

RESPONSE TO PUBLIC COMMENTS

Introduction

Improving the health and well-being of all residents in Connecticut and reducing the rising trends of Connecticut's health care costs depends on improving community health and health equity and preventing people who live, work, learn, and worship in communities from experiencing poor health. The proposed Health Enhancement Community (HEC) Initiative is aimed at supporting the health and well-being of individuals and families in communities across the state by improving community health and healthy equity and preventing poor health. This will be achieved through having Health Enhancement Communities (HECs) form and operate throughout the entire state. The HECs would work collaboratively to improve the social, economic, and physical conditions within communities that enable individuals and families to meet their basic needs, achieve their health and well-being goals, and thrive throughout their lives.

The HEC Initiative is a place-based initiative that will support long-term, collaborative, and cross-sector efforts that improve community health in defined geographies through broad, systemic change. HECs will implement multiple, interrelated strategies to address the social determinants of health that cause or contribute to poor health, health inequities, and health disparities in Connecticut's communities. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health include factors such as income and wealth, housing, health systems and services, employment, education, transportation, social environment, public safety, and physical environment.

The HEC Initiative also includes pursuing multiple innovative financing strategies to support and sustain HECs over time. The financing strategies would seek to reward HECs for health outcomes, health care savings, and other economic value they produce.

The HEC Initiative can create the right combination of conditions for moving the needle on prevention at a state level and help usher in a new era with prevention at the forefront of how Connecticut and the nation pursues—and pays for—the health and well-being of its residents. The HEC strategy is designed to address the complex and multi-factorial needs and challenges facing communities and “monetize” prevention so that activities and interventions that produce results can be sustained. With focused health priorities, effective structures, and appropriate financing, Connecticut can be the healthiest state in the country and the best state for children to grow up, slowing the growth of Connecticut's health care spending.

The Office of Health Strategy (OHS) and Department of Public Health (DPH) developed the draft framework following an intensive series of stakeholder engagements. These included direct engagement through in-person meetings, webinars, and emails with community members, existing collaboratives, health care providers, employers, community organizations, local government representatives, and others; meetings with stakeholder groups such as the Population Health Council and Design Teams, the Healthcare Innovation Steering Committee (HISC), and the Consumer Advisory Board; and work with Reference Communities which are existing community health collaboratives in Hartford, New London, Norwalk, and Waterbury with which the state contracted to engage in an in-depth framework design process from July to November 2018. The HEC Framework and Technical Report are a culmination of the planning process and articulated recommendations from stakeholders and stakeholder groups. The documents were approved for public comment by the HISC.

Public Comment

OHS and DPH received 20 public comments on the Connecticut State Innovation Model (SIM) Health Enhancement Community Initiative Framework and Technical Report. The comments can be accessed at the following links:

1. [Family Centered Services of Connecticut – Cheryl Burack](#)
2. [Connecticut Department of Children and Families – Charles Slaughter](#)
3. [Hispanic Alliance Mental Health Network \(HAMHN\)](#)
4. [Howard K. Hill](#)
5. [Frank W. Maletz, MD](#)
6. [Center for Health Care Strategies – Deborah Kozick](#)
7. [Connecticut Voices for Children – Sharon D. Langer and Karen Siegel](#)
8. [Connecticut Association of School Based Health Centers – Melanie Bonjour and Daniela Giordano](#)
9. [Anthem Blue Cross Blue Shield – Jill Hummel](#)
10. [Health Improvement Collaborative of Southeastern Connecticut – Russell Melmed](#)
11. [Department of Public Health – Christine Hahn](#)
12. [Connecticut Children’s Medical Center – Jane Baird](#)
13. [Reaching Home Health and Housing Stability Workgroup – Terry Nowakowski](#)
14. [North Hartford Triple Aim Collaborative – Gina Federico](#)
15. [Connecticut Hospital Association – Karen Buckley](#)
16. [Norwalk Health Department – Deanna D’Amore](#)
17. [Valandy Manohar, MD. and Supriyo Chatterjee, Msc MBA MA](#)
18. [OHS Consumer Advisory Board – Arlene Murphy and Kevin Galvin](#)
19. [United Way of Greater New Haven](#)
20. [Connecticut Health Foundation – Patricia Baker](#)

OHS and DPH have prepared the following responses to comments and questions.

1. **Family Centered Services of Connecticut- Cheryl Burack:**

Please recognize and recommend building on existing Connecticut child well-being interventions including the following:

The Nurturing Families Network through the CT Office of Early Childhood. The Nurturing Families Network is designed to prevent child abuse and neglect and improve health and developmental outcomes for children by providing screening, assessment, parenting education, home visiting and referral and linkage services to new parents and their children.

Home visiting is conducted by Family Support Workers trained and certified in the evidence-based Parents as Teachers curriculum. Family Support Workers can make weekly home visits for up to five years, with the frequency determined by the family’s needs and wants. FSWs act as teacher, supporter, advocate, catalyst, child development specialist and liaison to the larger community to help parents build parenting skills and educate parents about child development, child safety, child-rearing practices and other related aspects of positive parenting and to provide skill building in areas such as daily living skills including household management and budgeting. PAT includes developmental screenings in the areas of cognitive, language, social-emotional and motor skills to assist parents in understanding their children’s development and provide early identification of potential developmental delays and vision/hearing and health issues. Many families are also challenged by concrete external problems and the FSW will assist them by teaching problem-solving skills and effective use of community resources and linking them to other needed resources. All children will be linked to a medical provider to ensure that they receive well child care, immunizations on schedule, lead screening and other health services.

CT Medical Home Initiative through the CT Department of Public Health. Care Coordinators who are nurses and/or social workers provide culturally sensitive, developmentally appropriate care coordination services in support of community-based pediatric practice settings for children and youth with special health care needs (CYSHCN). An assessment is conducted that identifies strengths and needs in the following domains: medical, oral health, behavioral health, developmental, educational, recreational, financial, psychosocial. This results in a written Care Plan developed in partnership with the Care Coordinator, each child and family and their providers. Specialty providers, schools and other community resources are engaged in the process through face-to-face contacts, telephone calls and email. When appropriate, child, family and providers are convened to exchange information, answer questions and develop shared goals. The Care Plan identifies goals, planned interventions and desired outcomes along with action steps, timeline and responsible parties. The Plan addresses clinical and non-clinical (psychosocial, environmental, educational, recreational, vocational) needs. Copies of these care plans are offered to both families and providers to coordinate care. Portable health plans are also developed and can be placed with children, youth, parents, grandparents and caregivers, school, sports, child care providers and others to be available in case of emergency. Steps are taken to work toward the agreed-upon outcomes as the Care Coordinator works with the family and others to monitor and revise the plan as needed to facilitate service access. Care Coordinators also provide families with information about Husky, whether as a primary or secondary payer, and other insurance plans. They have assisted in the application process, educating them about eligibility requirements and benefits.

Circle of Security-Parenting currently funded by the CT Department of Children and Families, the United Way of Greater New Haven and community-based nonprofit organizations. Recognizing that the quality of parent/child attachment plays a significant role in the development and even life trajectory of a child, COS-Parenting is an early intervention to promote secure attachment. Used in a group or 1:1 setting, COS-Parenting promotes parental reflective functioning and the ability of the parent to recognize and respond to their young children's needs and help them manage their emotions.

Response A:

Thank you for your comment. The HEC strategy is designed to create a structure whereby existing effective prevention activities and interventions can be sustained and even expanded. The three programs referenced in your comment could be among those utilized by HECs to improve child well-being, if such programs align with the community's needs and reflect the input of the HEC's community stakeholders.

Depending on local needs and resources, some HECs may elect to incorporate the Circle of Security-Parenting program or Nurturing Families Network as part of an early intervention strategy to reduce exposure to adverse childhood experiences (ACEs). The care coordination work done through the CT Medical Home Initiative, aligns well with our [Primary Care Modernization \(PCM\) initiative](#), which is intended to strengthen practices' ability to support children with care coordination needs and to enable a greater focus on health promotion. We recognize that many child-focused systems of care throughout the state have organized to support CT Medical Home Initiative and care coordination for Children and Youth with Special Health Care Needs (CYSCN). These local collaboratives are important assets that may be well suited to focusing on systems, policies, and community interventions that place a greater emphasis on prevention.

2. Connecticut Department of Children and Families – Charles Slaughter:

First of all, thank you for putting this framework together. I particularly like the emphasis on assuring safe, stable, nurturing relationships, the focus on community-wide efforts, and the focus on upstream solutions.

While there is extensive evidence that safe, stable, nurturing relationships have a powerful impact on the health of children, there hasn't been a public health approach developed to build and strengthen safe, stable, nurturing relationships.

When we use the phrase "safe, stable, nurturing relationships," we are, in essence, talking about quality of relationship. If one wants look at the science of quality of relationship, the single best field of study to consider is the field of attachment theory. Attachment theory has a broad, deep, and long-term body of research that has provided much insight and guidance about the forces and strategies that impact quality of relationship.

While quality of relationship has a powerful and foundational impact on the health of children and adults, it is important to remember that quality of relationship also has a powerful and foundational impact on educational success, employment success, and success in relationships with other people. Thus, it is important to understand that any success with creating more and stronger safe, stable, nurturing relationships in a community will impact far more than the health of children and adults.

This wider impact is due to the fact that it is within relationships that various personal and relational capacities needed to thrive in life are created. In fact, it is important to also remember that these capacities are not genetic endowments. These capacities include self-regulation, curiosity, joy of learning, empathy, perseverance, self-motivation, safe emotional connection, impulse-control, sustaining attention, trust, kindness, and capacity to recover from adversity. It is these relationship-built capacities that impact health, educational success, career success, and success in relationships with other people. Another key point is that these capacities are best built in a quality of relationship that is supportive of secure attachment. Relationships that are not safe, stable, or nurturing will cause these capacities to be weak or even non-existent. Far too many kids and adults in CT cities and towns are either weak or lacking in these capacities. As a result, this is causing an adverse impact on their lives and a resulting adverse impact on their communities. A statewide strategy that focuses on helping more kids and adults have these capacities is essential to creating the crucial and absolutely necessary foundation needed to support improved health, improved educational outcomes, a more competent, creative, and resilient workforce, and a more thriving community.

Systems Design

First of all, there has been a statewide effort in CT since 2010 to build capacity in CT cities and towns to offer a new, attachment-based intervention, Circle of Security Parenting (COS P). This effort is very supportive of both the focus and structure of the CT SIM HEC design. That is true because COS P provides new, attachment-based, relationship tools that help parents, caregivers, and teachers build safe, stable, nurturing relationships with infants, children, adolescents, and other adults. Nearly 1,700 people from a wide variety of disciplines and settings in CT have been trained to offer COS P.

Part of the systems beauty of COS P is that, rather than being another program, it is a new tool that can be added to existing programs. That has supported the spread of COS P in CT.

While funding has been limited for training people to offer COS P, it does offer a template for creating a community-wide effort to ensure that many more kids have safe, stable, nurturing relationships. First of all, COS P gives providers a set of "new eyes" that allows them to view children's behavior from an attachment perspective rather than reacting to the behavior. COS P builds reflective capacity that allows parents, caregivers, and teachers to understand that the child's behavior is actually communicating a need the child has. COS P also helps them determine what the need is and then meet the need. While the end result is an improvement in the child's behavior, a more important impact of equipping kids to thrive in life is taking place.

One of the powerful forces impacting quality of relationship is the parent’s past, in particular, how they were parented in their own childhood. The past shapes how a parent, often unconsciously, “sees” their child’s behavior and how they interpret their child’s behavior. The result is that a parent, because of their own past, can view their child’s behavior as a threat, not as something safe and ordinary. And the needs a child has while exploring their world or while experiencing distress cannot be addressed. Thus, a parent’s past becomes a powerful force that can prevent the development or strengthening of a safe, stable, nurturing relationship. COS P uses a concept, Shark Music, to help parents recognize when their child’s behavior is triggering their past. That allows the parent to recognize and own their “Shark Music.” In turn, this helps parent to be able to meet their child’s need rather than getting angry at their child for having a need that set off their own “Shark Music.” It is absolutely vital that any intervention designed to build safe, stable, nurturing relationships address parents’ “Shark Music.”

Additionally, all relationships have ruptures. They are part of life and unavoidable. Ruptures can do powerful damage, especially when they are not recognized and not repaired. Ruptures ensure that a relationship is not experienced as safe, stable, and nurturing. Ruptures leave infants, children, and adolescents feeling unsafe, insecure, and unloved. It is important to note that many of the adverse experiences listed in the Adverse Childhood Experiences Questionnaire can also be viewed as ruptures without repair. The good news is COS P equips parents, caregivers, and teachers to recognize ruptures and then repair them. Interestingly, it is the repair that makes kids and adults more resilient.

COS P also provides a shared language for discussing parent-child relationships from an attachment perspective. This helps create more clear and precise communication about the quality of parent-child relationships.

In terms of systems change and systems building, there has been a strong force of attraction with COS P. As more people learn about it, more people want to be trained in it. The table below lists the wide variety of disciplines, programs, and settings that are using COS P in CT.

Social workers	Parent educators	Community agencies	Private practice clinicians	Mental health program staff
Home visiting programs	Supportive housing	Churches, synagogues	Pediatric clinics	Early Head Start
Head Start	Early Intervention	Child welfare	Neighborhood associations	Intimate Partner Violence
CASA	Community health centers	Youth and family service programs	Early childhood coalitions	Afterschool programs
Family resource centers	Programs serving foster parents	DMHAS YAS staff	Recovery programs	Fatherhood programs

We believe the force of attraction COS P provides helps achieve genuine and lasting systems change in two ways. First, it helps parents, caregivers, and teachers have less stress about children’s behavior, have a greater sense of self-efficacy in managing challenging behaviors, and have a greater level of positive connectedness. Second, it gives providers new relationship tools to share with parents, caregivers, and teachers. It also gives providers a sense of making a bigger impact on families. The 3rd impact on providers is that it seems to give them more joy about their work.

CT already has experience of building community-wide efforts to offer COS P and to build an attachment perspective in communities. New Haven, Middletown, Waterbury, and Manchester have efforts to build capacity to offer COS P to parents, caregivers, and teachers. Other communities have efforts with a more

limited focus. Since the relationship tools provided by COS P can be used with a wide variety of people, it creates the possibility of children in a community having safe, stable, nurturing relationships in multiple settings. We believe this creates the potential for children to be even more strongly equipped to thrive in life.

Childhood Obesity

A safe, stable, nurturing relationship is a powerful force in regard to childhood obesity prevention and likely in regard to childhood obesity interventions. The most powerful evidence to date is the impact of Minding the Baby (MTB). MTB is grounded in attachment theory and addresses the multiple and complex attachment, health, and mental health needs of at-risk families in a coherent, holistic way in order to enhance the mother-infant relationship. The three key elements of MTB are:

- Promoting secure attachment, parental reflectiveness, health & mental health, and self-efficacy.
- Supporting reflectiveness through relationships.
- Using an interdisciplinary approach.

A 2018 article of a randomized controlled trial with MTB revealed that 3.3% of the two-year-old children whose mothers began receiving MTB during their pregnancies were obese. Whereas, 19.7% of the two-year-old children whose mothers were in the control group were obese.

Additionally, there is a growing body of evidence that a focus on the quality of the parent-child relationship is an effective, and perhaps, even foundational, component to preventing and treating childhood obesity.

In regard to childhood obesity, it is important to consider the role of the personal and relational capacities mentioned earlier. In particular, two of the capacities, self-regulation and safe emotional connection, likely play a powerful role. A quality of relationship that builds and supports a child's capacity to self-regulate is essential to raising a child who can self-regulate with their eating. In effect, the child has the internal capacity to be aware of their fullness and stop eating when full. Obviously, it is absolutely essential that a parent honor and support their infant/child's self-regulating behavior. Jude Cassidy's 2017 article about her randomized controlled trial with COS P that shows an increase in inhibitory control with the children in her study provides strong evidence that COS P does build kids' capacity to self-regulate.

Additionally, having a relationship that provides a safe emotional connection when exploring their world and when experiencing distress, likely prevents a child from needing to turn to food to self-regulate their distress because they are able to get such deep and satisfying comfort from the relationship. Additionally, safe, stable, nurturing relationships help prevent distress and thus reduce the need to turn to food for comfort during distress.

Once parents acquire and use these new attachment-based relationship tools, that can create a strong foundation that will support the success of additional strategies to address healthy eating and physical activity. For example, these tools can allow a parent to create a family mealtime environment that builds a greater level of positive connectedness, important life skills, and important eating capabilities. In turn, this developmentally healthier mealtime environment will further strengthen these vital various personal and relational capacities.

Recommendations

1. A focus on building capacity to offer COS P in a HEC would very much strengthen the impact of a HEC. I'm certainly willing to offer my advice, guidance, and insight about how to do that.
2. Consider using a focus on the quality of the parent-child relationship as a foundational piece of the HECs efforts to address childhood obesity.

Response A:

Thank you for your comments regarding the Circle of Security Parenting program and Minding the Baby and the deep insight you bring with respect to the important role that attachment plays in child health and well-being. As outlined in the HEC technical framework, one of the first tasks of each HEC will be to identify existing entities, interventions, and efforts that effectively address the root causes of child well-being and healthy weight/physical fitness. By leveraging efforts that are already working, HECs will not only focus on preventing poor health but will select and implement strategies that improve the social, economic, and physical conditions within their community. Depending on community-specific needs and the community's stakeholder input, these strategies could easily be translated into building capacity for Circle of Security Parenting program and Minding the Baby as a means to strengthen the parent-child relationship and reduce the likelihood of adverse experiences.

I believe that your recommendation that we “focus on the quality of the parent-child relationship as a foundational piece” of the HEC Initiative is very much in line with our intent as well as the Population Health Council and many of our stakeholders. **Language has been added to emphasize strengthening the parent-child relationship as an important element of the HEC Initiative. (For example, see Section 3.3.3.1 of the HEC Technical Report.)**

3. Hispanic Alliance Mental Health Network (HAMHN):

We are a group of community stakeholders (Community agency director, direct service providers) and Connecticut College faculty members connected to the SECT-Health Improvement collaborative (L&M Hospital, Ledge Light Health District, other community partners), and form the Latinx Mental Health group connected to the SECT-HIC health improvement plan. We are working together seeking to reduce health and mental/behavioral health disparities and increase health and mental/behavioral health equity among underserved community members (i.e., communities of color and those living in poverty), particularly the Latinx community living in New London. This work was born out of the Community health assessment that took place in 2015 (Community health assessment), which informed the Community Health Improvement Plan (Community Health Improvement Plan). The disparities shown in the CHA included disparities in health (e.g., cardiovascular disease and diabetes), substance use (e.g., opioid addiction and overdose), lack of preventative care (e.g., emergency department use for chronic health conditions), mental health disparities (e.g., depression, anxiety), social isolation (e.g., lack of community trust and cohesion), food insecurity, and treatment access (e.g., lack of insurance and transportation). Those most affected by disparities related to health and mental health were folks of color and those with less access to financial resources. The Latinx community, in particular, showed the highest disparities related to hopelessness, depression and anxiety compared to their non- Latinx Black and White community counterparts. As such, our team (Latinx Mental Health Action Team; HAMHN) has endeavored to understand the social determinants that drive these disparities, and seek to address them at an individual, community, institutional and structural level in order to improve mental/behavioral health equity.

Our action team's focus in the past two years has been to organize, advocate/empower, and provide support to the Latinx community by not only understanding the social determinants that drive the disparities seen in the CHA, but also to improve access to quality and multiculturally responsive/competent mental/behavioral health services. As part of this ongoing work, as a group, we have identified individual, community, institutional and structural barriers that impeded access to quality mental/behavioral health care. In addition to this we are interested in understanding factors (individual, community, institutional, and structural) that might help to facilitate treatment seeking and access to quality services. We also focus on

the challenges facing providers who serve our Spanish and Non-Spanish speaking Latinx community members. Thus far, we have identified a number of barriers that impede access to quality mental/behavioral health care. These include (but are not limited to):

Structural, Institutional, Economic and Logistical barriers, and lack of bicultural/bilingual

clinicians and direct service providers: Commonly we hear that there are not “enough providers available”, which is certainly the case, however less often we hear about the barriers that exist for trained social workers, for example, to attain their licensure and join insurance panels. These are structural barriers that exist at the state and local (county/city/town) level. Moreover, pursuant to the Culturally and Linguistic Appropriate Service Standards (CLAS guidelines) developed by the Health and Human Services Office of Minority Health, agencies receiving federal dollars are to inform their services by these standards. Yet, there is still lack of clarity about how community-based mental/behavioral health agencies, and the healthcare/mental healthcare system in general, are held accountable when these standards are not met. We are aware that there are state policies that inform and guide, for example, physician training and licensure requirements (#SB 466 & PA 09-232 – HB 6678, respectively), nonetheless, we are less aware how these policies are implemented and regulated, nor do we have clarity on what oversight mechanisms exist at the state, county, town, or city-level to hold these systems accountable when they fail to provide CLAS-stated standards of care. While providing translation services (e.g., language line) is one positive step in this direction, there are a number of problems with solely relaying on this kind of approach to address service delivery. For example, this does not fully address the principal standard enumerated in the CLAS guidelines:

“Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”

Nor does it take into account the heterogeneity that exists with-in the Latinx community, or the generational differences that exist among this group of individuals that have a bearing on their treatment seeking beliefs and behaviors, service provision and outcomes (e.g., not all Latinx folks speak Spanish primarily, yet they too experience mental health disparities). Moreover, research suggests that those who are second generation+ (e.g., U.S. born Latinx folks) tend to be primarily English-speaking, moreover these individuals tend to experience worse health and mental health outcomes than recent immigrants. Further, it does not take into account other important intersections (e.g., sexual orientation, gender identity, race, nationality, socioeconomic status/class, documentation status, religiosity/spirituality, age, ability, etc.) that influence health and mental/behavioral health outcomes.

These nuances notwithstanding, in our conversations, we have identified that while non-Spanish speaking providers avail themselves of medical interpreters through the translation help-line this introduces a number of barriers when attempting to provide culturally-competent/responsive care. In our attempt to put together a database with the names of providers and agencies that provide Spanish-speaking services to the primarily Spanish-speaking Latinx-community (looking through publicly available insurance provider listings) we identified a number of problems that set up yet more barriers in accessing service-related information and care. Firstly, we ran across barriers when trying to attain up-to-date information about specific providers who rendered Spanish-speaking services. Secondly, some agencies were listed as having providers who offered services in Spanish, however, when they were called to confirm this information they shared that these providers were no longer at the agencies listed. Thus, out-of-date information was reflected on insurance websites. These are two examples of some of the problems we came across when attempting to attain up-to-date and accurate information from agencies regarding the linguistically appropriate services they provided. Additionally, we have heard examples of individuals who upon calling some agencies

inquiring about Spanish-speaking services, were told that they had to provide their own translator(s) if they opted for services at those agencies; this practice violates CLAS “Language assistance” guidelines/standards.

In addition to these institutional level barriers, structural level barriers exist that influence whether or not a person seeks mental/behavioral health services, thus driving and maintaining disparities. These socio-structural determinants of health include (but are not limited to): Current immigration-policy related barriers (e.g., ICE surveillance of Latinx-communities); over-policing of communities of color, racial profiling when out in the community; discrimination against communities of color in the health care system (e.g., clients referred to Spanish-speaking providers due to Spanish-sounding last name, regardless of whether or not these individuals speak Spanish as primary language, etc.); lack of communication and coordination between direct service providers and agencies; an overwhelmed bicultural/bilingual service provider workforce who are asked to do double the work without extra compensation (this leads to provider burn out and retention problems); community mistrust toward mental/behavioral health agencies/providers and the medical and medical-academic establishment; lack of transportation; and lack of understanding of Latinx with-in group differences, which impacts the quality of care clients receive. At the provider-level, another barrier that we have focused on are the difficulties that exist when bicultural and bilingual service providers seek licensure, and/or when licensed providers in private practice apply for inclusion on insurance panels. Thus, language is one of many barriers influencing access to quality care among the Latinx community, but it is not the only one.

Individual Factor Barriers (client-level): We have also discussed how personal level factors have a bearing on mental/behavioral health disparities, but these are to be understood in context. For example, understanding how personal/client-level factors interact with structural, institutional and societal level-barriers as enumerated above. These personal barriers include, but are not limited to: Differences in level of formal education, literacy, financial need and lack of insurance; Fear resulting from discriminatory immigration policy (e.g., ramped up deportation enforcement), proposed Public Charge policy changes and discriminatory policing has forced many Latinx individuals and families (e.g., undocumented individuals, mixed status families) to go “underground”, which means that oftentimes they forgo needed care due to fear that they will be asked about their documentation status; Individuals rely on personal and community strengths and “informal” sources of support (e.g., church clergy, family, friends) in order to try to deal with problems on their own, and when an individual's capacity to cope and/or sources of support are overwhelmed they reach out for services in crisis (e.g., use of Emergency room for preventable health and mental health issues); Mistrust toward professionals and agencies influence whether or not individuals/families seek and/or are satisfied with services they receive, which has a bearing on treatment retention and adherence; Cultural stigma toward help-seeking (e.g., in a self-reliance focused community seeking help can be perceived as a vulnerability); Lack of information about community resources (what is available, location, times, cost, etc.); and need for mental/behavioral health literacy such as recognizing red flags and knowing when to reach out for professional help.

Addressing Barriers:

There is wide variability within the Latinx community in terms of: immigration and migration history and culture of reception (e.g., xenophobia, anti-immigrant sentiment and violence), documentation status, primary language use, ethnic and racial identity, acculturation, experiences of acculturative stress, time living in the U.S., experiences with discrimination (housing, health and mental health provision, allocation of services, etc.) and differences in cultural values that influence whether or not, when, how and to whom, people reach out for help (do they reach out to social support networks, faith- based community, behavioral health professionals, etc.). Though many “Latinx values” are believed to be universal, how these values

manifest is ethnic/national group specific. An adequate understanding of the complexities involved in the lived experiences of the Latinx community is needed in order to provide sustainable culturally responsive services and care. Further, factors such as bias at the community-, agency- and provider-level need to be addressed before we can truly help those we, as a community, are attempting to serve. There must also be recognition of the cultural strengths that exist among our community providers and community members, as these can inform our prevention and intervention efforts. Further, the community's voice must be centered as much as possible/feasible when developing prevention/intervention programming as this is associated with engagement.

The barriers mentioned-above are among many of the Socio-Community based determinants of health/mental health influencing lack of access to care, which in turn influences the disparities we see in the community. Intervention and prevention programs need to take these factors into account in order to be culturally-responsive and relevant. Further, while on the one hand we need to focus resources on helping clients access mental/behavioral health care when they need it, on the other we have a shortage of licensed providers who can address the current demands of the Latinx community in New London. Ideally, some solutions could be to partner with local colleges, place job advertisements in print and social-media targeting bilingual and bicultural local community members, etc., in order to identify potential providers to increase the diversity of our direct-service workforce. We also need to ensure that retention efforts are a priority. Bicultural/bilingual providers that do exist are overwhelmed with community (and agency) demands for services and find themselves spread out thinly, overworked, and underpaid. Moreover, they do not know (in some cases) where to refer clients as their referral sources are also overwhelmed, resulting in backlogs and long waiting lists/times. This leads to professional burnout because the demands of the community outweigh the resources that are currently available. It can also perpetuate lack of, or delayed, treatment-seeking if/when community members (some who are in crisis) seek out services but then have to wait weeks to see a provider. Although these structural barriers are not easily remedied, we must, as a community, identify short and long-term goals to help address these problems.

Community Resources:

In the absence of timely and adequate structural changes, there have been (currently and historically) a number of resources at the community, provider, and client-level that have helped to address the needs of community members; yet more are needed. These have come in the form of community-based responses. Historically, these included home-based (Parent-Aide) program for families in need with limited mobility (transportation). This program is no longer in operation but it was successful in getting clients connected to services. Currently, the AHEC provides medical translation certified training, however, their continued operation is uncertain given lack of adequate funding. Despite these challenges, NL is home to a number of dedicated expert direct services providers who have been committed to providing culturally responsive care to the Latinx community. The providers, many of who are members in our network, combined, have 30+ years of experience providing services to the Latinx community. Thus, we have a wealth of expertise and resources that can be channeled to inform the provision of culturally competent services, and at the same time, these are not enough to meet current community needs. We are hopeful that the work of the SECT-HIC collaborative and action teams, and the SIM-HEC work will help us better serve our community members.

We hope this feedback is helpful.

Response A:

Thank you for your comments. We share the goals of reducing health disparities and increasing health equity among communities across the State of Connecticut. **Based on public input and the deliberations of**

the Population Health Council, an additional goal has been added to the HEC framework documents, to “Achieve health equity for all Connecticut residents.”

Access to culturally competent behavioral health services and other clinical services is critically important and sometimes challenging, including for the Latinx community for the reasons you describe. Although treatment for clinical conditions is not a focus of the HEC, we recognize that there is an important relationship between behavioral health problems and overweight, and that exercise can be an important part of a care plan. In addition, parental behavioral health problems such as depression can sometimes compromise healthy child development. Accordingly, expanding access to evidence-based behavioral health interventions for parents, such as the MOMS Partnership for maternal depression, are among those that might be considered by HECs.

Behavioral health treatment and access are also very much a part of our companion initiative [Primary Care Modernization \(PCM\)](#). The work of PCM includes developing a new model for primary care in Connecticut that supports providers in expanding their care teams and offers new ways for patients to access care outside of a traditional office visit.

Through PCM, behavioral health will be integrated into primary care thus reducing stigma and improving timely access to care in a potentially less stigmatizing primary care environment. Additionally, community health workers, many of whom will be recruited from communities of color, will offer support in a culturally responsive and competent manner. They will address social determinants of health, linking patients to essential community resources. PCM will help to address some of the individual, structural and cultural barriers that you highlight in your comments.

4. Howard K. Hill:

Pertaining to the African American Communities (specifically) of CT as it relates to Health and Health Equity, leaders must understand that issues impacting these communities are not only structural but they are also implicit but more importantly economic. In 2019 leaders of must stop ignoring the legacy of slavery and its impact on the Black Communities. There have been centuries of inequities placed on the community. It’s been so long it just seems normal to continue to recreate systems that produces the same results but state they will be different. I challenge the leadership to observe the race and ethnicity of those leaders who are making policy decision for the communities these and gauge when the last time anyone of them has spent one dollar in that community, or walked down a street, or been in a home of one of those residents. Observe the race and ethnicity of those who have been given the resources to help the community. Observe the senior leadership, mid-level management, who are they and ask the same questions of them. What is their personal vested interest in making the community healthy?

I invite anyone to a much deeper conversation on this issue. I have real solutions.

Response A:

We share concerns regarding health disparities among communities of color, particularly Black and African-American communities throughout the State of Connecticut. **Based on public input and the deliberations of the Population Health Council, an additional goal has been added to the HEC framework documents, to “Achieve health equity for all Connecticut residents.”**

It is our vision through this initiative that each HEC will develop their own structure to direct and oversee what is done in their geography. Each HEC structure should reflect the realities and needs of their particular community. All HECs will have a defined structure that ensures that community members have ownership of and decision-making authority about what matters most to them in their communities. **To this end, the Population Health Council approved revisions to the HEC framework documents that clarify the role of community members in the HEC structure, including that community members will be part of each HEC's Governance Body (see Section 3.3.5 of the HEC Technical Report for further detail).** The structures should reflect the diversity within the HEC communities and include diverse voices in all aspects of HEC formation and operation. We appreciate your comment and encourage you to stay involved in this process as the HEC initiative develops.

5. Frank W. Maletz, MD.:

Meeting attended : HEC New London CT - full day session 2018

Consent Agenda : Accept as written the two documents - Technical Report and Framework - excellent working foundations for baseline ,
“ where we are “ , point of departure toward NEXT s

IDEAL AND PRE EMINENT GOAL : Make CT THE **Healthiest** State in this country (while I prefer “ on the planet “ , we can certainly accept this to start)

- this is the “ driving philosophy “ for the PLATFORM of all things **Health**
- how do we change present mindsets from our predominantly “ sickness care , disease intervention nonsystem “ ? - change name / language ———-> thinking change which opens new cognitive scaffolds building onto the platform
- drop “ Constitution State / Nutmeg State ———-> CT - **THE State Of Health**

It is clear from the documents , drafts , and comments that we agree we are NOT starting from scratch - there is no need , desire , appetite for “ creative destruction “ - there is too much good and salutary in the present “ healthcare “ infrastructure (DPH , CT Hospital Association , excellent pre professional colleges and universities and professional institutions of higher education and research , strong community colleges / technical schools , organized State Medical Society and publication venue , and state connections to AMA , ACS , AORN , and others) - this commentator agrees

- BUT we do not need to add more “ complicatifications “ - layers of bureaucracy , infrastructure , silos , fragmentation , rules and regulations , and over - , under- , and peri - sights
- CT Hospital Association (CHA) is the epicenter for the 27 acute care hospitals already tactically , geographically positioned - therefore , home to 27 HEC s (my preference - all 27 would morph into HEALTHSPITALs)
- 3 “ systems “ : Yale / New Haven Health // HHC // Trinity Health - **THE State Of Health** mandates EPIC Corporation , source of each “ proprietary “ EHR to immediately provide interface (no additional charges) to make all health related information interoperable , interfunctional , and available to

service providers of **Health** at every point of care interaction including patient portal access ———

—> active “ participations “

- DPH becomes de facto DPH (Department of **Population Health**) - responsibilities and oversights :
- 1) collects and collates all “ enhancement “ ideas and protopilots statewide
- 2) defines metrics , parameters , measurables , and deliverables of success toward being # 1
- 3) assures savings to the new EcoSystem Of **Health** are transparent by project and by HEC - trends and applies rigorous analytics against our baseline data , monitors successes and progress with real-time feedback
- 4) reinvests savings fairly (“ equity “ AND “ equitable “) back to more health and wellness initiatives - no diversion , no non contributory “ pork “
- 5) maintains open access website - one interactive place for all that is **Health and Wellness and Well Being** enhancing
- 6) surveys global Best Practices and relates these , as applicable or when modified , to State projects and programs - “ instant “ dissemination of exemplars and their experience to fill CT gaps , needs , and identified deficiencies on the road to GOAL
- “ Basic Needs “ and “ Social Determinants of Health “ (Michael Marmot and WHO) are very , very low bars for the “ Healthiest State “ in this country - remember : healthiest for All , from birth to death
- 1) no exceptions
- 2) no “ priorities “ based on “ available resources “ (“ HEALTHIEST “ is the overarching platform - **THE** priority)
- 3) any “ Dys - ease “ is open for address and “ curing “ - social. cultural , ethnic , fiscal , educational / literacy , institutional , traditional
- 4) T Kuhn rules : the “ usual and customary “ paradigm is not working optimally - therefore , time for a new model , novel paradigm launch ie hospitals become HEALTHSPITALS (EPHOT s : Experimental Protopilot HEALTHSPITALs Of Tomorrow) , CHA becomes CHA (**HEALTHSPITAL**) , DPH becomes DPH (**Population**) and so forth
- 5) CT is perfectly positioned for this transformation , this experimental population protopilot , and predictable exponential success
- Each center (27) has its platform , paradigm , and marching orders - refer #1
- 1) DPH and State lets them go for 1 year - self organizing and emergent
- 2) **Health and Wellness** are the benchmarks
- 3) Primum non nocere is superseded by “ Primum faciatis aliquid boni “ (First do something of good / benefit / beneficence) and non nocere becomes “ Secundum “ (still relevant to mission , vision , values , and virtues - just not primary)
- 4) leadership , followership , and stewardship are local - integrated to each HEALTHSPITAL and reported to DPH
- 5) initial oversight is a peer review process
- 6) self motivation comes with each small and large win

- 7) recognition and celebration and re investment self incentivize each community directly without siphoning by non contributing intermediaries or obstructive barriers in wasteful or burdensome processes
- 8) virtuous cycles and epicycles of tangible , visible , sense-ible Health and Wellness improvements co create by continual co design feed forward iterative loops of further enhancements , self-reinforcing efforts ———> then going viral to scale with CT the planet 's Health source

Once CT SIM HEC actualizes our #1 Place in the true Healthcare Universe and mainstreams (no need to focus “ upstream “ , “ downstream “ , “ distracting stream “ - all enhancing “ streams “ flow to the whole) all efforts and endeavors to the platform , we will be self-sustaining requiring no funding , subsidy , special encumberings or artificial stipulations from external payers . We will also have developed an appropriately redundant, local ecosystem buffered against short and long term market perturbations with built in safety and security for all CT citizens.

This is our moment, on our watch to co design , then co create a future of Health , Wellness , and Well Being for everyone - CT first - then the globe !

Thank you for attention and consideration - more, thank you for this stellar baseline work.

Response A:

Thank you for attending the New London Reference Community’s day-long, deep dive session and for responding to our request for public comment on the HEC framework and technical report. We share your optimism about the potential of HECs for improving the health and well-being of all residents in CT. While you made numerous intriguing comments, your points about building on the state’s considerable assets without further complicating existing structures and systems are particularly well-taken.

At this time, it is premature to determine the exact number of HECs that could be established. While we anticipate that hospitals will participate in HECs, we do not foresee HECs as being hospital-centric. Rather, HECs will likely be built around existing community-based networks and will have governance structures that include multiple sectors, such as community members, community agencies and organizations, and various types of healthcare providers.

Your comments regarding the interoperability of health-related information are right on target with the Office of Health Strategy’s ongoing development of statewide information exchange and analytic services.

We concur with your recommendations for an incremental launch of HECs with emphasis on local stewardship and ownership. However, other commenters have noted the importance of centralizing some functions to support and enable local action. In line with your recommendations, the HEC framework also calls for establishing an advisory committee with representation across HECs. Such a committee would offer a peer review function and guidance on decisions related to financing and reinvestment.

6. Center for Health Care Strategies – Deborah Kozick:

We appreciate the opportunity to review CT’s HEC framework/technical report. Overall, this document seems thoughtfully informed by a broad range of stakeholders and effectively covers key areas of consideration with a good level of granularity that reflects practical understanding of model adoption and implementation. Below are some questions/feedback that came up during our review, including areas where further detail may be helpful:

p.38 – Good level of flexibility considered under HEC procurement process. To clarify, can a multi-site provider be part of multiple HECs?

Response A:

HECs themselves will make decisions about which partners will be part of their HECs. HECs will also propose which geographies they will serve and will finalize the boundaries of such geographies through an iterative process with the State. We expect there will be instances where some entities will decide to be part of more than one HEC if their locations or catchment areas cross HEC boundaries.

p.54 – Can you elaborate on what criteria CT will use to determine eligible anchor institutions? What process will state follow to identify/confirm anchor institutions?

Response B:

Although the draft framework identifies anchor institutions as an HEC strategy, the State has not yet discussed plans to designate anchor institutions in a formal way. However, given the unique role that anchor institutions currently play and could play in supporting local economies, HECs themselves may decide to pursue that option with their partners.

p.62 – More detail may be helpful with regard to how the proposed HEC governance structure will promote alignment across existing state departments and initiatives. Who specifically will align across state departments?

Response C:

The State Partnership described in the report is the proposed vehicle to align across state agencies and initiatives. **The framework has been edited to make that critical role clearer. See Sections 6.3, 8.1, and 8.2 of the HEC Technical Report.**

p. 75 – Can you say more about how standardized an approach will be encouraged among HECs in their use of CDAS data? How does the state plan to monitor the HECs' use of CDAS?

Response D:

The precise process by which HECs will use CDAS and the state will monitor that use have not yet been developed. The next phase of work will involve the development of uses cases in partnership with community representatives. Such uses cases will inform the development of CDAS capabilities necessary to support the HEC monitoring, management, and operations.

p. 103 – The community benefits funds approach seems like a promising avenue from our perspective, based on other states' efforts/pilots to date.

Response E:

Hospitals participating in HECs may decide to align their community benefit funds with HEC activities and/or HEC interventions may be selected to align with current community benefit fund uses. However, given limitations in the amount of available funds and the existing allocations of community benefit dollars to health-related activities, it is not anticipated that these will be a substantial source of funding.

p. 108 – a) As another potential approach, could hospitals also fund HECs through vendor contracts, rather than a more complex funding relationship?

Response F:

Each hospital will decide how they will participate in HECs. The draft framework does not assume that hospitals will be a primary source of funding and financing.

b) Many of the section headers are really similar language and are hard to discern. Might want to delineate more clearly. For example, the following are all quite similar:

- 7.2.1 – Near-Term Financing
- 7.2.1.1 – Near-Term Funding Sources
- 7.2.1.2 – Near-Term Finance Model
- Subheader to 7.2.1.2 – Financing Near-Term HEC Interventions

Response G:

Thank you for the suggestion. **The HEC Technical Report headers in Section 7.2 have been edited to make the delineation among sections clearer.**

p. 112 -113 – Nice breakdown of the different types of funding sources and their respective purpose/use (infrastructure, interventions, etc.). Perhaps a table could help illustrate this further?

Response H:

Thank you for the suggestion. **We added Table 10 (Near-Term Financing Options Summary) in the HEC Technical Report.**

p. 115 – a) The following statement could use more elaboration: “Under the HEC Initiative, the state will play a critical role in identifying, negotiating, and securing long-term funding agreements with purchasers to support HECs.” Can you say more here? For instance, would the state actively negotiate support from self-insured companies on an HEC’s behalf?

Response I:

Thank you for the suggestion. The most significant opportunities for long-term funding are with Medicare and Medicaid. Accordingly, the state envisions playing an active role negotiating with CMS to access support for the HEC model. Any opportunity with Medicaid would be brokered by the Department of Social Services. The state is in the process of analyzing the impact of HECs on commercial populations and associated healthcare spending. While this work may illustrate how commercial populations and employers and commercial payers can support near-term efforts, these purchasers are unlikely to be sources of long-term support. Finally, the state will play a role in long-term funding arrangements with federal sources of revenue unrelated to healthcare, such as Title IV-E spending for children in the child welfare system.

b) While we recognize the challenges with demonstrating a short-term ROI related to HECs given the nature of the interventions, requesting funding in exchange for a possible 10-year return may be a hard sell for purchasers. The HECs may not be able to collect enough near-term funding for a 10-year horizon without further state support.

Response J:

The State will pursue all possible options for near-term financing. Given that we also recognize the challenges of negotiating a 10-year agreement, the state will encourage the inclusion of interventions that can yield an ROI within 5 years.

p. 116 – The snapshot method seems like a promising approach – however, some clarification may be helpful. For instance, if someone moves into the community at Y5 and is included in the snapshot, how would their progress be tracked? Would Y5 be considered as their Y1? Or would there be some kind of lookback?

Response K:

The proposed “snapshot” methodology would measure performance for a defined HEC geographic population at specific points in time. For example, measurement would be taken during a baseline period and at subsequent points in time (e.g., Years 5 and 10) for the purpose of calculating shared prevention savings. The proposed “snapshot” methodology would not be longitudinal in nature, meaning it would not follow specific individuals over multiple years; rather, it would examine the totality of geographic population health at two difference points in time. A detailed methodology will be developed as part of a multi-payer demonstration to determine which differences between two periods in time could be attributed to HEC efforts and which differences may be as a result of factors beyond an HEC’s control (e.g., an influx in people with different health needs or socioeconomic status). As noted in the Technical Report, a preliminary list of attribution “control factors” could include: employment, income, health insurance coverage, food security and cash assistance programs and benefits, natural disasters, health epidemics (e.g. influenza, Zika virus).

p. 120 – Good discussion of the measurement approaches, but the two-step measurement approach could use some additional clarification. For example, if the overall state “savings” is actually a loss of \$10M, making the pool zero, but one HEC performed well and saves \$5M, do they not receive anything? That may be an issue and wouldn’t encourage successful HECs to sustain their performance.

Response L:

Your comments highlight a key design question. We will examine two options with CMMI with respect to shared savings. The preferred approach would be to allow individual HECs to receive a share of the savings that they generate, even if the HECs in aggregate (i.e., the state as a whole) does not generate a savings. This is the approach taken today in the Medicare Shared Savings Program. We believe that it is more likely that CMMI will require that the state as a whole generates savings before any individual HEC receives savings. Under this approach, if the state in aggregate achieves savings, such savings would be distributed to individual HECs based on their contribution to those savings.

p. 122 – Helpful diagrams to illustrate HEC financing options. Some questions related to how the HEC shared savings model will interact with the PCMH+ shared savings model:

- a) How would the risk for double-counting and double-paying savings be mitigated?
- b) What is the expected overlap between HEC and PCMH+ patients? Or are they attributed to a HEC or a PCMH+ entity, but not both? (Apologies if this was noted somewhere and we missed it!)
- c) How can the state/payers determine whether savings are achieved by the HEC or the PCMH+ model?

Response M:

All of today’s ACO-type shared savings models reward providers with savings if the total cost of care is reduced relative to a risk-adjusted cost benchmark. In other words, providers are rewarded given the average risk and projected cost of the population they serve.

For example, the CMS hierarchical condition categories (CMS-HCC) model is used to risk score the patient population of a provider that is participating in the Medicare ACO program. A population with a higher average HCC risk score will have a higher projected annual cost than a population with a lower risk score. If

an ACO's average patient risk score is 1.8, the provider is rewarded for savings based on the projected cost of a patient population with an average score of 1.8. If the ACO's average HCC risk score drops from 1.8 to 1.6, the provider is rewarded for savings based on the projected cost of a patient population with an average HCC risk score of 1.6. The provider does not receive any of the savings that resulted when the risk of their population dropped from 1.8 to 1.6 as a result of prevention.

Under the HEC model, Connecticut would be proposing to Medicare that Connecticut's HECs receive a share of the savings that result from a reduction in the HCC risk score of their Medicare population over 5 and 10 years. By design, it is easy to distinguish the savings that result from a reduction in health risk (in this case from 1.8 to 1.6) from the savings that accrue from better clinical care, given the population's health risk (in this case 1.6).

The most significant design challenge we face is how best to distribute the savings the result from prevention, which is to say a reduction in health risk. Given the multitude of cross-sector partners that will govern the HEC and the various investors that might contribute to short-term funding needs, care will need to be taken to ensure that distributions are fairly apportioned to those that contribute to the solution. This is part of the planning that must occur during the future planning and pre-implementation phases of the HEC initiative.

p.124 – There are likely very specific and relevant lessons from NY DSRIP around how to further mitigate funds flow issues between health care providers/hospital systems and community-based/social service providers (I imagine that you will explore these through your work with HMA/former NY DSRIP staff).

Response N:

We agree that New York's DSRIP program provides many valuable lessons and insights, including regarding funds flow and the role of community-based/social service providers in DSRIP Performing Provider Systems. Those lessons and insights have been included in our framework development to date and will continue through the next phase of design and implementation.

p. 130 – Can you add more detail regarding plans for the Medicaid Impact Model?

Response O:

OHS and DPH are currently working with the Department of Social Services (DSS) to design the Medicaid Impact Model. The first step in developing this model will be the preparation of summary files of the type used for the Medicare analysis, including files that will enable the actuaries to project health risk trend through the 2020 to 2030 demonstration period. Unlike the Medicare model, which focused exclusively on reducing overweight and obesity, OHS, DPH, and DSS are also examining how best to examine the near-term impact on health care utilization that might result from reducing ACEs. The state agency partners will provide additional information in future meetings of the Population Health Council. We anticipate that the Medicaid Impact Model will be completed during the summer of 2019.

p. 133 – Nice list of potential TA – helps concretize the discussion.

p. 139 – Regarding Phase 2, are HECs expected to have already vetted their proposed geographic region with other HECs before submitting their proposal to the state? Wondering how transparent this process will be for prospective HECs.

Response P:

It is anticipated that there will be a community-led design phase prior to undertaking a procurement to designate HECs. During this phase, prospective HECs will develop key elements of their proposed HEC plan, including what geographies they propose to serve. The intent is for the process to be very transparent. The initiation of this design phase is dependent on many factors, including having a final framework for the initiative approved, having start-up funding secured, and having sufficiently advanced the multi-payer demonstration negotiations.

p. 140 – Are you considering having the HEC designation be contingent on entities having secured a set amount of short-term funding?

Response Q:

HEC design and designation will require start-up funding. The state is exploring multiple options for securing those funds so that each HEC does not have to secure all of the funds they need to design and implement their HEC. HEC designation *may* be contingent on entities demonstrating that they have secured some portion of the necessary funds.

7. Connecticut Voices for Children – Sharon D. Langer and Karen Siegel:

Dear Office of Health Strategy,

Thank you for this opportunity to comment on the Health Enhancement Community Initiative Proposed Framework. Connecticut Voices for Children wholeheartedly supports efforts to promote health equity through community-based interventions and we extend our appreciation for the rigorous process of the Population Health Council in developing this framework. In that spirit, we hope you will consider the following suggestions:

- 1. Governance Structure:** The governance structure includes a separate entity for community participation. To avoid a silo-effect and promote meaningful engagement of community members, **we recommend that community members participate in the management team and governance structure directly**, rather than in a separate arm of governance. The proposed community arm has the potential to render community involvement less meaningful and risks alienating target communities. While it may not be feasible to ensure broad inclusiveness within a management team, Health Enhancement Communities (HECs) may choose to convene community advisory bodies to enable input from a broader demographic array of stakeholders as needed, while still including community representatives within the formal governance bodies.

Response A:

Thank you for your insights about the unintended consequences of how the framework documents describe the governance structure. We recognize that the recommended structure in the framework does not adequately show the intent to have a unified structure rather than three separate silos. One of the central purposes of having a structure with multiple interrelated arms is to provide community members with options for how they want to participate. We heard from a number of community members that they wanted to be meaningfully involved in the design and implementation of HECs, including being involved in making decisions. However, we also heard that they did not want the only option for participating to be sitting on a governance body. Having more than one option would enable community members to be part of making decisions and also lead and/or work on issues that matter most to them through the vehicle of their choice, including through community groups and governance bodies. The intent is also to ensure that community members participate on the governance body. In terms of the management teams or backbone

organizations, those are intended to be the staff who are responsible for operating and managing the HECs. The vision is that one of their functions will be to work closely with the governance bodies, community groups, and other possible groups such as community advisory bodies to ensure that all of the parts of the structure are working in concert. It is not intended to be the executive committee of the governance body. We also anticipate that HECs will develop other ways for community members to participate, including community advisory bodies. **We have revised the description based on your and other feedback, including input from the Population Health Council, to address this silo-effect and ensure that it is clear that community member involvement and decision-making is an integral part of how HECs will be designed, formed, and operated. We have also revised the document to clarify that community members will be part of each HEC's governance body, what the management team/governance body is and isn't, and how it will work with community members and partners, and that HECs should ensure broad inclusiveness of the communities in which they operate through defined mechanisms. See the HEC Technical Report, Section 3.3.5 and Figure 13 ("HEC Structure") for more detail.**

2. **Definition of Community:** The definition of community is unclear and does not highlight the need to address disparities in resources and health between the state's high- and low-income areas. By encouraging investment in HEC goals across town boundaries, HECs could present an opportunity to mitigate the impact of decades of housing discrimination and other effects of structural racism that have caused disparities in health and in community resources.

Response B:

Thank you for your comments. While we did define community members, you are correct that we did not define community or use a definition of community to describe the opportunity to address disparities across geographic areas. It is critical that we do that because HECs do create that opportunity. A central goal of having a statewide HEC Initiative that focuses on upstream causes of poor health is to address disparities among high- and low-income areas. **We revised the framework documents to define community (see Footnote #2 in the HEC Technical Report) and highlight how HECs can and should address long-standing disparities. Additional emphasis was placed on disparities in the Introduction to the HEC Technical Report as well as through the Population Health Council's addition of the HEC Initiative goal to "Achieve health equity for all Connecticut residents."**

3. **Measures and Benchmarks:** Health equity is a stated priority of this initiative, yet proposed measures would not evaluate the impact of the initiative on health disparities or specifically on populations of color in the state. Further, many of the suggested measures—including two of the three components of the composite child well-being prevention measure—are subject to racial bias. **We recommend considering other measures of child wellbeing**, particularly education metrics such as third-grade reading level. Further, section 4.4 of the technical report does suggest stratifying data by race and ethnicity and other demographic factors in order to target interventions to specific populations. **We recommend employing stratification to evaluate disproportionate impact and intended or unintended impact on disparities in health and its social determinants** so that HECs can understand how their work is or is not promoting health equity and adjust this work accordingly.

Response C:

The measures list is not yet finalized. There will be an inclusive process to identify, vet, and finalize measures. This will include vetting additional measures. In particular, the process will vet any measures that

may be subject to racial or other biases. Health equity/inequity measures will be incorporated into the measures list. That process also will consider how to employ stratification for the purposes you indicated. **Revisions were made to Section 4.4 (in particular, 4.4.1) of the HEC Technical Report to clarify these points.**

- 4. State Partnership and Coordination with Existing Resources:** The technical report details the creation of a robust state partnership similar to the state’s Behavioral Health Partnership. While blending and braiding of state funding and technical support from the state will be key to the success of these community collaboratives, **we suggest that a broader state resource for coordinating among existing programs and organizations** would alleviate the need for creating a new workforce and/or intensive pilot work to create new interventions. For example, the state is home to numerous evidence-informed home visiting and care coordination initiatives. Identifying gaps in coverage or areas in which additional capacity is needed and then encouraging HECs to invest in filling these gaps would be both less costly and higher impact than creating new home visiting initiatives. This is just one example of a community-based initiative that exists but is not evenly funded or distributed.

Response D:

The state will consider a broader state resource that could support HECs and the initiative. The state recognizes the need for some type of centralized resource to support and assist HECs (e.g., providing technical assistance and training, supporting shared learning across HECs, providing a technology platform, supporting select interventions across HECs). The State Partnership would also manage some core functions, such as identifying opportunities to align and fill gaps in existing state-funded programs and developing financing mechanisms. **The framework documents have been revised to articulate more clearly what a broader state resource could do to support HECs. Based on the Population Health Council’s recommendation, the framework now recommends that the State Partnership provide and/or contract with an Administrative Services Organization (ASO) to house all efforts for centralized technical assistance. See Section 8.2 of the HEC Technical report for additional detail.**

The intent is not to have the HEC focuses solely on developing new interventions. There are many existing interventions, such as your examples of home visiting and care coordination, that could be leveraged, aligned, or expanded to achieve the desired outcomes. HECs are in the best position to understand and develop strategies for how to do that locally, and the state could do that across agencies as part of the State Partnership, with HECs and the state working together where there needs to be an aligned strategy. **We have revised the framework documents to clarify that HECs and the HEC Initiative should leverage, align, and expand what is already in place and working instead of creating new interventions. See Section 3.3.4 (“HEC Interventions”) and the accompanying text box “Aligning Existing Resources” in the HEC Technical Report.**

- 5. Leveraging Innovation in Primary Care:** As noted in Connecticut’s Children’s Behavioral Health Plan, discussed in the SIM Primary Care Modernization Pediatric Design Group, and noted above, Connecticut boasts a number of robust community-based efforts to meet the goals of the HEC initiative. Yet, there remains a clear need to coordinate among these services, ensure full funding to meet community needs, and integrate these services with traditional health systems. **Efforts such as the patient-centered medical home model (PCMH), PCMH+, and the SIM efforts to promote primary care modernization should be linked to HECs**, including incentives to fund these community-based collaboratives, in an effort to address social determinants of health and provide the community-based supports that are proven to prevent illness and promote health equity. These initiatives will be stronger together than

either primary care efforts or HECs could be alone and they will have a stronger chance of long-term success if carried out in a coordinated fashion.

Response E:

We concur on the need to align the HEC initiative and care delivery/payment reform work streams. **A new section was added to the framework documents to highlight the common foundation and synergies between these two SIM initiatives: [Primary Care Modernization \(PCM\)](#) and the HEC initiative. See Section 3.3.7 of the HEC Technical Report.**

8. Connecticut Association of School Based Health Centers – Melanie Bonjour and Daniela Giordano:

As the CT Association of School Based Health Centers (CASBHC), representing and supporting the vital work of School Based Health Centers across the state, we would like to convey some general comments in regards to the Health Enhancement Communities (HEC) draft proposal (December 2018).

We appreciate the tremendous work and thought that has gone into the conceiving this framework of Health Enhancement Communities in order to support the health and well-being of children and families within their communities by improving community health and health equity and preventing poor health.

As noted under local and state public health and development infrastructure (in the Technical Report), “[...] there are currently 93 state-funded SBHC sites in 26 communities including sites located in elementary, middle, and high schools and in urban, suburban, and rural communities. Forty-five thousand students are enrolled in the SBHCs, and nearly 131,000 visits are provided annually. In Connecticut, the vast majority of SBHCs provide an interdisciplinary model of co-located medical and behavioral health services, with services provided by licensed medical and behavioral health clinicians. SBHCs provide mental health therapy in school for trauma, family violence, depression, anxiety, school phobia, grief/loss, substance use, and more. For many students, the SBHC serves as their usual source of care for reasons such as barrier-free access, availability of appointments on a same-day basis, convenience for families that can remain at work while the student receives care during the school day, no need for transportation to appointments, and a level of comfort and safety for students within their school environment. SBHCs also work closely with school nurses and administrators to identify students chronically absent or at risk for chronic absence”.

SBHCs also work hard to connect with children’s pediatricians, if they have identified one, or connect them to a pediatrician in the community, as well as create and strengthen relationships with specialists and other community resources, in order to support the whole child. SBHCs provide an array of educational resources to students and schools and focus on prevention and early intervention. The vision of SBHCs that all children and adolescents are healthy and achieving at their fullest potential, connects nicely with the vision for HECs. Healthy Kids Make Better Learners CASBHC P.O. Box 771 North Haven, CT 06473 203-230-9976
www.ctschoolhealth.org

We think incorporating SBHCs into these new place-based communities would be beneficial to the children and families that are intended to be served, as well as being part of the decision-making discussions going forward. Obviously, there remains a lot of thought and work to be done in regards to actual specific governance, management and financings structures that are required to set HECs on a path of success. We also appreciate and would like to stress the utmost importance of not just engaging but having the local and regional communities and diverse members of the community drive and lead the planning and implementation of this new way of doing things in pursuit of enhanced health and well-being for all.

Response A:

Thank you for so clearly articulating the role played by School-Based Health Centers (SBHCs) in promoting child, adolescent and family wellbeing and the broader health of our communities. The direct services as well as care coordination provided by SBHCs align well with an HEC's commitment to health improvement by expanding opportunities for healthcare and prevention in educational settings. It is interesting to note that as a place-based strategy, the co-location of SBHCs with schools is an inherent advantage in addressing SDOH and promoting holistic, family-centered care.

We envision that individual SBHCs can be an integral part of the cross-sector collaboration within the boundaries of a given HEC. Also, with its broad, state-wide perspective, the CT Association is positioned to inform how HEC governance is formally structured and how decision-making roles are defined.

9. Anthem Blue Cross Blue Shield – Jill Hummel:

Anthem Inc. (Anthem) appreciates this opportunity to comment on the Health Enhancement Communities (HEC) initiative draft framework and technical report.

Anthem is one of the nation's leading health benefits companies, serving over 74 million people through its affiliated companies, including more than 40 million within its family of health plans. As a committed participant in the healthcare markets, including the Medicare, Medicaid managed care, Individual (both on and off Exchange), Small Group and Large Group markets, we look forward to working with the Office of Health Strategy on its proposed framework regarding the establishment of HECs. Locally, in Connecticut, we cover over one million consumers through Commercial (Individual, Small Group and Large Group) and Medicare (Medicare Advantage and Medicare Supplement) plans, making us the largest health carrier in the State. We also have the largest penetration of value-based payment arrangements [a key enabler of a healthcare system focused on the Social Determinants of Health (SDoH) of any carrier in the State.

Anthem is encouraged by the plans the State of Connecticut intends to implement to improve population health. Anthem is committed to the health and well-being of diverse communities and supports the use of evidence-based research, robust analytics, direct feedback from consumers and advocates, and innovative strategies to address SDoH. We agree that improving population health depends on improving health literacy, community health opportunities and tools, and health equity. A focus SDoH can help ensure people who live, work and learn in our communities can continue to live a health life and focus on their well-being.

Anthem generally supports the proposed framework. However, we recommend Connecticut consider the comments provided below as the State advances the establishment of HECs.

Detailed Comments

Integrating Payers into HEC Initiative Efforts

Anthem agrees that the HEC initiative will require the engagement of numerous, cross sector stakeholders to implement community health, health equity, and prevention strategies. The current HEC framework lists community partners for collaboration, including healthcare providers, local health departments and social service agencies. However, payers were not included in this group. Payers are an integral partner in support community health, providing access to care, services and resources, and implementing effective prevention strategies. We urge that payers be engaged, and referenced throughout the HEC initiative, to help address health needs and connect consumers to health and social supports as well as community resources to improve the health outcomes of individuals in our communities.

Payers have unparalleled insight into the health of broad demographics and significant experience in innovating, collaborating and implementing population-health interventions. In addition to states and employers, which Connecticut identified in the framework as important stakeholders to engage, we strongly encourage Connecticut to view payers as key partners in HECs. Payers can implement programs across multiple, disparate employers, and therefore have a broader reach than any single employer. As 49 percent of the Connecticut workforce is employed by small businesses, payers could play an important role in coordinating and implementing interventions across this diverse group.

Additionally, the technical report outlines numerous roles that providers can play in supporting the success of the HEC. Anthem recommends that Connecticut also consider the role payers play, along with providers, in coordinating access to and delivery of services and supports. Payers have a unique and important perspective, as they partner with thousands of providers across all disciplines and have an ingrained understanding of how tackling SDoH can move the needle on health outcomes. These diverse relationships and deep understanding of health influencers, as well as access to claims for patients across all providers, can help improve coordination and ensure a more accurate and efficient implementation of the goals of the HEC initiative.

Given the important role that payers can play in the design, development and implementation of the initiatives of the Population Health Council, we request that the Council include payers in the HEC governing structure. The framework notes that the HEC governance structure should have a “balance of membership,” and we believe that including payers is important to delivering that balance. Payers like Anthem have experience communicating with large populations, providing training, and monitoring and measuring outcomes. Anthem has already proven its commitment to health in Connecticut as an active partner in Connecticut’s State Innovation Model (SIM) initiative. As Connecticut develops its HEC governance structure, we urge you to consider existing structures, such as the SIM Steering Committee and to assess whether there are ways to leverage the existing groups to help implement and optimize the initiatives of the Council.

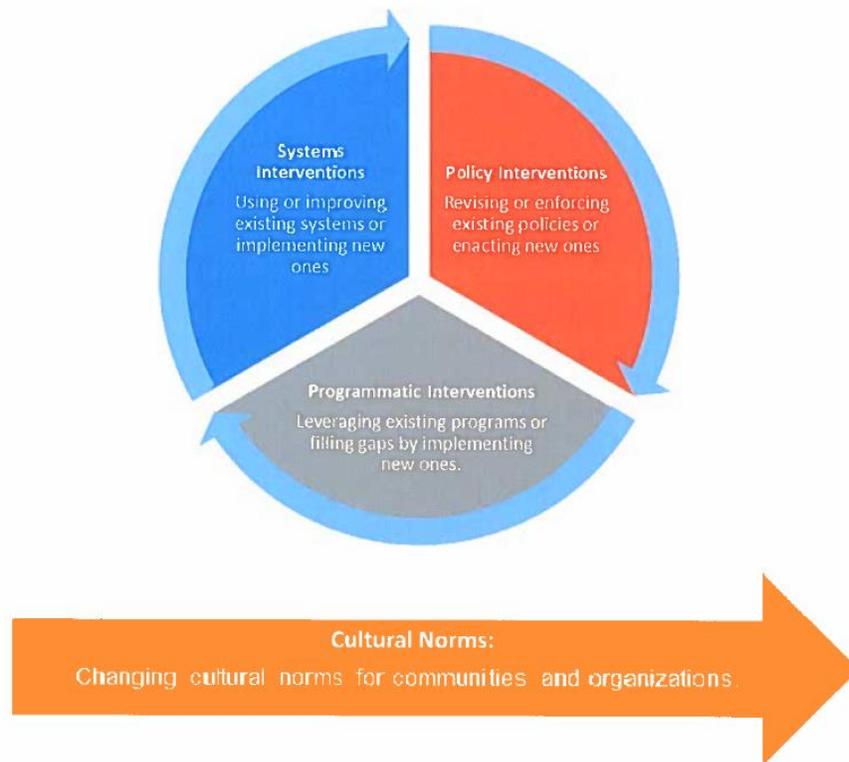
Response A:

Thank you for your eagerness to be part of the HEC Initiative and your ongoing support for the State Innovation Model Initiative, including Anthem’s active participation in the Healthcare Innovation Steering Committee. We agree that payers will play a critical role in HECs for all the reasons you detailed in your comments. We would welcome a conversation with Anthem and other payers about how to promote payer participation in HECs and the initiative. **The framework documents have been revised to reflect the important role of payers as it pertains to governance but also with respect to coordinating and implementing interventions across employed populations and beneficiaries enrolled in Medicare Advantage. This information was added to Table 3 in the HEC Technical Report.**

The Role of Culture in the HEC Intervention Framework

The HEC Intervention Framework lists four types of interventions: systems, policy, programmatic, and cultural norms. While we agree that these reflect the appropriate priorities for an SDoH framework, we believe that the framework may be improved by applying a consideration and emphasis on cultural norms across the three remaining areas, rather than treating cultural norms as its own siloed category of intervention. For example, any programmatic intervention should consider the ways in which cultural norms are being challenged or reinforced through the given intervention. This also applies to policy and systems

interventions, which should be implemented with an anticipated impact on cultural norms. Please see the attachment for a revised framework that we recommend be considered.



This recommended approach is reinforced by the technical document, in which the examples of cultural norm interventions are abstract and potentially less measurable, yet critically important. Culture is an element that runs throughout programs, impacts the functioning of systems, and influences policy development. Emphasizing a consideration of cultural norms across the other intervention areas has the greatest potential to influence those norms and will also help to orient intervention plans that are most relevant to consumers and their families and specific to the identified communities.

Response B:

We wholeheartedly agree that understanding and addressing culture and cultural norms is essential to the success of all interventions. The intent is for the four types of interventions to be mutually reinforcing and interwoven. We included it as a separate category for cultural norms because there are important interventions for HECs to consider that have the specific aim of changing cultural norms. An example would be a social marketing campaign that is intended to strengthen positive social norms about child well-being. Optimally such a campaign would be reinforced by systems, policies, and programs that require, encourage, and/or enable communities, organizations, individuals, and families to support child well-being. However, cultural norm interventions are specifically and primarily intended to shift norms. **We revised the framework documents to better describe the role of cultural norms when implementing new or making changes to existing systems, policies, and programs. See Section 3.3.4 of the HEC Technical Report.**

Financing of HEC Initiative

Anthem agrees that one of the major challenges of the HEC initiative will be ensuring stable and adequate financing. We agree that Medicare could serve as a long-term financing partner and that Connecticut should pursue securing federal funding. The Population Council, in considering funding options, should focus on sustainability and ensuring that funding mechanisms are balanced appropriately to guard against changes in policy, regulation or economic downturns.

Anthem recommends that Connecticut ensure that State agencies are coordinating and using existing funds wisely and in pursuit of the goals of the HEC framework. By implementing a “blended and braided” funding mechanism, Connecticut can ensure the HEC initiative is sustainable for the long-term. At the state level, blending and braiding are financing strategies that integrate or align discrete categorical funding streams to expand the reach of initiatives. “Blended” funds refers to blending program-level funds from two or more separate funding sources within one full-year program – costs are not allocated or tracked by individual source. When funds are “braided” two or more district funding sources are coordinated but revenues are allocated and tracked by categorical spending level. Connecticut should consider how to use not only SIM funds, but funds from other existing State programs to carry the work of the HEC framework forward and invest resources in building community capacity.

Response C:

The State Partnership will specifically explore opportunities to coordinate, align, and use existing funds to support HECs. We anticipate that this will require formal financial mapping activities that reveal opportunities for braiding and blending, especially cross-agency opportunities, that may not currently be apparent to agency staff or leadership. We also will provide information to HECs about opportunities to do the same locally.

Monitoring Progress in the HEC Initiative

One challenge for the HEC initiative will be monitoring program progress. To assess performance, the draft framework and technical report outline various measures of success including outcomes measured and targeted cost savings. Given Anthem’s extensive experience implementing health interventions and tracking outcomes, we recommend that Connecticut implement measures that allow for real-time evaluation of intervention success. Interventions should be nimble, and HECs should be able to terminate or alter ineffective interventions. Removing ineffective measures is common in other programs, such as the Medicare Quality Payment Program (QPP), where measures that do not continually improve health outcomes are removed (i.e., “topped out” measures). Continuous evaluation will support sustainable use of limited funds, as described above, and help ensure that the State and those charged with developing and implementing the goals of the Council are promoting such goals in a time- and resource-efficient manner.

Anthem recommends that the framework emphasize quality improvement strategies that allow for updates, reconfigurations, or termination of interventions over shorter time periods. One way to do this would be to track interim success indicators in addition to outcomes. For example, HEC partners could track the upfront utilization interventions, such as the number of individuals visiting a fresh food pantry, or the number of attendees at group exercise classes provided to the community. Measuring these interim indicators would help the Council and the HEC to determine whether an intervention, resulting from increased access to resources and services, is resulting in the behavior change required to produce the desired outcomes and achieving short-term goals. This will allow them to make changes that can enhance the effectiveness of the interventions and can help improve the overall success of such interventions.

Response D:

The process you describe will be essential for the success of HECs and the HEC Initiative and is not reflected in the current framework documents. **The framework documents have been revised to reflect a nimble, continuous quality improvement process. We also included a description of how measures should be selected, used, refined, or removed to support real-time quality improvement strategies and included language on the importance of interim indicators for those strategies. See Sections 4.3 and 4.4.1 of the HEC Technical Report.**

The HEC framework also includes the goal of “slowed healthcare spending in the state” as an outcomes measure. Anthem notes that the HEC initiative may not result in immediate savings. Therefore, we agree that Connecticut establish a sufficiently long timeframe (such as 5-10 years) for the realization of this measure. Additionally, we would caution against focusing solely on per capita spending and encourage Connecticut to consider health outcomes alongside changes in spending. Lastly, we recommend that any calculation of spending changes required as a result of this initiative be augmented by savings from avoided hospitalizations or medical care that could be considered attributable to an HEC intervention. This approach would help to avoid perverse incentives and ensure that individual well-being is the focus in efforts to reduce healthcare spending.

Response E:

Both the existing shared savings program models (e.g., EPCP, MSSP) and the HEC initiative emphasize a reduction in per capita spending. This can make it difficult to distinguish savings that are attributable and allocable to providers under the SSP model from those savings that are attributable and allocable to providers and community partners under HEC. As your question suggests, some healthcare outcomes, such as avoided hospitalizations, will result from clinical activities that serve the dual purpose of improving near-term outcomes (e.g., A1C control) and also secondary prevention outcomes (e.g., reduced incidence of retinopathy and end-stage renal disease). For that reason, although we intend to measure a broad range of health and healthcare outcomes, we are proposing to use a savings allocation model that aligns incentives and enables the distribution of resulting savings, without duplication. This model is described in brief in our response to question 6, page 17.

Clarification Regarding Anthem’s Enhanced Personal Care Program

Anthem would also like to take this opportunity to clarify how our Enhanced Personal Care Program could be more accurately reflected in the technical report. Since the model is for organizations with a foundation in primary care, rather than for primary care physicians only, it would be more accurate to state that it is a program for all healthcare providers that have a foundation of primary care. In addition, we recommend reference to the program’s “shared savings model” without specifically referencing risk (upside risk in particular). We appreciated your consideration of these minor clarifications regarding this program.

Anthem appreciates this opportunity to provide input on this framework and welcomes the opportunity to discuss our work and recommendations.

Response F:

Thank you for the clarification of your Enhanced Personal Care Program. **Table 8 of the HEC Technical Report has been revised accordingly.**

10. Health Improvement Collaborative of Southeastern Connecticut – Russell Melmed:

Please accept the following section-specific public comment on the Proposed HEC Technical Report on behalf of the Health Improvement Collaborative of Southeastern Connecticut.

Page 36: 3.3.1.3 – We encourage the technical report to include a detailed definition of health equity, rather than a footnote or reference to the Healthy People 2020 page. If the SIM would like to adopt the HP2020 definition, then the report should say so explicitly. Further the report should define other phrases for clarity: health disparity, health inequality, social determinants of health. These phrases are used seemingly interchangeably throughout the report, and a state report with such significant policy implication that lists improving health equity at its core should avoid such ambiguity.

Response A:

Thank you for your thoughtful comments on the HEC framework document. The state strives to develop a common language that all stakeholders can use to communicate about health equity and apply an equity lens in their daily work. We recognize that adoption and use across many partners can be challenging. **Therefore, a definition for “health disparities” has been added to the framework to complement the definition of “health equity” and to help ensure common and consistent use of these terms throughout the documents. (See the Introduction to the HEC Technical Report for these definitions).** Most definitions on this report have been standardized by the DPH Office of Health Equity, which has served as a guide for this project.

Page 38: 3.3.2 - Defining minimum population and Medicare beneficiary levels makes sense as presented but limiting the number of HECs to 8-12 does not. If the number of existing collaboratives across the state meeting the population thresholds already numbers beyond 12, forcing the collapse or aggregation of collaboratives introduces administrative hurdles that may imperil the procurement process. If there is a need to restrict the number of HECs in the State, then the report should support that number by presenting the evidence, which is currently omitted.

Response B:

The number of HEC’s proposed by the framework document is a *provisional estimation* of the number of feasible communities that could participate in the initiative to achieve statewide coverage. To a large extent, the HECs will be self-defined based on a history of collaboration and the ability to meet minimum standards, such as no overlapping boundaries and specific population thresholds. The process of establishing HECs will be iterative through a state procurement process with the goal of leveraging existing assets at a local level.

Page 41: 3.3.3.1 - HEC interventions should not be limited to focus on families, children, parents, and expectant parents to prevent ACEs. Interventions that focus on neighborhoods should also be permitted. For example, interventions that aim to improve neighborhood safety should be allowed.

Response C:

We agree that ACEs interventions will not be limited to focus on families, children, parents, and expectant parents to prevent ACEs and should include a focus on neighborhoods. **The framework documents have been revised to clarify that (see Section 2 of the HEC Technical Report).**

Page 62: 4.2.3 – Direct measures of the availability of affordable high-quality fruits and vegetables should be included as a secondary measure. This indicator is currently available through the Data Haven Wellbeing survey. It is only collected triennially in that survey, and therefore does not meet all 5 criteria stipulated in section 4.4 of the report. Nevertheless, a direct measure of one of the core objectives should be included. There are similar direct measures of access to safe spaces to engage in physical activity which should be considered for inclusion as well.

Response D:

Thank you for the suggestion of a secondary measure and identifying the data source. The measures list will be finalized through an inclusive process to identify, vet, and finalize measures. We will include this measure in that process for consideration.

Page 79: 6.2.3 – It is unlikely that there will be substantial redeployment of staff across existing collaborative membership agencies. Though the mission and visions may be very closely aligned, the extent to which the core function of existing agencies aligns perfectly with the chosen interventions of an HEC is likely to be low, making redeployment a choice between fulfilling a new function or continuing an existing one. Compounding this is the chronic and systemic underfunding of most of the membership agencies currently participating in collaboratives, providing limited flexibility to redeploy. New hires, either directly by the HEC or by membership agencies funded by the HEC will likely figure much more prominently than the 77% portrayed in the Hypothetical GHHEC Workforce presented in the report.

Response E:

The Hypothetical GHHEC Workforce example has been revised to reflect a more modest scenario.

Page 101: 7.2.1.1 – Existing collaboratives have been pursuing near-term funding for several years, and continue to do so, with inconsistent results. Grants and minor reallocation of core funds from partner agencies have been the most consistent sources of revenue but have not likely provided for the scale of interventions necessary to generate substantial or measurable cost savings for payers. Without systemic realignment of state resources to fund the initial 5-years, it seems unlikely that HECs will deliver the necessary cost savings to provide for sustainability of HEC work.

Response G:

We are in full agreement that “grants and minor reallocation of core funds from partner agencies have been the most consistent sources of revenue but have not likely provided for the scale of interventions necessary to generate substantial or measurable cost savings for payers.” Substantial new funding will be required to implement and scale HECs and HEC interventions, whether these collaboratives or interventions are entirely new or an expansion of current efforts. There are several elements of the proposed framework that are intended to substantially improve state and HEC-level efforts to capitalize activities during the first five years. As examples:

- A return on investment arrangement with Medicare and Medicaid is intended to expand opportunities to seek and secure investors such as philanthropic program related investments (PRI) and mission related investments (MRI).
- A statewide framework for improving community health will also improve Connecticut’s ability to pursue pay for success opportunities that are expected to emerge in the coming years, such as the recently announced US [Treasury SIPPRA funding opportunity](#). This too will help attract investors.
- A statewide framework will also improve Connecticut’s competitiveness for national private philanthropic opportunities.
- Finally, the state intends to pursue formal financial mapping among state agencies participating in the State Partnership for Health Enhancement, with the aim of identifying more efficient ways to blend or braid funds so that more resources can be flexibly directed toward health priorities.

11. Department of Public Health – Christine Hahn:

Please find my recommendations and comments below. This is such an exciting initiative for Connecticut!

Recommendations:

1. Provide background on the Population Health Council, e.g. what type of PH professionals comprise the Council, are they appointed or volunteer, what organizations do they represent, etc. If they reader is unfamiliar with this Council, he/she is left thinking, “who are they?”. A quick Google search does send you to the ct.gov page, but even this description is limited. Since many of the decisions are coming from this body, it would be helpful and beneficial to know who they are exactly.

Response A:

Thank you for responding to our request for public comment on the HEC framework and report and for your enthusiasm about this initiative. The roster of the Population Health Council membership is in Appendix 2 (page 167) of the framework document. Further detail about the members’ biographies can be found [here](#).

2. Per the Framework: “HECs may also decide to focus on other priorities in addition to these two. For example, a community group may decide that there is a more pressing priority that they want to address. HECs can choose to do that. That said, the financing models that the state will pursue to sustain the HECs will focus on these two priorities” (page 40).

a. While it is implicit that HECs will be responsible for finding funding streams for priorities other than the two chosen, I suggest adding a sentence to help prevent questions – something like, “HECs will be not be able to pursue state funding to finance outside priorities.”

Response B:

Thank you for this comment. While we want to make clear that HEC-related funding will be limited to the identified health priorities, we do not want to preclude the pursuit of state funding for such outside priorities. State agencies will continue to have non-HEC related priorities for which funds may be available. **[Edits have been made to the HEC Technical Report for clarity. See Section 3.3.3 of the HEC Technical Report.](#)**

General Comments:

1. I found the example in Appendix A [at the end of the Framework] very helpful! Great addition.
2. As general feedback related to the healthy weight and physical fitness priority, it is important to keep in mind the psychological factors associated with physical fitness, e.g. depression, etc. Improving access to healthy foods and safe physical spaces is important, however one's mental health is also critical. Is the intent of this priority to focus on people who are already motivated to improve their weight with high self-efficacy, but they simply have access issues/barriers? I believe this may minimize the pool of folks to which this priority relates – I would be interested to know the size of that pool (what percentage of residents does this omit). I am by no means an expert on mental health, but I am interested to know whether you all considered mental health when discussing this priority and whether it does, in fact, play a large role in one's lack of physical activity.

Response C:

We very much appreciate your statement of concern about individuals with mental health problems. It is not the intent of the healthy weight and physical fitness priority to focus only on individuals who have high self-efficacy nor is the framework itself intended to exclude specific populations. We anticipate that HECs will make decisions through the local planning and design process with respect to how best to target initiatives that are undertaken at the local level. In addition, we recognize the important link between mental health and activity level, for example, the dampening effect that depression has on initiating activity, and also the favorable impact that exercise can have on recovery from depression and other mental health problems. In a subsequent phase, we expect to release a menu of interventions that has been shown to work and have shown a return on investment. We will specifically look for interventions that address the connection between mental health and healthy weight/physical activity.

3. Per the Framework, "If HECs decrease the trajectory of health problems associated with child exposure to ACEs and obesity in Connecticut over a 5- and 10-year period, the associated health care savings can be calculated and a portion of the savings made available by purchasers to reinvest in HECs" (page 24).
 - a. This is fantastic! My only question is what is the percentage and will it be consistent among all HECs – and if not, how will this percentage be calculated?

I am eager to watch the progress of this work! Thank you for opening the review process to public comment.

Response D:

The details of the funds distribution methodology will be developed in the next design phase. General distribution percentages will need to be negotiated with and agreed to by purchasers (e.g., Medicare). While we do not yet know the specific methodology, we envision distribution would be proportional to each HEC's measured contribution to the reduction in health risk for their communities. This means some HECs may share in savings whereas others may not depending on whether or not or to what degree they contributed to reducing health risk.

12. Connecticut Children's Medical Center – Jane Baird:

Connecticut Children's Medical Center is pleased to provide public comment on the Connecticut State Innovation Model (SIM) Health Enhancement Community (HEC) Initiative Proposed Framework. Connecticut Children's Office for Community Child Health (OCCH) innovates systems and programs that promote children's optimal healthy development, strengthen families, and support communities. OCCH does this by serving as the organizing entity for a variety of community-oriented programs that address a range of determinants influencing children's optimal healthy development, as outlined in Figure 1, and serving as a

critical community resource to community-based partners. Our three core strategies include: 1) strengthening existing community-oriented programs and the community-oriented programs of our partners; 2) facilitating synergies among internal community-oriented programs and the community-oriented programs of our partners; and 3) serving as an innovation incubator for promising approaches that improve short- and long-term health, development, and well-being outcomes for children.

Figure 1: Flower Diagram

OCCH programs and emerging social innovations focus on deploying strategies that foster health promotion by leveraging cross-sector collaboration to build effective, efficient systems of care for children and families. This approach, as well as efforts to promote a child health services first policy agenda and Connecticut Children’s Medical Center’s broader vision of making the children of Connecticut the healthiest in the nation, align with the HEC Initiative Proposed Framework, goals, and intended outcomes.

We applaud the development of a state-wide initiative that prioritizes making Connecticut the best state for children to grow up by addressing the social determinants of health as a strategy to mitigate against Connecticut’s rising health care costs, and believe this approach will lead to both financial and social returns on investment. We organized our thoughts based on what we believe will be essential components for the HEC Proposed Framework to effectively, efficiently, and sustainably improve child well-being in Connecticut pre-birth through age 8.

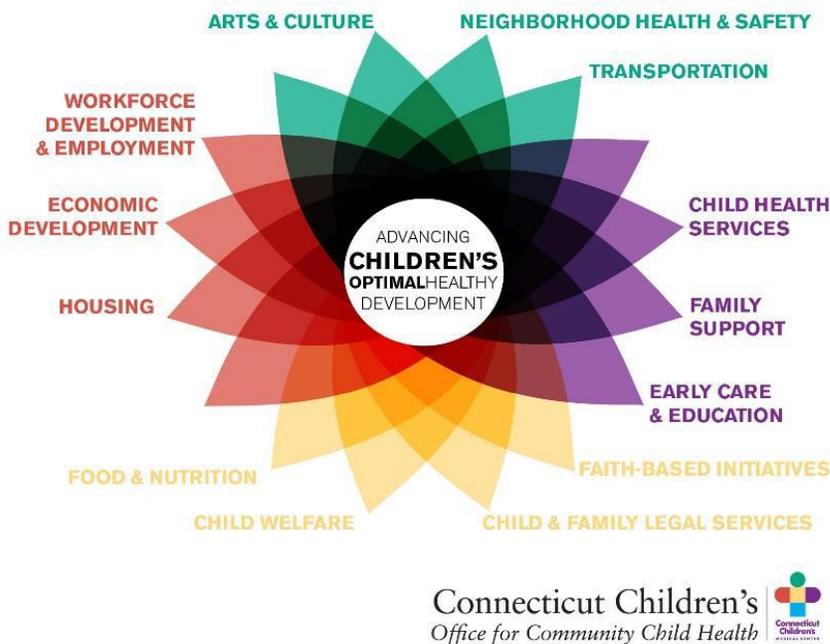


Figure 1: Flower Diagram

Pediatric Primary Care Transformation

As indicated in the HEC Initiative Framework, innovative financing models that prioritize and incentivize health promotion and disease prevention, instead of more traditional fee-for-service models, will be essential to support implementation and sustainability of strategies that achieve their intended outcomes. To date, most innovative financing models focused on controlling healthcare spending among chronically-ill populations that result in immediate cost savings for the healthcare system. Few financing models have been developed and tested that prioritize long-term cost savings by investing in and integrating health-related social services into primary care, even though the evidence demonstrates many chronic, long-term health conditions that adults live with have their roots in early childhood.

Given the near universal access of pediatric primary care to children and families, it is the ideal setting to support practice transformation. OCCH acknowledges the potential for significant short-term cost savings resulting from improved coordination and management of care for children and adults with chronic and/or complex health conditions. That said, the potential for long-term cost savings stemming from promoting all children’s optimal healthy development and reducing the likelihood of chronic health conditions is also great. Investing in the development, implementation, and evaluation of a *continuum of care and services* (Figure 2), as described in the HEC Initiative Framework, that prioritizes children’s optimal healthy development, will yield valuable returns on investment across multiple child- and adult-serving systems, including but not limited to child health, behavioral health, special education, child welfare, juvenile justice, and corrections. [From a societal perspective, such investments](#) are critical to ensure long-term workforce development, stable housing, the economic development of communities, and even national security (e.g., a fit military, cybersecurity). See page 619 in the linked document.

Figure 2: Continuum of Care and Services



Pediatric primary care transformation needs to happen on two-fronts. First, we need innovative financing models that empower pediatric primary care providers to take a more comprehensive role addressing a child and families’ needs, enabling them to make meaningful contributions to population health goals identified by HEC communities. The Child Health and Development Institute of Connecticut, Inc. (CHDI) recognized a need to explore how pediatric primary care payment reform could support improvements in child health services, mitigate the impact of the social determinants of health, and enhance population health. With the support from the Connecticut Health Foundation and The Children’s Fund of Connecticut, CHDI convened a multi-disciplinary study group to explore the opportunity and create a set of recommendations. The study group’s findings and recommendations were recently published in *Healthier Kids, Healthier Connecticut: A Vision for Redesigning Pediatric Primary Care and Transforming Pediatrics to Support Population Health: Recommendations for Practice Changes and How to Pay for It*, a joint policy brief and report available [here](#). The proposed model includes three key characteristics and five recommendations, outlined in Table 1.

Table 1: Model Characteristics and Recommendations from Study Group

Model Characteristics	Recommendations
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- **Flexibility:** Providers need flexibility to implement innovative practices, such as longer or weekend hours, embedding behavioral health or other practitioners in the practice, or group visits so families can learn from each other.
- **Focus on Outcomes:** To ensure the care is improving health, the system must measure and reward providers for achieving specific outcomes, such as [reduced] infant mortality, healthy weight, optimal healthy development, school measures, or healthy lifestyle measures.
- **Payment that Supports Innovation and Health:** Moving away from traditional fee-for-service payments would allow providers more flexibility in how they care for their patients. The system must build on elements that deter providers from realizing savings by limiting needed care. This would mean linking payments to a robust set of performance and quality metrics that reflect best practices in care delivery for children.

1. Reward health promotion and prevention – not just treating illness – for all children.
2. Develop payment methods that support the restructuring of pediatric primary care in ways that improve population health, health equity, and address costs.
3. Measure outcomes and build the body of evidence demonstrating long-term return on investment for pediatric primary care.
4. Require all payers to participate in the new system.
5. Efforts to eliminate fragmentation in services must be accompanied by reduced fragmentation in funding.

Second, pediatric primary care providers need access to training and support that will allow them to institute the necessary practice changes and take a more integrated, comprehensive role supporting children’s optimal health, development, and well-being. CHDI and OCCH currently support two initiatives that do just that. Educating Practices in the Community is a comprehensive, community-based, child health provider outreach and training program that assists providers in implementing practice changes that are supported by community and states resources. Training topics include but are not limited to behavioral health screening, care coordination in the medical home, obesity prevention in infancy and early childhood, and trauma screening, identification, and referral in pediatric practice. The Practice Quality Improvement Program seeks to improve the quality of care delivered to patients by initiating and facilitating continuous quality improvement projects for physicians, including projects that result in MOC Part 4 credits, AMA PRA Category 1 credits™, and/or NCQA Medical Home recognition. Combined, these two programs seek to transform child health services by introducing providers to emerging trends in pediatric health and integration of identified best practices into provider operations.

While the above points are specific to the primary care environment, we believe the future state of compensation will and should be a mix of value-based capitation while still including fee for service for more tertiary or higher cost interventions which will never be completely alleviated.

Response A:

Thank you for your helpful comments about maximizing primary care financing to enable health promotion in children. We recognize that pediatric settings are optimal to test practice innovation and payment reforms. Equally important is the potential of pediatric populations to exhibit health improvement outcomes at various levels of human development that can also be associated with long-term returns. The goals of [Primary Care Modernization \(PCM\)](#) are precisely aiming in that direction, including building core capabilities to strengthen the pediatric team (e.g., expanded care teams, behavioral health integration, care coordination, universal home visits, eConsults, and telemedicine solutions), a payment model that supports

the flexibility necessary to innovate and provide more wholistic care and services, a focus on—and rewards for—outcomes, and performance metrics that reflect and drive best practices in care delivery . Other capabilities may include community purchasing partnerships and shared appointments to engage family members.

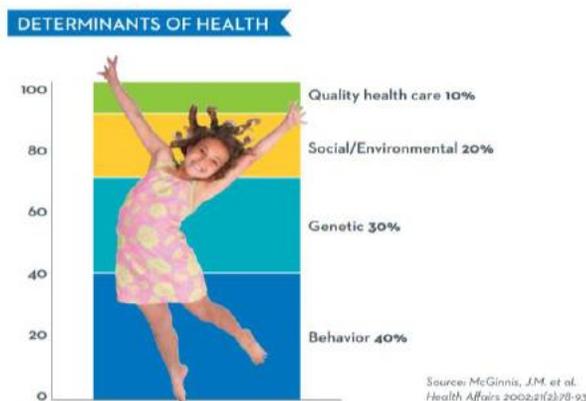
Additionally, both the HEC and the PCM strategies are designed with a multi-payer agreement in mind. We agree that an integrated financing system will reduce service fragmentation, which is consistent with the standardized development of quality and performance measures for the implementation of new payment models.

We also agree that training programs like the Educating Practices in the Community and Practice Quality Improvement Program programs as well as technical assistance and other supports are essential to transforming care and service delivery.

Integrating Health and Social Services

While quality health care is a key determinant of children’s optimal healthy development, the critical contributions of social, environmental, genetic, and behavioral factors demand a comprehensive, coordinated, cross-sector approach, as demonstrated in Figure 3. OCCH’s experiences support state-driven integration of healthcare and health-related social services. Our experiences working with numerous Connecticut state agencies, including but not limited to the Department of Public Health, Department of Social Services, Department of Children and Families, and the Office of Early Childhood, in strengthening both the efficacy and cost effectiveness of such processes as health promotion, early detection, care coordination, and access to pediatric care reinforces the feasibility and benefits of such collaboration. For example, the Care Coordination Collaborative Model, an innovation developed by the Connecticut Children’s Center for Care Coordination, brings together care coordinators from diverse sectors to enable synergy and collaboration; more effective problem solving for children and families; and fiscal efficiencies by minimizing duplicative efforts.

Figure 3: Determinants of Health



We also appreciate that the HEC Initiative Framework recommends key priorities, parameters, design principles, and goals but empowers communities to decide how their HEC will be operationalized, having long embraced the notion “all politics is local.” Much of the work to innovate and diffuse novel solutions to contemporary community child health, development, and well-being needs occurs at the community-level

and is place-based, requiring buy-in, support, and investments from local champions, such as community members and leaders, local service providers, and municipal government. Our own experiences cultivating, testing, and bringing to scale social innovations, whether they be developed internally by Connecticut Children's or by our community-based partners, such as Help Me Grow, Easy Breathing for Schools, Kohl's Starting Childhood Off Right, and Mid-Level Developmental Assessment, align with HEC's focus on place-based, as well as other design principles including but not limited to community ownership and involvement, community health, health equity, upstream interventions, and leveraging existing assets.

Efforts to 1) enhance protective factors that build resilience and mitigate the impact of adverse childhood experiences (ACEs) and 2) deploy interventions that address ACEs by meaningfully integrating health and health-related social services and cultivating effective social innovations need to happen in the context of comprehensive system building and build upon existing efforts to support children and families. We appreciate the HEC Intervention Framework, the cyclical relationship between systems interventions, policy interventions, cultural norms interventions, and programmatic interventions, and that HECs will have the discretion to select interventions most relevant to their communities. Our experience teaches us that place-based initiatives are most effective and sustainable when supported by overarching, comprehensive systems.

Response B:

We appreciate your enthusiasm for the place-based nature of the HEC Initiative and the intervention framework. We also recognize that OCCH is making a notable contribution to developing and scaling child-oriented integrated systems of care and is among the state's assets that we anticipate could be part of the local and statewide solutions process. Your experience in developing these systems could provide many communities with a potential foundation for planning more prevention-oriented child well-being systems. Through the initiative, the state will also encourage HECs to leverage, align, or scale existing community-based interventions. We look forward to soliciting your experience and insights in implementing and scaling such interventions and creating integrated clinical and community initiatives, which is the intent of the PCM and HEC initiatives. **We have added OCCH as an example of a leveraging opportunity into the HEC Technical Report. (Section 6.3.3.9.)**

Measurement, Evaluation, and Reporting

Appropriate measurement, evaluation, and reporting that enable programs, policy makers, and evaluators to assess the efficacy of interventions will be essential to assess the effectiveness of HECs at achieving their intended outcomes and their ability to meaningfully impact child health, development, and well-being. While the proposed primary prevention measures for the health priority aims (a composite measure of a child's safety, stability, and school readiness and the prevalence of adult and child obesity) and the process and outcome evaluations of interventions (systems, policy, programs, and cultural norms) are a starting point to assess the effectiveness of HECs at supporting a population health agenda, additional measurements and evaluation strategies need to be leveraged to meaningfully assess impact.

In an effort to assess our impact promoting children's optimal health, development, and well-being, OCCH adopted the Strengthening Families Protective Factors Framework developed by the Center for the Study of Social Policy. Our work has predominantly focused on strengthening protective factors that enhance the capacity of a family to support a child's healthy development. In collaboration with programs, OCCH developed strategies to measure the impact of our interventions on critical factors such as parental resilience, social connections, concrete support in times of need, and families' capacity to promote their children's social and emotional competence. To complement our measurement of proximate, family-level

protective factors, we also seek to build our capacity to utilize a broader set of measures at the community and system level that capture our impact across the childhood spectrum.

In partnership with CHDI, the Connecticut Children’s Care Network, and payers, we are also developing quality metrics that reflect essential components of pediatric primary care that are fundamental to children’s optimal health, development, and well-being. Measures that support health promotion, early detection, and connection to services have been vetted within the context of data available from electronic health records, claims systems, and audits.

As outlined above, we believe pediatric primary care transformation and meaningful integration of health and social services are key components for the success of HECs. Metrics that demonstrate that Connecticut and HEC communities are making meaningful progress in these areas, as well as their resulting impact, will be essential to improving child well-being, making Connecticut the healthiest state in the country, and slowing the growth of Connecticut’s healthcare spending.

Response C:

We appreciate the suggestions to improve the HEC framework provisional measures with impact indicators such as parental resilience, social connections, and capacity to promote children’s social and emotional competence. **We revisited this section of the HEC Technical Report and added that measures that support health promotion, early detection, and connection to services may be added to the provisional measures list if a timely data source is identified or state reporting requirements are expanded to capture this data at the provider level. (See Section 4.2.1.)** We will review the Strengthening Families Protective Factors Framework and identify any aspects of that framework that can inform or improve the HEC Initiative. We will examine how the validation process of metrics about protective factors can substantiate their incorporation in the HEC child well-being measure set.

13. Reaching Home Health and Housing Stability Workgroup – Terry Nowakowski:

Evidence shows that housing stability has significant importance in a child’s formative years and that homelessness or lack of stable housing is associated with negative outcomes like low educational achievement, poor health and developmental delays.

Further, children who are homeless have higher rates of child welfare involvement, which could lead to foster care placement. Children who age-out of foster care have high rates of homelessness when they become adult.

Response A:

We expect that HECs will focus on important interventions such as housing stability for exactly the reasons you indicate. Ample evidence shows that lack of affordable housing and poor housing quality causes or contributes to poor health outcomes. This topic also was discussed many times during our community member feedback sessions as a root cause of poor health. Thus, we have included multiple housing-related interventions in Appendix 4. Child Well-Being Intervention Examples. This list provides examples of child well-being interventions that HECs may choose to implement. Additionally, we provide more information on the vital relationship between housing and health in Section 2.3.2 Economic and Housing Instability of our HEC Technical Report.

14. North Hartford Triple Aim Collaborative – Gina Federico:

The North Hartford Triple Aim Collaborative, which represented the interests of metro-Hartford as a SIM HEC reference community, is pleased to submit the below comments on behalf of our collaborative. We are grateful for the opportunity to participate in this work. The vision for HEC's in our state is a great one and we look forward to continuing to partner on this critical work.

Scale One overarching issue of the HEC Framework is an understanding of the scale of the endeavor. To determine the appropriate structure, governance, engagement/key sectors, and geography, what needs to be considered first is the size and scope of the initiative. For example, will the HECs start with one contract (e.g., Medicare) and focus on a narrow set of outcomes (e.g., healthy weight)--or will the initial work be broader than that? Detailed financial modeling regarding the back-end savings, HEC incentive payments and timeline needs to occur prior to determining how much upfront investment/structure is appropriate and affordable. Overall, the approach needs to be "fit for purpose." As currently drafted, the proposed framework seems overly heavy and expensive given the potential work areas. Many details on the "who" and "how" need to be titrated to link specifically the health improvement focus (though it may be evolving) of the work. Early childhood stakeholders may not be needed as part of a health improvement strategy for seniors. Are investments in state-side, multi-regional and multi-site data teams needed to stand up HEC work from the outset? Should Framework described "backbone" entities be hiring direct service employees AND overseeing systems work and contracting if this will also be happening at the state level? These questions are better answered when much more specific financial models are available. Indeed, the Connecticut Behavioral Health Partnership is a model that is referenced and may be a better option than the HEC Framework as described.

Response A:

We concur with the spirit of the comment that this is an ambitious endeavor and that it will require further specificity as individual HECs begin to establish. The HEC strategy is intended to be a statewide initiative. The scale is by design broad to meet the requirements of CMS that the financial arrangement yield sufficient federal savings to qualify for a multi-payer demonstration. We do, however, anticipate two tracks for implementation—with HECs most ready to implement starting first. Those HECs participating in the second track would start after they have demonstrated a sufficient level of readiness.

We have conducted an initial financing modeling of potential Medicare savings and are now working on modeling potential savings with other purchasers. The timeline will have key dependencies, including the status of multi-payer demonstration negotiations and securing near-term funding and financing.

Many of the details of what HECs will be and do are intentionally not included in the framework. That is because the intent is to have many of the decisions made by communities and prospective HECs, including decisions about the structure and process by which decisions will be made. The intent is that the HEC Initiative should not be largely "top-down" initiative. While the state plays important roles, ensuring that many of the decisions be made from the "bottom up" increases the likelihood of success and matches with what was expressed by many stakeholders.

The intent is for the state to provide for some centralized support for HECs and the operation of the initiative as a whole. The form, scope, and functions of that will be decided in the next phase of design. For example, a state "backbone" function may be limited to technical assistance and a fiduciary role if financing is secured through public payers or others with interests across multiple jurisdictions. However, HECs will be expected to have staff to manage the HEC, implement interventions, etc.

Geography The NHTAC and our stakeholders have many concerns about the geographic specifications of the HEC Framework. Overlaying new boundaries/structures will add to confusion and will not fully leverage current work, programs, and synergistic funding. In addition to complicating the process, new areas may exacerbate the lack of coordination that exists across silos already. For the HEC framework to be a success, working across sectors is a must. We ask that you look the state's already established 9 regional planning organizations, or do a deeper dive into the other cross cutting statewide regions to think about how this work may be organized. If the HEC's are new areas, how can they leverage existing lines or what is the rationale for these new configurations? It will be hard, if not impossible, to plan for any regions until the financial scope is established. As the document notes, there was no real input from rural areas in the HEC process, which could be a huge issue if statewide coverage is the goal. Our recommendation would be that the next set of planning should focus on these critical questions and offer structured participation in this area. We have questions how this work relates to regionalization, the strengthening of health districts, the stark health inequities and differences of urban center communities, rural areas and suburban communities. Also, the report (and the longer technical report) often reference policy work. Considering how policy works to create health value in a state like CT it is essential to review this further in the context of the geography discussion as it will likely not match up with outlined health financing instruments based on the offered model.

Response B:

We acknowledge the complexities in defining geographic boundaries for HEC performance and accountability. The HEC framework emphasizes the need for flexibility as the HEC configuration is drawn relative to existing collaborations and partnerships. Aside from the criteria for statewide coverage, lack of overlap and minimum population thresholds, the new boundaries are mostly self-defined by the communities. Given that defining a boundary requires on-the-ground knowledge of what the local and regional geographic complexities are, most stakeholders expressed a strong desire for HECs to propose their geographies rather than having the state define HEC geographies. However, the state will work with communities to resolve issues that may arise among prospective HECs.

We recognize that there must be start-up funds to support the formation and implementation of HECs. We also agree that the multi-payer demonstration negotiations have to be sufficiently advanced to initiate the next design phase, which includes HECs proposing their geographies. However, this initiative is not a typical grant-funded initiative where all the funds are in place ahead of time and the specific uses of funds are clearly and often narrowly defined. Rather the intent of the HEC initiative is to create the market conditions that enable HECs to test new interventions or scale multiple existing evidence-based strategies that will significantly move the needle on community health, health equity, and prevention in their geographies. A long term financing arrangement with CMS will require that we propose to do these things on a large scale. This in turn will require that we secure near-term dollars from multiple funding and financing sources, each of which comes with its own requirements and timing. The state is and will continue to aggressively pursue those sources and, with HECs, will make adjustments as needed to the initiative based on the availability of those dollars.

Equity/Community Voice There are concerns about ensuring equity across the HECs. Connecticut is home to some of the worst inequity in the country. Life expectancy can be as much as 10 years different in a span of a few miles. Yet, the HEC reads like all CT residents would be included in interventions and correspondingly get equal access to funds to support HEC goal areas. Yet, urban centers and areas of high poverty will need extra funding supports and intervention types to make the same positive health impacts in their community.

Regionalization in the context of HECs should not be considered lightly and could exacerbate the already large gap in health that exists between our urban centers and suburban areas. Similarly, our rural communities pose different challenges and these will require a different set of tools to overcome challenges in the state's rural areas. Finally, while community voice is embedded into the framework, it is not considered in its practical application. More work and scholarship needs to be applied in this area.

Response C:

We share your concern about ensuring equity for the reasons you indicated. The intent is for interventions to reach those that need it most and for HECs to have resources to do so. The specifics of how this will be accomplished are still a work in progress. We will continue to seek input from urban, suburban, and rural communities to inform the "how." It is anticipated that prospective HECs will also propose ways of addressing urban, suburban, and rural inequities across Connecticut as part of a design phase.

The practical application of the framework will be developed by prospective HECs in a community-led design phase. Given the unique context in which each HEC will operate, we believe that a "bottom up" approach to design will yield the best possible results.

Measures We recommend that the measures for the HEC work focus more on primary measures that assess promotive and preventive factors that lead to good health. If funding is to be allocated to upstream solutions then success should be measured by preventing the negative health outcome (obesity, neglect) not reducing an occurring deficit. In addition, it seems that the "process" for measures data is overly complicated and may affect the integrity of the data. Data sharing agreements are arduous and need a high degree of security when working with individual level outcomes. More time needs to be invested in how measures will be set, housed and tracked for different populations and to support program objectives.

Response D:

We appreciate the concerns expressed about measures and the process for measuring. The system of metrics associated with HEC is a work in progress. The HEC framework offers a set of provisional primary and secondary measures. In the next phases of the pre-procurement plan, the project will incorporate stratification of the indicators and further validation. The question of multiple teams dedicated to data analytics is unresolved at this time. However, such an approach will depend on the ongoing capacity building for Community Health Needs Assessments and OHS's concurrent development of statewide health information exchange and analytics services.

Financing Monetizing prevention savings and investing a "portion" of the savings back into community health promoting initiatives is a great layer of work OVER accountable health care models--and should be appropriately nested as such. Much more work needs to be done in understanding how near term and longer term financing instruments will "act" as part of this system--particularly how savings will be categorized and attributed in the ecosystem to drive sustainable investment. For example, how will pediatric primary care payment reform be reconciled with the child well-being goal of the HEC? Shared savings and reduced medical costs are likely not to "show up" in healthcare and investment of healthcare dollars in our young residents and potentially short term investments may be higher in this focus area even over time as we build a healthier Connecticut for our youth.

In addition, based on the model set forth in the Framework, there is a high likelihood of competition for funds between HECs. If a statewide framework is looking for grants/tax credits/debt alongside 7+ regional health collaboratives there will be clear winners and losers and this could exacerbate the current health inequity in the state. This is also true for any national funders--for instance most Foundations doing program related investments are national in scope and therefore local/regional HECs may not be positioned to compete in this marketplace--though a state-wide ask would do better. A central "funding" arm that could co-develop work and act as a "backing" entity may be a much better solution to this critical issue.

The funding sources outlined in the "braided and blended" financing section are not sufficient and are double counted. Many listed sources are only very specific to certain kinds of projects (for example new market tax credits) and/or are already in use in the current ecosystem (wealthy donors). In general, redirecting resources will not create additional resources to a community. Community benefit of local non-profit hospitals, as your longer Framework suggests, are not really a viable option due to their current allocation of over 94% to unreimbursed care shortfalls. Hospitals may need significant incentives to change their community investment portfolio. And while funds could be spent on community investments related to the HEC, but more work needs to be done to understand this potential investor. For example, as hospitals and health systems merge changing territory and landscapes served by these dollars need to be considered.

Response E:

The framework document discusses the need for near-term financing as savings to the healthcare sector will require 5 to 10 years to begin to accrue. The framework provides several options for short-term funding and financing that will be pursued in both the pre-procurement and the early implementation phase.

The long-term sustainability of HEC's is mostly predicated on a statewide multi-payer solution which addresses the question of local competition for funds. However, this is not the same for near-term funding and financing where priorities between funders and recipients in different regions must align. This tension is an ever-present issue and will not be a product of the HEC implementation or fully solved by the HEC Initiative. However, a statewide support system as you suggested could help mitigate disparities in access and distribution of funds and create opportunities to access funds, such as with national foundations, that most communities could not. We do not assume that all funds from all sources are available to support HECs. The framework only outlines opportunities that will be explored and, as always, there may be refinements made based on the outcomes of funding exploration and pursuit. We also do not assume that hospital community benefit funds will be a key sustainability solution—although hospitals participating in HECs can explore opportunities supporting and/or aligning with HECs.

Regarding pediatric primary care payment reform and child well-being, the Primary Care Modernization straw model proposes to include universal home visits undertaken by pediatric medical homes and funded by commercial payers and Medicaid. This is likely to result in [immediate offsets in emergency department utilization](#) sufficient to pay for the intervention while also offering the prospect of reduced developmental risk over the near and long term. Within the period of the HEC initiative, we are aiming to achieve reduced abuse and neglect rates and fewer child welfare placements, which is expected to result in significant reductions in ED and hospital utilization, as children in [child welfare use a disproportionate share of such services](#) (see page 4 of the 2016 DCF Semi-annual Summary). Finally, in acknowledgement of your point that much avoidable social use and cost lies outside of the healthcare systems, we believe it will be important if not essential to pursue pay for success opportunities to capture reductions in other federal funding streams, such as Title IV-E funding for children in placement. This is consistent with the recently announced US

[Treasury SIPPPRA funding opportunity](#), which we anticipate will be the first of a series of opportunities of this type.

Governance Structures/Readiness Overall the timeframe to accomplish the HEC process activities seems incredibly short. We believe that readiness is a huge issues in moving to work. Starting without addressing key issues--even in the reality of some very specific near term funding--would not set up the initiative for success. Many (if not most) of the stakeholders that were engaged in the process did not have the opportunity to collaboratively work on the design of this initiative. We believe getting reference communities and other like-minded community collaborations together would be extremely beneficial. In addition, co-design would allow proper reflection on how to use this process to align incentives and interests and have HECs be a part of existing infrastructure--rather than create a new system and process. Our strong preference would be to spend time in Phase 1 working with interested parties to design a HEC path and related governance structures that are reflective of short/med/long term funding. This would include financial modeling of all components of the work.

Response F:

The timeline for HEC design and implementation is not yet final and has many dependencies that will adjust it appropriately. While adjustments may be required, we believe that a 24-month pre-implementation period is a reasonable provisional assumption. We concur that readiness is a significant issue and, as such, propose two tracks for implementation—with the first “most ready” track starting first and the second track starting after they have had time to enhance their readiness.

We also agree that it is essential to secure adequate start-up funds as well as to have had the CMS financial arrangement negotiations sufficiently advanced. Those are two critical dependencies that will impact the timeline of subsequent phases.

The involvement of the four regional health collaboratives was critical to the development of the HEC framework. Having a framework that describes the key elements of the initiative and HECs is necessary to support a more detailed and community-led design process as well as design at a state level. The community-led design process—prior to HEC designation and implementation—would be to answer many of the questions you indicated. We agree that bringing together multiple community collaboratives to “cross-pollinate” ideas and discuss issues would be very beneficial and will be considered as the state further develops its plans.

15. Connecticut Hospital Association – Karen Buckley:

We appreciate the opportunity to comment on the Office of Health Strategy’s proposed Health Enhancement Community (HEC) Initiative framework. The Connecticut Hospital Association (CHA) and Connecticut hospitals have focused on promoting health equity, supporting communities and, recently, addressing social determinants of health. Connecticut hospitals and health systems support the intent of the Initiative, which is indeed a comprehensive and impressive effort to draw healthcare organizations and community together to promote wellness and prevent poor health. We applaud the proposed HEC Initiative framework where it aligns with these areas of focus and seeks to improve community health and reduce healthcare costs.

However, we have some concerns with the framework as presented. Our initial concern is that the HEC Initiative framework builds on a healthcare system that is underfunded and, with respect to hospitals, is based on an unsustainable hospital tax and Medicaid reimbursement that is well below the cost of providing care. We are also concerned about some of the proposed funding mechanisms and how it is contemplated that decisions will be made. We believe it is imperative that new, not redirected, dollars be available for a program of this significance. In addition, we have specific concerns, as follows.

Funding

We agree that upfront funding will be required to implement HECs, and we appreciate that the proposal specifies a variety of financing options for consideration. However, we are concerned with proposals to use available hospital “community benefit funds,” as it is based on the premise that the HEC can simply transfer community benefit funds for support of the Initiative. This is not the case. Redirecting hospital benefit dollars is problematic; on its face, it has the potential to run afoul of federal community benefit reporting requirements.

The proposal does not take into account that a high percentage of hospitals’ reported community benefit include Medicaid and Medicare shortfalls and uncompensated care. These funds are in recognition of underpayment for services provided, and they are not cash available to spend. Page 2 of 2

In addition, the proposal to use or transfer “community benefit dollars” does not recognize that hospitals, through an extensive community health needs assessment and informed planning process, which includes community partners, direct funds toward their communities. In 2017, Connecticut hospitals and health systems provided more than 12.4 million services to individuals and families at a cost of \$1.7 billion. While we appreciate the proposal to leverage existing assets and not duplicate efforts, redirecting existing dollars being used to address community health may not produce the desired effect. We think it may unintentionally put in jeopardy successful programs already in existence.

We also have concerns related to financing the long-term sustainability of this model. Funding options are based on the assumption that the HEC Initiative framework can be supported through savings achieved through its implementation. The proposal indicates that it will take 5 to 10 years to achieve savings. While this is a laudable goal, we believe the likelihood of additional benefit funds being available due to Medicaid and Medicare costs being fully reimbursed and through cost savings is slim.

Response A:

We agree that it is imperative that new, not redirected, dollars be available for a program of this significance although we believe that it is reasonable expectation of all participants, whether public or private, to continually re-assess the value and effectiveness of existing investments. Hospitals participating in HECs may decide to align their community benefit funds with HEC activities and/or HEC interventions may be selected to align with current community benefit fund uses. We acknowledge the limitations in the amount of available funds and the existing allocations of community benefit dollars to health-related activities. Therefore, it is not anticipated that these will be a substantial source of funding.

Scope and scale

The HEC implementation timeline allows 24 months to develop governance, finalize financing, establish information technology support, and address statutory and regulatory changes. While we agree that the goals of the Initiative are bold and aggressive, we are concerned about whether they can be realistically

achieved in the timeframe. We suggest reducing the scale of the Initiative and perhaps reevaluating the timeline to accommodate the substantial amount of infrastructure development involved. We believe the three health priority areas identified for HECs to pursue are appropriate and well-supported in the framework discussion. We agree that a key tenet of the work should be that it is focused on what matters most to communities and that governance structures should include representation from all stakeholders.

Response B:

The timeline for HEC design and implementation is not yet final and has many dependencies. While adjustments may be required, we believe that a 24-month pre-implementation period is a reasonable provisional assumption. In addition, we recognize that not all prospective HECs would be immediately able to design their HEC and be ready to implement. We anticipate two tracks on implementation—with HECs most ready to implement starting first and the next track starting after they have had some additional time to prepare.

The scale is intended to be broad to meet the requirements of CMS that the financial arrangement yield sufficient federal savings to qualify for a multi-payer demonstration.

Data collection

The proposal indicates that a robust IT and data infrastructure is required for the Initiative to be successful. As presented, the framework seeks to capture a comprehensive amount of data. We are concerned that the level of collection, aggregation, and interoperability required may not be achievable. It does not take into account the current limitations of the state in this area.

Response C:

We recognize Connecticut's historical limitations in health data collection, aggregation, and interoperability. However, OHS is currently developing statewide health information technology services to support health information exchange and also analytics through a newly established Core Data Analytic Solution (CDAS). We intend to undertake a use case development process with local collaboratives in the coming year to inform the further development of the CDAS. Our intent is to enable access to information to support the design, management and monitoring of local level HEC interventions. For additional information, please see the health information technology section of the [State Innovation Model AY4 Operational Plan](#).

We are also concerned that the proposal does not fully contemplate the existing state and federal laws regarding data confidentiality and the privacy of consumers.

Response D:

HECs will have access only to de-identified and aggregated data, such as hot spots, that can guide their activities. Identifiable data will only be available to caregivers with a clear HIPAA relationship to any particular patient.

We appreciate the opportunity to comment on the HEC Initiative framework and look forward to continued discussion.

16. Norwalk Health Department – Deanna D’Amore

Please accept the following comments from the Norwalk Health Department, part of the Greater Norwalk Community Health Improvement Collaborative, in support of the Health Enhancement Communities concept, noting suggestions for revisions to the current proposed framework.

First, the Norwalk Health Department believes the following elements to be the strongest and most encouraging elements of the proposal.

- **Overall Premise/Intention:** The Health Department and our community partners are very enthusiastic about the prospect of a financially sustainable infrastructure to address community health, health equity, prevention, and social determinants of health/root causes of poor health. During our community discussions as a Reference Community, we heard strong, enthusiastic support for this approach from our community partners, community members, and professionals who serve residents as case managers, clinicians, home visitors, educators, and more.
- **Community Engagement:** The Health Department strives to engage community members in a meaningful way throughout our work and appreciates the Population Health Council’s emphasis on community member involvement/representation at every level of the HEC framework.
- **State Support:** The Health Department appreciates the Population Health Council’s recognition of the need for state support across all HECs and agrees that HECs will need technical assistance, templates, shared data/IT infrastructure, and a mechanism for sharing best practices in implementation. We recommend that the state supplement the local financial resources in each HEC with investment to support start-up costs (discussed later).
- **Data/IT Infrastructure Plan:** The Health Department supports the establishment of a statewide, centralized, open access database for outcomes analysis and tracking, and appreciates that the state recognizes its role as the lead in this important infrastructure element for the HEC.

In addition to these strengths and promising elements, please consider the following concerns and suggestions for improvement. We believe that these are opportunities to strengthen the proposed framework and give the HEC model the best chance for success.

- **Financing:** The Norwalk Health Department appreciates the work being done to establish a long-term financial sustainability/reinvestment system for HECs. Still, it will be extremely challenging for HECs to raise all the necessary start-up financing alone. Consider just a few of the costs mentioned or implied in the proposed HEC framework:
 - wages and fringe for an independent, unaffiliated HEC management team
 - programmatic staff (whether new hires or support for agencies currently engaged in the work)
 - workspace, furniture/equipment, and overhead costs
 - compensation (including stipends), training, childcare and transportation for community representatives and governance body
 - various expenses associated with intervention implementation
 - communication and promotion costs to increase awareness of and participation in HEC activities

In addition, although some non-traditional funding options are listed in the proposed framework as examples, the bulk of the near-term financing is still expected to come from traditional sources such as philanthropy and hospital community benefit funds. If we want to create a truly innovative structure for improving community health outcomes and equity, then HECs cannot rely on current funding models. Instead, state and federal stakeholders must be willing to invest in that model up front. Also, in many

regions, these traditional funding streams are already strained and/or committed to existing work. Depending on the location and size of the HEC, local or regional sources may be unable to cover these costs on their own, even if they were willing to divert existing resources to this new model.

In short, a significant financial investment from the state of Connecticut, the SIM project, and/or other stakeholders is absolutely necessary for the HECs to have a chance to succeed.

Response A:

The intention is *not* for the HECs each to have to raise all the necessary start-up funding alone. The state is exploring and will pursue multiple sources of start-up funding and investments for HECs, including from non-traditional sources. That said, there may be sources of funds that local HECs are best positioned to pursue and secure—recognizing that not all sources of funds will be available for these purposes.

- **Downstream Measures:** The HEC Initiative Proposed Framework states that “Unlike clinical initiatives, HECs will focus on improving community health and health equity and preventing poor health by addressing social determinants of health. HECs will focus on implementing ‘upstream’ interventions that impact factors that cause or contribute to poor health, health inequity, and preventable costs.” (page 7) As stated earlier, the Norwalk Health Department applauds this approach. However, this emphasis on “upstream” interventions must be more strongly reflected in the provisional measures listed in 4.2.2 and 4.2.3 of the Technical Report. As drafted, most of these measures (especially related to healthy weight and physical fitness) seem to address the very downstream outcomes that have always been traditionally used as measures of success.

Some say “What gets measured, gets valued” or “What gets measured, gets done.” If a primary goal of the HEC is to incentivize upstream approaches, health equity, and transformation of the social determinants of health (housing, education, food access, transportation), then we suggest that the HEC framework include those metrics in its Measurement and Performance system. This may require additional data development work at the state level, but it would help the HECs meet their potential.

Response B:

We agree that the selection of the right measures is critical for precisely the reasons you indicated. We acknowledge that the original proposed measures focused on measures of individual well-being but have since expanded to include community, place, and economic measures. The measures included in the technical report were proposed and not yet finalized. Since then the proposed measures have received substantial attention and were discussed with the technical assistance provider [State Health Access Data Assistance Center \(SHADAC\)](#) and local measure development and data collection experts like [Yale Center for Outcomes Research and Evaluation](#) and [DataHaven](#). Through these conversations, we have discussed measures used in other states, including California, Minnesota, and Washington on projects like the [Robert Wood Johnson Foundation’s Culture of Health Action Framework](#) and the Well-Being in the Nation (WIN) Framework. An example of some specific measures that we did not originally propose but are now considering include built environment, neighborhood scores, youth safety to and from school, affordable rent, and poverty measures.

There will be an inclusive process to identify, vet, and finalize measures. This will include vetting additional measures that better measure upstream interventions, health equity, and social determinants of health.

- **Readiness of the Data/IT Infrastructure Plan:** The HEC framework and funding mechanisms rely on accountability and accurate measurement. This means that the successful implementation of the state Data/IT infrastructure plan is essential for the success of the HEC. We strongly recommend that the state adequately fund and support this system to ensure its strength and usability.

Response C: Please see Response C to Question 15.

- **Disconnect from Clinical Care:** The Health Department appreciates that the SIM project is devoting resources to and paying attention to community health in addition to medical/clinical care. With that in mind, we urge the Population Health Council and the SIM office to consider that although they are different, they are inextricably linked. The current framework and division of activities within the overall SIM project seems to deal with these sectors in relative isolation. We urge the Population Health Council to develop mechanisms to link the HEC work with clinical care, other SIM activities within the clinical care sector, and innovative projects in this sector overall, such as those listed in the SIM Workgroups and Work Streams in Appendix 6).

Response D:

We agree that the linkages among other SIM initiatives, particularly how the [Primary Care Modernization \(PCM\)](#) and the HEC Initiative will work in concert needs to be articulated in the framework and part of the mutual implementation plans. **We have revised the framework documents to describe the linkages. See Section 3.3.7.**

Thank you for this opportunity to provide comments and feedback on the HEC Framework. The Norwalk Health Department looks forward to continuing this important work to develop and fortify a framework for multi-sector collaboration, community engagement, and financial sustainability to improve community health and healthy equity.

17. Valandy Manohar, MD. and Supriyo Chatterjee, Msc MBA MA:

The Health Enhancement Community Proposed Framework document describes two Health Priorities as recommended by the SIM Population Health Council:

- 1). Improving Child Well-Being in Connecticut Pre-Birth to Age 8 Years: Assuring all children are in safe, stable, and nurturing environments
- 2). Improving Healthy Weight and Physical Fitness for All Connecticut Residents: Assuring that individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so

In this public testimonial, we would like to elaborate by highlighting the use of School-Based Health Centers (SBHC) in the HEC initiatives and in the ongoing healthcare reform (PCMH+). Both have common ground and mutually contribute to health outcomes.

As per the HEC Technical Report – “In 2018, there are 93 state-funded SBHC sites in 26 communities including sites located in elementary, middle, and high schools and in urban, suburban, and rural communities. Forty-five thousand students are enrolled in the SBHCs, and nearly 131,000 visits are provided annually.” However, in another source – “Of the 1,163 public schools in Connecticut, only 75 schools have comprehensive SBHCs that provide both medical and mental health services (2012).” Clearly, School-Based Health Centers (SBHC), which can provide a broader outreach and effective care, are in small numbers in Connecticut and can provide opportunities for improvement in care.

The benefits in deploying and using SBHCs are well known. With the availability of additional resources, e.g. Community Health Workers (CHWs) and enhanced SBHCs, healthcare delivery can improve outcomes and health equity.

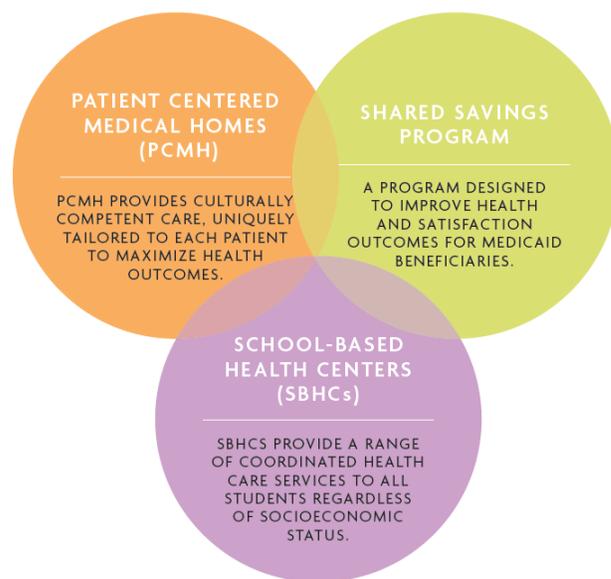
To integrate SBHCs in to the ongoing healthcare reform efforts, the following needs to be addressed:

- Formal inclusion of SBHCs into the Medicaid program
- Improve SBHC’s data systems and infrastructure
- Billing and coding of Medicaid services at SBHC

The Reference Communities of the HEC Initiative utilize resources that may be used, perhaps with additional features, in the fusion of PCMH+ and the HEC.

For example, HEC’s data and HIT infrastructure – CDAS and AIMS resources.

This diagram illustrates the important role SBHC can play in underserved communities by establishing links with Patient centered Medical Homes (PCMH).



SBHCs ARE A KEY PART OF THE HEALTH CARE DELIVERY SYSTEM IN CONNECTICUT ... THEY ARE ESPECIALLY EFFECTIVE IN ADDRESSING THE NEEDS OF CHILDREN AND ADOLESCENTS IN LOW-INCOME AND UNDERSERVED COMMUNITIES.

Source: School-Based Health Centers: Critical to Health Reform and Improved Outcomes for Students - CT Health Foundation February 2017

From Dr. Velandy Manohar:

During my tenure as the Psychiatrist member of the Integrated Medical team called POD D: My colleagues - 2 PCPS, Child and Adult Psychiatrist, LCSW, Nurse and 2 Nursing Assistants coordinated our capacities and resources to assist staff of the SBHC’s all over the state. The need arose to coordinate care when we had to address the needs of the children and the challenges posed by severe family stressors by their mother - a victim of battery placed in a DV shelter and the behavior patterns of the alleged perpetrator. Early identification and coordinated interventions can mitigate the severe consequences of ACES experienced in Childhood.

The children and parents may be diagnosed with AUD or SUD, comorbid MH and medical diagnosis. All the members of the team can with timely consultation and diligence, follow through more efficiently and comprehensively address legal issues, housing [some families are homeless], transportation issues, medical, and psychiatric needs. We are better able to address the needs of parents and children whose family members are confined in Correctional facilities more often than we can imagine to try to mitigate the

debilitating 30 million word Vocabulary gap, impact of living in very destabilizing communities on Brain development and the capacity of the children to perform to their full potential in early grades which can contribute to their longer term health and wellbeing, resilience and longevity.

SBHCs currently serve as de facto medical homes for children in many low-income and minority populations who lack access to care in other settings. [This is especially true form families that are homeless or living in temporary shelters.] Establishing strong linkages between PCMH and SBHCs would benefit underserved children and adolescents. In the Middletown CHC, through my work with the integrated medical team, we made use of a high-quality digital network that supported a secure and effective EHR across the State. We could keep track of the preventive health-promoting interventions that must be implemented by the network of teams in SBHC and PCMH across the state regardless of where our patients are located. An Outreach program was called 'WYA-Where You Are' - this allowed the staff to treat various members of the family in different locations and keep coordinating MH and Medical care.

In summary, we would like to suggest that the HEC Initiative explore the formal integration of an HEC intervention at a Reference Community that is using a SBHC with an established PCMH program at the SBHC.

Response A:

Thank you for articulating how well the role of SBHCs in our communities aligns with the vision for HECs. The accessible services and care coordination provided by SBHCs support our commitment to health equity and addressing the social determinants of health in low-income communities.

You raise important questions about the role of SBHCs in the context of statewide health care reform efforts, particularly payment reform and shared-savings programs. We have much more to learn about the value of investing in SBHCs to reduce exposure to ACEs in the prenatal and earliest years of life. To this end, individual SBHCs and the CT Association of School-Based Health Centers can provide important input into how collaborative governance is structured, and decisions are made both within and across HECs.

18. OHS Consumer Advisory Board – Arlene Murphy and Kevin Galvin:

We are sharing as Public Comment, the UConn Health Disparities Institute CT Report Card on Health Equity Among Boys and Men Of Color. The link is below.

https://health.uconn.edu/health-disparities/wp-content/uploads/sites/53/2019/01/uconnhdi_CTBMOCReportCard.pdf

This amazing Report was presented to Consumer Advisory Board on February 5, 2019. Consumer Advisory Board felt it was extremely important that the Population Health Council take this report into consideration. It provides vital information describing health disparities and the factors that are behind them. Recommendations on pages 10-12 are key to the development of effective Health Enhancement Communities.

Understanding and addressing health disparities is one of the greatest health challenges facing Connecticut. We urge that this report be carefully considered as part of developing the Health Enhancement Initiative.

Response A:

Thank you for sharing this informative report. We share your concern regarding health disparities, especially among communities of color throughout the State of Connecticut. After reviewing the recommendations

listed in the CT Report Card on Health Equity Among Boys and Men of Color, we have identified areas of overlap between their report and the HEC initiative. We believe that the HEC initiative aligns well with the report's recommendations on community, including increasing knowledge and awareness among CT's boys and men of color and their families about risk and opportunities for improving health, and meeting boys and men of color where they congregate, and live.

Additionally, other SIM initiatives including [Primary Care Modernization \(PCM\)](#) and the Community Health Worker (CHW) Certification initiative also align well with the report's recommendations including fortifying statewide infrastructure for clinical-community integration, funding culturally and linguistically appropriate Community Health Workers models to eliminate navigation and utilization barriers to clinical and community health services, establishing off-peak hours for primary care practices, improving the integration of primary and behavioral health services, and recruiting and training racial/ethnic minority men to serve as Community Health Workers. The work of PCM will include developing a new model for primary care in Connecticut that supports providers in expanding their care teams and offers new ways for patients to access care outside of a traditional office visit. Through PCM, behavioral health will be integrated into primary care thus reducing stigma and improving access to care. Additionally, community health workers, another expansion of the care team, would address and provide resources for social determinants of health, and offer services in a culturally responsive and competent manner. Lastly, patients would be able to access care outside of traditional hours through telemedicine, phone, text and email.

19. United Way of Greater New Haven

Comments submitted by:

- Crista Marchesseault, M.A., Operations Director, Minding the Baby® National Office
- Costas Meghir, PhD, Douglas A. Warner III Professor of Economics, Yale University
- Susan Nappi, MPH, Senior Director of Community Impact, United Way of Greater New Haven
- Arietta Slade, Ph.D., Co-Founder and Director of Training, Minding the Baby, Yale Child Study Center
- Charlie Slaughter, MPH, RD, Connecticut Department of Children and Families

Background

There is extensive evidence that safe, stable, nurturing relationships have a powerful impact on the health and wellbeing of children, and that the absence of these contribute directly to negative health, mental health, and academic outcomes. To date, however, public health approaches are not designed to build relationship capacities in caregivers and communities. As such, the patchwork of programs and health promotion policies that do exist fail to reflect recent advances in molecular biology, genomics and epigenetics, neuroscience, and social science, namely that relationships matter.

Scientific evidence for the importance of quality relationships in a child's life comes from a number of domains. The first is attachment theory, which has over the past 40 years provided a wealth of research to support the notion that secure early relationships with parental figures are key to emotional, social, cognitive and academic success, while insecure attachments are linked to a range of negative social, emotional, and life course outcomes. The second is the newly emerging study of early childhood adversity and toxic stress, which links both adverse childhood experiences and toxic stress to a range of negative health, mental health, and biological disruptions, obesity being key among them. The third is what is known as the "Heckman equation", which links later economic success to early interventions that support parent and child development and emphasize stimulation in early childhood. Taken together, these domains provide the evidence that strong bonds fostered early in life is predictive of lifelong health. We suggest that the Health Enhancement Community initiative takes into account these domains when creating prevention strategies that will produce long term outcomes.

Current Approaches/Models For Consideration

There are numerous initiatives in Connecticut and beyond that show promising results and address both quality of relationship/attachment and obesity. We believe these initiatives offer promising approaches and already established networks that may help guide HEC efforts. We offer descriptions and findings for your review and consideration:

Minding the Baby: Minding the Baby® (MTB) is a preventive, interdisciplinary, attachment-based, reflective home visiting intervention for young families. MTB has been designated as evidence-based by the U.S. Department of Health and Human Services and is one of only 18 models with this designation. An interdisciplinary team provides intensive in-home services, targeting maternal and child health and mental health, parent-infant attachment, developmental guidance, parenting support, and maternal life course outcomes. MTB is grounded in recent neuroscientific, epidemiologic, and economic evidence that early adverse childhood experiences result in profound disruptions in stress regulation and immune system functioning, leading to lifelong health and mental health problems – and, in many cases, early death.

MTB aims to build resilience by 1) interrupting the intergenerational transmission of early adversity and toxic stress, 2) promoting the development of secure attachment and decrease rates of disorganized attachments, and 3) promoting positive health behaviors in both mothers and children. Such work is integral to the development of a range of long lasting and crucial non-cognitive social and emotional competencies, beginning in the preschool years. Thus, MTB directly targets both the prevention of early childhood adversity and the development of a range of positive health behaviors, including healthy eating.

MTB outcomes from 2 federally funded randomized controlled trials (RCTs) include a range of significant health, attachment, and behavioral outcomes when compared with controls. **Health outcomes:** lower rates of obesity and higher rates of normal weight in MTB toddlers, higher rates of on-time pediatric immunization, lower rates of rapid subsequent childbearing, and lower rates of child protection referrals in intervention families. **Socioemotional outcomes:** lower rates of disrupted, atypical mother-infant interactions at 4 months, higher rates of secure attachment, and lower rates of disorganized attachment in MTB children. **Parent outcomes:** higher rates of reflective parenting in MTB mothers. **Follow-up studies:** At 1-3 year follow-up, MTB preschoolers had lower rates of maternally reported externalizing disorders (acting out behaviors). At 2-8 year follow up, MTB children had fewer internalizing and externalizing disorders; their mothers had lower Body Mass Indices, and were more likely to parent in a supportive fashion.

The consistent finding that secure attachment is promoted and disorganized attachment prevented in MTB indicates that the relational elements of adversity are substantially ameliorated by the intervention. Further support is provided by the fact that MTB involvement substantially impacted the development of behavioral problems in the school years. The finding that 3.3% of the two-year-old children whose mothers began receiving MTB during their pregnancies were obese whereas 19.7% of the two-year-old children whose mothers were in the control group were obese strongly indicates that a focus on the quality of the parent-child relationship is an effective, and perhaps, even foundational, component to preventing and treating childhood obesity.

Early Childhood Stimulation: The Reach up and Learn Curriculum, which initially started in Jamaica, began with the observation that children in poverty had worse developmental outcomes. In addition to decreased access to food, shelter and healthcare, their caregivers are often so focused on survival that they are also lacking in play. Given that play is crucial for brain development, the curriculum incorporates play and teaches caregivers practical skills to stimulate their child's brain development. The curriculum has been tested in numerous contexts, including Jamaica, Colombia, Bangladesh and India with both short-term and long-term follow

ups demonstrating large and significant improvements in cognition and even labour market outcomes when applied to infants 1-3 years old in ultra-poor settings also associated with malnutrition. This curriculum is delivered either through home visits or in a playgroup setting and aims at improving development on a number of domains, including cognition, language, motor skills and executive functioning. The program can be delivered by individuals from within the communities who will be mentored and trained by a network of social workers or equivalently qualified individuals. These community workers can be trained to offer a broader range of services and assistance to the families. The results reinforce the value of high-quality home visiting programs for children in the United States.

MOMS Partnership: The mission of the MOMS Partnership® is to reduce depressive symptoms and increase social and economic mobility among over-burdened, under-resourced mothers, thereby strengthening generations of families to flourish and succeed. The MOMS Partnership imagines a world where every mother receives optimal mental health care, where her basic needs are met, and where the community is responsive to her needs. This mission is fulfilled by:

- Conducting mental health treatments specific to mothers
- Developing a maternal mental health-literate, community-based workforce
- Providing leadership for and conduct research on family mental health and its connection to social and economic mobility
- Providing centralized family economic success and job readiness supports

Among the results of past evaluations:

- 78% of MOMS participants complete the program compared to average of 30% nationally of a similar population who adhere to their mental health treatment.
- 76% of MOMS participants experience a decrease in depressive symptoms from beginning to end of the MOMS program. Of those experiencing a decrease, the average participant experienced a 48% drop in depressive symptoms.
- MOMS participants have a 67% decrease in parenting stress from beginning to end of the MOMS program.
- Children of MOMS participants attend 6 more days of school per year compared to children of non-participants.
- The percentage of women working at least 15 hours a week dramatically increases after participating in the MOMS Partnership - from 15% at time of enrollment to 39% at six months after graduating from MOMS.

Circle of Security Parenting: Circle of Security® Parenting™ (COS-P) is a parent-reflection program implements decades of attachment research in an accessible step-by-step process for use in group settings, home visitation, or individual counseling. Since 2010 there has been a statewide effort in CT to build capacity in cities and towns to offer COS-P. COS-P provides new, attachment-based, relationship tools that help parents, caregivers, and teachers build safe, stable, nurturing relationships with infants, children, adolescents, and other adults. Part of the systems beauty of COS P is that it can be incorporated into existing programs and facilitated by non-clinical staff. This has been critical to the spread of COS-P across the state. While funding has been limited for training people to offer COS P, it does offer a template for creating a community-wide effort to ensure that many more kids have safe, stable, nurturing relationships. Nearly 1,700 people from a wide variety of disciplines and settings in CT have been trained to offer COS-P. In the Greater New Haven region alone, over 700 parents, caregivers, and educators have participated in COS-P groups from 2014 to present. Preliminary findings indicate that COS-P has an effect on maternal depression. Moreover, caregivers and teachers have reported a decrease in conflict with children in their care and an increase in closeness.

Recommendations for HEC Implementation:

Given past and current approaches that promote healthy attachment across the lifespan we recommend leveraging these resources to shape the HEC focus and infrastructure.

Specifically, we suggest that HEC efforts:

- Focus on building capacity to offer successful models or components of models already rooted within CT
- Address childhood obesity through the lens of quality of caregiver-child relationship
- Ensure that backbone organizations managing the HECs are model-neutral and can convene diverse and multidisciplinary groups.
- Consider programs that will improve parenting and achieve child stimulation from birth to school based on a combination of home visits, playgroups and followed by high quality preschool interventions.

Response A:

Thank you for your comments. We strongly concur with your opening points of emphasis:

- Secure early relationships with parental figures are key to emotional, social, cognitive and academic success, while insecure attachments are linked to a range of negative social, emotional, and life course outcomes.
- Early Childhood adversity and toxic stress are linked to a range of negative health, mental health, and biological disruptions, obesity being key among them.
- Economic success is linked to early interventions that support parent and child development and emphasize stimulation in early childhood.

We also agree that the evidence supports your conclusion that “strong bonds fostered early in life are predictive of lifelong health.” The HEC framework document is intended to encourage interventions that take into account these and other evidenced-based principles of child development when creating prevention strategies that will produce long term outcomes.

A number of models exist today in Connecticut, as outlined in your remarks, and these models align with the HEC goals for child well-being to ensure safe, stable, nurturing relationships and environments. While the framework document encourages individual HECs to leverage existing programs and established networks that focus on preventing Adverse Childhood Experiences (ACEs) and increasing protective factors, we do not establish this as a formal requirement, leaving open opportunities for innovation and the introduction of new, evidenced-based programs that may be worthy of adoption in Connecticut. That said, we expect to provide a more thorough menu of potential evidence-based interventions. The programs you listed will be among those. In addition, we recognize that programs that promote child stimulation from birth through Kindergarten should be among the interventions that HECs consider as a means to improve child well-being.

The ACEs oriented interventions attend to the quality of the parent-child relationship and, as such, are among the interventions that can favorably impact childhood obesity. However, there are other tools that HECs are encouraged to consider such as promotion of breastfeeding and community norms around a healthy diet and the importance of exercise.

Consistent with your recommendations, the framework documents propose that HEC governance structures include a balance of membership, including community members that represent the diversity of the communities the HECs serve and involve multiple sectors. The backbone organizations/staff must identify methods to ensure that community members have multiple means to exercise their decision-making roles and involve various sectors in evaluating interventions, leveraging assets, and addressing needs. While it is a worthy aspiration that the backbone organization be model-neutral, as a practical matter, we do not believe that this is something that can be established as a formal requirement or enforced.

20. Connecticut Health Foundation – Patricia Baker

Dear State Innovation Model Steering Committee and Population Health Council,

I write on behalf of the Connecticut Health Foundation in response to the “Health Enhancement Community Initiative Proposed Framework.” We applaud the effort of all those involved in designing this important initiative.

We support refining the health enhancement community design and moving in to the implementation phase of the initiative. However, we recommend the following adjustments:

Putting health equity at the forefront

We agree that making Connecticut the healthiest state in the country is an ambitious yet achievable goal. However, it is important to acknowledge that the metrics used to rank states by overall health commonly overlook persistent health disparities. Though Connecticut is consistently highly ranked in the overall health rankings, the state currently ranks 40th in health disparities. As a result, becoming the top-ranked state might not address the glaring disparities that exist.

- Rather than focus on making Connecticut the healthiest state, we recommend the health enhancement community initiative focus on eliminating health disparities to advance health equity, a critical goal of both SIM and the health enhancement community initiative.
- We suggest the framework clearly indicate what success would like in terms of health equity and the specific objectives the health enhancement community initiative will strive to accomplish.
- While healthy weight and fitness and prevention of adverse childhood events all compound to impact health outcomes particularly for people of color, we recommend the health enhancement community initiative framework identify how their efforts over time will impact the SIM initiative goals such as reducing the incidence of diabetes and asthma.

Response A:

We appreciate your comments about elevating the focus of health equity and health disparities in the HEC Initiative. **Based on your comments and the Population Health Council’s recommendation, an additional goal has been added to the HEC framework documents, to “Achieve health equity for all Connecticut residents.”**

While asthma is not specifically identified as a health priority in the HEC Initiative, we expect that HECs will implement strategies to improve housing quality, which will reduce environmental triggers and lead to better asthma control. In addition, we are examining whether the child and family interventions to reduce ACES may also enable more effective asthma management.

Our existing and future healthcare delivery reform efforts will also continue to emphasize asthma management and a reduction in associated health disparities. Through the Prevention Service Initiative, the State Innovation Model supported creating formal community-clinical linkages between community-based organizations and healthcare providers to implement evidence-based asthma in-home remediation services. These services focus on effective asthma management and the removal of environmental triggers in the home. PCM will build on this work by providing practices with a number of resources that support asthma control and the engagement of diversity communities that are affected by asthma. For example, under PCM, practices will employ Community Health Workers (CHWs) to support patient education and engagement, the identification of social determinant risks, and linkages to services and supports that address those risks, such as HEC resources that support housing quality. In addition, community purchasing partnerships (one

example of which is the Prevention Service Initiative), is a proposed permitted use of the PCM supplemental primary care funding.

Promoting an equitable governance structure

We agree that it is imperative to include community members within the governance structure of health enhancement communities, but the requirements proposed in the framework could have the unintended consequence of perpetuating the isolation of community members from decisionmakers. Having a structure that defines separate roles for community groups, the management team, and formal governance would likely create a dynamic in which community voices remain outside of formal processes of decision-making or even worse pits groups against each other.

- We suggest simplifying the governance structure to ensure that everyone sits with equal voice and power at the decision-making table.
- Because some health enhancement communities will cover large geographic areas and communities with different needs and priorities, we recommend that the framework address how perspectives from different communities will be heard and evaluated.

Response B:

We recognize that the recommended structure in the framework does not adequately show the intent to have a unified structure rather than three separate silos. One of the purposes of having a structure with multiple interrelated arms is to provide community members with options for how they want to participate. We heard from a number of community members that they wanted to be meaningfully involved in the design and implementation of HECs, including being involved in making decisions. However, we also heard that they did not want the only option for participating to be sitting on a governance body. Having more than one option would enable community members to be part of making decisions and also lead and/or work on issues that matter most to them through the vehicle of their choice, including through community groups and governance bodies. **We have revised the description based on your feedback and other feedback, including Population Health Council feedback, to address the silo problem and better describe how HEC structures could optimally function to elevate and integrate community voices. See Section 3.3.5 of the HEC Technical Report.**

Accountability and sustainability

We recognize the importance of sustainability within this model, but it is unclear from the framework what organization or entity is accountable for results and how future savings will be shared with community organizations that are providing services within health enhancement community.

- We suggest the framework clarify who is responsible for results, how results are measured, and how funding related to results will be distributed.
- It is critical to avoid overpromising. The next phase should include economic modeling to identify long term feasibility for payers and identify how the health enhancement communities can be sustainable. While we appreciate this is a design for a possible submission to CMS, we caution the state to consider when you start the formal HECs until there is clear agreement with Medicare. This does not preclude investing SIM dollars in allowing the convening to begin, but be very wary of starting this and not following through with a pathway to sustainability.
- For the health enhancement community initiative to be successful, it needs to be linked to the transformation in primary care. We suggest updating the framework to show a clear connection between the proposed initiative and the primary care modernization work.

- We suggest piloting the health enhancement community initiative in one or two locations to test the model before a larger implementation.
- Technical assistance for health enhancement communities will be crucial to their outcomes. We recommend that coaching or other forms of technical assistance be a key part of the model.

We appreciated the Population Health Council’s work to move forward an initiative to improve population health. As an organization focused on health equity and improving health outcomes for people of color, we recognize this work as critical to reducing racial and ethnic health disparities. Thank you for considering our perspective. We remain committed to working with you to advance the health of Connecticut residents.

Response C:

The next phase of planning will further develop the framework with respect to responsibility for results, how results are measured, and how funding related to the results will be distributed. The state is continuing to develop the provisional measure set and measurement strategy. A final measurement set will need to be agreed upon with our stakeholders, negotiated with our purchaser partners, and subject to a baselining and projection process to ensure that state-level and HEC-level targets have been established sufficient to support program monitoring and accountability.

We appreciate your cautions about not overpromising or taking premature steps. The initiation of the planning phase and ultimately HEC designation and implementation is dependent on many factors, including having a final framework for the initiative approved, having start-up funding secured, and having sufficiently advanced the multi-payer demonstration negotiations.

We agree that the linkages between the [Primary Care Modernization \(PCM\)](#) and the HEC Initiative with work needs to be articulated in the framework and part of the mutual implementation plans. **We have revised the framework documents to describe the linkages. See Section 3.3.7 of the HEC Technical Report.**

The HEC strategy is intended to be a statewide initiative. The scale is by design broad to meet the requirements of CMS in developing a financial arrangement and yield sufficient shared savings for the multi-payer demonstration. While we do not anticipate being able to start with a small pilot given the imperatives of the multi-payer demonstration, we do anticipate two tracks for implementation—with HECs most ready to implement starting first and the next track starting after they have developed more readiness.