KEY CONSIDERATIONS:

HEC Reference Communities in Connecticut

SIM Population Health • November 2017

Connecticut's Health Enhancement Community (HEC) initiative will foster regional community-wide collaboration to address a wide range of factors that influence health. **The SIM Population Health Planning team is weighing approaches to identify HEC reference communities and engage them in developing regional and state HEC strategies.** HEC reference communities are multi-sector health collaboratives that are generally defined as a coalition of partners from health, social service, and other sectors working together to promote healthier people, better care, smarter spending, and health equity. This brief provides context for stakeholder discussion about the best approach to engage ongoing community health collaboratives in the strategy development process.

Core Elements of an Effective HEC:

Multi-Sector Partnerships

- Strong buy-in from a diverse set of stakeholders.[1]
- Clarity regarding roles and responsibilities.
- Sound governance structure.[2]
- Effective communication strategy. [3]
- Lever opportunities presented by providers and payers in the health care sector. [4]

Health Improvement Activities

- Defined goals and objectives.[3]
- Planning and priority setting.
- Community Health Improvement Plan.[2]
- Targeted population.
- Coordinated root cause prevention.

Process and Outcome Measures

- Systems for reliable and valid data.[5]
- Selection and use of measures to meet accountability and performance targets.
- Community Health Needs Assessment and asset mapping process.[6]
- Social determinants of health data for vulnerable populations.[7]

Sustained Funding Mechanisms[5,6]

- Sustainable funding model that supports ongoing cross-sector activities.
- Reliable revenue streams to cover the full cost of partnership.
- Rewards investors proportionate to the economic value of health improved.

1. Nonprofit Finance Fund. 2017 Partnership Assessment Tool for Health. Partnership for Health Outcomes Project, Center for Health Care Strategies, Inc.
2. Network for Regional Healthcare Improvement. 2016. When regional health improvement collaboratives and states work together: Lessons learned from health improvement partnerships.
3. Barnes PA, Erwin PC, Moonesinghe R. Measures of Highly Functioning Health Coalitions. *Am J Public Health*. 2014;104(12):e43-e47.

State Examples and Current Connecticut Activities of Cross-Sector Partnerships:

Multi-Sector Partnerships

State Examples	Connecticut Activities
California's Accountable Communities for Health (ACH) model is a multi-sector alliance of major health care systems, providers, along with public health, key community and social services organizations, schools and other partners. While the geographic area served is not specific to population size or a recognized boundary, ACHs must demonstrate key criteria relating to partnerships, structure, leadership, defined geography and activities. Washington's nine Accountable Communities of Health (ACHs) bring together community members to work on shared regional goals that serve each of the nine counties together encompassing the entire state.	Connecticut currently has several active community health collaboratives in regions throughout the state, each representing entities from a broad range of sectors (i.e. The Greenwich Community health Improvement Partnership, Greater Danbury Region Collaborative, Primary Care Action Group, Southeastern CT Health Improvement Collaborative, Healthier Greater New Haven Partnership, Greater Waterbury Health Improvement Partnership, etc.).

Health Improvement Activities

State Examples	Connecticut Activities
Michigan's five Community Health Innovation Regions (CHIRs) work together to target three populations: individuals with frequent ED utilization; individuals with multiple chronic conditions; and healthy mothers and babies. Iowa's Community Care Coalitions (C3s) pursue care coordination interventions that address the state's SIM population health focus areas—tobacco, obesity, and/or diabetes—as well as social determinants of health.	Among the numerous community health needs assessments (CHNAs) and associated health improvement plans (CHIPs) implemented in Connecticut, common identified health priorities include chronic disease, diabetes, mental health, substance abuse, access to care, and several socioeconomic and environmental factors.

Process and Outcome Measures

State Examples	Connecticut Activities
Washington's ACHs are receiving data via regional dashboards through the Analytics, Interoperability and Measurement (AIM) strategy. Through AIM, Washington is investing in infrastructure development and analytic capacity to improve whole person care and inform health improvement strategies. Minnesota has formed a data analytics sub-group that includes regional ACH representatives, which has identified six priority areas and data sources focused on social and environmental determinants of health.	Connecticut non-profit hospitals are required to regularly complete CHNAs and perform implementation planning with input from public health experts and community members. The state is also advancing a Health Information Exchange and has selected social determinants of health as a use case priority.

Sustained Funding Mechanisms

State Examples	Connecticut Activities
Michigan's Community Health Innovation Regions (CHIRs) have distinct funding categories (Administrative, Planning and Design, Foundational, Health Transformation, Administrative) to support initial set-up, development of infrastructure, program development, roll-out, etc. Washington's ACHs are funded by their Delivery System Reform Incentive Program (DSRIP) that links delivery system transformation to measureable outcomes, coordinated and directed by the ACHs across the state.	Connecticut communities and the state have not yet developed a strategy to sustain cross-sector collaboration beyond short-term local contributions and grants.

4. Center for Health Care Strategies. 2016. Supporting social service and health care partnerships to address health-related social needs.
5. Bailey, SBC. Focusing on solid partnerships across multiple sectors for population health improvement. *Prev Chronic Dis* 2010;7(6):A115.
6. National Quality Forum. 2015. Multistakeholder Input on a National Priority: Improving population health by working with communities—Action guide 2.0.
7. Center for Health Care Strategies. 2016. Measuring social determinants of health among Medicaid beneficiaries: Early state lessons.