Community and Clinical Partnerships: Lessons from the Prevention & Wellness Trust Fund Project

**SITUATION**

**Healthcare Crisis:** Prevention vs. Treatment
- **An individual’s health status** is determined by social determinants:
  - 50% lifestyle choices and available options
  - 40% due to environmental toxins and genetic predisposition
  - 10% by access to health care
- **Americans’ health dollars are spent:**
  - 88% on access to care and treatment
  - 8% on environmental and genetic factors
  - 4% on lifestyle choices and options

**A New Rationale**
- In 2012, the Massachusetts Legislature acted on this mismatch by passing Chapter 224:
  - Emphasis on cost containment
  - Focus on access to primary care and strategies to address health disparities
  - Investment in prevention with a focus on linking health outcomes to cost containment
  - Led to the creation of the Prevention & Wellness Trust Fund

**AIM**

**Prevention & Wellness Trust Fund (PWTF) – Overall Goal**
- Support community-based partnerships and provide evidence-based interventions to:
  - reduce rates of the most prevalent and preventable health conditions
  - increase healthy behaviors
  - increase the adoption of workplace-based wellness or health management programs
  - address health disparities

**Goals for the Worcester PWTF**
- More successfully address preventable health conditions and manage chronic disease
- Reduce health care costs through systematic change
- Add value by linking clinically prescribed activities to home and community-based resources

**POPULATION**

**Focus on portion of city** (105,742 residents)
- Lowest income and most diverse neighborhoods in the city at the greatest risk for health disparities
- Population composition for the area of focus:
  - 42% Black, 32% Hispanic/Latino
  - 27% live in poverty (Worcester is 20.1% compared to state 11.0%)
  - 12% live in poverty (Worcester is 20.1% compared to state 11.0%)
  - Childhood poverty is 31.4% compared to state 18%

**Conditions of Focus**
- Pediatric Asthma
- Hypertension
- Senior Falls (aged 65 and older)

**STRATEGY**

**Interventions**
- **Focus on conditions with prevention strategies** that have been proven to be:
  - **Effective:** Improve health outcomes
  - **Cost-effective:** Have a return on investment
  - **Timely:** Work within the timeframe of PWTF
  - **Equitable:** Reduce health disparities

**Prevalence of Priority Health Conditions**

**PWTF Intervention Activities**

**RESULTS**

**Percent of Patients Seen** (March – May 2015)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Baseline</th>
<th>Pediatric Asthma</th>
<th>Hypertension</th>
<th>Senior Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worcester</td>
<td>56.2%</td>
<td>56.1%</td>
<td>58.9%</td>
<td></td>
</tr>
<tr>
<td>MA State</td>
<td>768</td>
<td>1006</td>
<td>940</td>
<td></td>
</tr>
</tbody>
</table>

**Percent of PWTF Patient Referrals with Feedback Report**

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94%</td>
</tr>
<tr>
<td>No</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Achievements: Year 1**

**Implementation:**
- Asthma (n=9), HTN (n=4), Falls (n=5)
- Community Health Workers (N=23) serving as clinical-community linkage
- Asthma template is live & piloted by all sites; completed 102 home assessments
- Completed falls assessment tool; completed 50 home visits
- Provided CDSMP and SMBP for around 30 patients
- IT infrastructure investments to support e-referral capacity at one clinical site
- Presentations at multiple conferences

**Sustainability**
- Incorporated clinical screenings and referral process into standard operating procedures
- Established strong working relationships between clinical and community partners

**Lessons Learned**

**Opportunities**
- Learning opportunities with other eight partnerships
- Building infrastructure to address health inequities in the community
- Developing evaluation and reporting tools for community and clinical groups
- Potential to connect and use e-referral as a standard tool

**Challenges**
- Communications across different systems
- Evaluation and ROI – short period to demonstrate health improvement
- Infrastructure needed to support this work is just being developed now (assessments, systems, databases)
- Data systems in use are siloed and it is expensive and difficult to connect

**CONCLUSION**

**Going forward - Our Vision**

- Extend care into the community:
  - Clinical and Community Linkages
  - CHW are new care team members
  - Bi-directional information to track patient progress
- Change health culture to impact population health
- Expand to other health conditions to help bend the cost curve