Health Enhancement Community Initiative: Preview – Refined Straw Model

Population Health Council

September 27, 2018 – DRAFT FOR DISTRIBUTION

Agenda

1. Meeting Objectives	5 minutes
2. Timeline	5 minutes
3. Brief Reference Community Presentations	20 minutes
4. Stakeholder Engagement	10 minutes
5. Health Priorities	20 minutes
6. Geography	5 minutes
7. Governance	15 minutes
8. Centralized Support	15 minutes
9. Financing	15 minutes
10. Next Steps and Q&A	10 minutes
	Current time allotment is 2 hrs.

Meeting Objectives

Purpose of today's meeting:

- Hear from Reference Communities about their design input
- Review new developments and changes based on input from the PHC design team meetings and other stakeholders
- Preview key concepts that will appear in the refined HEC strawperson model
- Obtain PHC input on key questions

Current Timeline

Step	Timeframe
PHC to receive draft HEC Report	On or about Monday October 22
PHC to participate in webinar reviewing HEC Report structure and feedback process	On or about Tuesday October 23 (to be scheduled)
PHC to provide feedback on report in PHC meeting and approval to distribute to HISC with agreed upon changes	Thursday November 1 (rescheduled from Oct 25)
HISC review and approval of report	November – December
Public Comment period	December – January
PHC to review public comment recommendations and changes to HEC Report	January – February
HISC review and approval of HEC Report	February

CT HEC Reference Communities

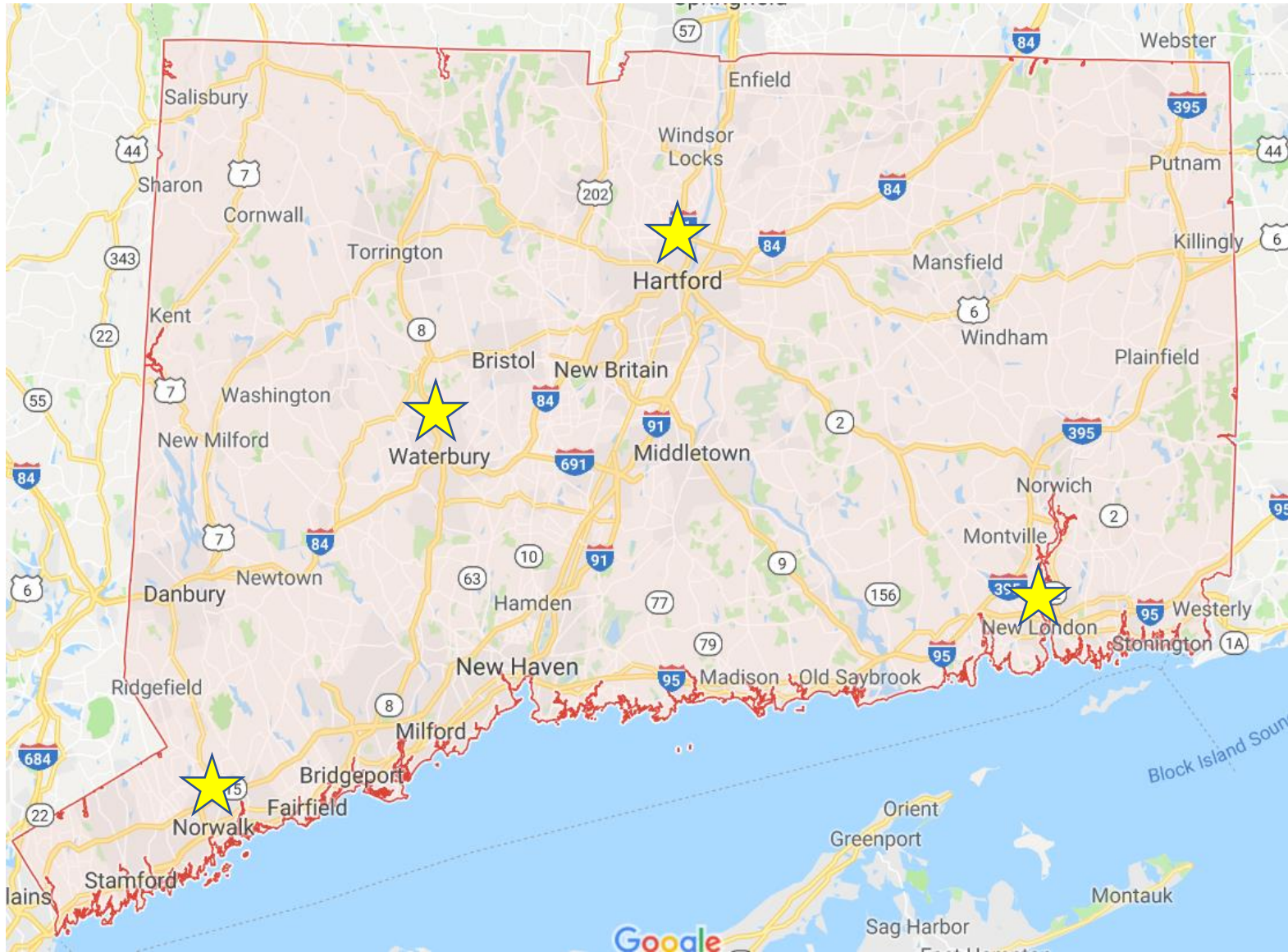
- Reference Communities were selected by the State through an RFP process to provide recommendations on HEC design and community-specific solutions to support development of an actionable HEC strategy

The Goals of the Process are to:

- Give the Reference Communities and their communities a voice in the design of the HECs
- Get recommendations that are reality-based and actionable in communities

Reference Communities

- 4 Reference Communities
  - Norwalk
  - Waterbury
  - Hartford
  - New London



Reference Communities

Placeholder - slides to be added

Stakeholder Engagement

Community Member Engagement: Design Principle

- Community members must be involved in all stages of HEC formation and operation.
  - HEC success depends on community members shaping what HECs are and do by sharing their perspectives about their lived experience within communities, including nuanced insights about needs and opportunities, informal and formal resources and networks that can support HEC activities and lasting change in their communities, and real-world experience with what has worked and not worked in the past. Involvement should include:
    - Direct involvement in designing how assets and needs are assessed; designing the HEC structure; designing the strategies for leveraging assets and addressing needs; and selecting, implementing, and evaluating interventions.
    - Involvement in HEC governance structures
    - Multiple mechanisms for community members to exercise their role on governance bodies, including options other than daytime meetings.
    - Support for community members to meaningfully engage in HECs, including through training and leadership development
    - Regular multi-directional communication strategies that will include community members as both recipients and deliverers of communications

Community Member Engagement

- Information from the **SIM Listening Sessions** and **State Health Improvement Plan** engagement influenced the selection of the priorities and other aspects of the model
- **Consumer Advisory Board** is providing input on the community engagement process so that:
  - The process meaningfully captures input of community members
  - The community member input helps shape the HEC design
  - Community members hear how their input shaped the design

Community Member Engagement

- **Reference Communities** are engaging consumers to provide input on HEC design in multiple ways
  - Hartford had 3 community members participate in the deep dives
    - Examples of how their input was used in the design:
      - A community member gave an example of a child who recently drowned to illustrate that you have to implement multiple related strategies, including addressing programs, policies, and cultural norms to prevent it from happening again
        - *This was one of the inspirations for the intervention framework.*
      - A community member said the state should define the regions or be part of it otherwise it will take too long for collaboratives to decide.
        - *This influenced the HEC and State process for defining geography.*
      - Two community members said that the HEC model should the adopt the community involvement philosophy of "nothing for us without us" and gave input on multiple ways to ensure that community involvement is meaningful (e.g., funds specifically for community engagement, requirement of having community members at every table, multiple roles to collect outreach information and bring that back/represent to group, capacity building for community leaders and members, alternative engagement times for those who work)
        - *This influenced the proposed community involvement and governance elements.*

Community Member Engagement

- **Reference Communities**
  - Hosting community conversations and mini-focus groups
  - Facilitating discussion sessions at existing community events

Community Member Engagement

- **Bridgeport and New Haven Community Collaboratives** also participated in webinars about the proposed HEC model and some participants will engage community members to get input on the model
  - For example, HMA will present on the proposed model at a Clifford Beers Clinic family meeting and the chair will facilitate a discussion to get the input of the families
- A **Rural Forum** will be hosted by OHS, DPH, and local health departments in a rural area to get input on how the proposed design should reflect the realities of rural communities.

Planned and Ongoing Stakeholder Engagement

Planned and ongoing stakeholder engagement includes:

- **State agencies** – Forum/webinar and individual meetings with key agencies
- **Local health departments** – Webinar held on 9/18
- Other key groups such as the **Healthcare Cabinet, CT-AAP Executive Committee, Behavioral Health Partnership Oversight Council, Medical Assistance Program Oversight Council, PCMH+ provider entities**
- **Foundations and funders**
- **CHCACT and CHC, Inc.**
- *We estimate more than 180 individuals/entities have been reached through HEC stakeholder engagement and Reference Community efforts so far.*

Health Enhancement Community Initiative

Proposed Features

- HECs will be new, multi-sector collaboratives operating in defined geographic areas that will be accountable for achieving prevention, health risk, and health equity improvements, and cost reductions for select health priorities
- HECs will implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs.
- HECs will operate in an economic environment that is sustainable, including rewarding communities for prevention, health improvement, and the economic value they produce.

Health Priorities

Primary Priorities Across HECs

Improve Child Well-Being

Increase Healthy Weight and Physical Fitness

Improve Health Equity

HECs may also select additional priorities but the intent is to have a statewide focus.

HEC Proposed Prevention Priorities

HEC Child Well-Being Goal: Assuring safe, stable, nurturing relationships and environments*

HECs would implement interventions to prevent Adverse Childhood Experiences (ACEs) and increase protective factors that build resilience among children 0-5 years old. Interventions would target:

- Physical, sexual, and emotional abuse
- 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
- Domestic violence towards a parent
- Incarceration of a household member

HECs may also implement interventions that address other types of trauma or distress such as food insecurity, housing instability, or poor housing quality.

HEC interventions may focus on families, children, parents, and expectant parents.

** Source: CDC Essentials for Childhood*

Child Well-Being Age Range: 0-5 or 0–17?

	0-5 years old	0-17 years old
Pros	• Better to focus if limited resources • Treatment gap for younger children and early investment pays off many times over in future cost savings, according to CDHI, organization within CT focused on 0-6	• Incidence of child maltreatment is higher in adolescents than in young children • More data in order to stratify in each HEC • Adheres to many ACE studies (<18) • Addresses building resilience and not just prevention • More intervention options
Cons	• Stratifying data will be difficult based on lower numbers • Harder to reach population – HECs will need good connections with child-serving systems • Fewer interventions for kids under 6.	• Not enough focus

HEC Proposed Prevention Priorities

HEC Healthy Weight and Physical Fitness Goal: Assuring individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so.

Healthy weight and physical activity are defined as:*

- *Healthy Weight:* Maintaining a healthy body weight (based on CDC BMI guidelines**)
- *Physical Activity:* At least 150 to 300 minutes of moderate-intensity activity per week to prevent weight gain.

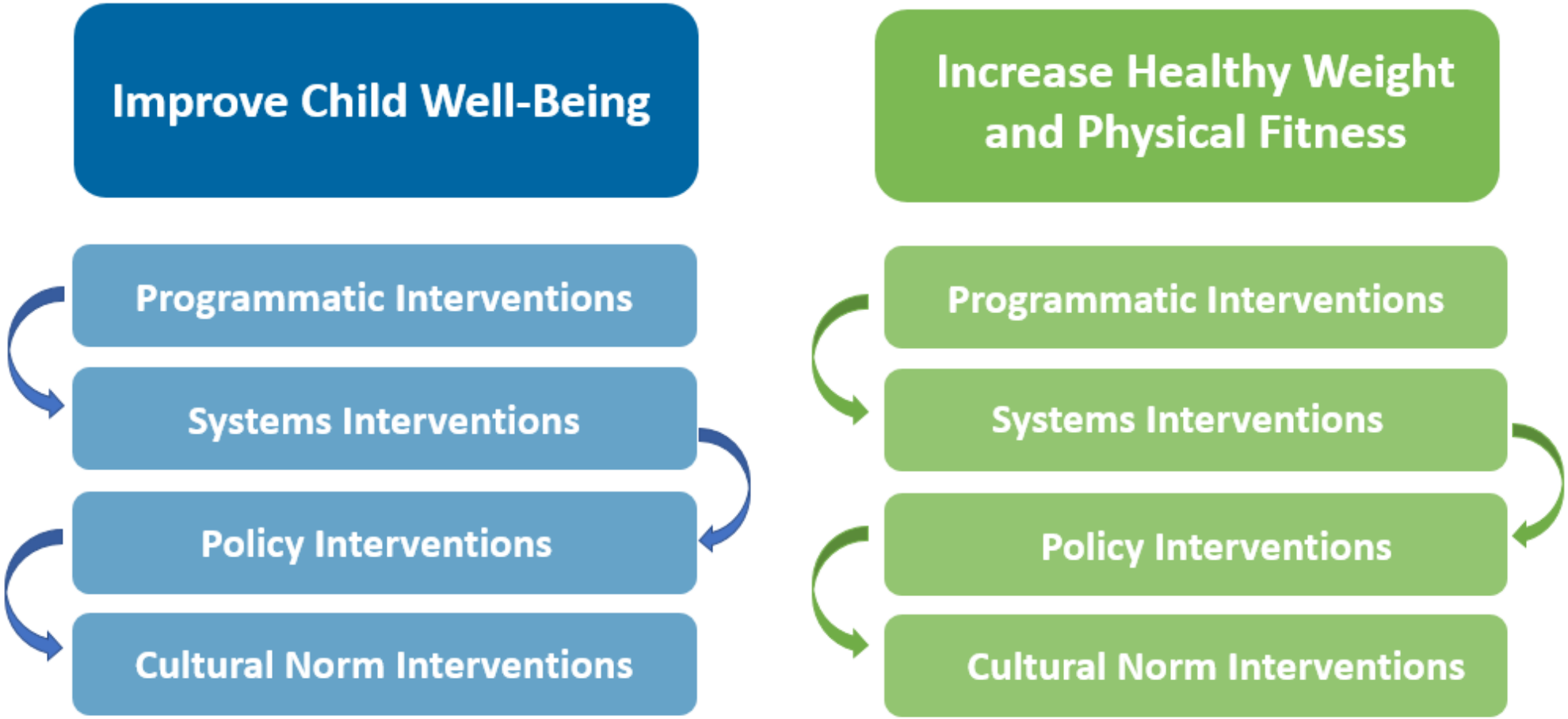
HECs would implement interventions to prevent overweight and obesity across the lifespan and the associated risks of developing serious health conditions. Interventions would target:

- Access to and consumption of healthy foods and beverages
- Access to safe physical activity space
- Reducing deterrents to healthy behaviors

** CDC*

**** https://www.cdc.gov/obesity/adult/defining.html; https://www.cdc.gov/obesity/childhood/defining.html

HEC Proposed Intervention Framework



Geography

HEC Geographies: Proposed Elements and Process

- HECs will have defined geographies for which they are accountable.
- State hopes to provisionally have 8-12 HECs and wants every geography in Connecticut included in an HEC.
- HEC geographies will be defined during an iterative State process.
  - The process will start by prospective HECs proposing geographies based on criteria defined by the State and providing rationale for their proposed geography.

HEC Geographies: Proposed Minimum Criteria

- HEC boundaries will not overlap.
- Each HEC will need to demonstrate that their proposed geography meets both of the following minimum population thresholds:
  - 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, and are functional from a governing perspective.

Governance

HEC Governance

- HECs will need to have a formal governance structure with clearly defined decision-making roles, authorities, and processes.
- The governance structures will 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.
- There will need to be a balance between "focus and flexibility" so that HECs can quickly progress from making governance structure decisions to identifying and implementing strategies.

HEC Proposed Governance Framework

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 form a new legal entity. • HECs will need to include community members in their governance structure, including in decision-making governance bodies, and community organizations that directly address root causes of poor health in their communities.
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 contents of their bylaws.

HEC Proposed Governance Framework

Governance Structure Element	FOCUS Required by State	FLEXIBILITY Determined by HECs
Backbone organization	• HECs will need to have a defined backbone organization(s) that can perform or contract for the key functions required to operate an HEC.	• HECs will determine which organization(s) will be the backbone organization(s) and the structure and scope of their responsibilities.
Formal contracts for services	• HECs will have 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).

Centralized Support

Centralized Support

- The State recognizes the need to play a critical role in assuring the support (directly or through another method) that HECs and the HEC Initiative will need to succeed, including:
  - Pursuing financing, including Medicare, Medicaid, and other payers
    - Possibly facilitate access to one or more fiduciaries to support financial management for HECs
  - Pursuing legislative and regulatory changes that will support HECs and enable the HEC Initiative
  - Providing mechanisms for easing data exchange, collection, and reporting
  - Providing a centralized resource for technical assistance, training, tools, templates, a learning community, and other types of support as HECs plan, form, implement interventions, measure and report outcomes, and receive financing

Statewide HEC Committee

- Proposed design includes establishing a statewide committee that will guide the implementation and performance of the HEC Initiative, including:
  - Progress of implementation
  - Securing funding and financing
  - Strategies and improvements for healthy equity, prevention benchmarks, and reducing costs
  - Critical state and local policies
- Will comprise representatives from each HEC, community members, and other key stakeholders
  - Member categories and process for selection not yet determined
- Committee precise scope and roles have to be further considered and decided

Financing

Medicare Impact Model

- The HEC Medicare Impact Model is quantifying the potential short-term and long-term savings impact of the HECs on Medicare with consideration for how to modify the analysis for other payers.
- Using publicly available Medicare data, the Medicare Impact Model examines per capita costs for the Medicare population with and without HEC interventions.
- Primary analysis suggests that reducing the prevalence of obesity among the Medicare population (age 65+) by approximately 5 percentage points over a 10-year period (2021 – 2030) could yield cumulative health care cost savings of $1 billion or more.

HEC Funding Figure

- **Question: should we include a target figure for *net new investment* for HECs? Example: $30 million in net new investment annually**
- Is this helpful? Inspirational? Believable? Considerations:
  - Would need to make it clear that this not from the General Fund
  - *From Nonprofit Finance Fund:*
    - If it includes existing resources, it is an easier number to get to but would need more in-depth knowledge regarding funding availability/options at the local HEC level
    - If it is net new funds, it's a more challenging amount
  - Would need to distinguish between funding phases and when this figure changes or transitions to other types of financing
- What advantages or disadvantages do you see with including a figure vs. not?
- What does the PHC recommend?

Next Steps and Q&A