



Massachusetts' Prevention and Wellness Trust Fund

Financing Source: One-time assessment on acute hospitals and payers
Financing Amount: \$57 million over four years
Focus: Asthma

The Prevention and Wellness Trust Fund (PWTF) of Massachusetts healthcare reform legislation (Section 60 of Chapter 224 of the Acts of 2012) seeks to “reduce health care costs by preventing chronic conditions.” It is designed to address four priority chronic conditions including pediatric asthma. The pediatric asthma program activities include Care Management for High-Risk Asthma Patients; Home-Based Multi-Trigger, Multi-Component Intervention (minimum of three home visits, asthma self-management and education, trigger remediation supplies, environmental services); Comprehensive School-Based Asthma Management Programs; Comprehensive Head Start-Based Asthma Management Programs; and Asthma Self-Management in Primary Care. In 2014, nine communities have been funded to be PWTF sites: Six offer pediatric asthma interventions, and five have initiated home-based asthma visits. (Of the six PWTF sites, one had an established home-based asthma visiting program funded by another mechanism.)

Financing Mechanism

The Prevention and Wellness Trust Fund (PWTF) funding source is a one-time assessment on acute hospitals and payers. The funds, totaling \$57 million over a four-year period, have an allocation formula, and no more than 75% (\$42,750,000) can be used for grantee programs. Services provided by the grantee programs include pediatric asthma services. Each grantee received approximately \$250,000 for their capacity-building period and \$750,000 to 1.5 million per implementation year.

In 2013, the Massachusetts Department of Public Health (DPH), which administers the trust, issued a competitive Request for Responses (RFR). Applicants were required to assemble a team that included clinical, community, and municipalities or regional planning agencies, to ensure strong clinical and community linkages. The grant was awarded to the group as a “partnership.” The lead organization, defined as the coordinating partner, is the direct point of contact with the Department of Public Health and is responsible for the operations of the partnership. Nine partnerships were awarded grants in 2014. Each partnership has a governing body that includes representatives from all or most of the partner organizations in their project.

Grants were awarded in 2014 to fund programs until June 2017. The program is being evaluated, and implementers are exploring methods to make it sustainable. Currently, a report is due to the legislature in January 2017. The fiscal year starts July 1. The decision to continue the program after June 2017 may be immediate or otherwise.

Program Operations

The Department of Public Health manages the overall program, which is overseen by the Prevention and Wellness Advisory Board. Chapter 224 states that the interventions proposed need to be evidence-based (Chapter 224, Section 60, paragraphs d, e, and h). The RFR focused on five key strategies: use of evidence-based interventions, targeting of areas and populations with high disease incidence and/or high healthcare costs as well as targeting risk factors and diseases that lead to significant cost savings, promoting strong linkages between clinical settings and community organizations and resources, maximizing the return on investment, and promoting sustainable changes.

The Department of Public Health’s Asthma Prevention and Control Program (APCP) created an asthma home visiting protocol manual for the PWTF community health workers (CHWs) providing asthma home visits. This manual details

<https://nchh.org/tools-and-data/financing-and-funding/sustainable-financing-mechanisms/>

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guidance for each visit, educational materials for the families, and a checklist for CHWs to use at each visit. The APCP also offers training on the home visits and a mentoring program for CHWs who are new to the intervention. In addition, APCP offers a CHW supervisor training.

Eligible Population Served and Service Providers

Individuals 18 years or younger who meet the high-risk definition and have poorly-controlled asthma in accordance with the NAEPP guidelines are eligible.

Asthma home visiting eligibility criteria

- Not well- or very poorly controlled asthma as assessed by standardized asthma control test, or
- Have been hospitalized for asthma in the last 12 months, or
- Have visited the emergency room for asthma in the last 12 months, or
- Have had an unscheduled office visit for asthma in the last 12 months, or
- Have had one or more episodes/year of oral corticosteroids because of worsening asthma in the last 12 months.

Sites can be more restrictive in defining high risk but should not be more permissive.

Staffing

Programs can use CHWs, visiting nurses, home inspectors, or any combination best suited for their community. Programs are allowed flexibility in the model; however the CHW model is strongly emphasized. Whatever combination of providers is employed, programs have to offer at least three visits, provide supplies, involve CHWs, and promote a strong connection to the primary care physician.

Billing for Services

The PWF grant allows programs to fund “uncovered” services. Services offered in clinics are encouraged to be billed as traditional services. Grantees are required to have at least one CHW who is a full-time employee (FTE). They can employ a part-time CHW if they are able to show case load that does not require an FTE.

Outcomes and Evaluation

The PWF grantee program is built upon the use of data to measure results and drive change. Primary data sources for quality improvement include referral data taken from the electronic referral system (e-referral), electronic medical records of participating clinicians, and data collection from community-based organizations focused on their interventions. The Department of Public Health adopted the Institute of Healthcare Improvement’s (IHI) Learning Collaborative model to support grantee quality improvement (QI) efforts. The Department of Public Health encourages partnerships to use Plan-Do-Study-Act (PDSA) cycles to improve their intervention delivery.

Some partnerships have documented outcomes in the program’s annual report: The Worcester Partnership’s pediatric asthma intervention has demonstrated a [substantial reduction in ER visits](#) among high-risk asthma patients. Absenteeism also decreased, and CHWs from three clinical sites have completed over 100 home visits during the first year of implementation.

Return on Investment

PWF has also engaged Harvard Catalyst, external evaluators, who will work on a return-on-investment analysis. Their initial report is due January 2017.

Lessons Learned

It is important to have data on programs. The strong evidence base for the efficacy of asthma home visiting was essential to its selection during the advisory board’s extensive review for four priority conditions identified for the PWF program. It is important to continue to explore collaboration options after receiving funding which may generate new assignments. Implementing this program exposed the need for “intermediary groups” – seasoned groups that have used CHWs for many years and implemented evidence-based practices – who could guide and encourage new and emerging programs on the path of home-based asthma visiting programs.

For More Information

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<https://www.mass.gov/orgs/bureau-of-community-health-and-prevention>