Connecticut State Innovation Model Health Enhancement Community Initiative

Population Health Council Meeting
April 26, 2018
3:00 pm – 5:00 pm

Meeting Agenda

1. Introductions

2. Public Comments

3. Minutes

4. Updates

5. PHC Interviews

6. Sustainable Financing

7. Process for Selecting Interventions for Financial Modeling

8. Reference Community Engagement

9. Stakeholder Engagement

10. Chapter Headings and Key Questions

11. Discussion

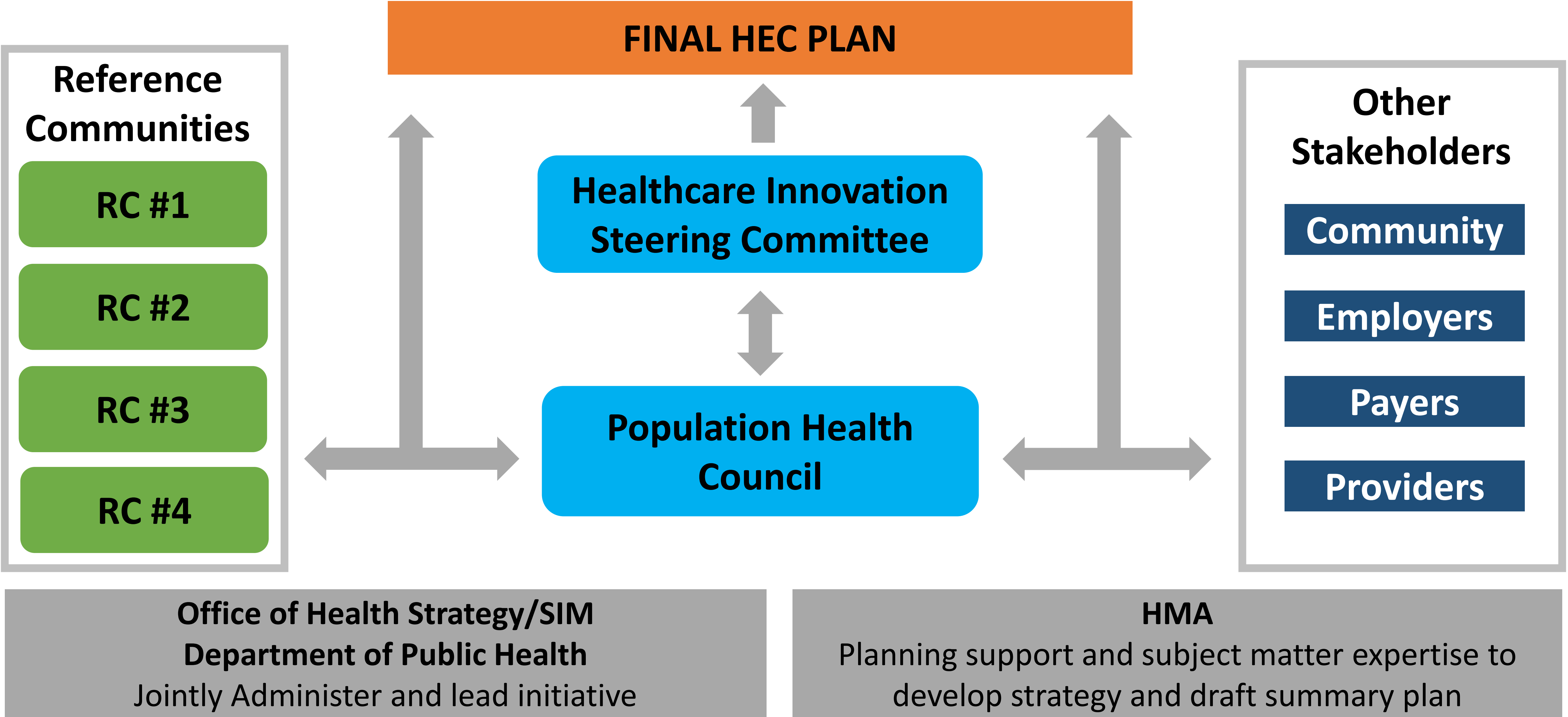
12. Closing Comments

Today’s Meeting

Meeting Objectives

- Provide overview of Population Health Council interviews
- Review and validate the process for selecting interventions for financial modeling
- Share input on the HEC strategy development process and what is critical for success

Approach emphasizes a multidirectional flow of information and input to support decision making



PHC Interviews

PHC Interview Progress – 75% Complete

Category	Name	Representing
Housing	Elizabeth Torres	Bridgeport Neighborhood Trust
FQHC	Craig Glover	Norwalk Community Health Center
Community Health Expert	Rick Brush	Wellville
Small Employer	Martha Page	Hartford Food System
Health Data Analytics Expert	Hayley Skinner	ProHealth Physicians
Behavioral Health Agency	Susan Walkama	Wheeler Clinic
Local Public Health Agency	Steven Huleatt	West Hartford Bloomfield HD
Consumer/Advocate	Garth Graham	Aetna Foundation
Consumer/Advocate	Lisa Honigfeld	Child Health and Development Institute
Consumer/Advocate	Patricia Baker	CT Health Foundation
Consumer/Advocate	Tekisha Dwan Everette	Health Equity Solutions
Advanced Network	Lyn Salsgiver	Bridgeport Hospital
Consumer/Advocate	Hyacinth Yennie	Neighborhood Revitalization Zone
Large Employer	Hugh Penney	Yale University
CT Hospital Association	Elizabeth Beaudin	CT Hospital Association
Advanced Network	Frederick Browne	Griffin Hospital

PHC Interviews: PHC Process

- Need more discussion and interaction from council members
- Need more vision setting driven by PHC members
- State-provided data is very good; need more business/economic data to form basis of PHC recommendations
- Emphasized the need to focus on children's issues as well as adults
- Group composed well to include a wide array of stakeholders; perhaps consider more representation from consumer groups
- Should be regular discussion on SIM updates and how pieces fit together

PHC Interviews: Potential Attributes of Successful Health Enhancement Communities (HECs)

- Meet patients where they are in the community
- Need a sustainable payment model with state, federal, private payer, and private business participation
- Need to address current fragmentation in the system
- Need to focus on measures that truly impact improved outcomes and be careful to not ask communities to be accountable for what they can’t control
- Infrastructure support for organizations that leads to a glide path of self sustainability

PHC Interviews: High-Priority Public Health Challenges

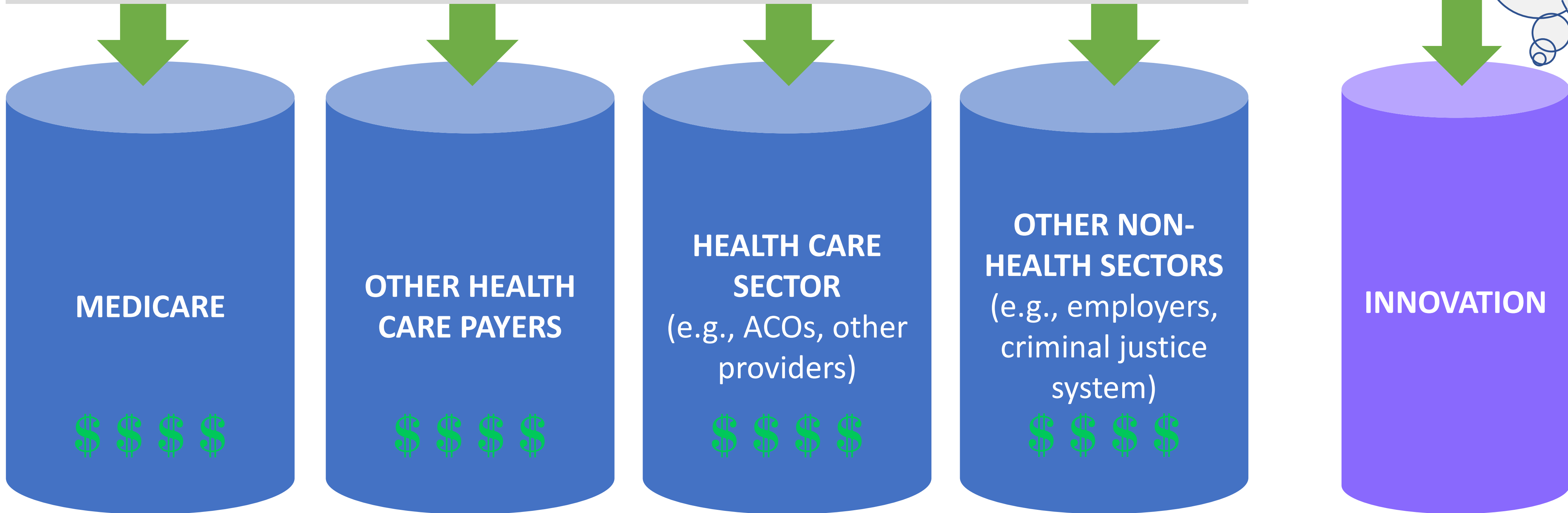
- Challenges with health equity; must find a way to focus on areas in greatest need that fall through the cracks
- Early intervention and children's health issues (e.g., obesity, behavioral health)
- Behavioral Health
- Diabetes
- Heart Disease
- Root causes (e.g., underemployment, housing, food insecurity)

PHC Interviews: Critical Elements of HEC Implementation

- Use of and financing for Community Health Workers
- Strong governance structures based in the community
- Strong commitment from state and local leaders
- Clear and attainable outcome goals
- Assist communities in attracting investment to address social determinants of health
- Data that is culturally sensitive and easily understood by community members
- Employ interventions that represent proven strategies and are based in evidence
- Accountability for measures that the community can control and impact

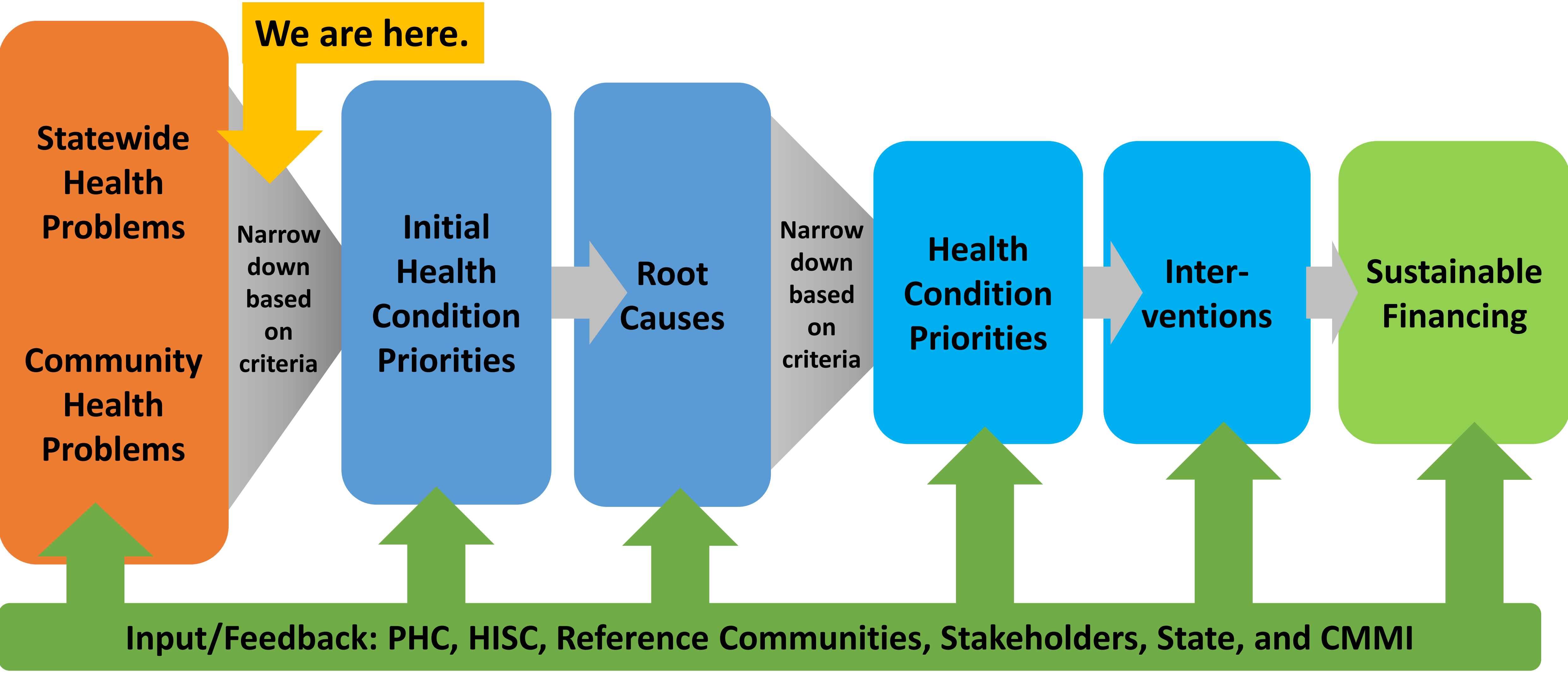
Sustainable Financing

To Secure Sustainable Financing…



Process for Selecting Interventions for Financial Modeling

Process for Selecting Interventions



We will Examine the Root Causes that Focus on Achieving Health Equity

Health Disparities Remain a Pressing Problem in Connecticut

Black children are 5X more likely to go to the ER for asthma than white children.

Source: Connecticut Department of Public Health

Latinos are more than 2X as likely to be uninsured as whites.

Source: Kaiser Family Foundation

Black residents

are nearly 2X as likely as white residents to have diabetes.

Source: Connecticut Department of Public Health, Behavioral Risk Factor Surveillance System

Source: https://www.cthealth.org/what-is-health-equity/

CT Statewide and Community Health Problems

Statewide Health Problems

Community Health Problems

- Environmental scan of statewide and community health problems previously completed
- Incorporating the extensive prior work that has been done to identify health priorities, including:
  - SHIP Health objectives
  - SIM Health objectives
  - Reference Communities initial priorities
    - Community Health Needs Assessments and other sources

Summary of Health Conditions Identified

- Heart disease and high blood pressure
- Diabetes
- Asthma
- Obesity (child and adult)
- Tobacco use
- Maternal, infant, and child health
- Oral health for children
- Childhood lead poisoning
- Substance use including opioids
- Mental health
- Developmental conditions
- Sexually transmitted infections
- Vaccine preventable diseases
- Emerging infectious diseases
- Unintentional injuries (e.g., falls)
- Injuries from violence

Although they are not **health conditions**, other **health priorities** identified included health care access, cost, insurance, and health care delivery system issues, as well as environmental factors.

Sources: SHIP health objectives, SIM health objectives, Reference Communities initial priorities

Healthy CT 2020 SHIP Health Objectives

Objective Topics	Targeted Objectives
Maternal, Infant, and Child Health	Unplanned pregnancies, prenatal care, birth outcomes, breastfeeding, oral health for children, developmental screening
Environmental Risk Factors and Health	Childhood lead poisoning, drinking water quality, air quality
Chronic Disease Prevention and Control	Heart disease and high blood pressure, diabetes, asthma, oral health for children, obesity, smoking
Infectious Disease	Vaccinations for children, pregnant women, and childcare providers; vaccinate adults against seasonal flu; vaccinate adolescents for HPV; chlamydia and gonorrhea; HIV/AIDS; Hepatitis C; healthcare associated infections; emerging infectious disease

Healthy CT 2020 SHIP Health Objectives

Objective Topics	Targeted Objectives
Injury and Violent Prevention	Falls, unintentional poisonings, motor vehicle crashes, seatbelt use, motorcycle deaths, suicide, firearms, sexual violence, child maltreatment
Mental Health, Alcohol, and Substance Abuse	Mental health emergency room visits, excessive drinking by youth and adults, non-medical use of pain relievers, illicit drug use, screening for autism, screening for trauma
Health Systems	Health insurance coverage, community-based health services, patient-centered medical homes, transportation to access health services, quality and patient safety standards for health systems, adoption of nation Culturally and Linguistically Appropriate Services (CLAS) standards by health and social service agencies, professional health workforce shortages and diversity, funding to align with prevention and population health priorities

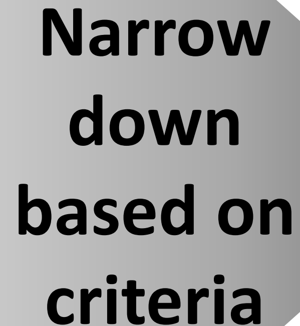
CT SIM Health Objectives

Objective Topics	Targeted Objectives
Population Health	Adult diabetes, adult obesity, adult smoking, high school youth cigarette smoking, child obesity, premature death due to cardiovascular disease
Healthcare Costs	Inpatient care insurance cost per member per year, outpatient care insurance cost per member per year
Healthcare Delivery	Adults with regular care source; hospital readmissions; well-child visits; mammograms; optimal diabetes care; asthma – emergency department usage; hypertension medication; follow-up after emergency department discharge for mental health, alcohol, or other drug use; follow-up after mental illness hospitalization; antidepressant medication management; treatment initiation and/or engagement for alcohol or other drug dependence
Health Insurance Transformation	Person centered medical home plus, community and clinical integration program, beneficiary participation in shared savings plan, value-based insurance design, primary care physician participation in any shared savings plan

Initial Top 3 Priority Areas Identified, by Reference Community

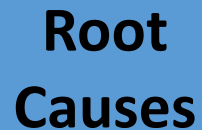
RC1	RC2	RC3	RC4
Access to care • Including mental health and substance abuse	Access to care for low-income populations and prenatal care	Access to health care	Access to healthy and nutritious food
Healthy lifestyles • Overweight/ • obesity • Tobacco use	Healthy lifestyles • With attention to risk factors for diabetes among Black residents	Obesity/ chronic disease	Child and family well-being
Asthma	Mental well-being and substance abuse • Opioid use disorder • Latinx mental health	Mental health/ substance abuse	Community safety

First Winnowing Process: To Select Initial High-Priority Conditions

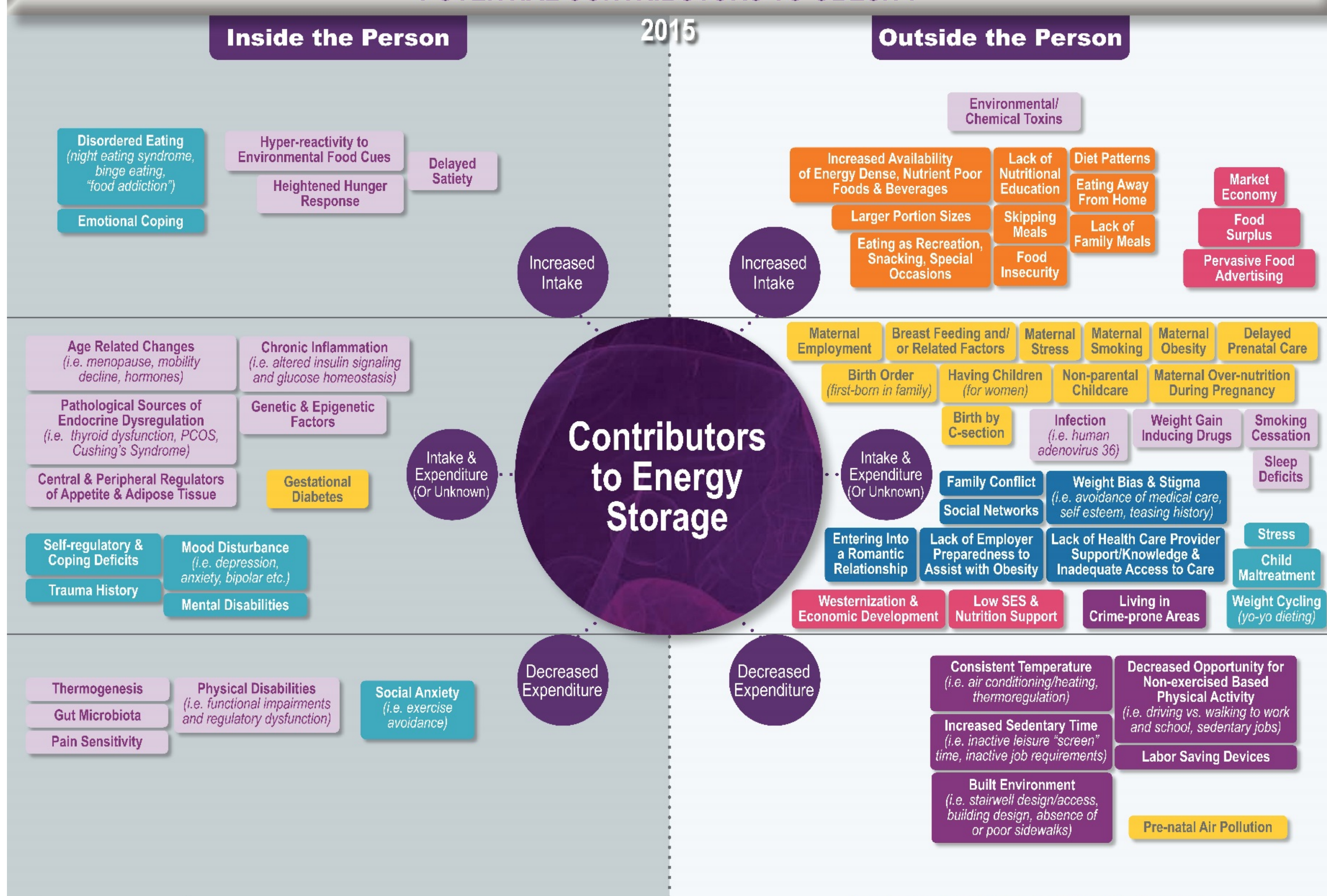


- Criteria for selecting:
  - Conditions already identified in other planning processes
  - Conditions that have outcomes that can be measured
  - Conditions for which there is some evidence of a return on investment (ROI)
  - Conditions that related to children and adolescents 0-18 years *and* adults
  - Emerging conditions
  - *Other criteria?*

Next Step: Consider Root Causes of the Initial Identified Conditions



- For the initial health conditions, we will examine the root causes
- Root causes are the underlying causes or contributors of the health problems:
  - Includes social determinants of health and structural inequities
    - Conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
    - Policies that create new or exacerbate current inequities across communities and population groups



POTENTIAL* CONTRIBUTORS TO OBESITY
2015
Inside the Person
Outside the Person
Disordered Eating (night eating syndrome, binge eating, "food addiction")
Emotional Coping
Hyper-reactivity to Environmental Food Cues
Heightened Hunger Response
Delayed Satiety
Increased Intake
Increased Intake
Environmental/ Chemical Toxins
Increased Availability of Energy Dense, Nutrient Poor Foods & Beverages
Larger Portion Sizes
Eating as Recreation, Snacking, Special Occasions
Lack of Nutritional Education
Skipping Meals
Food Insecurity
Diet Patterns
Eating Away From Home
Lack of Family Meals
Market Economy
Food Surplus
Pervasive Food Advertising
Age Related Changes (i.e. menopause, mobility decline, hormones)
Chronic Inflammation (i.e. altered insulin signaling and glucose homeostasis)
Pathological Sources of Endocrine Dysregulation (i.e. thyroid dysfunction, PCOS, Cushing's Syndrome)
Genetic & Epigenetic Factors
Central & Peripheral Regulators of Appetite & Adipose Tissue
Gestational Diabetes
Intake & Expenditure (Or Unknown)
Contributors to Energy Storage
Intake & Expenditure (Or Unknown)
Self-regulatory & Coping Deficits
Trauma History
Mood Disturbance (i.e. depression, anxiety, bipolar etc.)
Mental Disabilities
Maternal Employment
Breast Feeding and/ or Related Factors
Maternal Stress
Maternal Smoking
Maternal Obesity
Delayed Prenatal Care
Birth Order (first-born in family)
Having Children (for women)
Non-parental Childcare
Maternal Over-nutrition During Pregnancy
Birth by C-section
Infection (i.e. human adenovirus 36)
Weight Gain Inducing Drugs
Smoking Cessation
Sleep Deficits
Family Conflict
Social Networks
Weight Bias & Stigma (i.e. avoidance of medical care, self esteem, teasing history)
Entering Into a Romantic Relationship
Lack of Employer Preparedness to Assist with Obesity
Lack of Health Care Provider Support/Knowledge & Inadequate Access to Care
Stress
Child Maltreatment
Westernization & Economic Development
Low SES & Nutrition Support
Living in Crime-prone Areas
Weight Cycling (yo-yo dieting)
Thermogenesis
Gut Microbiota
Pain Sensitivity
Physical Disabilities (i.e. functional impairments and regulatory dysfunction)
Social Anxiety (i.e. exercise avoidance)
Decreased Expenditure
Decreased Expenditure
Consistent Temperature (i.e. air conditioning/heating, thermoregulation)
Increased Sedentary Time (i.e. inactive leisure "screen" time, inactive job requirements)
Built Environment (i.e. stairwell design/access, building design, absence of or poor sidewalks)
Decreased Opportunity for Non-exercised Based Physical Activity (i.e. driving vs. walking to work and school, sedentary jobs)
Labor Saving Devices
Pre-natal Air Pollution
OBESITY SOCIETY
Research. Education. Action.
www.obesity.org
Contributor/Influencer
Environmental Pressures on Physical Activity
Biological/ Medical
Maternal/ Developmental
Economic
Food and Beverage Behavior/Environment
Psychological
Social
* Potential contributors indicate anything that has been put forth in the research literature as a question of investigation and is not intended to be a verification of whether or not; or the extent to which, each may or may not contribute.

Overall Root Causes of Health – Economic Stability

Root Cause/Enabler	Statewide	Highest County	Lowest County
% of Total in Poverty (1)	9.8%	11.2% (New Haven)	6.8% (Litchfield)
% of Children in Poverty (1)	12.6%	15.8% (New Haven)	7.6% (Litchfield)
Point-in-time Homeless Count (2)	3,387 – Total 736 - Children	Not available	Not available
Unemployment Rates – Not Seasonally Adj. (3)	4.7%	5.7% (Windham)	4.4% (Middlesex)
Labor Force Participation Rate (1)	66.6%	68.5% (New London)	65.3% (Hartford and Windham)
% of Households Receiving Food Stamps/ SNAP (1)	13.1%	17.2% (Hartford)	6.8% (Tolland)
Households with No Vehicles Available (1)	9.1%	11.0% (Hartford)	5.0% (Litchfield)

Source: (1) US Census American Community Survey 1-Year Estimates, 2016; (2) Connecticut Coalition to End Homelessness, 2017; (3) Bureau of Labor and Statistics, February 2018.

Overall Root Causes of Health – Education

Root Cause/Enabler	Statewide	Highest County	Lowest County
# of Children Enrolled in Care for Kids Program to Pay for Child Care Costs (1)	22,025	6,904 (Hartford)	518 (Tolland)
4-Year Graduation Rate (2)	87.9%	Not Available	Not Available
% Population 25+ with No High School Diploma or Equivalent (3)	9.5%	12.8% (Windham)	4.8% (Tolland)
% of Population 25+ with a High School Diploma or Equivalent and No College (3)	27.5%	34.0% (Windham)	22.1% (Fairfield)
% of Population 25+ with a Bachelor's Degree or Higher (3)	38.6%	46.6% (Fairfield)	24.0% (Windham)
% of Population 5+ that Speak English "Less Than Very Well" (3)	8.2%	12.0% (Fairfield)	2.4% (Tolland)

Source: (1) Connecticut Office of Early Childhood, 2012; (2) Connecticut State Department of Education, 2016-17; (3) US Census American Community Survey 1-Year Estimates, 2016.

Overall Root Causes of Health – Social and Community Context

Root Cause/Enabler	Statewide	Highest County	Lowest County
% of Teens and Young Adults Ages 16-24 Who are Neither Working Nor in School (1)	11%	12% (Hartford, New Haven, and New London)	7% (Middlesex and Tolland)
Association Membership Rate per 10,000 Population (1)	9.4	10.6 (Litchfield)	7.3 (Tolland)
Residential Segregation – Black/White, 0 = Complete Integration, 100 = Complete Segregation (1)	63	63 (Fairfield and Hartford)	53 (New London)
Residential Segregation – Non-White/White, 0 Represents Complete Integration, 100 Complete Segregation (1)	50	51 (Fairfield)	33 (Litchfield)
Inmate Population in the CT Department of Correction (2)	13,794	Not available	Not available
% of Inmate Population Accused (2)	27.6%		
% of Inmate Population Sentenced (2)	72.4%		

Source: (1) Robert Wood Johnson Foundation County Health Rankings, 2018; (2) CT Department of Correction, February 2018.

Overall Root Causes of Health – Social and Community Context

Table 1. A Snapshot of Connecticut's Civic Health Findings

		CT*	U.S. Avg	CT Rank	+/- % since 2010**
COMMUNITY LIFE	Volunteer	27.8%	25.4%	22nd	-3.3%
	Give to charity ($25 or more)	56.2%	50.1%	12th	-2.2%
	Work with Neighbors on a Community Issue	8.6%	7.6%	22nd	+1.3%
	Belong to a Community Group	35.1%	36.3%	36th	-1.8%
POLITICAL PARTICIPATION	Register to Vote in 2012 Presidential Election	70.5%	71.2%	34th	n/a
	Vote in 2012 Presidential Election***	62.7%	61.8%	26th	-4.5% (from 2008)
	Register to Vote in 2014 Midterms	65.1%	64.6%	29th	-1.5%
	Vote in 2014 Midterms	46.7%	41.9%	19th	-2.6%
	Vote in Local Elections (Always or Sometimes)	63.5%	58.5%	24th	n/a
	Contact a public official	13.8%	10.8%	19th	+0.1%
SOCIAL NETWORKS	Eat Dinner with Family (Frequently)	88.7%	87.8%	28th	+1.3%
	Talk with Neighbors (Frequently)	45.5%	41.4%	11th	+2.6%
	Exchange Favors with Neighbors (Frequently)	11.7%	12.1%	33rd	-2.9%
INSTITUTIONAL PRESENCE	Public Schools (A Great Deal or Some)	88.1%	84.5%	13th	n/a
	Media (A Great Deal or Some)	59.2%	55.0%	12th	n/a
	Corporations (A Great Deal or Some)	63.9%	64.5%	36th	n/a

* 2013, unless otherwise noted
** 2010, unless otherwise noted
*** Nationally, voter turnout reached a 40-year high in 2008.

Source: 2016 Connecticut Civic Health Index.

Overall Root Causes of Health – Health and Health Care

Root Cause/Enabler	Statewide	Highest County	Lowest County
Population to Primary Care Physician Ratio (1)	1,180:1	1,980:1 (Windham)	1,060:1 (Hartford)
Population to Dentist Ratio (1)	1,180:1	2,110:1 (Windham)	960:1 (Hartford)
Population to Mental Health Provider Ratio (1)	290:1	480:1 (Tolland)	220:1 (Hartford)
% Uninsured	4.9%	Not available	Not available
% of Adults with At Least 1 Primary Care Provider (3)	85.2%	Not available	Not available
% of Adults That Needed to See A Doctor in the Past Year But Could Not Due to Cost (3)	10.9%	Not available	Not available
% of CT Residents Enrolled in a QHP Through Access Health CT That - Understood the Use of the Insurance Word "Premium" - Understood the Word "Formulary" (4)	- 80% - 34%	Not available	Not available

Source: (1) Robert Wood Johnson Foundation County Health Rankings, 2018; (2) US Census American Community Survey 1-Year Estimates, 2016; (3) BRFSS, 2015; (4) UConn Health, Health Insurance Literacy Survey Report, April 2017.

Overall Root Causes of Health – Neighborhood and Environment

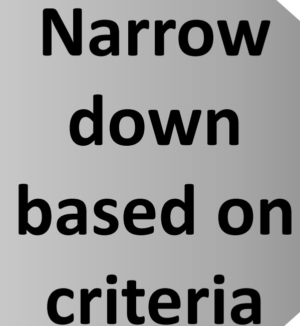
Root Cause/Enabler	Statewide	Highest County	Lowest County
HUD Public Housing Household Members (1)	22,819	Not available	Not available
% of Household With At Least 1 of 4 Housing Problems: Overcrowding, High Housing Costs, or Lack of Kitchen or Plumbing Facilities (2)	19%	22% (Fairfield)	12% (Tolland)
Average Daily Density of Fine Particulate Matter in Micrograms Per Cubic Meter (2)	8.2	9.5 (Fairfield)	7.3 (Litchfield)
Counties with Presence of Health-Related Drinking Water Violations (2)	All	N/A	N/A
Homicides Per 100,000 Population (2)	3	4 (Hartford and New Haven)	1 (Litchfield, Middlesex, Tolland, and Windham)
Firearm Fatalities Per 100,000 Population (2)	5	6 (Litchfield, New Haven, and Windham)	4 (Middlesex)

Source: (1) HUD Resident Characteristics Report, 12/1/16-3/31/18; (2)Robert Wood Johnson Foundation County Health Rankings, 2018.

Root Cause Mapping

- What are the root cause of adult diabetes?

Second Winnowing Process: To Select Health Condition Priorities



- Criteria for selecting:
  - Conditions for which there are statewide and community interventions that can address root causes
  - Conditions for which there are evidence-based interventions that have an ROI that accrues to the sustainable financing buckets
    - Medicare, other payers, healthcare sector, and other sectors
  - Conditions that have been successfully addressed in other similar place-based initiatives
    - And have gotten sustainable financing

Selecting Interventions

- To be selected based on process just outlined, which will include:
  - ROI research
  - Iterative processes with the PHC, Reference Communities, Stakeholders, the State, and CMMI
- Will develop a financial model for those interventions that will be used to support the sustainable financing models

Example of Similar Initiative

Minnesota and Community Development Financing Institutions

- Multiple examples in Minnesota with CDFIs working with health organizations
  - https://www.minneapolisfed.org/publications/community-dividend/cdfis-emerge-as-key-partners-in-improving-community-health
- Examples: Grocery Access Task Force – Health Food Financing Initiative; Healthy Futures Fund (housing)
- Financing model: CDFIs play a critical role in addressing the social determinants of public health—which include education levels, income levels, and the characteristics of the neighborhoods in which we live, work, and play—by financing the development of infrastructure that makes good health possible. Affordable housing, community health facilities, and healthy food retail stores are some examples of health-related infrastructure improvements that CDFIs finance.
- Investors include: Major payors, banks, etc.

Next Steps

- HMA completes initial root cause mapping to initial conditions for vetting
- Complete environmental scan
- Research interventions with demonstrated return on investment (ROI)

Reference Communities

Reference Community Engagement Process

- 4 Multi-Sector Reference Communities selected
  - Contracting underway!
- Reference Communities will be asked provide recommendations and community-specific solutions to support development of an actionable HEC strategy

The Goals of Engagement are to:

- Give the Reference Communities a voice in the design of the HECs
- Get recommendations that are reality-based and actionable in communities
- Make the process as meaningful and painless as possible

Reference Community Engagement Process

- HMA will work hand-in-hand with Reference Communities to develop recommendations

1. Initial information meeting to discuss process
2. 3 initial webinars to provide detail on:
   - Draft menu of interventions and measures
   - Examples of HEC-like initiatives
   - Sustainability and social finance

   PHC Members are welcome/encouraged to join the webinars!
3. Pre-work with easy-to-use templates and tools
4. Coaching calls

Reference Community Engagement Process

5. Deep dive session
   - 1.5 days work sessions to work through key topics and recommendations
   - Facilitated by HMA
6. IT and workforce assessment
7. 3 planning webinars on:
   - Governance and partnerships
   - Sustainability activities and funds flow
   - Accountability and tracking

   PHC Members are welcome/encouraged to join the webinars!
8. Coaching calls, including with Subject Matter Experts

Reference Community Engagement Process

9. Half-day planning session
   - Facilitated by HMA
10. PHC – Reference Community Meeting
    - Discuss planning and recommendations
11. Reference Community reports
    - Final deliverable
    - HMA will provide easy-to-use templates and review
    - Coaching call/webinar to be added if needed

Reference Community Engagement Timeline

Item	Target Dates
Informational Meetings	Week of April 30 – Week of May 7
Pre-work Webinars	Week of May 14 – Week of 22
Coaching Calls	Week of May 14 – Week of May 22
Deep Dives	Week of May 28 – Week of June 4
IT and Workforce Assessments	June 20
Planning Webinars	Week of June 11 - Week of June 18
Coaching Calls	Week of June 18
Planning sessions	Week of June 25
PHC – RC Meeting	July/August Meeting
RC Report – Phase 1	July 15
RC Report – Phase 2	August 31
RC Report - Final	November 30

Reference Community Source for Prioritizing Interventions and Understanding of Root Causes

	RC1	RC2	RC3	RC4
Method of identifying Interventions	Community Health Needs Assessment	CHIP and CHA	CHA and CHIP	Community Health Needs Assessment.
Understanding of Root Causes	Working cities – poverty as a social determinant	CHA incorporates the social determinants of health and the CHIP includes strategies to address the root causes of poor health.	CHA is a comprehensive discussion social determinants of health and disparities	Employment and reducing poverty among young adults key goals.
Finance Model	Foundation, hospital health center, united way public health	Hospital and health district as primary	Health department, hospital and philanthropy	United Way, Not for Profits, Foundation

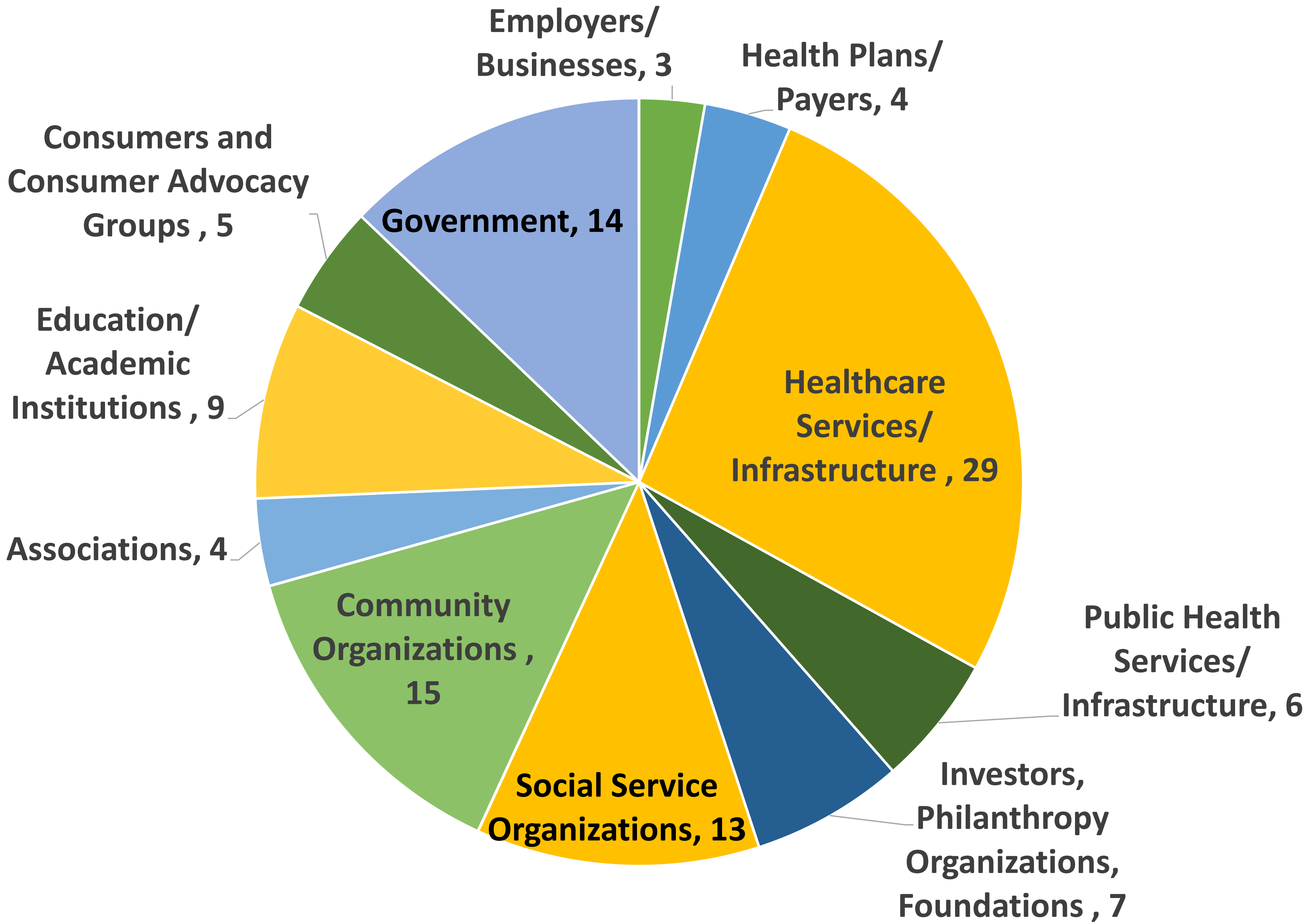
Stakeholder Engagement and Communication Plan

Sectors That Will Be Engaged

- Employers and businesses
- Health plans/payers/insurers
- Healthcare services/infrastructure
- Public health services/infrastructure
- Investors, philanthropy organizations, foundations
- Social service organizations
- Community organizations
- Associations
- Education/academic institutions
- Consumers and consumer advocacy groups
- Government
- Existing stakeholder groups and workgroups

There are currently 170+ individuals/entities on the list of stakeholders we expect to engage in the process in some way, spanning across all these sectors.

Reference Communities: Approx. # of Entities that will be Engaged, by Sector



Methods of Engagement

- Multi-sector engagement via **Reference Communities**, the **Population Health Council**, and the **Healthcare Innovation Steering Committee**
- Presentation and discussion at existing **workgroup and committee meetings** (e.g., Consumer Advisory Board)
- **Interviews**
- **Forums** targeting specific groups
- **Economic Value Modeling** with 2-3 employers
- Materials to be posted online for **public review and comment**
- Review of **existing relevant stakeholder reports and recommendations** from previous planning processes

Goals of Engagement include:

- Give the broader community a voice in the design of HECs
- Understand root causes, existing assets
- Obtain community buy-in and support
- Identify resources to support the implementation and sustainability of HECs
- Identify the roles of key sectors in the HECs
- Confirm or modify underlying assumptions

Health Enhancement Community Plan

Sections, Chapter Headings and Key Questions

I. Executive Summary
II. Reference Community Illustration
III. What is a Health Enhancement Community?
IV. Learning from Reference Communities
V. Financing
VI. State Accountability
VII. Summary of Recommendations and Next Steps
VIII. Appendices

Discussion and Closing Comments

APPENDIX

The Massachusetts Prevention and Wellness Trust

- MASSACHUSETTS PUBLIC HEALTH ASSOCIATION with many partners and collaborators
- MASSCHUSETTS with focus on health disparities and mental health co-occurring conditions in prioritized areas
- Economic modeling by Urban Institute: An investment of $10 per person would yield significant savings.
- Financing model: $60 million for four-years; 75% for local community-wide comprehensive initiatives; 10% on workplace wellness; and 15% on infrastructure. Funded by an assessment on insurers and well-resourced hospitals.
- Legislature Passes bill in 2012; DPH released RFPs in 2013.
  - http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness-fund/

Focus Areas

PRIORITIES:
- Tobacco use
- Childhood asthma
- Hypertension
- Elder falls prevention

OPTIONAL:
- Obesity
- Diabetes
- Oral Health
- Substance Abuse

In addition, the Trust calls for attention to the reduction of health disparities and the consideration of mental health co-occurring conditions in the prioritized areas.

Sustainable Funding Model for Prevention

- CALIFORNIA ALLIANCE FOR FUNDING PREVENTION *"Making Prevention Possible"*
  - http://www.phi.org/resources/?resource=concept-paper-the-california-alliance-for-funding-prevention
- CALIFORNIA –in all counties but primarily focused on disadvantaged communities
- Stated ROI from The Trust for America's Health: "The Trust for America's Health found that an investment of $10 per person per year in proven community-based disease prevention programs could yield nearly $1 over and above the cost of the program for the first one-to-two years of these programs, a return on investment (ROI) of 0.96., rising to $5.6 within 5 years and $6.2 for every $1 invested within 10 to 20 years. This return on investment represents medical cost savings only and does not include the significant gains that could be achieved in worker productivity, reduced absenteeism at work and
- Financing model: Innovative investment strategies, equitable distribution, and a wellness fund.
- CONVENED IN MAY 2015

Strategic investment, in upstream prevention will protect, not deplete, the coffers of government.