representatives and senators supporting the bill</p>
March 2012	<p>Massachusetts Health Council holds a day-long conference on “Return on Investment on Prevention and Wellness,” which features a lunch address by MPHA, Rep. Lewis, and Sen. Chandler to educate and mobilize in support of the Prevention Trust proposal.</p>
March-April, 2013	<p>HSPH holds competition among graduate students to propose methods to integrate public health into payment reform. The competition includes a week-long series of presentations from 36 speakers (including MPHA) representing state and city government, public health organizations, patient advocacy groups, business and insurer groups, and medical providers. Teams of 5-6 students then write proposals to present to a panel of expert judges including legislators. The final winning proposal is presented at the State House, and includes the Prevention Trust proposal.</p>
Ongoing	<p>Meetings with key legislators with constituents to urge support of the Prevention Trust</p> <p>Mini “Lobby Days” of groups of supporters visiting legislators and dropping letters and fact sheets into legislator’s mailboxes</p>

Chronology *continued*

April 2012	State House rally and associated media coverage
May 2012	<p>House releases its proposed payment reform bill, which includes a Prevention Trust, but no dedicated funding source</p> <p>Senate releases its version of payment reform bill, which includes a Prevention and Wellness Trust funded at \$100 million over 5 years</p> <p>Senate passes its version of payment reform bill, Advocates push unsuccessfully to eliminate sunset provision</p> <p>The Alliance for Business Leadership hosts a call with its members to discuss prevention in the payment reform bills, featuring presentations from MPHA and John McDonough of the Harvard School of Public Health</p>
June 2012	<p>House passes its version of payment reform bill. An amendment is passed to dedicate \$20 million over 4 years to the Prevention and Wellness Trust Fund</p> <p>One-time hospital (which hits only large hospitals without a large percentage of Medicaid funding) and insurer assessment is determined as source for Prevention and Wellness Trust Fund. Other other priorities include a fund to support distressed hospitals and support electronic health records infrastructure. Advocates press hard for minimum of \$100 million for the Trust over five years.</p> <p>Greater Boston Interfaith Organization holds State House rally and lobby day, focused on two priorities, one of which is the Prevention Trust</p> <p>Trust for America's Health (TFAH) releases "Bending the Obesity Cost Curve in Massachusetts" directly to Conferees, leadership, and press. The brief, which focuses on potential savings from community-based prevention, is rushed to publication and coordinated closely with MPHA to have maximum impact on the conference committee deliberations.</p> <p>69 Representatives and Senators send a letter to the Conferees and leadership urging at least \$100 million</p>
July 2012	Conference Committee passes final bill that includes \$60 million over four years for the Prevention and Wellness Trust Fund
August 6, 2012	Governor Deval Patrick signs Chapter 224, including the Prevention and Wellness Trust, into law

Addendum

Completed Interviews on Health Care Reform and Prevention

1. Cheryl Bartlett, Commissioner of the Massachusetts Department of Public Health
2. Valerie Bassett, former Executive Director of the Massachusetts Public Health Association (MPHA)
3. Barbara Ferrer, Executive Director of the Boston Public Health Commission
4. Matt Fishman, Vice President for Community Health, Partners Healthcare
5. Anuj Goel, Vice President, Massachusetts Hospital Association
6. Christie Hager–Director, Region 1, Department of Health and Human Services
7. Sarah Iselin, Strategic Planning Director, Blue Cross Blue Shield
8. Rep. Jason Lewis, Co-chair of Prevention Caucus
9. John McDonough, Professor of Public Health Practice, Harvard School of Public Health
10. Maddie Ribble, Director of Policy and Communications, MPHA
11. Brian Rosman, Research Director, Health Care for All (HCFA)
12. Susan Servais, Executive Director, Mass. Health Council
13. Amy Whitcomb Slemmer, Executive Director of HCFA
14. Nancy Turnbull, Harvard School of Public Health, Board Member of the Connector, Harvard School of Public Health
15. Cheri Andes, former Executive Director and Lead Organizer, Greater Boston Interfaith Organization (GBIO)
16. Deborah Wengrovitz, member Temple Israel and GBIO

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