CONNECTICUT
STATE INNOVATION MODEL (SIM)

HEALTH ENHANCEMENT COMMUNITY INITIATIVE PROPOSED FRAMEWORK

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The Health Enhancement Community (HEC) strategy is an initiative of the Connecticut State Innovation Model (SIM), which is jointly implemented by the Office of Health Strategy (OHS) and the Department of Public Health (DPH). The HEC team comprised Mark Schaefer, PhD; Faina Dookh; Mehul Dalal, MD; Mario Garcia, MD; Kelly Sanchez; Amy Smart; Kristin Sullivan; and Trish Torruella. Report contributors: Diane Aye, Yongwen Jiang, Celeste Jorge, Laura Hayes, Lloyd Mueller, Laurie Ann Wagner, and Xi Zheng.

This report was prepared by Health Management Associates (HMA), a leading independent national research and consulting firm. Its primary authors were Deborah Zahn; Rob Buchanan; Mary Goddeeris; Liddy Garcia-Bunuel; Tom Dehner; Melissa Corrado; Jessica Foster; Capri Dye; Maria Dominiak of Airam Actuarial Consulting; and Elise Miller, Kristin Giantris, and Norah McVeigh of the Nonprofit Finance Fund. HMA contributors were Cathy Homkey; Art Jones, MD; Cara Henley; Ellen Breslin; Hope Plavin; Heidi Emerson; Tim Beger; and Emma Sinkoff.

Connecticut State Innovation Model
HEALTH ENHANCEMENT COMMUNITY FRAMEWORK

Revised April 2019

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[1] and preventing people who live, work, learn, and worship in communities from experiencing poor health. The proposed Health Enhancement Community (HEC) Initiative presented in this framework and described in more detail in the accompanying HEC Technical Report, 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.

COMMUNITY HEALTH

Community health means that the social, economic, and physical conditions within a community enable individuals and families to meet their basic needs, achieve their health and well-being goals, and thrive throughout their lives.

HEALTH EQUITY

Equity in health refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. Efforts to promote equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill.

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. Such change requires addressing the significant and longstanding structural inequities and disparities[2] in health outcomes and

[1] Health equity definition adapted from the World Health Organization Concept Paper as cited by the American Medical Student Association.

[2] *Health disparit*ies are defined as avoidable differences in health that result from cumulative social disadvantage. Specifically, "…differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence." Adapted from Stratton A, Hynes MM, and Nepaul A (2007). Defining Health Disparities. CT DPH, Office of Health Equity Strategic Plan, 2015-2018.

resources among Connecticut's communities. The HEC Initiative, therefore, focuses on creating opportunities for communities to address the upstream and underlying factors that are contributing to poor health in their geographies. HECs will implement multiple, interrelated strategies to address the social determinants of health[3] 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.[4]

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.

Framework Development

This HEC framework articulates the vision and goals for the HEC Initiative and recommends key priorities and parameters for the initiative and HECs. It does not include all the details or decisions about what the model will be and how it will look in communities. The intent is for communities to make many of the decisions about what HECs are and do so that those decisions reflect the realities of their communities.

This framework is meant to guide a more detailed planning phase in 2019. During this phase, many of the elements of the model will be further developed. Communities will develop plans for becoming HECs through an iterative process that includes involving community members in decision-making for HEC design, formation, and operation.

This HEC framework was created with extensive input during an iterative stakeholder engagement process. That process included input from a diverse set of stakeholders across Connecticut, including more than 225 community members and more than 50 groups, organizations, agencies, and/or individuals. The input from stakeholders was used to develop the framework and/or validate key elements of the framework, including the priorities, parameters, and processes described in this report.

The stakeholder engagement process included:

- Working 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 Reference Communities provided recommendations on most aspects of the framework. The Reference Communities collectively include more than 100 organizations and have broad representation, including the following sectors: academic institutions; associations; community members; community organizations; consumer advocacy groups; employers and businesses; government; health care systems and providers; health plans/payers; investors, housing organizations; philanthropic

[3] Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Date accessed 10/8/18.

[4] National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in Action: Pathways to Health Equity.* Washington, DC: The National Academies Press. https://doi.org/10.17226/24624.

organizations; public health agencies; and social service organizations. (Additional detail on the Reference Communities and how their input contributed to the framework are in Section 5 of the Technical Report.)

- Engagement of **community members**, through direct engagement by the Reference Communities and Health Management Associates, the consulting firm working with the state. The engagement process included meetings and facilitated discussion sessions with existing community groups and at existing events, community conversations and mini-focus groups, brief in-person surveys, and key informant interviews. Healthcare Innovation Steering Committee (HISC) members and the Consumer Advisory Board (CAB) also provided input on the community engagement process for developing the framework and on future engagement as HECs form and operate.
- Meetings with stakeholder groups such as the **Population Health Council** and Design Teams, the **HISC**, the **CAB**, the **Connecticut Health Improvement Coalition SHIP Advisory Council,** the **Medical Assistance Program Oversight Council (MAPOC),** the **Healthcare Cabinet**, the **Health IT Advisory Council**, and the **Behavioral Health Partnership Oversight Council** to get input on the HEC framework and key elements.
- **Interviews and meetings** with specific stakeholder organizations and individuals across multiple sectors.
- **Targeted webinars** to share information and seek input from local health departments, Federally Qualified Health Centers, School-Based Health Centers, and other state agencies in Connecticut.
- A broad **communication strategy** that included dissemination of information through SIM e-newsletter updates and **public posting** of materials and webinars on the SIM website.

A more detailed description of planning process approach and stakeholder groups engaged is provided in Appendix 2 of the Technical Report. Additional community member and stakeholder engagement will occur in 2019.

HEC Framework Design Principles

Several principles emerged throughout the stakeholder engagement process that guided the development of the HEC design.

- **Community Ownership and Involvement:** Given their unique and essential perspectives and insights about their communities, HECs' success depends on the ongoing involvement of community members in making decisions about things that matter most to them. It is also essential that there is a balance of power within the HEC structure so that community members have a real voice in HECs and that community members reflect the diversity of the populations within the HEC geographies.
- **Community Health:** Improving community health is a central outcome of the HEC Initiative. Although preventing poor health is a key outcome of this effort, it is not sufficient to achieve the goals of the HEC Initiative. Rather, the HEC Initiative also focuses on improving the social, economic, and physical conditions within a community that enable individuals and families to

meet their basic needs, achieve their health and well-being goals, and thrive throughout their lives.

- **Health Equity:** Because much of what is driving poor health outcomes is related to health inequities, improving health equity[5] will be a central outcome of the HEC Initiative. To that end, HECs and the State will embed a focus on health equity throughout the HEC Initiative. The HEC Initiative overall and each HEC will be accountable for demonstrating improvements in health equity based on specific measures of health equity. The state and HECs also will implement strategies and interventions that specifically address health equity.
- **Social Determinants of Health and Upstream Interventions:** Unlike clinical initiatives, HECs will focus on improving community health and healthy 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. HECs may also implement "midstream" interventions that prevent health risks or mitigate the impact of poor health.
- **Place-Based:** 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. Place-based initiatives are built on a recognition that where people live can limit their potential for leading healthy lives and restrain their economic mobility. Although Connecticut ranks fifth in overall health nationwide, these rankings represent the population on average and mask the significant health disparities that persist—disparities that start early and carry throughout the lifetime.
- **Sustainability:** The HEC Initiative began developing and pursuing sustainability strategies as it developed this framework rather than waiting until the initiative is underway. This enables the options and considerations for how HECs would be sustained to influence framework decisions, thus creating a clearer path to sustainability.
- **Focus:** The HEC framework includes components that will be the focus across all HECs. Requiring all HECs to be aligned in key areas increases the likelihood of achieving state-level outcomes that will be required under long-term financing strategies. It also enables the state to better coordinate and support HECs and fosters cross-HEC collaboration.
- **Flexibility:** The framework balances that focus with flexibility for HECs in several areas. The design reflects the need for HECs to have the flexibility to adapt how they are structured and what they do to address the needs of their communities and partners effectively.
- **Speed to Action:** The framework reflects the desire to have HECs established and implementing interventions as quickly as possible. Although some planning and ramp-up time is essential, the intent of the design is to build on previous collaborations and efforts and provide targeted support so that HECs can more readily and effectively advance to the action phase.
- **Leveraging Existing Assets:** Local and state efforts have created a strong foundation of community members, state and local agencies, community collaboratives, providers, other stakeholders, and other groups committed to improving community health and health equity

[5] Disparities, Healthy People 2020. (n.d.). *Office of Disease Prevention and Health Promotion*. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities. Date accessed 8/8/18.

and preventing poor health. Each HEC and the HEC Initiative will leverage these key assets by connecting, improving, or expanding existing efforts to maximize benefit while implementing new interventions to fill gaps. They also will leverage existing efforts to improve health outcomes, such as the existing Medicaid Person-Centered Medical Home Plus (PCMH+)[6] Participating Entities and Medicare Accountable Care Organizations, organizations that are focused on population health improvement and community integration as a means to succeed in these shared savings programs. The HEC Initiative design encourages maximizing these existing assets over creating an entirely new infrastructure.

- **Scale and Scope:** The HEC Initiative, by design, has a broad scale and scope and requires a different approach than a typical grant program. Unlike a grant program, the HEC Initiative aims to create market conditions that enable HECs to expand, leverage, and launch evidence-based strategies that will significantly improve community health, health equity, and prevention in their communities and across the state. Given the desire to move the needle across the state in a meaningful way, the HEC Initiative will be designed, implemented, and sustained with support from various funding and financing mechanisms and with a multi-payer demonstration being the source of long-term financing. The scale of the HEC strategy has to be significant enough to meet CMS requirements that the financial arrangement yield sufficient federal savings to qualify for a multi-payer demonstration. However, given what it will take to create and implement HECs, this framework anticipates two tracks for implementation—with HECs most ready to implement starting first. Those HECs participating in the second track would begin after they have reached a sufficient level of readiness.

The HEC Framework

The Population Health Council proposes the establishment of the HEC Initiative and HECs. The HEC Initiative envisions having sustainable, multi-sector collaboratives in every geography in Connecticut that implement community health, health equity, and prevention strategies in their communities and reduce costs and cost trends for critical health priorities. Specifically, HECs will:

- Be collaboratives that include community members and partners from multiple sectors.
    - Examples of sectors include community members, community-based organizations, health care providers, local health departments, local government, social services agencies, schools, housing agencies and providers, transportation agencies and providers, and others.
- Be accountable for improving community health, health equity, and prevention and reducing costs and cost trends for the health priorities.
- Have a defined geographic area that they serve.
- Have formal structures, defined ways of making decisions together, and multiple methods for ensuring community member ownership and involvement.

[6] **Medicaid's PCMH+** provides person-centered, comprehensive and coordinated care to HUSKY members. The PCMH+ program works to improve HUSKY members' overall health and assists with access to services like access to healthy food, transportation to appointments, and assistance in finding community agencies that support housing or employment.

- Select and implement strategies that address social determinants of health that cause or contribute to poor health, health inequity, and preventable costs.
- Be sustainable, including through financing that rewards HECs for improving health, preventing poor health, and producing savings and economic value.

At the heart of the recommended HEC Initiative are:

- **Goals** that are ambitious in the potential magnitude of their impact but achievable over the next 5-10 years
- **Health priorities** that are focused, can make a significant impact on the health of and health inequity among Connecticut's residents across the lifespan, and for which there are existing or new interventions that work
- **Key elements** that enable them to function; ensure community member ownership of what matters most to them; implement coordinated, multi-pronged strategies among multiple sectors; and achieve defined outcomes
- **Financing** that can support and sustain community prevention strategies and accrue to who produces the savings and other economic benefits through those strategies

Goals

The HEC Initiative has four ambitious but achievable goals:

- Make Connecticut the healthiest state in the country.
- Achieve health equity for all Connecticut residents.
- Make Connecticut the best state for children to grow up.
- Slow the growth of Connecticut's health care spending.

Although Connecticut ranks fifth in overall health nationwide—behind Massachusetts, Hawaii, Vermont, and Utah,[7] it fell two spots from being ranked third in 2016.[8] Additionally, between 2015 and 2017, Connecticut experienced a downward trend in rankings related to healthy weight, including physical activity and diabetes, as well as measures related to child well-being, including children in poverty, low birthweight births, and infant mortality.[9,10] Across these 5 measures, Connecticut currently ranks well

[7] America's Health Rankings, 2017 Annual Report. https://www.americashealthrankings.org/learn/reports/2017-annual-report/state-summaries-connecticut. Date accessed 8/14/18.
[8] America's Health Rankings, 2016 Annual Report. https://assets.americashealthrankings.org/app/uploads/ahr_annual-report_executive_summary_v1.pdf. Date accessed 8/14/18.
[9] America's Health Rankings, 2016 Annual Report. https://assets.americashealthrankings.org/app/uploads/ahr_annual-report_executive_summary_v1.pdf. Date accessed 8/14/18.
[10] America's Health Rankings, 2015 Annual Report. https://www.americashealthrankings.org/explore/annual/measure/Overall/state/CT?edition-year=2015. Date accessed 10/17/18.

below the top 10 states.[11] Connecticut could rise to be the healthiest state in the country through efforts to help individuals and families live longer and healthier lives. A rise in health ranking could also boost the state and local economies by supporting a healthy and productive workforce. The goal of the HEC Initiative is to move Connecticut into first place for overall health within 10 years.

Doing so, however, would require addressing healthy inequities and the significant disparities in health outcomes and health risks in many communities as well as improving the health trajectories for Connecticut's children and aging population. For example, the need for affordable, stable housing is essential to the health and well-being of individuals and families. Yet the National Low Income Housing Coalition ranks Connecticut as the ninth most expensive state for rental housing.[12] A household in Connecticut must make $24.90 an hour to afford a two-bedroom rental, more than double the current minimum wage rate of $10.10 an hour. Households behind on rent sometime in the previous 12 months have shown increased risk for fair or poor caregiver and child health, maternal depressive symptoms, child lifetime hospitalizations, and household material hardships.[13]

Connecticut is also ranked fifth among the states for children to grow up—behind New Jersey, Massachusetts, Vermont, and New Hampshire.[14] This ranking is based on measures of infant mortality, food insecurity, high school graduation,

SUSTAINABILITY

The upfront emphasis on sustainability is a defining feature of the HEC model. Many community health improvement initiatives and cross-sector efforts have struggled with sustainability or ceased to exist because they have been supported through time-limited funding. The current health care payment system also does not support the sustainability of prevention or community health interventions or structures because it is missing a critical piece of the equation: paying for preventing health conditions, not just treating them. Historically, health care payment models reimbursed providers on a fee-for-service basis. Each service, treatment, or hospitalization was paid "per unit" or "per day," which meant that providers earned more money when their patients were ill. More recent payment models, such as shared savings arrangements, promote better health care by sharing cost savings tied to better care with health care providers. However, neither of these models promote preventing illness. While preventing health conditions saves money and can produce other economic benefits, those savings or benefits do not generally accrue to the communities and organizations that helped produce the results. Paying for prevention—and ensuring that the dollars go to who produced the result—requires the innovative financing strategies described in this report.

[11] The 2017 Connecticut rankings for the five measures are as follows: Physical Activity – 18, Diabetes – 19, Children in Poverty – 21, Low Birthweight Births – 22, and Infant Mortality – 15.
[12] National Low Income Housing Coalition (2018), Out of Reach The High Cost of Housing. https://nlihc.org/sites/default/files/oor/OOR_2018.pdf Accessed 10/29/2018.
[13] Unstable Housing and Caregiver and Child Health in Renter Families. Megan Sandel, Richard Sheward, Stephanie Ettinger de Cuba, Sharon M. Coleman, Deborah A. Frank, Mariana Chilton, Maureen Black, Timothy Heeren, Justin Pasquariello, Patrick Casey, Eduardo Ochoa, Diana Cutts. Pediatrics Feb 2018, 141 (2) e20172199; DOI: 10.1542/peds.2017-2199. http://pediatrics.aappublications.org/content/pediatrics/141/2/e20172199.full.pdf Accessed 10/29/2018.
[14] End of Childhood Report 2018. *Save the Children*. https://www.savethechildren.org/us/about-us/resource-library/end-of-childhood. Date accessed 8/14/18.

violence-related injury deaths, and teen birth rates. The goal of the HEC Initiative is to move Connecticut into first place as the best state for children to grow up within 10 years.

Although Connecticut ranks fifth in overall health nationwide, these rankings represent the population on average and mask the significant health disparities that persist—disparities that start early and carry throughout the lifetime. Connecticut currently ranks 40th in disparities in health status, where the higher the ranking the larger the disparities. White residents of the state are approximately 1.5 times more likely to report high health status than Black or Hispanic residents, residents making $75,000 or more annually are 2.4 times more likely to report high health status than those making less than $25,000 annually, and college graduates are 2.8 times more likely to report high health status than non-high school graduates.[1]

Connecticut is a higher-cost state in overall health care spending per person relative to the national average, and health care spending has consistently outpaced growth in the state economy. Although the state's health care spending growth was slightly lower than the national average between 2004 and 2014, Medicare spending data show that Connecticut is both high-cost and higher-growth relative to national averages.[15] Connecticut is also the highest cost state for Medicare in New England. Taken together, these historical trends demonstrate the need for Connecticut to control health care spending. In contrast to Medicare, Connecticut Medicaid has reduced its per-person spending by a greater percentage than any other state in the country.[16] [17] However, the goal of the HEC Initiative is to further reduce Connecticut's overall trajectory of per person health care spending related to the rising incidence and prevalence of acute and chronic illness and related health inequities, opportunities that are especially prominent among low-income populations, including those enrolled in Medicaid.

Health Priorities

To achieve these goals, the Population Health Council recommends that the HEC Initiative and HECs focus on the following health priority aims:

- **Improving Child Well-Being in Connecticut Pre-Birth to Age 8 Years:** Assuring all children are in safe, stable, and nurturing environments[18]
- **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

Improving Health Equity: Given that health equity is essential to achieving all of the initiative's goals, the Population Health Council recommends that the HEC Initiative embed health equity throughout the HEC Initiative. This is necessary because much of what is driving poor health outcomes for these priorities is related to or due to health inequities. Improving health equity requires targeted strategies. Therefore, health equity will be woven into all aspects of the initiative, including at the state and

[15] Medicare Geographic Variation Public Use File, 2007-2016.
[16] Financial Trends in the Connecticut HUSY Health Program, Presentation to the MAPOC 2/9/18. https://www.cga.ct.gov/med/council/2018/0209/20180209ATTACH_HUSKY%20Financial%20Trends%20Presentation.pdf. Date accessed 10/12/18.
[17] Lassman, D., Sisko, A.M., Catlin, A., Barron, M.C., Benson, J., Cuckler, G.A., Hartman, M., Martin, A.B., and Whittle, L. (2017). Health Spending By State 1991-2004: Measuring Per Capita Spending By Payers and Programs. *Health Affairs, 36*(7). doi: https://doi.org/10.1377/hlthaff.2017.0416.
[18] Centers for Disease Control and Prevention's Essentials for Childhood Framework. https://www.cdc.gov/violenceprevention/childabuseandneglect/essentials.html. Date accessed 8/6/18.

community levels. The HEC framework includes health equity throughout the design, including having specific measures of health equity and interventions that specifically address health equity.

Achieving these aims would improve community health and prevent a host of serious health conditions and early death of residents throughout the state. These aims can be achieved by reducing the prevalence of Adverse Childhood Experiences (ACEs) and the prevalence of overweight and obesity as well as associated serious health conditions and consequences for both. Both are important by themselves but were also selected because they significantly contribute to increased morbidity and mortality, diminished quality of life, and increased health care costs of other health conditions, and thereby produce a compounding impact.

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.

Improving Child Well-Being Pre-Birth to Age 8 years

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse, neglect, and household dysfunction.[19] A 2016 survey of child caretakers in Connecticut found that 19.4 percent children aged birth to 17 years had two or more ACEs. More than half of adults in Connecticut report experiencing at least one ACE in childhood and 21.3 percent report three or more ACEs.[20]

Ample evidence reveals the associations between ACEs and risky health behaviors, chronic conditions, diminished life potential, and early death and shows that health risks increase as an individual's number of ACEs increases.[21] For example, one study found that individuals with six or more ACEs died 20 years earlier on average compared to individuals who had none.[22] The economic cost of child abuse and neglect in the U.S. in 2008 has been estimated at $124 billion, with an estimated lifetime cost per victim of $212,012.[23]

A 2016 survey of child caretakers in Connecticut found that 19.4 percent of children aged birth to 17 had two or more ACEs.[24] Notably, 57.4 percent of Hispanic respondents and 53.6 percent of Non-Hispanic, Black respondents reported at least one ACE, compared to 42.2 percent of respondents overall.

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[19] Adapted from the Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences. Date accessed 10/8/18.

[20] Connecticut Department of Public Health (CT DPH), 2017

[21] Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/acestudy/about_ace.html. Date accessed 10/8/18.

[22] Brown, DW, Anda, RF, Tiemeier, H, et al. (2009) Adverse childhood experiences and the risk of premature mortality. *Am J Prev Med, 36*(5), 389-96.

[23] Fang X, Brown DS, Florence CS, Mercy JA. (2012) The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse Negl.* 36(2), 156–165.

[24] 2016 National Survey of Children's Health. The survey defined adverse family experiences as: (1) socioeconomic hardship, (2) divorce/separation of parent, (3) death of parent, (4) parent served time in jail, (5) witness to domestic violence, (6) victim of violence or witness of neighborhood violence, (7) lived with someone who was mentally ill or suicidal, (8) lived with someone with alcohol/drug problem, (9) treated or judged unfairly due to race/ethnicity.

Additionally, children living in households with incomes over 400 percent of the Federal Poverty Level experienced at least one ACE less frequently (25.6 percent) than respondents overall (42.2 percent).

An initiative led by Chris Kelleher of the Center for Evidence-based Policy in Oregon identified characteristics of a mother at the time of a child's birth that increased the risk of child maltreatment and entry into foster care.[25] This list included the maternal/child characteristics of smoking during pregnancy, low birthweight, and teenage pregnancy as well as socioeconomic, educational, correctional, and other characteristics of the caregivers and home life. In Connecticut, approximately 12.8 percent of births to Black or African American mothers, 8.5 percent of births to Hispanic mothers, and 9.5 percent of births to mothers who have not completed high school classify as low birthweight. [26]

While studies on the effect of ACEs on health indicators often control for socioeconomic variables, ACEs have also been shown to be associated with education, unemployment, and poverty status beyond childhood.[27] Individuals with four or more ACEs were 2.34 times as likely to not graduate high school, 2.3 times as likely to be unemployed, and 1.5 times as likely to live in a household reporting poverty.

Increasing Healthy Weight and Physical Fitness

Overweight and obesity is a significant problem for all ages. More than a quarter (25.3 percent) of Connecticut adults are obese, with rates higher among adults who are Black or African American, Hispanic or Latino, have not graduated high school, or have annual household income below $25,000.[28] Adults fitting these characteristics also exhibit higher rates of diabetes, high blood pressure, and inadequate physical fitness. Black or African American adults exhibit an estimated age-adjusted diabetes prevalence rate of 13.8 percent compared to the overall Connecticut adult rate of 8.2 percent and exhibit an estimated obesity rate 11.5 percent higher than the overall Connecticut adult rate.[29]

An estimated 16.2 percent of Connecticut children are obese and consistent disparities are present in data related to healthy weight and physical fitness of children in Connecticut. Of children with an adult caregiver without a high school degree, an estimated 36.1 percent eat fast food at least twice weekly compared to 31.5 percent of all Connecticut children and exhibit 10 percent higher rates of obesity than children overall.[30]

The contribution of overweight and obesity to morbidity and mortality have been well studied. Individuals who have obesity have been shown to have an increased risk for many conditions, including hypertension, Type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer.[31] Estimates of the economic cost of obesity

[25] Data, Evidence, and Modeling: The Oregon Experience. Chris Kelleher. Center for Evidence-based Policy presentation at Southern California Open DataFest. January 24, 2017.
[26] Connecticut Office of Vital Records, 2015.
[27] Metzler, M, Merrick, MT, Klevens, J, et al. (2016). Adverse childhood experiences and life opportunities: Shifting the narrative. *Children and Youth Services Review, 72*, 141-149.
[28] CT DPH, BRFSS 2015.
[29] *Ibid*
[30] CT DPH, BRFSS 2011-2015.
[31] Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: the Evidence Report, 1998.

total $149.4 billion in 2014 dollars nationally.[32] In 2014, an estimated $1.36 billion in medical expenditures in Connecticut were attributable to obesity in the 855,000 obese adult residents, $439 million of which were attributable to Medicare and $140 million to Medicaid.[33]

Key HEC Elements

Described in greater detail in this framework, the Population Health Council recommends implementing HECs throughout Connecticut. HECs will operate in defined geographic areas. HECs will be existing, altered, or new collaboratives with defined structures that comprise community members and partners from multiple sectors such as community-based organizations, health care providers, local health departments, local government, social services agencies, schools, housing agencies, and others. HECs will select and implement strategies that address social determinants of health and be accountable for improving community health, health equity, and prevention outcomes and reducing costs and cost trends for the health priorities. HECs will be sustainable, including through financing that rewards HECs for improving health, preventing poor health, and producing savings and economic value.

HEC Geographies

The Population Health Council provisionally recommends that about 8-12 HECs be established. This would ensure a manageable number of HECs, correspond with many existing community collaboratives, and ensure that every geography in Connecticut is included in an HEC. HECs will have defined geographies in which they will implement interventions and be accountable for achieving defined outcomes. Prospective HECs will propose their geographies, which will be finalized during an iterative state process. In most cases, HECs will need to meet the following minimum criteria for HEC geographies:

- An HEC will not overlap boundaries with another HEC.
- Each HEC will need to demonstrate that their proposed geography meets both of the following minimum population thresholds:[34]
    - At least 20,000 Medicare beneficiaries
    - At least 150,000 people
- Each HEC shall provide justification for their proposed geography and demonstrate how the boundaries are rational, do not exclude high-need geographies or populations, and are functional from a governing perspective.

The Population Health Council recognizes that many rural communities will not meet the population thresholds yet may have compelling reasons to define their HEC based on a geography that only includes rural areas. Therefore, the Population Health Council recommends that rural areas may request that the population threshold criteria be waived for the purpose of forming an HEC as long as there is an

[32] Kim, D.D. et al. (2016). Estimating the Medical Care Costs of Obesity in the United States: Systematic Review, Meta-Analysis, and Empirical Analysis. *Value in Health, 19*(5), 602 – 613.
[33] Wang YC, Pamplin J, Long MW, et al. (2015). Severe obesity in adults cost state Medicaid programs nearly $8 billion in 2013. *Health Affairs, 34*(11), 1923-1931.
[34] The purpose of these thresholds is to have enough Medicare beneficiaries for a potential Medicare financial arrangement.

alternative methodology for reliably measuring the population for the purpose of assessing performance (e.g., establishing agreements with other rural areas to be measured jointly).

In some instances, existing community collaboratives may already meet the geographic criteria for HECs stated above. For others, collaboratives may need to join other regions or include a geographic area that has not been included previously. There are some parts of the state that may need to create new collaborations to form an HEC. Some prospective HECs may propose structures that allow communities to retain some independence in governance and work together on all or some interventions. For example, rural communities may propose to form HECs using this structure and include geographies that are not in contiguous geographies. In addition to these examples, other configurations may also be proposed and will be considered under the HEC procurement process.

HEC Priority Interventions

The HECs and the financing models will focus on the two health priorities that present many options for interventions. The Population Health Council recommends that each HEC have the flexibility to select and adapt interventions that reflect the realities of and what will work best in their communities.

Improving Child Well-Being for Connecticut Pre-Birth to Children Age 8 years: To address the child well-being priority aim, HECs will implement interventions to 1) prevent ACEs and 2) increase protective factors that build resilience and mitigate the impact of ACEs.[35] The Population Health Council recommends that HECs focus on pre-birth to children age 8 years. Interventions can focus on one or more of the following ACEs:

- Physical, sexual, and emotional abuse
- Emotional and physical neglect
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use by a household member
- Divorce or separation of a parent
- Violence in the household and/or the community
- Incarceration of a household member

Given its profound impact on the health of children and adults, a key focus of interventions will be on supporting and strengthening the quality of the parent-child relationship. HECs may also implement interventions that address other types of trauma or distress such as death of a parent or guardian, separation from a caregiver, poor nutrition, food insecurity, housing instability, poor housing quality,

[35] Alter A and Cornell E. (2019) Child Health and Development Institute of Connecticut, Inc. *Building Resilience in Young Children: Experiences Promoting Protective Factors in Six Pediatric Practices.* https://www.chdi.org/publications/reports/impact-reports/promoting-protective-factors-through-pediatric-primary-care-experiences-six-practices/. Date accessed 4/18/19.

bullying, and discrimination.[36] HEC interventions may focus on families, children, parents, and expectant parents to prevent ACEs.

Improving Healthy Weight and Physical Fitness for All Connecticut Residents: To address the healthy weight and physical fitness priority aim, HECs will implement interventions to prevent overweight and obesity across the lifespan as well as the associated risks of developing serious health conditions. For the HEC Initiative, healthy weight and physical fitness are defined as:

- ***Healthy Weight:*** Maintaining a healthy or healthier body weight[37]
- ***Physical Fitness:*** At least 150 to 300 minutes of moderate-intensity activity per week to prevent weight gain[38]

HECs could implement interventions that increase access to and consumption of healthy, affordable foods and beverages, increase access to physical activity space, and/or reduce deterrents to healthy behaviors. Interventions can target food insecurity and inadequate nutrition in communities. Interventions can also support individuals who are already overweight or obese but who lose weight and retain the weight loss as it still reduces their risk of developing or delays the onset of serious health conditions such as diabetes, heart disease, and stroke.

Given a growing body of evidence that a focus on the quality of the parent-child relationship is an effective and essential component to preventing childhood obesity, HECs will also be encouraged to include interventions that support and strengthen the quality of the parent-child relationship. This would provide a powerful link between child well-being and healthy weight/physical fitness interventions.

HEC Interventions Framework

Moving the needle on improving child well-being and healthy weight and physical fitness requires that HECs coordinate and implement multi-pronged strategies and interrelated "upstream" interventions that address social determinants of health causing or contributing to poor health, health inequity, and preventable costs associated with ACEs and overweight and obesity.

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[36] Examples of ACEs adapted from *The Adverse Childhood Experiences (ACE) Study. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. May 2014,* the Center for Youth Wellness (https://centerforyouthwellness.org/health-impacts/#hi-sec-1), and stakeholder feedback.

[37] A healthy weight for adults means having a Body Mass Index (BMI) below 25 kg/m^2. A BMI at or greater than 25 kg/m^2 is overweight and at or greater than 30 kg/m^2 is obese. For children and teens of the same age and sex, a BMI equal to or above the 85th percentile and below the 95th percentile is overweight and equal to or greater than the 95th percentile is obese. https://www.cdc.gov/obesity/adult/defining.html and https://www.cdc.gov/obesity/childhood/defining.html. Date accessed 8/6/18.

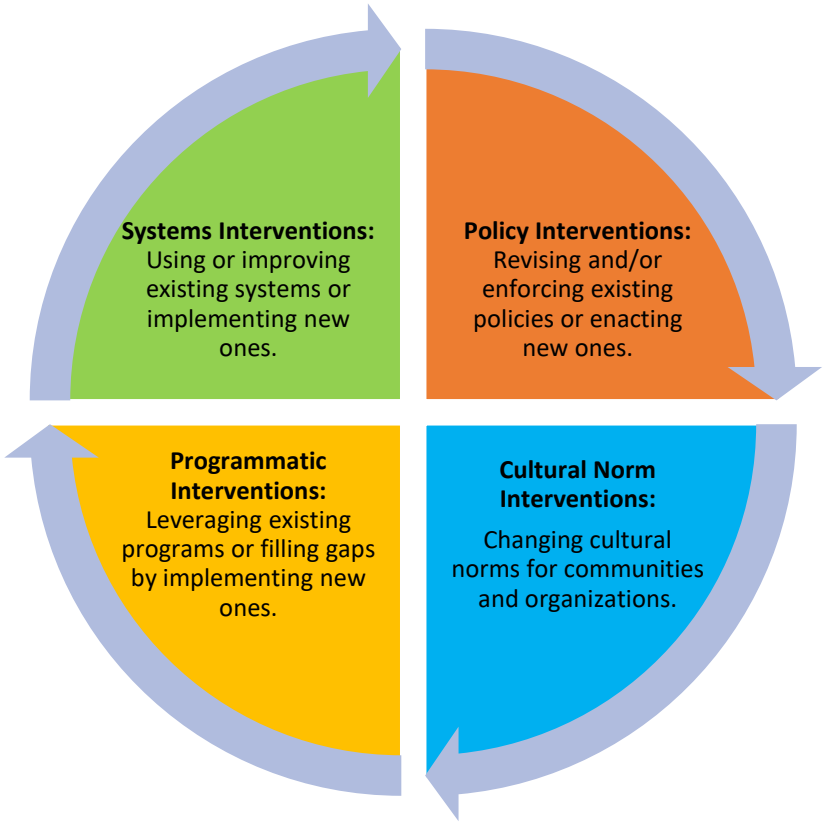
[38] Or could engage in 150 minutes of vigorous-intensity aerobic physical activity per week or an equivalent combination of moderate- and vigorous-intensity activity. https://www.cdc.gov/cancer/dcpc/prevention/policies_practices/physical_activity/guidelines.htm. Date accessed 8/6/18.

The Population Health Council recommends that HECs select and implement interventions that span four key areas (Figure 1):

- Systems
- Polices
- Programs
- Cultural norms[39]

While HECs will identify and implement interventions in each of these areas, HECs will have the flexibility to select interventions that are most relevant in their communities and among their partners. The expectation is that HECs will connect, improve, and/or expand existing interventions and implement new interventions to fill gaps.

Figure 1. HEC Intervention Framework



Interventions also should be interrelated or mutually reinforcing. For example, an HEC could implement systems and policies to better support and sustain an existing program. Although the intervention framework will be a focus of the HEC Initiative, HECs will have the flexibility to select interventions in those categories that are most relevant in their communities and among their partners. The state or other entities such as large employers also may sponsor interventions that could have statewide impact.

[39] "Cultural norms" are intended to include cultural norms in communities and organizations/institutions.

Some interventions may not be specific to individual HECs, and the proposed State Partnership for Health Enhancement (described below) or agencies within it may implement or sponsor interventions that can have a statewide impact. For example, social marketing campaign development and implementation is often a labor-intensive, costly endeavor. Given that, the State Partnership or specific agencies may be in the best position to develop the campaigns, as it has with other topics such as the opioid crisis.[40] HECs could then implement and, as needed, adapt campaigns in their communities.

HEC Engagement and Inclusion of Key Sectors

HECs will have to address the multiple, interrelated social determinants of health related to ACEs and overweight and obesity. That necessitates having multiple sectors involved in HECs, including sectors that can address those factors but have not been at the table among many community collaboratives to date. Each HEC will need to define the roles of the different sectors and entities. While the stakeholder engagement process thus far has identified HECs as being in the best position to define those roles based on their geographies and interventions, they should be guided by options and examples in this framework and in the Technical Report.

HEC Structure

Each HEC will have to create a structure that supports how it will govern itself, operate on a daily basis, implement interventions, and achieve the outcomes of the initiative. HEC structures will include:

- A **governance structure**, including a governance body that provides strategic direction and oversight to the HEC and governance agreements that dictate how the structure will make decisions and function
- A **management team and/or backbone organization** that reports to the governance body and leads the daily operations of the HEC
- **Partners** who implement interventions, including community groups, organizations, and other partners

1. Governance Structure

Each HEC will need to develop a formal governance structure to oversee what it does in its geography. The governance structure will have clearly defined decision-making roles, authorities, and processes. The HEC's governance structure must enable the HEC to perform key functions, including but not limited to providing oversight of the HEC's performance against state health and health equity benchmarks and HEC intervention metrics; fiscal planning and performance; and mitigating risks (e.g., risks related to performance under financing models).

Although each HEC will need to develop a governance structure that reflects the realities of its community, all HECs should have a defined structure that:

- Ensures that community members are directly involved in decision-making about how HECs are designed, form, and operate

> The guiding principle should be "nothing for us without us."
>
> *From a Hartford Community Member*

[40] "Change the Script" Campaign to combat the prescription drug and opioid misuse crisis.

- Reflects the diversity within the HEC communities and includes diverse voices in all aspects of HEC formation and operation, including in decision-making roles
- Ensures that all individuals and sectors involved in governance have an equal voice and power in decision making
- Does not create silos that marginalize community members, partners, and sectors
- Can effectively make decisions, oversee the HEC, and achieve outcomes

Community Member Involvement

HEC success depends on community members shaping what HECs are and do and having decision-making authority. Community members have unique perspectives about their lived experience within communities, including nuanced insights about needs and opportunities, informal and formal resources and networks that can support HEC interventions and create lasting change in their communities, and real-world experience with what has worked and not worked in the past. Community groups across Connecticut have been and should remain at the forefront of efforts to improve community health and health equity.

As such, HECs should implement multiple strategies to ensure that community members are meaningfully involved in the governance structure, including in making decisions about what HECs are and do. HECs should:

- Seek out and use what community members have said in previous community engagements to reduce the burden of asking communities members what they have been asked before.
- Directly involve community members in designing and making decisions about how assets and needs are assessed, how HECs are structured, strategies for leveraging assets and addressing needs, and evaluating interventions and success.
- Have multiple mechanisms to make it easy for community members to provide input and exercise their decision-making roles, including conducting work in community settings and afterhours; providing support (e.g., payment, transportation, food, and child care), and providing training and leadership development.
- Respond to and meaningfully use the input that community members provide.
- Implement ongoing multi-directional communication strategies, including:
    - Community members communicating to the HEC governance structure and partners what matters to them, what they want to accomplish, and what they are doing in the community
    - Communications from the HEC governance structure and partners that show how community members' input shaped what the HEC is and what it does
    - Communications that are easy to understand, in plain language, and in languages that communities speak and read

Governance Body

Each HEC would have a governance body that would operate like a Board of Directors. The governance body would oversee the HEC. Among other roles and responsibilities, each HEC's governance body would define and support the HEC's overall vision, mission, and key strategies; monitor and respond to HEC performance; exercise proper financial oversight; ensure compliance with all legal and regulatory requirements; and hire and supervise the Executive Director. The governance body would delegate operational and managerial authorities and responsibilities to the Executive Director.

To be effective and support an inclusive process, the governance body should include a balance of membership, including community members who represent the diversity within HEC communities and multiple sectors that address community health, health equity, prevention, and social determinants of health.

Governing Agreements

The governance structures that HECs create also need to be effective within each HEC's unique context (e.g., geographies, populations, partners, infrastructures) and be nimble enough to adapt if circumstances change. At the same time, the intent is to enable HECs to quickly progress from making governance structure decisions to identifying and implementing strategies. Given the need for a balance among those needs, there will be some requirements for HEC governance structures that will ensure a degree of functionality while allowing flexibility for HECs where it supports their effectiveness and speed to action. Table 1 indicates the HEC governance structure elements the state will require versus what HECs can determine.

Table 1. Minimum Governance Agreements Required by the State and Determined by HECs

Governance Structure Element	FOCUS Required by State	FLEXIBILITY Determined by HECs
Partnership agreements	• HECs will need to have formal partnership agreements among organizations that will be part of governance structures and decision making.	• HECs will determine the form of the formal agreement, who will be included in it, and how entities outside of the agreements will be involved in HECs. • HECs will not be required to but may decide to form a new legal entity
Bylaws	• HECs will need to have bylaws with clearly defined roles, governance bodies, terms of service, decision-making parameters and processes, etc.	• HECs will determine their structure and the determine the roles, authorities, parameters, and processes in their bylaws.
Formal contracts for services	• HECs will need to have formal contracts with the entities providing significant administrative or other services.	• HECs will select the administrative service provider(s), determine their roles, and develop the contract(s).

2. HEC Management Team/Backbone Organization - Executive Director, Staff, and Funds

Each HEC would have an Executive Director leading the initiative and staff supporting the HEC. The Executive Director would be hired by and report to the governance body and, similar to other Executive Directors, have defined authority to make decisions on behalf of the HEC. For example, the Executive Director would develop an HEC budget, have the budget approved by the HEC governance body, and then manage the budget on a daily basis, including making decisions about allocating resources as allowed by the scope of their authority.

Depending on how each HEC decides to staff their HEC, the Executive Director and staff could be formed as a separate management team or could be backbone organization providing an Executive Director and staff. Executive Director and staff are responsible for HEC operations, including but not limited to managing and directing the daily activities of the HEC; collecting, compiling, and sharing data to support HEC decision-making and performance; managing the input among all HEC partners and ensuring the use of input in decision-making; providing support for interventions; staffing the governance body; managing pooled funds; fundraising; monitoring and managing performance; strategic planning; and reporting.

They would manage the arrangements with and provide resources and support to the community groups, organizations, and partners that are leading or participating in interventions. In some cases, the staff may lead or support interventions directly.

Optimally, the Executive Director would also be responsible for a pool of funds that support their HEC and can be used as defined by the governance body. Initially, the funds could come from multiple sources that are indicated in the accompanying HEC Technical Report. In the long term, this pool would also include funds from the long-term financing being pursued under this initiative. The HEC may also include other funding that is not under the direction the Executive Director. However, having a funding pool would enable the Executive Director to make decisions about funding that support the overall HEC, do not require approval from the governance body, can be quickly deployed, and are independent of any single HEC partner. The Executive Director would also work with the governance body to develop parameters and processes for the use and flow of financing from the long-term strategies that the state is pursuing, develop agreements among HEC partners, and manage the relationship with the fiduciary agent if one is needed.

3. Partners

Each HEC would work with and support various partners that are responsible for implementing select interventions. Described below, these would include 1) community groups and 2) organizations and other partners.

Community Groups

The Executive Director and staff would provide support to community groups that comprise community members who come together to work on the issues and interventions that matter most to them in their communities or specific neighborhoods. Community members are defined as people who live, learn, work, and worship in communities. For the purpose of community member involvement, community members should largely include people who are *not* leaders or staff of organizations or agencies.

Community groups would lead the selection and implementation of key interventions in their communities. As examples, they may decide they want to advocate for the enforcement of housing

policies or changes to zoning laws to support better access to healthy, affordable food. They may decide to work on developing better systems for formerly incarcerated community members to get jobs or help service providers improve how they work with parents.

These groups would receive resources (e.g., community organizers hired by the HEC, other staff such as Community Health Workers, training, and data analysis) to support and sustain their efforts. In some cases, community groups may work with each other on issues that matter to multiple groups. In other cases, they may choose to work with organizations that support their efforts.

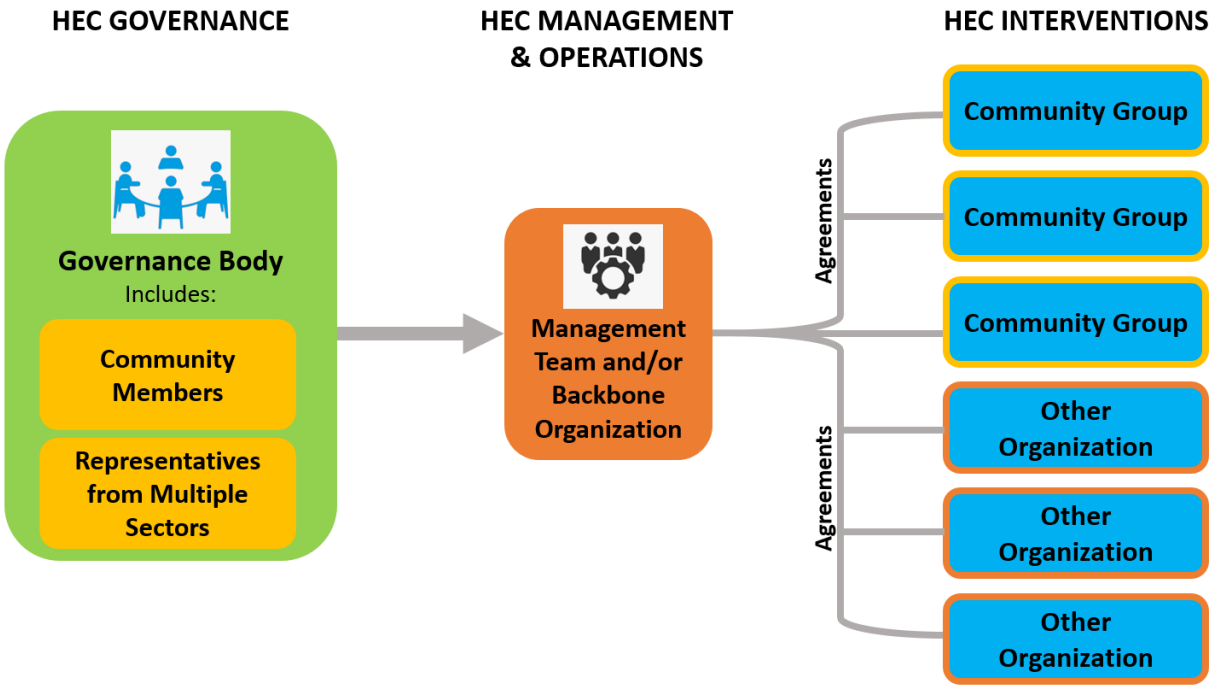
Community group participation would be *in addition to, not in lieu of,* community member participation in the governing body and other methods for including community members in decision making. Having these groups lead HEC interventions also provides community members with options for how they choose to participate in HECs, which was expressed as important in the HEC stakeholder engagement process.

While there are existing community groups in some Connecticut communities or neighborhoods, HECs may also need to support new groups or groups that need assistance changing or evolving what they do today.

Organizations and Partners

Each HEC would contract with or otherwise work with or support local organizations or partners on interventions. HECs would select organizations or partners that would lead activities related to select interventions. As examples, organizations that already provide home visits may come together to align what they are doing so that families get more cohesive and seamless services in their homes. The local school district may work with their schools on changing policies to allow community members to have access to the vegetables and fruits produced by community gardens located on school grounds. A number of organizations and partners may work together to expand training in Circle of Security Parenting, a parent-child attachment-based intervention, across the HEC. The HEC will determine which arrangements it will enter into and the exact nature of the arrangements. See Figure 2 for an HEC structure diagram that includes all of the components described above.

Figure 2. HEC Structure



Aligned Strategies: Primary Care Modernization and Health Enhancement Communities

Primary care plays a vital role in the health of populations. Primary care can provide both curative and preventative services that have the potential to save lives and help sick people live longer, healthier lives. Primary care providers and their teams are positioned to see and act on structural conditions that produce disease.[41] If they are properly equipped and resourced, traditional primary care can play a much larger role in promoting the conditions that make people healthy and prevent disease and serve to bridge the gap between clinical medicine and population health. Primary Care Modernization (PCM) proposes to combine new primary care capabilities with flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently. The goal is to design a new model for primary care that:

- Expands and diversifies patient care teams
- Expands patient care and support outside of the traditional office visit
- Doubles the investment in primary care over five years through more flexible payments

PCM can collaborate and support the achievement of the HEC goals and health priorities through multiple means. As examples, PCM primary care practices could share knowledge gained through interactions with families to identify health issues that may impact larger populations within HEC geographies as well as conduct assessments and provide education and counseling related to HEC health priorities and interventions. Optimally, PCM primary care practices and HECs would develop

[41] Galea, S., & Kruk, M. E. (2019). Forty Years After Alma-Ata: At the Intersection of Primary Care and Population Health. The Milbank Quarterly.

mechanisms for sharing information and insights that are critical to improving population and community health across clinical and community settings and continuously monitor and improve the policies, systems, and programs to ensure that they are effective in addressing the needs of populations.

HEC Prevention Measures and Benchmarks and HEC Outputs

HECs will be held accountable for a core set of prevention outcome measures that will be consistent statewide and directly relate to the two health priority aims. The measures will be evaluated at both the state and HEC level. A provisional measures list is included in the accompanying HEC Technical Report and was developed based on stakeholder input, evidence connecting the measures with the two priority aims, and identified data sources. However, this list is not final and will continue to evolve through the collaborative HEC design process prior to procurement and under the direction of the state. A measures committee will monitor the list through the lifespan of the HEC Initiative to ensure the measures chosen continue to support the HEC goals. The final measures/measurement data selected must meet the following criteria: significantly meaningful to the HEC goals, specific to the attributed population within each HEC, collected and reported with minimal lag time, stratified to the extent possible by population characteristics, and easily accessible to each HEC. Based on the provisional list, the primary prevention measures for the health priority aims are: 1) a composite measure[42] of a child's safety, stability, and school readiness and 2) the prevalence of adult and child obesity. The HECs also will be accountable for additional secondary prevention and health equity measures that will complement the primary prevention measures. Additionally, because the success of the HEC initiative will rely on more than just programmatic activities, each HEC must choose process and outcome measures for each of the four types of interventions: systems, policy, programs, and cultural norms. Unlike the prevention outcome measures, this set of measures will be unique to each HEC and selected through an iterative community engagement process. All selected measures must allow for real-time evaluation. Each HEC will develop consistent continuous quality improvement processes related to how measures are selected, used, refined, or removed based on interim indicators.

The intent of the HEC measurement approach is to create multiple levels of measurement that incorporate a set of standard validated measures to provide meaningful comparisons of achievement and improvement in health across HECs. Cost-effective and valid strategies for incorporating local and innovative measurement tailored to a community's defined priorities and interventions will also be explored.[43] This will include exploring opportunities to use novel data sources and incorporate rapid feedback of information to HECs, community members, and communities for planning and implementation.

HEC Measurement and Reporting

While HECs will be responsible for tracking HEC-specific process and outcome measures, the HEC Initiative requires a statewide data solution to collect, aggregate, and provide the necessary data to HECs and to the state to monitor and evaluate HEC performance. Through a complementary SIM data exchange initiative, Connecticut is developing a Core Data Analytics Solution (CDAS). CDAS will aggregate

[42] A composite measure is a combination of two or more individual measures in a single measure.
[43] This layered approach to measurement is strongly supported by groups such as the CMMI's Health Care Payment Learning and Action Network. https://innovation.cms.gov/initiatives/health-care-payment-learning-and-action-network/.

data from multiple sources, produce timely data for HECs, and accept process and outcome measure data from HECs. CDAS will allow the state to monitor state-level progress obtained by HECs.

HEC Workforce

HECs will require both an administrative workforce within a defined management team/backbone organization that can perform or contract for the key functions required to operate an HEC as well as a workforce for implementing interventions in communities. Central to the HEC Initiative will be deploying a non-clinical workforce such as community organizers and Community Health Workers (CHWs).

The HEC workforce strategy will including aligning current resources and hiring new staff. Alignment of current resources is critical to building a sustainable, effective, and efficient program. An initial step in building the HEC infrastructure will require assessing and quantifying available workforce resources within the community for potential redeployment or alignment with the HEC activities. Existing community collaboratives within the HEC may presently run interventions aligned with the HEC priority aims but disconnected from other HEC resources and partners. Aligning that workforce by creating data sharing policies and better coordination across the HEC could enable the HEC to leverage the work currently performed by these partner agencies. In addition, the new jobs created by HECs will create employment opportunities and contribute to the local and state economies.

State Support for HECs

Using Connecticut's Behavioral Health Partnership[44] as a model, the Population Health Council recommends establishing a multi-agency partnership, the State Partnership for Health Enhancement (State Partnership), to oversee and administer the HEC Initiative. The State Partnership would comprise multiple state agencies that have purviews that include child well-being and healthy weight and physical fitness. As with the Behavioral Health Partnership, the State Partnership would support HECs in multiple ways. This includes pursuing legislative and regulatory changes that will support HECs and enable the HEC Initiative. This also includes enabling the provision of an Administrative Services Organization (ASO) as a centralized resource for technical assistance and other types of support as HECs form and implement interventions and establishing an HEC Advisory Committee that would advise on the implementation and performance of the HEC Initiative.

HEC Financing

The HEC Initiative seeks to incentivize and reward communities for improving community health and health equity and preventing poor health instead of more traditional accountable health care models that typically reward improving health care and reducing avoidable utilization of health care services after someone has a health condition. Therefore, a central objective of the HEC Initiative is to provide a

[44] The Connecticut Behavioral Health Partnership's goal is to provide access to a more complete, coordinated, and effective system of community-based behavioral health services and support. It was established through legislation (PA05-280 and later PA10-119) and comprises the Department of Children and Families (DCF), the Department of Social Services, the Department of Mental Health and Addiction Services, Beacon Health Options, and a legislatively mandated Oversight Council. The Oversight Council comprises legislators and their designees, behavioral health consumers and advocates, medical and mental health practitioners, state agencies, and insurers. The partnership is designed to create an integrated behavioral health service system for Connecticut's Medicaid populations, including children and families who are enrolled in HUSKY Health and DCF Limited Benefit programs.

sustainable pathway to monetize prevention savings and reinvest a portion of the savings back to the HECs.

To achieve these ambitious goals, HECs will require a mix of near-term, upfront financing in the first five years of implementation as well as sustainable long-term sources of financing beyond five years. It is anticipated that the near-term financing options will serve as a bridge to longer-term sustainability options. A variety of near-term financing options exist to fund HEC activities, including:

- **Debt:** Potential sources of loans to HECs include foundations, private financial intermediaries (called Community Development Financial Institutions) that deliver financial services to underserved populations and areas, commercial banks seeking to meeting state and federal community reinvestment requirements, and some hospitals.
- **Grants:** HECs may be able to access grant dollars from foundations, corporations, high-net worth individuals, and non-profit hospitals, which are often sources of local investment in the community.
- **Tax Credits:** HECs may be able to tap into tax credit programs that help economically distressed communities attract private funds from investors. These programs are mostly tied to real estate projects and new affordable housing.
- **Outcomes-based Financing Models:** Outcomes-based financing models are new and evolving approaches that are expected to be significant sources of HEC funds. These programs provide rewards based on outcomes demonstrated. For example, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, run by the Connecticut Office of Early Childhood (OEC), began a pilot where bonus payments are made to service providers for achieving outcomes related to full-term birth, child health and safety, caregiver employment, and family employment.
- **Pooling or Reorienting Existing Funding Sources:** There are opportunities to leverage existing sources of funding in new ways to pay for HEC services. For example, *braided funding* strategies coordinate funds from various public and/or private sources and allocate them towards services, with specific tracking and accountability for each source. As an example, the United Way 211 Child Development Infoline (CDI) is a service that is supported through funding from multiple Connecticut state agencies. *Blended funding* approaches merge funds from various sources into one pooled funding stream and allocate the funds for services. For service providers, this mechanism provides a flexible, results-driven funding stream. The Performance Partnership Pilots for Disconnected Youth (P3) is an example of a national program that allows grantees to blend discretionary funds from the Departments of Education, Housing and Urban Development, Justice, and Health and Human Services and creates flexibility for grantees to test comprehensive, outcomes-based strategies to achieve improvements in educational, employment, and other key outcomes for disconnected youth. *Wellness trusts*, also referred to as Community Health Funds, are mechanisms that aggregate funds to support community-based population health or prevention activities. Wellness trusts are a relatively new concept. In one recent example, the Massachusetts Department of Public Health administered the Prevention and Wellness Trust Fund from 2012-2016, funded by a one-time $60 million assessment on insurance and hospital revenue. The fund provided grants to nine community-based prevention initiatives focused on pediatric asthma, hypertension, tobacco use, and elder falls.

- **Public Health Insurance Programs:** Potential mechanisms to leverage federal funds to support HECs include a "multi-payer model agreement" with the Centers for Medicare & Medicaid Services (CMS) and Medicaid Delivery System Reform Incentive Payment (DSRIP) programs. Access to resources are conditioned on state commitments to control health care spending, quantify and monitor savings that accrue to Medicare and Medicaid, and demonstrate other outcomes for Medicare and Medicaid beneficiaries.

Long-term financing options will likely rely upon ongoing collaboration with purchasers of health care and other services such as Medicare, Medicaid, and the state employee health plan administered by the Office of the State Comptroller (OSC). Under the HEC Initiative, the State Partnership will play a critical role in identifying, negotiating, and securing long-term funding agreements with purchasers to support HECs. Specifically, the State Partnership will engage key purchasers in developing prevention-oriented shared savings arrangements with HECs. These shared saving arrangements will measure and capture health care cost savings that accrue as a result of achievement on prevention benchmarks. 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.

Medicare has strong potential to be an early long-term HEC financing partner. Connecticut spends more per person than almost all other states. Connecticut ranked fifth in Medicare per capita spending in 2014—behind only New Jersey, Florida, New York, and Maryland. Therefore, the magnitude of the financial opportunity among Connecticut's Medicare population is vast. The compounding effect of prevention-oriented interventions would yield an increasing amount of annual health care savings over time. Even a small decrease in Medicare expenditures over a 5- or 10-year time horizon would result in billions of dollars saved. Reinvesting a portion of those savings back into communities would enable communities to sustain HECs and their work to improve community health and health equity and prevent poor health. Because the funds would be generated by producing savings, they could be used to support HECs and their work overall, even though those savings are based on obesity outcomes. This, in turn, creates new, long-term opportunities to improve health and well-being for all of Connecticut's residents.

REINVESTMENT OPPORTUNITY

Medicare has strong potential to be an early and significant long-term HEC financing partner. The magnitude of the financial opportunity among Connecticut's Medicare population is vast. Even modest reductions in obesity prevalence over a 5- or 10-year time horizon would save Medicare billions of dollars. Reinvesting a portion of those savings back into communities would enable communities to support and sustain HECs and their work. This, in turn, creates new, long-term opportunities to improve health and well-being for all of Connecticut's residents.

HECs will need to have the capacity to receive and manage monies from multiple sources or they will need to rely on a fiduciary agent under contract with the HEC or the State Partnership to manage and disburse the funding on an HEC's behalf. Moreover, HECs will need to have formal governance processes in place to develop and manage the internal flow of funds before major sources of funding are received. The State Partnership will collaborate with HECs, consumer groups, and other stakeholders (e.g., private and public-sector employers, municipalities, and state agencies) to provide a

set of guidelines, about how HEC funds could be distributed. The guidelines will need to be sensitive to any constraints or requirements set by funders and purchasers. The State Partnership will require annual public reporting on HEC internal funds flow to ensure HECs remain accountable to their communities.

HEC Designation and Implementation

HECs will be designated through a state procurement process that will occur in three phases: first **Pre-Procurement**, where communities interested in becoming HECs begin to work with community members and stakeholders to develop initial plans for key HEC areas; second, **HEC Procurement and Pre-Implementation**, where the State will issue a Request for Applicants (RFA) to designate HECs and will provide technical assistance, training, and access to Subject Matter Experts to assist applicants; and third, **HEC Implementation**, where selected HECs will begin implementation based on their level of readiness. This process will foster, from the beginning, collaboration between the State Partnership and HECs and among HECs. This will help ensure that designated HECs are ultimately structured to promote their success and sustainability.

The HEC Initiative will be implemented through a 10-year, multi-phased approach that is estimated to begin April 1, 2019, and aligns with the HEC designation process.

- **Phase 1: Pre-Procurement (Months 0-10).** In this phase, the State Partnership will be established to oversee and support the HEC Initiative. If feasible, communities will begin to define their prospective HEC. Stakeholder and community engagement will initiate and continue through this phase as the HEC model is finalized. Groundwork will be laid for recommended statutory/regulatory changes to support the HEC model and goals. The State Partnership will work to establish the infrastructure needed to select and support HECs. The process to ultimately select the individual HECs will also be established, including the development of the HEC Request for Applicants (RFA), evaluation criteria and process, and award notification and contracting process/terms. Communities interested in becoming HECs will work with community residents and stakeholders to prepare for the HEC RFA release in Phase 2.
- **Phase 2: HEC Procurement and Pre-Implementation (Months 11-21).** In this period, prospective HECs will apply and be designated as HECs and undergo a brief ramp-up period to prepare for and ultimately implement interventions selected for and by their communities. The HEC financing model will be negotiated with potential funders and the HEC financing model will be finalized with the commitment of near-term financing. The State Partnership will establish and implement centralized HEC supports, including establishing the information technology infrastructure, the statewide technical assistance model, and the development and initiation of an HEC Advisory Committee.
- **Phase 3: HEC Implementation (Months 22-120).** This phase will involve the full implementation of HECs across Connecticut and include the implementation of interventions in HECs' geographies. The HEC financing model will be finalized with near- and long-term funding identified and secured. The State Partnership will implement ongoing monitoring and reporting of the HECs and adjustments to the model will be made to achieve and maximize outcomes. The State Partnership will also provide ongoing support to HECs through statewide strategies identified in Phase 1 and 2. HECs will report on progress annually and demonstrate results

within this period, and any shared savings incentives/arrangements achieved will be distributed to HECs accordingly.

Conclusion

The HEC Initiative can create the right combination of conditions for moving the needle on community health, healthy equity, prevention, and costs/cost trends at a state level and improving the health and well-being of individuals and families in communities across the state. This initiative can also help usher in a new era for 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 shift payment models to reward communities that produce savings and other economic benefits. 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, achieve health equity for all Connecticut residents, and slow the growth of Connecticut's health care spending.

Appendix A: Example of a Health Enhancement Community

Ultimately, HECs should improve the health and well-being of individuals and families in communities across Connecticut. This hypothetical HEC example illustrates what the vision of an HEC is and what an HEC can do to improve child well-being and healthy weight and physical fitness. Note that this example is to show how the different HEC elements described in this report could operate together. *All details are for illustrative purposes only.*

Geography: As a prospective HEC, an existing community collaborative reached out to two neighboring communities and negotiated their inclusion in the HEC based on data analysis that showed some similar patterns of need, community resident listening sessions and key informant interviews, and previous successful joint efforts. Their proposed geography includes urban and suburban rural areas and meets the state's requirements.

Community Assets and Needs: To develop their application to become an HEC and their implementation plan, the prospective HEC collected and collectively reviewed data and information from multiple existing and new quantitative and qualitative sources to gain a detailed and nuanced understanding of assets and needs. These included community activities throughout their proposed geography; recent community needs assessments; and input from community-based organizations, local agencies, health care providers, faith-based organizations, child care providers, and schools. The HEC also used the state data exchange system, CDAS, to identify "hot spots" related to child well-being being and healthy weight and physical fitness indicators as well as indicators related to the root causes of ACEs and overweight/obesity. The data and information were used to identify HEC strategies.

Partnerships: The original community collaborative comprised 30 organizations, including multiple health and health care-related community-based organizations; the local health department; a federally qualified health center that is a Medicaid PCMH+ Participating Entity; two hospitals that are part of a joint Accountable Care Organization; multiple health and health care focused community-based organizations; the YMCA; Planned Parenthood; United Way; and a local a community foundation. Given their analysis and knowledge of what is contributing to ACEs and overweight/obesity in their geography, they expanded their partners to include existing community groups; the Community Action Agency; housing agencies; schools and school districts; community colleges; government agencies and departments; community-based and social service organizations that contribute to community health; social justice organizations and advocates; faith-based, civic, and cultural organizations; economic development offices; Community Development Corporations; elected officials; policy and advocacy organizations; law enforcement agencies; Chambers of Commerce; employers; substance use disorder providers; behavioral health providers; and transit districts. They developed a participant agreement that clarified roles and expectations, including those related to resources from and for each partner. One of the local employers, the two hospitals, and the health center have all agreed to identify ways they can further support community health by contributing to the economic vitality of the communities in which they operate.

Structure: The prospective HEC developed a structure that includes three existing community groups, a management team/backbone organization unaffiliated with an organization, and a formal governance structure. The management team/backbone organization worked with the community groups to provide data to inform their decisions and identify needed resources. Given that they brought many new

partners to the table, they recognized the need to develop a governance structure that balanced the need to make decisions quickly with methods for including all their partners in some way to guide good decision-making and keep partners engaged in the HEC process. They formed a governing body with an upper limit of 20 members, which is responsible for oversight of the HEC and routine decisions. They ensured that each sector had balanced representation on the governing body. They also established a full membership committee and other key committees (e.g., finance, performance) that include other participants. The governing bodies and committees, the processes for electing members and officers to that governing body and terms of service, the scope of authorities, the process by which the governing body makes decisions, the roles and responsibilities of its members, etc., were codified in a partnership agreement and bylaws, which each member had to sign. They contract with one of their local hospitals as a fiduciary agent and contract with a local law firm for as-needed legal support. The management team/backbone organization compiled and shared existing data and information from previous community engagement efforts with the community groups and governance structure to develop an initial plan for HEC interventions, measures, and roles of each arm of the structure and participating partners.

Interventions: The HEC first identifies existing entities, interventions, and efforts to address the root causes of child well-being and healthy weight and physical fitness in their geography and develops a plan to leverage what is already working and fill gaps by implementing new interventions. Led by the community groups, the HEC identifies several interventions. As examples, for child well-being they implemented interventions aimed at:

- **Systems**: Creating an annual community report card for child well-being that is used by all HEC partners to assess progress on goals, determine resource allocation, and raise and maintain the visibility of child well-being.
- **Policy:** Expanding access to legal aid services related to housing quality and discrimination. Community advocacy to ensure enforcement of existing housing policies.
- **Programs**: Aligning existing home visitation programs to create a unified approach and a seamless experience for families. Securing financing to expand affordable housing in a community identified as a "hot spot."
- **Cultural Norm**: Implementing "Breaking the Cycle" social marketing campaign, which helps parents understand and stop the cycle of abuse and addresses the stigma associated with parents needing help in parenting as well as a campaign to promote community and institutional norms for a shared, community-wide responsibility for child well-being. Implementing Partnering with Parents, which is a parent-designed curriculum to help service organizations develop better partnerships with parents.

Measures and Performance Monitoring: Through an iterative process with community groups and HEC partners, the HEC identifies process and outcome measures for each of their interventions, using validated measures where they exist. They also are accountable for performance under the state's prevention and health equity scorecard and benchmarks. The HEC's Performance Committee, which is part of its governance structure, is charged with continually monitoring performance, reporting to the state and supporting community groups in developing corrective action plans. The HEC uses the CDAS dashboards and the data that are stratified across race/ethnicity, socioeconomic status, and other population characteristics to continually identify the needs of their population and assess performance.

They also develop specifications and processes for collecting data from their partners and other sources and upload their process and outcome measure data directly to CDAS. They develop and release periodic, easy-to-understand updates about HEC progress and performance throughout their network and communities, including at community meetings where they can get additional design and implementation feedback.

HEC Advisory Committee: The HEC has a member on a statewide HEC Advisory Committee. Among other actions, members create and HECs advocate for a policy to alter SNAP benefits to provide incentives for healthier foods.

Centralized Support: The HEC also uses resources from the ASO created to support HECs and the overall HEC Initiative. The HEC uses sample agreements and bylaws in a Governance Package developed for HECs and receives training and technical assistance from experts on interventions that improve health equity, group facilitation skills, and using CDAS, among other support.

Financing: The HEC is supported by pooled funds from the two hospitals' community benefits funds; braided funding from local, state, and federal sources; local and state foundations; and, later in the lifecycle of the HEC, a portion of shared savings from health care purchasers such as Medicare and Medicaid. The management team/backbone organization distributes funding based on pre-established policies developed by the HEC. The HEC also supported their housing partners in pursuing a Low-Income Housing Tax Credit for low-income housing. The HEC is part of the Multi-Payer Demonstration, which enables the HEC to secure significant long-term financing through the overall HEC Initiative achieving defined prevention and cost benchmarks.