Population Health Council
Health Enhancement Community (HEC) Report - 10/22/18 Draft
Summary of Comments Received

For 11/1/18 Population Health Council Meeting

Responses to each report comment that HMA received from the Population Health Council (PHC) are provided below. This summary is being provided as a supplemental reference document for the 11/1/18 PHC meeting, but we do not plan to discuss each comment during the meeting.

For reference, text highlighted green below indicates this issue/comment is in the meeting slides for discussion.

This document is organized by:

1. Responses to Comments and Questions
2. Comments Proposing to Adopt Without Further Discussion
3. Other/No Action Needed

1. Responses to Comments and Questions

#	From	Section #	Page #	Comment	Response
1	Rick Brush (Wellville)	1	13	Re: the State Partnership, it would valuable to also pursue cross-budget opportunities. For example, a savings to one budget (e.g., special education costs) might require more investment from a different budget (e.g., home visiting for prenatal/early childhood). Another way to do this might be to allocate general budget dollars to pay for outcomes that have multiple benefits across budgets. Are there examples of this happening in CT today? If not, what would that require?	To be considered/decided as part of next phase of design (after report).
2	Rick Brush (Wellville)	1	13	Re: HEC Financing, see above – in addition to HC payers, there are likely significant opportunities for HECs to impact the state's multiple budgets, via "savings" and "revenue." The state could be a major "purchaser" of improved outcomes, with greater opportunities if cross-budget impacts are considered. Is this anticipated in the HEC initiative?	Yes, this is anticipated in the HEC Initiative. Section 7.2.2.1 states, "Beyond the health care sector, other purchasers of services could value HEC prevention efforts and consider options to align ongoing resources or develop outcomes-based strategies. These may include state and local government agencies that focus in whole or in part

#	From	Section #	Page #	Comment	Response
					on child well-being and healthy weight/physical fitness and/or who participate in the State Partnership."
3	Rick Brush (Wellville)	3.3.2+	37-38	Re: Defining HEC Geographies, did you consider Hartford's suggestion that an alternative to grouping contiguous communities (e.g., city + suburbs), another approach would be to group urban communities (or rural communities) that have similar demographics even if they are not contiguous? Maybe that's example 3 on page 38.	The report does not prohibit non-contiguous geographies. HEC geographies will be defined during an iterative State procurement process.
4	Rick Brush (Wellville)	3.3.4.5	43	Re: "The Population Health Council proposes that the State Partnership provide a menu of interventions…" – in Hartford, we've had questions about how and when this menu will be put together. Any specifics to share?	Additional specifics will be provided.
5	10/29 PHC Webinar	4		Measures: • Add policy and systems measures. (Martha Page, Pat Baker) • Add hunger as an indicator (Pat Baker)	To be considered/decided as part of next phase of design (after report). Measures discussion part of 11/1 PHC meeting slides.
6	Lisa Honigfeld (CHDI)	4.3.3	60	Consider policy measures: inclusion of nutrition requirements in early care and education sites with verification through state licensing system; inclusion of socio-emotional learning in home visiting requirements	Will add language to clarify/strengthen requirements around systems/policy intervention measures. To be considered/decided further as part of next phase of design (after report). Measures discussion part of 11/1 PHC meeting slides.
7	Alice Forrester (Clifford Beers)	4		Will there be a "community report card for child wellbeing?" I understand that the overall HEC data points have to be universally collectable, but I worry if we leave the more drilled down data to the HEC communities, and not "require" certain holistic perspectives, we will not get at the underlying issues related to protective factors related to amelioration of ACES and child well-being. For example, social connectedness, Resilience, Concrete support in time of need, Knowledge of parent and child development, Social and emotional competency of children. There has been a lot of work in the National Child Traumatic Stress network (NCTSN) to develop resilience screeners for pediatric offices to begin to collect some of this data….	Will add as an example intervention. To be considered/decided further as part of next phase of design (after report).

#	From	Section #	Page #	Comment	Response
8	Alice Forrester (Clifford Beers)	4		Whether the primary composite scores or the secondary scores, I think holistic thinking is critical. It must include looking at health and social influences, Safety and crime, economic well-being, education and workforce readiness and social and emotional well-being. (how do we track social and emotional well-being may be cumbersome, but DPH does surveys- perhaps we can require surveys every 2 years)	To be considered/decided as part of next phase of design (after report). Measures discussion part of 11/1 PHC meeting slides.
9	Alice Forrester (Clifford Beers)	4		*A.* ***Substantiated child abuse/neglect cases…I suppose this is ok, but racial disparity is a grave concern with this data.*** What about using the PRAMS for secondary measures? DPH collects it and although there are some issues related to maternal self-reporting, perhaps we know enough of the PRAMS to determine which data points might be very helpful? https://portal.ct.gov/DPH/Family-Health/Pregnancy-Risk-Assessment-Monitor-System/Connecticut-Pregnancy-Risk-Assessment-Monitoring-System-PRAMS	Will add clarifying language to note risk of bias in child abuse/neglect data. PRAMS data does not meet needs for benchmark data. Measures discussion part of 11/1 PHC meeting slides.
10	Alice Forrester (Clifford Beers)	4		*B.* ***Chronic Absenteeism (CA)*** I wonder if we might be able to take advantage of the CT DOE's Connecticut's Next Generation Accountability System. I have some worries about just collecting Chronic Absenteeism. Although research shows the direct correlation of chronic absenteeism and high school graduation, which is of course, is a good indicator of well-being, I am uncomfortable that we might have unintentional consequences with this data. First off in CT chronic absenteeism includes all absences, excused, unexcused and **disciplinary absences** (excluding ½ suspension). From a recent webinar presented by CT DOE about tracking chronic absenteeism, 1 out of 10 kids in CT have chronic absence. There are high rates of CA in urban schools and black and brown kids are 2 x's higher in their chronic absenteeism rates than others. Kids with learning disabilities are also higher in chronic absenteeism. Many social determinants which may indicate adversity are indicated as barriers to school attendance such as transportation, family stress and school avoidance. We have a high rate of bias and racism in school disciplinary practices as reported by CT Voices. For example, Latino students are 25% more likely to be expelled from school than their other racial counterparts. Because disciplinary and LD are included in CA data, I wonder if we could use some other points collected from the Next Generation system?	Reviewed and recognize some measures have bias. Is there a way to control for bias? Can't solve in this paper but will mention. To be considered/decided further as part of next phase of design (after report). Measures discussion part of 11/1 PHC meeting slides.

#	From	Section #	Page #	Comment	Response
				The "Connecticut's Next Generation Accountability System" is pretty interesting, and easier to use. You can pull data from state, districts and individual schools. And HES's as well as the State can use the data. http://edsight.ct.gov/relatedreports/using_accountability_results_to_guide_improvement.pdf (from DOE): It is a broad set of 12 indicators that help tell the story of how well a school is preparing its students for success in college, careers and life. The system moves beyond test scores and graduation rates and instead provides a more holistic, multifactor perspective of district and school performance and incorporates student growth over time. It was developed through extensive consultation with district and school leaders, Connecticut educators, state and national experts, CSDE staff, and many others. The system was conceived and developed under ESEA Flexibility and approved by the U.S. Department of Education (USED) on August 6, 2015. It was later included as part of Connecticut's state plan under the Every Student Succeeds Act (ESSA). So for each school it tracks: • Academic achievement (Performance Index) • H 2. Academic growth • H 3. Assessment participation rate • H 4. Chronic absenteeism • H 5. Preparation for postsecondary and career readiness – coursework • 6. Preparation for postsecondary and career readiness – exams • 7. Graduation – on track in ninth grade • 8. Graduation – four-year adjusted cohort • 9. Graduation – six-year adjusted cohort • H 10. Postsecondary Entrance Rate • 11. Physical fitness • 12. Arts access As you can see it has a broader holistic presentation of the school's ability to determine success for students. I would respectfully suggest looking at this system instead of just absenteeism. Perhaps it is not that useful for the age range you are looking at (I believe birth to 8?) but perhaps you can get just K-3 scores from DOE? That might not be possible, but…	

#	From	Section #	Page #	Comment	Response
11	Alice Forrester (Clifford Beers)	4		**Some other secondary data points about pre and post pregnancy are:** Insurance before getting pregnant, prenatal care paid by Medicaid, enrolled in WIC during pregnancy, child birth enrollment, parenting classes, smoking cessation, home visits by healthcare worker, food stamps, TANF	To be considered/decided as part of next phase of design (after report). Not all are adopted based on criteria, reliable data, regularly updated, and no perverse incentive. Measures discussion part of 11/1 PHC meeting slides.
12	Alice Forrester (Clifford Beers)	4		*C. Performance level on all six domains of the Kindergarten Entrance Inventory (includes: literacy skills, numeracy skills, physical/motor skills, creative/aesthetic skills, and personal/social skills Inventory results will be aggregated to the district and state level, grouping students into three performance levels by domain.* **I support this measure…buy see below for an argument for more holistic secondary measures and or measures from the HEC communities:** Reference: Child Trends, 2010 https://www.childtrends.org/wp-content/uploads/2010/12/2010-18Measurement.pdf (From Child Trends) **School Readiness Depends on Supportive Families, Schools, and Communities.** In addition to the developmental features of children's readiness that have been highlighted in this brief, school readiness goes beyond a measurement of children's competencies at any particular point in time. There are other key factors that contribute to children's readiness for school, such as the family context, the context and quality of their child care arrangements prior to school entry, and the resources available within the community to support at-risk children and families such as health, mental health, family support, and nutrition services. In addition to considering the academic and developmental supports children need to be prepared for success in school, states should also consider what supports are needed to have "ready schools" and "ready communities." Ready schools foster communication and continuity between early care and school settings and support successful transitions from preschool to kindergarten. Ready communities provide high-quality comprehensive programs and services to support at-risk families with young children and work with state leadership to communicate the needs of their community's young children.	Confirmed use of K Entrance Inventory. Additional feedback to be considered/decided as part of next phase of design (after report). Measures discussion part of 11/1 PHC meeting slides.

#	From	Section #	Page #	Comment	Response
13	Lisa Honigfeld (CHDI)	4.2.1	57	Regarding the secondary measure: I think you really percent of students identified during kindergarten and first grade as need special education services, but not receiving early intervention services before arriving at school for kindergarten. Suggest % of children arriving at kindergarten without having attended preschool. The evidence is pretty clear that quality preschool pays off by a magnitude of 7, per James Heckman.	To be considered/decided as part of next phase of design (after report). Potential future secondary measures pending identification/development of data source. In 11/1 PHC meeting slides.
14	Rick Brush (Wellville)	4.5-4.6	61-63	So, is the evaluation essentially pre-post, with some adjustments?	To be considered/decided as part of next phase of design (after report).
15	10/29 PHC Webinar	5, Appendix 2		Community involvement: Need to ensure that community engagement on design includes diverse voices. (Pat Baker)	Discuss during 11/1 PHC meeting. Adding this detail to the Reference Community information and in appendix.
16	10/29 PHC Webinar			Community organizing groups: Clarify what the locally owned and directed community organizing groups: What does that mean? What does that look like? How do you hold HECs accountable in this regard? Clarify how that works with the 2 primary health focus areas. (Pat Baker, Martha Page)	Discuss during 11/1 PHC meeting. Will clarify in sections that discuss community organizing groups.
17	Alice Forrester (Clifford Beers)	6		My first question may have been answered in other webinars: is SIM creating a data system to collect the children's wellbeing data and will it be able to manage data cross department lines**? More importantly, will this system be able to be adapted for use within the HEC communities?** I also think that the HEC data needs to be able to actually look at more precise neighborhoods within the HEC; perhaps using census track data. I am sure you have seen this reference (2004, but useful): Tracking Children's Health: https://www.ncbi.nlm.nih.gov/books/NBK92196/	Yes, the Core Data Analytics Solution (CDAS) will support HEC management and reporting of child wellbeing data. (Described in report Section 6.1).
18	Rick Brush (Wellville)	6.2.1	74	Include a more specific/detailed description of the financial/fiduciary role (e.g., managing financial flows among investors/payers and providers, including contracts). The brief mention of "accounting of funds" does not seem to cover it all.	To be considered/decided as part of next phase of design (after report).
19	Rick Brush (Wellville)	6.3.3.4 & 6.3.3.5	80-82	Re: State Agencies… It's important that HECs have a comprehensive inventory of all of these state agencies' activities and budgets in their respective geographic territory. This could facilitate better coordination, important partnerships and opportunities to reduce total spend while delivering better total outcomes. Ideally, each HEC would know the total HC + SS spend, and work to improve impact per dollar spent/invested. See note above about cross-agency budget and/or general budget opportunities. Sounds like the Multi-System Trauma Informed Collaborative (MSTIC), Bridgeport	To be considered/decided as part of next phase of design (after report).

#	From	Section #	Page #	Comment	Response
				Baby Bundle program, and the early childhood trauma collaborative might be examples of this.	
20	Rick Brush (Wellville)	6.4.1 & 6.3.4.2.	86-87	Re: "The design of the HEC payment model must align with, but not duplicate, the savings strategies that are already in place in Connecticut." -- Can you provide some examples of how this alignment will happen (e.g., HECs that have PCMH+, ACOs, VBID, etc.)? How will funds flow? How to distinguish (or integrate?) existing and new savings strategies that involve the same entities…without double counting?	To be considered/decided as part of next phase of design (after report).
21	Rick Brush (Wellville)	7.2.2.2	110	Isn't the 10-year time period also problematic for payers who see high switching rate (e.g., every 2 years) among enrollees?	To address issues of population churn, the snapshot attribution approach described in Section 7.2.2.3 envisions pre- and post-measurement with adjustments for various factors beyond HEC control. That said, purchasers will want to see results and prevention-oriented outcomes that are specific to their beneficiaries/ members. Therefore, separate attribution criteria will likely need to be developed for each purchaser engaged in a shared savings arrangement.
22	Rick Brush (Wellville)	7.2.2.2 -7.2.2.3	110-112	Re: Performance Period and Attribution – It would be helpful to know the process by which these challenges will be resolved.	To be considered/decided as part of next phase of design (after report).
23	Lisa Honigfeld (CHDI)	8.4.1.1	132	Interested in Maryland model as a way to engage hospitals in HEC work. Where can I get more information to share with state's two children's hospitals?	More information is available here: https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
24	Rick Brush (Wellville)	9	134-138	Will HECs selected in Phase 2 receive financial support from SIM/the state (e.g., for ramp-up, capacity building), in addition to the T.A. they will receive? And/or are they expected to fund this locally (e.g., through the strategies noted in section 7)? Or,	To be considered/decided as part of next phase of design (after report).

#	From	Section #	Page #	Comment	Response
				potentially, through a multi-payer model agreement with CMS? … This will certainly be a question, so it would be good to address this in the draft, even if it needs to be at a high level. Some framing of the anticipated amounts available/required and uses of funds during various phases would be helpful.	

2. Comments Proposing to Adopt Without Further Discussion

Will be adopted as described in the "Response" column.

#	From	Section #	Page #	Comment	Response
25	10/29 PHC Webinar	1		Executive Summary • Page 5 – With the collaborative examples, add patients, families, and the requirement that must represent the populations of the geographic area. Requirement around representation of diversity in the community. (Pat Baker) • Add a goal for health equity. Add explicit language – while in the top 10, we are lagging for populations of color. Give some data. (Pat Baker) • Say that disparities start early and they carry throughout the lifetime. Contributes to why these prioritized areas are important. • Add something about opportunity to braid funding high up, need to feature prominently. (Pat Baker)	Will add language to Executive Summary and in environmental scan/need section. Health equity is in 11/1 PHC meeting slides.
26	Rick Brush (Wellville)	1	5	"Improving the [health, well-being and health equity] of [all] residents in Connecticut…"	Will incorporate change. Health equity is in 11/1 PHC meeting slides.
27	Rick Brush (Wellville)	1	5	"The design emphasizes:" … Could also emphasize here: • Eliminating health inequities • Addressing root causes of health and well-being	Will incorporate change.
28	Rick Brush (Wellville)	1/all	all	General comment: throughout the document, there is a focus on prevention (avoiding illness) vs. producing health and well-being. This framing is familiar to HC providers and payers, which is an important stakeholder group. However, this framing also risks a narrowly defined set of interventions, providers, outcomes, value, etc. Preventing disease or adverse experiences is not the same as building resilience, strong social connections, sense of control and purpose, hope and happiness. There's evidence that these latter goals can have a more profound, lasting impact on outcomes that matter to financial stakeholders, residents, communities, and the state. While a focus on	Will include a definition and language on community health. Community health is in 11/1 PHC meeting slides.

#	From	Section #	Page #	Comment	Response
				prevention will help to achieve improvements/savings over 5-10 years, it might not be sufficient change the long-term trajectory.	
29	Rick Brush (Wellville)	1	7	In the section re: CT's standing among states, you cover health outcomes and costs. Seems important to include health equity gaps here as well (ie, the significant difference between sub-populations living in the same state).	Will add more language on health disparities. Health equity is in 11/1 PHC meeting slides.
30	Rick Brush (Wellville)	1	7	"However, ~~the~~ a goal of the HEC Initiative is to further reduce Connecticut's overall trajectory of per person health care spending…"	Adopting.
31	Rick Brush (Wellville)	1	8	I think I have commented on this previously (but sorry if this is late in the game): Why do we call out physical activity and not call out nutrition (which is probably the bigger influence of healthy weight and other outcomes)? – *"**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 equal opportunities to do so"*	Emphasize nutrition as part of the healthy weight/physical fitness goal.
32	Rick Brush (Wellville)	1	8	Comment re: this sentence: "These aims can be achieved by reducing the prevalence of adverse childhood experiences and the prevalence of overweight and obesity as well as associated serious health conditions and consequences for both." -- Again, prevention alone won't necessarily achieve the two health priority aims…e.g., child well-being is not produced only by an absence of ACEs and overweight and obesity.	Will include a definition and language on community health. Community health is in 11/1 PHC meeting slides.
33	Rick Brush (Wellville)	1	8	"improving health equity will be a central feature" (is this a feature or outcome?)	Adopting.
34	Rick Brush (Wellville)	1	12	"The HEC workforce strategy will ~~including~~ include aligning current resources…"	Adopting.

35	PHC Measures Design Team Webinar (10/25)	4		Measures that are in the draft report were reviewed with the PHC Measures Design Team on Thursday, October 25. Outcomes/revisions they proposed:
				• Possibly add child wellbeing measures on protective factors
				  ○ PHC Design Group Members are researching possible measures;
				  ○ Will add to secondary measures if measures are reliable, updated regularly, and do not create perverse incentives.
				• Ensure HECs are focused upstream at root causes even though measures are further downstream (e.g., prevalence of diabetes)
				• Ensure HECs are accountable for environmental changes to improve built environments to improve walkability, etc.
					Adopting. Will add clarifying language to better emphasize provisional nature of list. Will also add clarifying language to emphasize the HEC-level measures, process for choosing those, and accountability.
					Measures discussion part of 11/1 PHC meeting slides.

#	From	Section #	Page #	Comment	Response
36	Alice Forrester (Clifford Beers)	4		I would also suggest tracking # of infants removed from their birth mothers at birth.	Adopting. In 11/1 PHC meeting slides.
37	Lisa Honigfeld (CHDI)	4.2.1	56	More accurate measure is "children who moved school more than once in the past two years"	Adopting. In 11/1 PHC meeting slides.
38	Lisa Honigfeld (CHDI)	4.2.1	56	Surprised that no asthma measure got in here; ER use for asthma, absenteeism for asthma, it is a good healthy housing measure	Adopting. In 11/1 PHC meeting slides.
39	Lisa Honigfeld (CHDI)	4.2.1	57	Suggest there is a breastfeeding measure	Adopting. In 11/1 PHC meeting slides.
40	Lloyd Mueller (DPH)	4		Lloyd Mueller's, Epidemiologist 4 Health Statistics and Surveillance Section Comments regarding on the HEC report on Measures Pages 54-63 + Appendix-1. Suggested edits that may make this section stronger: • On page 54, section 4.1, there is a reference to improving healthy weight but no mention about assuring healthy food sources in the community. Is that something you want to add? • At the top of page 55 you referred to the situation with "perverse incentives" and say that that discussion will be excluded. However, the paragraph goes on to give an example of a perverse incentive. I suggested that section be moved to a footnote since it takes the reader's attention away from the main point. • In the 2nd paragraph the last sentence ends with – "within a data and analytics solution." This phrase seems vague and I think it would benefit from a clear description. • Was this referring to, school age, or adult employment? • At the top of pg-56 --It says that "certain adverse caretaker/child characteristics have a marginal effect on a child's risk for maltreatment." • In table 4, the top section refers to "primary composite measure" and it's a labeled "Composite measure of child safety, stability and school success". However, I'm not sure that the 3rd bullet really gives a measure of school success, since it refers to performance on the kindergarten entrance inventory. Does that make sense?	Adopting.

#	From	Section #	Page #	Comment	Response
				• In tables 4 and 5 and appendix 1, there is no discussion about the level of geography for these measures, are they statewide countywide town specific? This seems like an important omission. The justification above assumes the need for "small area" population data but this discussion does not highlight that need. • Figure 12, the text bubble at the top refers to "Goal to meet prevention benchmarks…", But by my thinking the word should be prevention "targets", since a "benchmark" simply reflects where you're coming from/starting. • Figures 13 and 14 provide an outline of the CDAS system. To me this looks like the "cookie jar" of health data. Since this outline is aspirational, and would it take some time to implement, I wonder if that point should be made either in the figure titles or in the associated text. • Appendix 1 lists a series of "denominator descriptions". Strikingly, the denominator descriptions never reference quote 'population". I think these labels are oversimplified, for example "total children divided by 1000". I suggest inserting the word "population" whenever appropriate, to make this sound more realistic.	
41	10/29 PHC Webinar			Section 6 • Data/IT: Seems overly optimistic. Clarify - Will all the HECs have the ability to use and interpret the data? What did we find from the RCs in this regard? (Steven Huleatt) • Workforce: Concerned about the new hires – this might worry employers and be a reason not to engage. Incorporate examples, what RCs did in terms of hiring staff, demonstrate RC alignment toward that goal. Talk about the challenges and say something about them. Say something about the near-term bridge funding to longer term financing that will support new hires. Clarify who's the expected employer. (Steve Huleatt)	Adopting. Will add clarifying language.
42	Lisa Honigfeld (CHDI)	Page 11	11	Child well being: make distinction between reducing adverse events and building resilience among young children. They go together, but need to make this distinction so it is clear that interventions need to address parents and their nurturing behaviors. I echo Alice Forrester's thoughts here.	Adopting. Will add clarifying language.
43	Lisa Honigfeld (CHDI)	2.1.1	18	Here, too, need to make distinction between exposure to ACES and building resilience. They are two separate activities.	Adopting. Will add clarifying language.
44	Lisa Honigfeld (CHDI)	2.1.2	22	Reference substantial data that show that obesity begins early. Prevention needs to start with early feeding behaviors.	Adopting. Will add clarifying language.

#	From	Section #	Page #	Comment	Response
45	Lisa Honigfeld (CHDI)	2.2.2	27	Note that quality of housing has many health implications: lead, asthma, safety. 2.2.4 is not the place to address this	Adopting. Will add clarifying language. Housing is in 11/1 PHC meeting slides.
46	Lisa Honigfeld (CHDI)	2.3	31	Warrants call out of emphasis on primary care as the key to addressing health and lowering costs. This would set the stage community-based solutions that tie HECs to primary care.	Adopting. Will add clarifying language.
47	Rick Brush (Wellville)	2.2.5	28-29	In the "Chronic and Toxic Stress and Trauma" section, important to note (more broadly) the "weathering effect" of being a person of color in the U.S. It's not just about higher rates of victimization and incarceration.	Adopting.
48	Lisa Honigfeld (CHDI)	3.3.5.1	44	Add school based health centers	Adopting.
49	CT Association of SBHCs Webinar (10/23)			School-based health centers asked to be included in the HEC model.	Adopting. Language will be added to the report about SBHCs.
50	Lisa Honigfeld (CHDI)	6.2.2 to 6.2.3	74 to 75	Clarify CHW work in relation to other places in SIM initiatives that onboarding CHWs and define vis-à-vis care coordinators	Adopting. Will add clarifying language.
51	Lisa Honigfeld (CHDI)	7.2	95	Somewhere in this section the narrative needs to recognize that there is quite a bit of money in the system now for community services….schools, head start, WIC, etc. HEC funding should leverage existing funding to bring coordination and efficiency to community-based services that are operating in silos from one another.	Adopting.
52	Rick Brush (Wellville)	7.2.1.1.	100-102	For another variation that has elements of outcomes-based & blending & wellness trust, see: "Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities."	Citation will be added.
53	Lisa Honigfeld (CHDI)	7.3.1.2	122	Am not seeing how the Medicare analysis described is going to be helpful when major outcomes and focus is on people so much younger….seems like a birth cohort analysis would yield more relevant cost data	Adopting. Language will be added to clarify/explain why attention is devoted to the Medicare analysis. More will be added in the Medicaid section. Further analyses are not anticipated prior to sending report to HISC.

#	From	Section #	Page #	Comment	Response
54	10/29 PHC Webinar	7		Financing: • Need a better bridge to explain the benefit of the Medicare cost analysis. (Lisa Honigfeld doesn't find it that helpful in relationship to the major outcomes). • Make braided funding bold/ prominent, pg. 94-95. (Pat Baker)	Adopting. Will add language to Section 7.
55	Lisa Honigfeld (CHDI)	8.3	129	Add a bullet that recognizes the statewide policy implications of the Statewide group…..these folks could provide major policy recommendations that would restructure service delivery in ways that supported HEC work. Example: require that CHW training and certification include connecting parents to community parenting resources, or that early care and education licensing requirements include ban on serving juice to infants and toddlers, or that early care and education programs participate in Child and Adult Care Food Program (a federal opportunity to bring healthier eating to day care and preschools.	Adopting.
56	Rick Brush (Wellville)	Appendix 2	150-151	Re: "Reference Community: North Hartford Triple Aim Collaborative Members"… -- Add: Hartford HealthCare -- Combine: North Hartford Promise Zone/City of Hartford Office of the Mayor -- Delete: Community Solutions	Adopting.

3. Other/ No Action Needed

#	From	Section #	Page #	Comment	Response
57	Rick Brush (Wellville)	1	14-16	Great idea to include an example of a HEC – very helpful!	n/a
58	Rick Brush (Wellville)	4	54-58	Please refer to comments made during last week's measures webinar, and additional submissions from Lisa Honigfeld and Alice Forrester.	Referred to in this document.
59	Rick Brush (Wellville)	6.2.4	75-76	The illustrative example is helpful!	n/a