CONNECTICUT
HEALTH IMPROVEMENT COALITION

Partners Integrating Efforts and Improving Population Health

HEALTHY CONNECTICUT 2020
ADVISORY COUNCIL

Meeting Summary
July 17, 2018
9:30 am - 11:30 am

Meeting Purpose and Outcome
To set the context for SHIP reporting and version 2.0 and discuss ideas for SHIP 2.0 design based on successes and learnings from SHIP 1.0.

Attendees
Comr. Raul Pino, CT Dept. of Public Health; Patricia Baker, CT Health Foundation/Advisory Council Chair; Robyn Anderson, Advanced Behavioral Health, Inc.; Mary Boudreau, Connecticut Oral Health Initiative; Judy Dicine, Office of the Chief State's Attorney; Phyllis DiFiore, CT Dept. of Transportation; John Frassinelli; Dept. of Education; Robyn Gulley, North Central Area Agency on Aging; Brenetta Henry, Consumer Representative; Lynne Ide, Universal Health Foundation; Shawn Lang, AIDS CT; Marcus McKinney, Faith-based community representative; Terry Nowakowski, Partnership for Strong Communities; Janet Storey, CT Dept. of Mental Health and Addiction Services; Kathi Traugh, Connecticut Public Health Association; Nancy Yedlin, Donaghue Foundation; Rob Zavoski, CT Dept. of Social Services; Amy Mirizzi, CT Dept. of Public Health; Marijane Carey, Carey Consulting; Cathy Sisco, Wheeler Clinic/Connecticut Clearinghouse; Rachel Leventhal-Weiner, CT Data Collaborative; Deb Zahn, Health Management Associates; Donna Burke, Health Resources in Action; Kristin Sullivan, CT Dept. of Public Health; Sandy Gill, CT Dept. of Public Health; Laurie Ann Wagner, CT Dept. of Public Health; Melissa Touma, CT Dept. of Public Health; Chantelle Archer, CT Dept. of Public Health

SHA Pre-Planning Update
Kristin Sullivan provided an update on SHA 2.O pre-planning activities including the role of the DPH Data Advisory Committee, timeline for activities, and current activities which include a proposed vision for SHA/SHIP 2.0; identification of specific populations to be included, key strategies and frameworks to guide planning such as CDC 6|18 initiative, and proposed criteria for prioritizing indicators. Council members commented on the Vision and specific populations to be included as follows:

- Add "stakeholders" back into the vision. It should say "partners and stakeholders". There can be stakeholders who are not partners.
- Add the part about "measurable improvements in health outcomes" back into the vision.
- The shift towards people is powerful.
- Add in "accountability" to address enforcement.
- "Health system partners" was changed to "partners" to be more inclusive.
- We should consider looking at people who were formerly incarcerated (disaggregation of data should be a principle). This population needs to be included in the SHA/SHIP.
- Populations of color should be added to the list of specific populations the SHA will focus on.
- Address issues in rural communities.

- 6|18 Initiative – https://www.cdc.gov/sixeighteen/
  - This is an initiative between CDC, health care purchasers, payers, and providers. It targets six common and costly health conditions that can be prevented or improved: 1) tobacco use, 2) high blood pressure, 3) health-care-associated infections, 4) asthma, 5) unintended pregnancies, and 6) diabetes – and initially, 18 proven specific interventions that formed the starting point of discussions with purchasers, payers, and providers.
  - Comr. Pino shared that DPH was invited by the CDC to put in an application to provide technical assistance at a national level to start moving more towards the SHIP 6|18 interventions. DPH is trying to align with national strategies as well as find funding for these alignments.
  - **Q:** Is there a reason that addiction isn't on the list? **A:** These are the conditions that will have the greatest economic impact if we address them. The initiative is not intended to exclude other areas, like addiction. DMHAS has the primary function of addressing addiction and substance misuse; DPH has some initiatives through the Office of Injury and Violence Prevention.
  - **Q:** Is there a roadmap on the 6|18 initiative that shows how things like housing and oral health fit into/impact the six conditions? **A:** 6|18 is more like a menu to choose from. It doesn't exclude work on housing, healthy homes, etc. It means that we are trying to align with the national approach on these. Connecticut has one of the highest health care costs in the country.

Cross-Sector Collaboration on Data: 500 Cities Data Challenge

Rachel Leventhal-Weiner from the CT Data Collaborative presented on the 500 Cities Data Challenge, an example of cross-sector collaboration on data. The CT Data Collaborative is a public/private partnership that maintains a data portal consisting of federal and state data. They have a range of data available and work with organizations to help them better understand data. The 500 Cities Data Challenge is a collaboration between the Centers for Disease Control & Prevention, the Robert Wood Johnson Foundation, and the CDC Foundation. The focus is on Hartford with the hope that data will be scalable to other cities across the state. The goal is to understand the relationship between housing and health via geospatial analysis. The analysis will be completed by September 2018 followed by a final report that will be completed by the end of the calendar year. They have also partnered with an academic institution – Trinity College. Health measures include health outcomes related to asthma, heart disease, high blood pressure, cholesterol, mental health, oral health, stroke etc.; prevention measures such as health insurance, health care visits, medication compliance, screening; and risk behaviors such as binge drinking, smoking, obesity, sleeping less than 7 hrs. /day. Additional focus will be placed on the housing stability index and housing conditions. Public facing work will include connecting with advocacy groups in neighborhoods. Council members suggested connecting with housing associations, and churches/houses of faith. Council members also commented on the following:

- Hep C cases in Hartford neighborhoods are correlated to concentrations in housing and is a barrier to treatment for Hep C.
- Health Equity Index could benefit from this work
- Free use of DPH studio/webinar to highlight findings
- Geo mapping is very useful to identify concentrated high risk areas and is currently being used to identify water systems close to highways that receive salt treatment during the winter for additional testing and high salt water content.

SHIP 2.0 Pre-Planning: Collaboration Models to Consider for SHIP Structure

1. *Connecticut's Opioid Response* – Amy Mirizzi, the director of DPH's Office of Injury Prevention and the Injury & Violence Prevention Action Team Co-Lead presented on a cross-systems collaboration to address the opioid epidemic in Connecticut. This collaboration involved a working partnership between the Office of the

Chief Medical Examiner (CME), the Department of Mental Health & Substance Abuse (DMHAS), and the Department of Consumer Protection (DCP) to create an infrastructure to communicate the implementation of the Connecticut Opioid Response (CORe) Plan at the local and community level. Six local health departments and districts received funding from DPH to develop the infrastructure, and the DPH Opioids and Prescription Drug Overdose Prevention Program developed local-level and statewide data reports to capture fatal and nonfatal drug overdose trends in Connecticut. As a result of this intervention, 10 pilot communities now have a local infrastructure in place, and the 10 local health departments meet bimonthly as a group to share statewide updates and community level initiatives. The DPH funded local health departments are Hartford, New Haven, Bridgeport, Waterbury Health Departments, Quinnipiac Valley Health District, and Ledge Light Health District. The DMHAS funded health departments are East Shore, Torrington, Uncas, and North Central Health Districts. Local health departments share data at the community level with EMS, local coalitions, and other partners to engage residents and design targeted interventions. Mass media buys include "Change the Script" messaging to change the stigma around addiction. Provider level trainings are done through the Yale School of Medicine. Other initiatives include syndromic surveillance and data from poison control to map overdoses. A new law requires EMS to report opioid response calls to the poison control center.

2. *Health Enhancement Communities* - Deb Zahn from Health Management Associates presented an overview and status of the Health Enhancement Communities (HECs) initiative, a component of the population health planning initiative conducted by DPH and the Office of Health Strategy through the State Innovation Model (SIM) grant. This work will build on and align with SHIP/SIM activities. HECs look at upstream interventions to prevent conditions and poor outcomes. Design of HECs include accountability, boundaries, focus and activities, indicators, addressing health disparities, infrastructure (data, workforce), sustainability, regulations, stakeholder engagement, and State role. The goal is to identify the root causes of poor health, identify interventions and determine sources of funding that would be sustainable long-term. Topic areas that HECs would focus on include Child Wellbeing and Healthy Weight and Physical Fitness. Within these areas, HECs would look at programmatic, systems, policy and cultural norm interventions (e.g., programs like "change the script"). Next steps will be to refine program design elements with stakeholders, and reference communities, SIM Population Health Council, and the Healthcare Innovation Steering Committee. Reference communities selected through competitive process include Hartford, Norwalk, Waterbury and New London. A written HEC plan in the fall, will lay out the overall HEC framework and design questions.

Implications for SHIP 2.0 - Open Discussion
In light of both presentations on Connecticut's Opioid Response and Health Enhancement Communities, Advisory Council Members discussed possible implications for SHIP 2.0.

Comments

- Ensure we do not work in silos and that efforts connect.
- The priorities selected - Child wellbeing and Healthy Weight - are topics that need attention and that can prevent disease and disability.
- Cross-sector collaboration is valued.
- Funding is driven by payers and the CDC; chasing money is unavoidable.
- Economic Benefit model is important to look at where benefits accrue, where savings are and where the health delivery system is investing.
- We need to look at general spending, not just money spent on prevention efforts (e.g. housing subsidies, cleaning streets etc.)

Announcements

- Mary Boudreau announced that she is retiring from the Connecticut Oral Health Initiative Inc.
- *State Oral Health Improvement Plan (UPDATE)* – In late May of 2018, DPH contracted with the Connecticut Oral Health Initiative, Inc. to facilitate and write a new state oral health improvement plan. Mary Boudreau invited members to review a draft of the plan and provide feedback before its submission to DPH.
    - *UPDATE:* The plan was submitted to DPH on August 8, 2018 with its release planned for September 2018.
- Kathi Traugh announced the upcoming training on systems change innovation webinar series that will feature the SIM/DPH Prevention Service Initiative later in August.

Next Steps/Updates

- October 23, 2018; 9:30am-11:30am, DPH Lab in Rocky Hill

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Healthy Connecticut 2020

State Health Improvement Plan

Advisory Council Meeting

Tuesday, July 17, 2018

9:30 AM - 11:30 AM

DPH State Lab - 395 West Street, Rocky Hill

Meeting Purpose and Outcomes

Partners Improve Health Outcomes through Cross-Collaboration and Policy, Systems, and Environmental Approaches

- Provide input on the SHA 2.0 pre-planning activities
- Discuss potential structural options for SHIP v.2.0 based on learnings from two collaborative models that include a focus on Policy, Systems, and Environmental Change.

Pat Baker, Advisory Council Chair

Welcome & Introductions

Agenda

Time	Min	Item	Presenter
9:30	*10*	**Welcome and Introductions**	*Pat Baker, AC Chair*
9:40	*20*	**SHA Pre-Planning Update**	*Kristin Sullivan, DPH*
10:00	*20*	**Example of Cross-Sector Collaboration on Data: 500 Cities Data Challenge**	*Rachel Leventhal-Weiner, CT Data Collaborative*
10:20	*30*	**SHIP 2.0 Pre-Planning: Two Models to Consider for SHIP Structure** 1. Connecticut's Opioid Response 2. Health Enhancement Communities	*Amy Mirizzi, DPH & Injury & Violence Prevention Action Team Co-Lead* *Deb Zahn, Health Management Associates*
10:50	*30*	**Implications for SHIP 2.0 – Open Discussion**	*All/HRiA*
11:20	*10*	**Next Steps/Next Meeting Date**	*Pat Baker, AC Chair*

Kristin Sullivan, DPH

SHA Pre-Planning Update

SHA Pre-Planning Update

- SHA Pre-Planning Activities
- Criteria for Prioritized Data Collection
- Outcomes from Data Advisory Committee (DAC) Meetings
- Questions

Role of the DPH Data Advisory Committee

- Help refine the vision for the SHA/SHIP 2.0
- Identify health indicators that will be recommended for inclusion in the SHA
  - Must include **context of populations or social determinants of health** such as unemployment rates, percent of registered voters, graduation rates, education level, transportation, income, housing stock, home values, park acreage, etc.
- Identify and apply prioritization criteria to identify a recommended list of topics and health indicators for inclusion in the updated SHA
- Facilitate the data gathering process

SHA Timeline for Pre-Planning Activities

Activity	Timeframe
DAC Meeting #1	June 14, 2018
DAC Meeting #2 Groups Identified/Invited	June 22, 2018
Data Indicator Lists Due	July 6, 2018
DAC Meeting #2	July 10, 2018
Data Indicator List Finalized	Late August 2018
DAC Meeting #3	Late August/Early Sept 2018
Data Gathering	Fall 2018

Proposed Vision for the SHA/SHIP 2.0 Report

Healthy Connecticut 2020 Vision

The Connecticut Department of Public Health, local health districts and departments, key health system partners, and other stakeholders integrate and focus their efforts to achieve measurable improvements in health outcomes.

Revised Vision for Discussion

Through effective assessment, prevention, and policy development, the Connecticut Department of Public Health and its partners provide every Connecticut resident equitable opportunities to be healthy throughout their lifetimes.

Proposed Criteria for Prioritized Data Collection

All indicators must be:

- Reliable or validated (studies in the larger literature show strong consistency and validity)
- Available over time (5 years ago or newer)
- Available by population sub-group and/or geography (e.g., county level)

Consideration also given to indicators that:

- Reflect a health condition or issue affecting a sizeable population/high cost to society
- Associated with high morbidity/mortality or multiple outcomes
- Assesses/enables monitoring over time of progress toward health equity
- Comparable to national benchmark/aligned with national initiatives
- Feasible opportunities for improvement that are aligned with current programmatic efforts and/or movable in 5 years
- Easy to communicate and enables the telling of a comprehensive "story" about the health status of CT residents
- Used consistently in CT DPH/sister agency reports

Other Input

Specific Populations

- Aging/elderly
- LGBTQ
- Immigrants/Refugees
- Non-English Speakers
- Disabled
- Incarcerated

Key Strategies/Framework

- Focus on conditions that can be prevented or improved (CDC 6|18 Initiative)
- Social determinants of health
- Health equity across the lifespan
- Build on what's been done - align with other assessments/ indicators

Questions

Rachel Leventhal-Weiner, CT Data Collaborative

Example of Cross-Sector Collaboration on Data: 500 Cities Data Challenge

Connection Data Collaborative
500 Cities Data Challenge

Presentation to the State Health Improvement Coalition Advisory Council, July 17, 2018

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500 Cities: Data Overview

- Collaboration between CDC, the Robert Wood J
  the CDC Foundation
- City- and census tract-level small area estimates
  disease risk factors, health outcomes, and clinic

- In Connecticut: Hartford, New Britain, Waterbury, Danbury, New Haven, Bridgeport, Norwalk, Stamford

500 Cities: Methodology

- Used multi-level regression and poststratification links geocoded health surveys and demographic (Census 2010 and ACS)

- Used data from CDC's Behavioral Risk Factor S (BRFSS) and the National Survey of Children's Health

500 Cities **Data Challenge**

The sponsors: the Urban Institute and the Robert Wood Johnson Foundation

The Challenge: Use 500 Cities data to design innovative solutions for social factors related to community health.

The partners: Connecticut Data Collaborative and the Liberal Arts Action Lab

The timeline: It's on! (through April 2019)

The goal: Promote more comprehensive cross-collaborative approaches to foster a broader "Culture of Health" in urban areas

Question: By marrying the 500 Cities data with local open data sources, we can explore and explain the relationship between health and housing in a concrete way for Hartford's most disinvested neighborhoods. Identify whether there are concentrated pockets of disinvestment where we might target resources, which may result in improved health conditions of the residents

Method: Geospatial analysis examining housing data with health data

Analytical strategy

- Map health indicators
- Compile and map measures of housing quality
- Investigate the relationship between housing and health
  - Grouping tracts into highest stability/ lowest stability and best conditions/ worst conditions
  - Exploring health indicators across the tracts in order to compare them

500 Cities Health Measures

- Health Outcomes
- Prevention
- Unhealthy behaviors

Housing Stability Index

Indicators

- Rent to income ratio
- Housing costs to income (homeowners)
- Eviction rate
- Foreclosure rate
- Assessed value per square foot
- Homeownership
- Length of tenure

Housing Conditions

Data sources:

- Reports of housing code violations
  - Reported by the Housing Code Enforcement Office & Department of Public Health
  - Including lack of essential services, rodents, bedbugs, etc.
- Vacancy (USPS)
- Property crimes and quality of life crimes, measured by police reports

Contact us:

Connecticut Data Collaborative
mrn@ctdata.org

Liberal Arts Action Lab
megan.brown@trincoll.edu

CONNECTICUT
DATA
COLLABORATIVE

Example of Cross-Sector Collaboration on Data: 500 Cities Data Challenge

- Q&A
- Implications for the SHA

SHIP 2.0 Pre-Planning: Two Models to Consider for SHIP Structure

Amy Mirizzi, DPH & SHIP Injury & Violence Prevention Action Team Co-Lead

1. Connecticut’s Opioid Response

Opioid and Prescription Drug Overdose Prevention

Issue: The Mental Health and Substance Abuse (MHSA) Action team identified that no local infrastructure existed to communicate the implementation of the Connecticut Opioid Response (CORe) Plan at the local and community level.

- Promote and facilitate professional awareness and training
- Support public awareness strategies
- Implement community-level interventions
- Increase data sharing across relevant agencies and organizations

Strategy/Intervention

- Six (6) local health departments and districts (LHDs) are funded by DPH to develop infrastructure to implement CORe Plan at the local-level
- DPH Opioids and Prescription Drug Overdose Prevention Program developed **local-level and statewide data reports** to capture fatal and nonfatal drug overdose trends in Connecticut
- New Unintentional Drug Overdose Reports are provided to the six (6) LHDs funded by DPH
- Design targeted community prevention strategies and evaluate interventions

Cross-Systems Collaboration

- Working in partnership across systems:
  - OCME: Data reports available on a quarterly basis
  - DMHAS: Funds an additional four (4) Local Health Districts
  - Began meeting with all 10 LHDs on a bi-monthly basis
  - DCP: Added prescription data from the Connecticut Prescription Monitoring and Reporting System (CPMRS)
  - April 2018: Statewide data went to all local health departments and districts
- LHDs share data at the community-level with community partners, such as LE, EMS, local coalitions, and other partners, to both engage residents and design targeted, timely interventions

Result

- Local infrastructure is now in place in ten pilot communities.
- DPH and DMHAS convene the 10 LHDs implementing opioid prevention work bimonthly as a group for technical assistance and to share statewide updates and community-level initiatives.

- A regular forum exists to bring together multiple statewide partners with local-level initiatives as well as the CT Association of Directors of Health.

The Office of
Governor Dannel P. Malloy

CHANGE the SCRIPT

Change the Script is a new statewide program that connects town leaders, healthcare professionals, treatment professionals, and everyday people with the resources they need to face prescription drugs and opioid misuse - and write a new story about what we can accomplish when we all work toward a shared goal. The campaign is intended to provide useful, usable materials, anchored by a consistent message, to help address the opioid crisis at the most local levels. There are 3 distinct parts to the campaign:

A toolkit that contains creative materials such as advertisements, posters, billboards, direct-distribution pieces, radio scripts, and other materials that can be co-branded by an engaged party and used locally. **Ready-to-use materials** that do not require customization are also available for distribution and use at the state level.

A targeted campaign to prescribers to increase awareness and utilization of the CPMRS. It utilizes digital ads, direct mail, social media, posters, flyers and journal advertising to reach prescribers and pharmacists.

An educational campaign for state residents that helps to increase awareness of the dangers of opioid and prescription drug misuse while focusing on decreasing the stigma of addiction and promoting life saving measures such as naloxone and treatment. The campaign materials available for use include social media messages, PSAs (radio and TV), billboards, posters, and brochures.

Substance Use

portal.ct.gov/Office-of-the-Governor/Substance-Use

Connecticut's Official State Website

Search Connecticut Government...

CT.GOV HOME / GOVERNOR DANNEL P. MALLOY / SUBSTANCE USE

Substance Use

For substance use treatment 24/7, call 1-800-563-4086 (includes detox, and prescription opioid or heroin addiction treatment)

Naloxone Pharmacies

Locate pharmacies where Naloxone (Narcan) is available.

Change the Script

Prevention, Treatment, and Recovery Resources for people facing Drug Misuse and Addiction.

Treatment

Locate treatment and recovery services.

drugfreect.org

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www.ct.gov/dph/SHIPCoalition

LET'S PUT A LID ON

KNOW MORE before you TAKE MORE

CHANGE the SCRIPT

For resources, go to drugfreect.org

Connecticut Prescription Monitoring and Reporting System (CPMRS) integrating with EHRs

CPMRS-EHR integration streamlines the workflow by saving time and allowing fast access to patients' controlled substance prescription history reports. Users no longer have to log into different systems because the CPMRS patient reports populate directly in the facility's electronic health record.

Consider integration. Contact the Prescription Monitoring Program for more information.

For more information about the CPMRS, contact:
Connecticut Prescription Monitoring Program
860-713-6073 • dcp.pmp@ct.gov • www.ct.gov/dcp/pmp

CPMRS Login • www.drugfreect.org

This email was developed in part by the U.S. Department of Justice (DOJ), Office of Justice Programs - Award # 2016-PM-BX-0009 and under grant number 1U79SP022110 the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not represent the official position or policies of U.S. DOJ, SAMHSA or HHS.

1. Connecticut's Opioid Response

- What were the elements/enablers of success?
- How can we build on infrastructure and systems that have experienced success?
- How can we enhance this work through deeper collaboration among SHIP Action Teams?

Deb Zahn, Health Management Associates

2. Health Enhancement Communities

CONNECTICUT Office of Health Strategy

Connecticut Department of Public Health

Health Enhancement Community Initiative

State Health Improvement Plan Advisory Council

July 17, 2018

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Partners Integrating Efforts and Improving Population Health

www.ct.gov/dph/SHIPCoalition

Health Enhancement Community Initiative

PROVISIONAL DEFINITION

A Health Enhancement Community (HEC) is:

- Accountable for health, health equity, and related costs for all residents in a geographic area
- Uses data, community engagement, and cross sector activities to identify and address root causes
- Operates in an economic environment that is sustainable and rewards communities for health improvement by capturing the economic value of Improved health

- Focuses on creating the conditions that **promote and sustain cross-sector community-led strategies focused on prevention**.
- **Aligns with health improvement work underway** in communities, previous and current SIM work, and adds sustainability and scale focus.
- Intentionally leverages thoughtful, **community-driven planning processes** to refine the HEC design.

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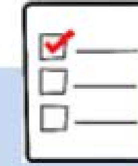
Envisioned Core Elements for HECs

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]

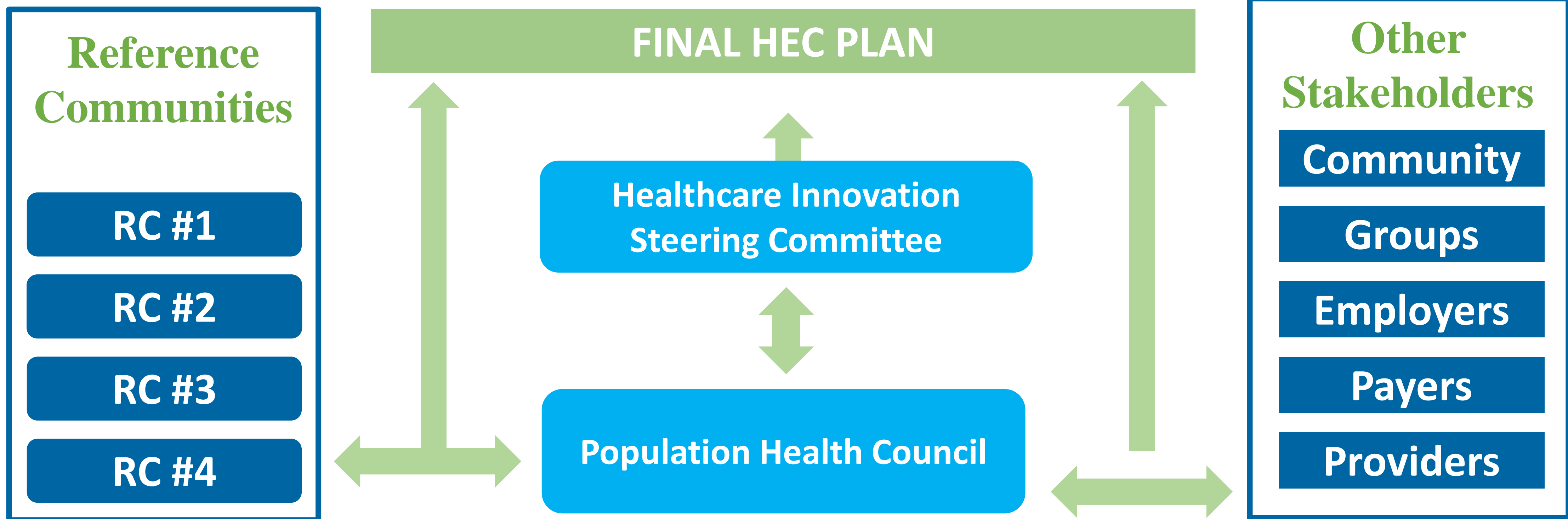
Sustained Funding Mechanisms[5,6]

- 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.

Key Design Questions

DOMAIN	DESIGN ELEMENTS
Accountability	Define the appropriate **expectations** for HECs.
Boundaries	Define the best criteria to set **geographic limits**.
Focus and Activities	Define **what HECs will do to improve health and health equity** and appropriate flexibility/variation.
Indicators	Define **appropriate measures** of health improvement and health equity.
Health Equity	Define **approaches to address inequities and disparities** across communities
Infrastructure	Define the **infrastructure needed** to advance HECs (HIT, data, measurement, workforce).
Sustainability	Define **financial solution** for long-term impact.
Regulations	Define **regulatory levers** to advance HECs.
Engagement	Define how to ensure **meaningful engagement from stakeholders**.
State Role	Define **State's role.**

Multidirectional Flow of Information and Input to Support Decision Making



Office of Health Strategy/SIM
Department of Public Health
Jointly administer and lead initiative

HMA
Planning support and subject matter expertise to develop strategy and draft summary plan

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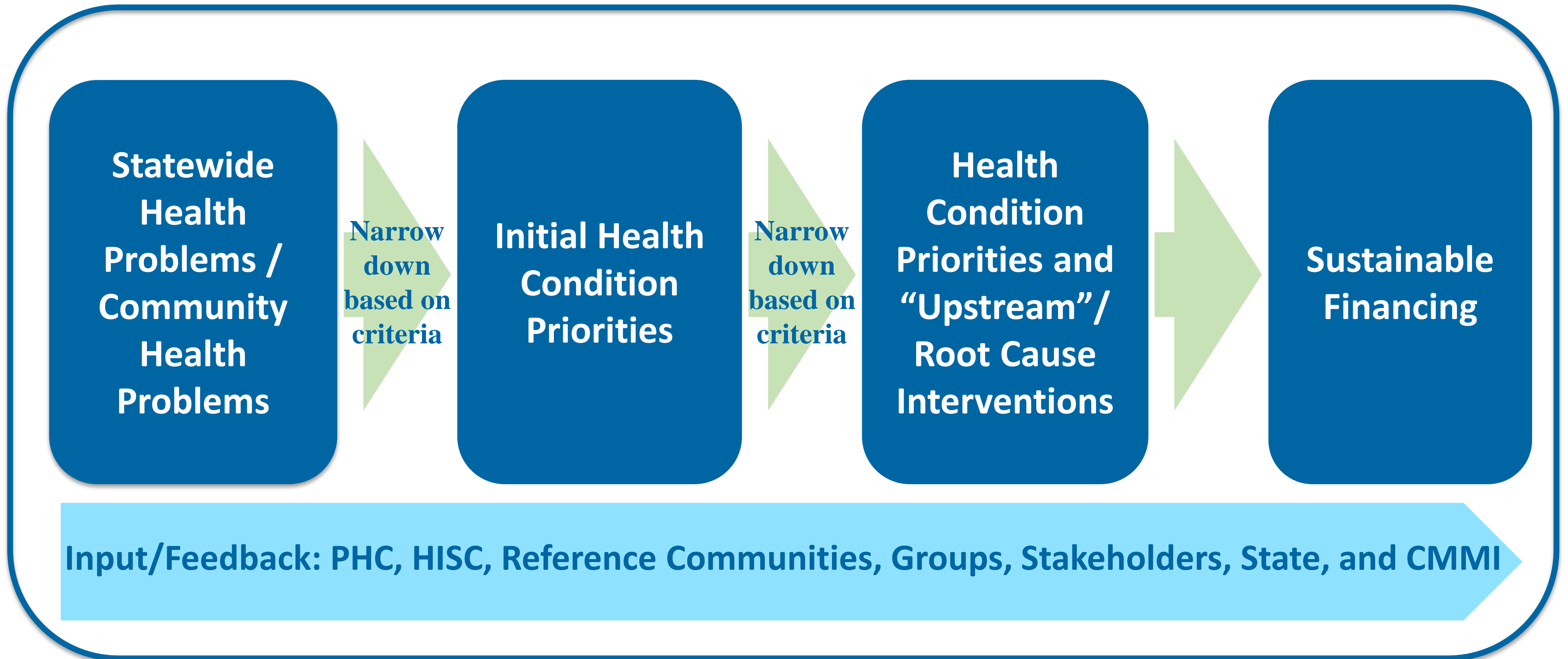
Design Engagement Goals

- Give the broader community a voice in the design of HECs
- Understand "on the ground" realities
- Validate or modify underlying assumptions
- Identify the roles of key sectors in the HECs
- Identify existing and needed resources to support the implementation and sustainability of HECs
- Obtain "OKs" on design

Process for Selecting Health Conditions Priorities and Interventions



PRIORITIES FOCUS AREAS

CHILD WELL-BEING
Preventing Adverse Childhood Experiences*

HEALTHY WEIGHT & PHYSICAL FITNESS

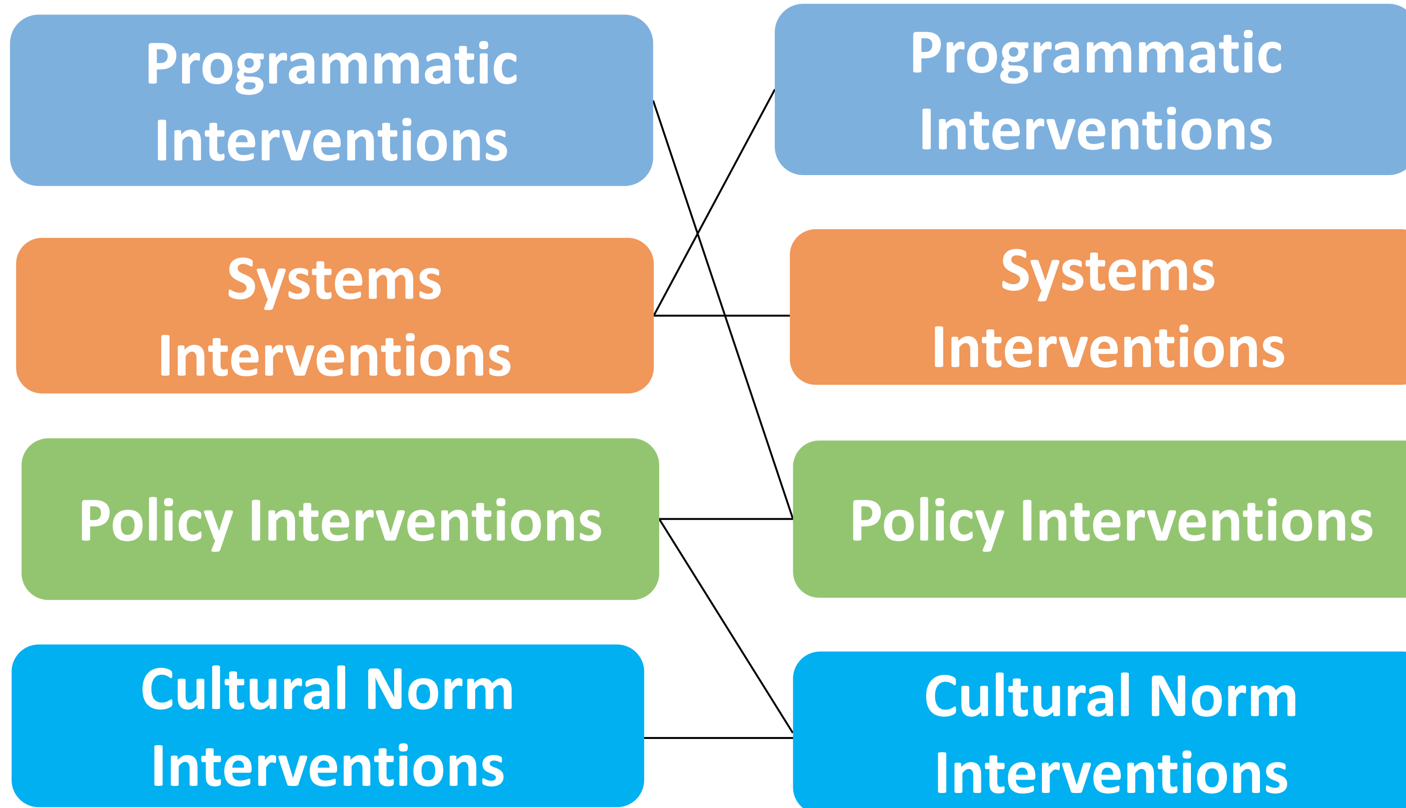
Root Causes – Social Determinants of Health

“Upstream” Interventions to Prevent Conditions and Poor Outcomes

FOCUSED CATEGORIES

Interventions selected by HECs using criteria

Complementary statewide interventions



With some interventions deliberately for more than one health condition

Populations could be targeted (e.g., people in “hot spot” areas within the geography)

* Defined by CDC’s Essentials to Childhood

Economic Benefits of HECs

The Economic Benefit Model will quantify the economic benefits of what the HECs do.	Key aspect of HEC Initiative is being able to measure specific economic benefits and where they accrue to assess success and to develop investment strategies

HMA is **developing an analytical model** with Airam Consulting to inform the sustainability approach of the HEC model including:

- Impact of the HECs on Medicare and other payers, which will be used to pursue a federal financing arrangement
- Impact of the HECs on the economy, which will inform other implementation options and sustainability strategies

Next Steps

SUMMER	Refine HEC program design elements in collaboration with stakeholders, Reference Communities, Population Health Council, and Healthcare Innovation Steering Committee
FALL	Develop a written HEC plan that lays out overall HEC framework and answers key design questions

2. Health Enhancement Communities

- What does this model suggest about structuring SHIP 2.0?
- What can we learn from the model's ROI and outcomes data?

All/HRiA

Implications for SHIP 2.0 - Open Discussion

Implications for SHIP 2.0 - Open Discussion

- Given the two models, what do we want to take into consideration for the structure (organizing framework) for SHIP 2.0 based on what we’ve learned today?

Next Steps/Next Meeting Date

- Tuesday, October 23th, 9:30-11:30

Thank You!