PRE-PLANNING HEALTH ENHANCEMENT COMMUNITY INITIATVE

Final Report

Waterbury HEC - Greater Waterbury Health Partnership
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Contents

Overview

The purpose of this document is to demonstrate the fulfillment of scope of work items in Phase 2 of the Pre-Planning HEC grant. Please include any supporting documents as appendices (a-g), or as separate documents with the corresponding appendix as the title.

Partners

Lead Applicant

Include a brief background of your organization, and why you pursued this grant.

Waterbury's Health Enhancement Community planning process has been spearheaded by the Greater Waterbury Health Partnership (GWHP). GWHP was founded in 2013 by Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, and the United Way of Greater Waterbury. The City of

Waterbury Department of Public Health provided leadership to the Partnership's activities as the backbone entity. However, GWHP currently has its own full-time staff of two people. There are 46 multi-sector organizations which have participated in the collaborative since its formation, and four workgroups (Access to Care, Chronic Disease, Infant & Maternal Health, and Substance Abuse).

Among other collaborative work, GWHP has partnered to ensure the collection and dissemination of population health data by completing a Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) biannually. These assessments help partners understand and interpret the local social determinants of health and their impact on residents of the greater Waterbury area. This data informs our work to improve population health in greater Waterbury through community partner engagement and improved strategic alignment.

Our community has been partnering on the HEC process since the first phases of this work, including serving as a Reference Community to explore the possibilities for health enhancement through collaborative action. Our efforts rest on a foundation of community partnerships and a history of valuing and participating in continuous learning. In 2016-2017, GWHP participated in a six-month Center for Disease Control (CDC) national learning cohort to pilot use of the CDC's Community Health Improvement Navigator and learn best practices for community health strategies to address priorities of the Affordable Care Act. We were one of only ten collaborations selected for this learning cohort.

Following our success in working together as a Reference Community, partners agreed that it was desirable to move forward with the HEC process in Phase I pre-planning and Phase II of the grant.

Participant Organizations

Detail those participant organizations that contributed and supported the accomplishment of priority aims, goals, and requirements set forth in the contract.

The Greater Waterbury HEC and GWHP work in concert with several local community and human service initiatives, and we anticipate continuing and expanding on these relationships as part of a HEC process. Participating organizations currently include:

- Chesprocott Health District
- City of Waterbury Health Department
- The Connecticut Community Foundation
- Greater Waterbury YMCA
- Pomperaug Health District
- St. Mary's Hospital
- StayWell Health Center, Inc.
- United Way of Greater Waterbury
- Waterbury Bridge to Success
- Waterbury Hospital

Key Deliverables

Detail in the below sections how you fulfilled the Phase 2 scope of work. Questions and prompts have been provided to guide your answers. Where appropriate, your answers should include how you demonstrated engagement of community residents, and how you maintained multisector engagement in the planning process.

HEC Partners

Who did you convene? Were these partners already part of a collaborative, or did you bring them together? Are there still existing gaps in your community with organizations that have not joined? If so, what is the barrier to their joining? Were partners engaged all at once, or was it over time? What concerns did partners have? How did you address these concerns? What are partners most eager or engaged around? Please include any supporting documentation in Appendix B.

As a continuation of our work as a Reference Community, we reconvened the list of partners listed in the section above and considered the question "Who isn't represented that falls inside the HEC framework and should be here?" During this discussion, there was a review of the map of HEC awardees, with particular attention to the large amount of overlap that exists between the Waterbury and Northwestern Connecticut HEC geographical areas. (This is covered in more detail in the Geography section below.)

An engagement session with the suburban health districts, community members and stakeholders was also held in order to identify primary and secondary drivers impacting need and look at expanded partnerships and geographic scope. A meeting summary from the engagement session is included in Appendix B.

During this process we learned that our partners were sensitive to the number of meetings being held and the demands on their time, and we adjusted accordingly by reaching out via email and only holding meetings when necessary. Once the COVID-19 pandemic hit, we paused our activities until the situation stabilized, as our partners were in crisis response mode and did not have available time or energy to work on HEC matters.

Once we resumed our activities, we found additional ways to be responsive to demands on our partners' time, including developing a streamlined process for the adoption of our interventions, MOUs, etc. That process included sending out a packet of materials for partner review, comment, and adoption. The packet included:

- Results of a resident survey to collect information about current and potential health interventions related to Child Well-Being and Healthy Weight
- Proposed Governance By Laws
- The Memorandum of Understanding to be executed by partners
- A matrix of interventions and metrics for measuring outcomes

Partners also received a link to a Google form to collect additional thoughts or feedback on our collective work. A copy of the cover page for the packet is included in Appendix B.

Not surprisingly, municipal health departments continue to have limited availability to engage in HEC related activities due to the pandemic. As a result, the process for adoption of an MOU with the Waterbury Health Department has been delayed. We will continue to engage the department and additional new partners as the next phase of our work continues.

Preliminary or core set of interventions

Please detail the preliminary or core set of interventions the community identified. Describe how you selected them. Include how they align with the health priorities, and if applicable, how they enhance or align with other endeavors partner communities are working on. Please include any supporting documentation in Appendix C.

We developed our set of preliminary interventions after meeting with our partners to examine primary and secondary drivers in our service area related to the HEC priority aims, reviewing data sources such as our Community Health Needs Assessment, and surveying community residents about local programs and barriers to service.

For each of our fifteen proposed interventions, we identified a provider (or possible provider) and whether the intervention:

- targets child well-being, healthy weight, or both priorities
- fits into one of five domains: care coordination, chronic disease, environment, exercise, or food
- involves program, system, policy, and/or cultural changes
- would be new or is currently provided

We then determined the data metrics to be deployed and outcome measures tied to those metrics for each intervention based on what was most readily available and attainable.

A comprehensive matrix showing all fifteen interventions and metrics for measuring outcomes is provided in Appendix C.

Geographic area and target population

What is the proposed geographic area and target population for a future HEC? Why were the area and target population chosen? What were your challenges related to determining geographic area and how did you resolve them? What issues were not resolved that need to be addressed in the future? Please include any supporting documentation in Appendix D.

Geography:

Based on our earlier work as Reference Community and pre-planning, we anticipate that our HEC would align with the region served by GWHP in Greater Waterbury, including the City of Waterbury and 20 suburban towns (Beacon Falls, Bethlehem, Bridgewater, Cheshire, Goshen, Litchfield, Middlebury, Morris, Naugatuck, New Milford, Oxford, Prospect, Roxbury, Southbury, Thomaston, Warren, Washington, Watertown, Wolcott, and Woodbury).

We faced one particular challenge with our geography: under the current HEC areas recognized by the state, there are six towns which overlap and are served by both the Greater Waterbury Health Partnership and the Northwest Connecticut Community Foundation (Bethlehem, Goshen, Litchfield, Morris, Warren, and Washington).

In order to address this overlap, the Greater Waterbury HEC Leadership Team met with representatives of the Northwest Region to discuss this challenge and come to a sense of resolution. A series of maps were reviewed to look at a number of applicable geographies: the statewide HEC map, local health districts, the service area for three community foundations, and a map showing local overlapping HEC

boundaries, keeping in mind the Office of Health Strategy's population threshold of 150,000 to 300,000 people.

Participants explored varying patterns of usage of health care providers in local rural, urban, and suburban areas – where do people commonly go for services? Factors which impact usage include transportation corridors, traffic patterns, school districts, where people work and shop, hospital and ambulance service areas, and privacy concerns.

Other considerations included:

- How "swing" towns (which could potentially be part of either HEC) would understand what the implications are for which HEC they would be joining – neighbors should be able to understand what they are getting.
- The impact of declining population of some towns, and of an aging population in some towns as well.
- If possible, it would be desirable not to split school districts between HECS.
- The role of other forms of collaboration, such as local Councils of Government

After some discussion, we will not be combining geographies at this time.

The maps from this meeting are included in Appendix D.

Target population:

Broadly speaking, the populations we would target include:

- Children who are at risk for obesity or for being underweight. A BMI analysis conducted by Waterbury School Nurses demonstrated that 39% of children entering kindergarten in Waterbury and 45% of students entering high school were not at a healthy weight in 2015.
- Adults at risk of diabetes. As of 2018, 37% of adults in the region were overweight, and 28% were obese. 10% of adults over age 18 have been diagnosed with diabetes in the region.
- Children and adults with asthma. 11% of adults in the region, and 13% of adults in the City, have been diagnosed with asthma. Waterbury experiences high volumes of emergency department encounters related to asthma and avoidable admissions. Although the percentages of people with asthma do not vary significantly from the state, the number of people reporting frequent asthma attacks at a rate of once a week is 28% in Waterbury compared to 20% in Connecticut, and slightly less in Greater Waterbury at 23% (DataHaven, 2018).
- Children and parents at risk of adverse effects from ACEs. One possible target population would be families with children who experienced disciplinary events in school. An investigation by the Office of the Child Advocate found that in the six month period between September 2018 through March 2019, there were about 200 calls to police made by Waterbury elementary and Pre-K through Grade 8 schools as a result of a child's behavior, typically either a behavioral health crisis or an act of physical aggression by a child or multiple children. Children as young as four or five were the subject of some calls to police. The Office of the Child Advocate found that more than half of the schools called police to respond to children

more often than they called community mobile crisis intervention teams. (Office of the Child Advocate, 2020)

Governance structure, accountability mechanisms

Detail the proposed governance structure and accountability mechanisms. Describe specifically the role of community residents in ongoing HEC governance. Please include any supporting documentation in Appendix E.

Our HEC represents multiple sectors and is comprised of public, private and community stakeholders reflective of the diverse needs of the community. It strives to operate with transparency, collaboration, and in a manner which engages the community around health outcomes. As outlined in our MOUs, the HEC reports to the GWHP Steering Committee on the implementation, operation, and evaluation of the HEC and any other matters as assigned by the Greater Waterbury Health Partnership Steering Committee.

As described in the bylaws, HEC participants have an explicit responsibility to recruit and nominate new Participant Community members to ensure that the HEC broadly represents the Greater Waterbury community. This responsibility also includes helping to orient new members.

Our proposed bylaws outline specific roles and responsibilities for participating communities, the HEC Chair, Vice Chair, ad hoc committees, and the backbone organization.

Community residents will be able to serve on ad hoc committees and will be engaged at appropriate intervals during the HEC process. For example, the Community Health Needs Assessment that will be conducted next summer will be an important opportunity for residents to provide feedback and input on our priority framework.

The proposed HEC bylaws are included in Appendix E.

Community/resident engagement strategy

Detail the community/resident engagement strategy. Did your group have any issues engaging with residents? If so, why? How was your community flexible with meeting scheduling and location, childcare arrangements, transportation, and utilizing alternative technologies for engagement? Share lessons learned regarding which strategies were more effective vs. less effective. Please include any supporting documentation in Appendix F.

Originally, our community we planned to hold two focus group meetings with community residents, led by resident facilitators as part of our community engagement strategy. Locations under consideration were in the North End, South End and East End of Waterbury.

After COVID-19 hit and in person gatherings were no longer possible, we used this triage tool to evaluate the situation, and made the decision to pause our community engagement work for the months of April and May. We resumed our community engagement work in June with a survey to gather resident input on health interventions that align with healthy weight and child well-being. Residents were asked thirteen questions to rate their awareness of existing programs, identify barriers to obtaining services, and make suggestions for new services in these areas.

The survey instrument was developed by the HEC Leadership Team. The draft instrument was then reviewed by a HEC Equity Review Committee to make sure the text was appropriate, accurate and culturally responsive. Edits were made to the instrument as a result. The survey was translated into Spanish and input on similar surveys was solicited from other HECs in the state.

A link on Constant Contact and an invitation to fill out the survey in either English or Spanish was posted on the following social media outlets:

- Greater Waterbury YMCA Facebook page - 4,600 followers
- GWHP staff personal Facebook page - 400 connections
- Waterbury Observer Facebook page - 26,000 followers

The survey was also sent to:

- All 200 contacts in the GWHP mailing list
- The Connecticut Community Foundation
- Easter Seals
- Food Pantries
- The United Way of Greater Waterbury
- Waterbury Bridge to Success
- Wellmore

In addition to receiving 75 survey responses, eight residents expressed interest in learning more about GWHP and the HEC process. Full results from the survey are included in Appendix F.

Memorandum of Agreement

Include the Memorandum of Agreement(s) in Appendix A.

Data and measurement

Detail your community's data collection, measurement development, and related analysis. Include identified: community characteristics, strategies, and opportunities or barriers. Describe your future goals around data infrastructure that would optimally support HEC function. Please include any supporting documentation in Appendix G.

The Greater Waterbury Health Partnership collaborates with clinical partners on a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in the greater Waterbury region. The assessment examines a variety of community characteristics and indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The CHNA process enables us to examine community health feedback and data comparatively over three cycles, 2013, 2016 and 2019. The findings from the assessment are deployed by the partnership to prioritize public health issues and develop strategies and a unified community health implementation plan focused on meeting community needs.

We will be undertaking our next CHNA in the summer of 2021, and will be able to incorporate the HEC priorities of child well being and healthy weight into the assessment.

Future data infrastructure goals that would optimally support our HEC function include:

- Standard data elements used across all HECs.
- Adoption of a standard electronic medical record (EMR) across the city of Waterbury and the region.
- Citywide use of new databases, such as the service episode database Unite Us.
- Maverick system through Waterbury Department of Public Health to receive and collect data on Covid positive residents.
- Linkages with statewide initiatives such as the Syndromic Surveillance System should be developed at the state level to minimize duplication of effort.
- Consideration of data collection challenges from rural areas. For example, every two years GWHP collects data for the 21-town region. Statistically significant data is collected for Waterbury, Naugatuck, New Milford, and the health districts that include the towns of Cheshire, Prospect, Wolcott and Oxford, Woodbury and Southbury. The remaining twelve towns do not have a large enough population to sample at a statistically significant level.
- Aligning regions with existing regional networks such as the Councils of Government or Regional Behavioral Health Action Organizations (RBHAOs) to assist in data collection efforts and a better understanding of cross-sector initiatives that are targeting similar high need populations.

Slides showing data reviewed are included in Appendix G.

Lessons Learned

Detail the cumulative lessons learned from both Phase 1 and Phase 2 of the HEC Pre-Planning initiative. Include any supports you could benefit from that you think other HECs might find useful as well (e.g., training, technical assistance, centralized infrastructure elements like data analytics support, etc.).

- *Shifting context:* Without question, the COVID-19 pandemic has shifted many aspects of health care delivery across the region and the state. Finding innovative, cost effective ways to respond to the changes in the health care landscape will remain a challenge for the foreseeable future, particularly given the financial pressures that are straining many parts of the system. In addition, changes in partner leadership (such as the director of a local hospital), the healthcare industry (such as hospital mergers) and the federal, state, and local political environment will influence the development of HECs in unknown ways.
- *Policy disincentives*: Existing state and federal policy disincentives should be explicitly acknowledged and taken into consideration as the HEC RFP is designed (e.g., Medicare will not pay for multiple services in one day).
- *Culturally appropriate and accessible language:* HECs should be required to use culturally appropriate, clear, plain language in interventions, resident engagement and governance activities, with technical assistance offered by the state when needed.

- *Support for groundwork needed before implementation:* Before a HEC model can be successfully implemented, HEC collaboratives need financial assistance from the state to undertake larger data collection efforts. For example, in order to respond to design challenges such as the overlapping geography issue outline above, our HEC would need to undertake an in-depth survey of resident patterns and preferences for receiving health care. Such a study is beyond our capacity financially. It would be helpful if the state could engage a firm to be of assistance to all the HECS, similar to the way in which Datahaven assists on the CHIME database.

- *Fiscal sponsorship:* Fiscal sponsors have regulatory, statutory and internal management requirements that may impact the operation of a HEC. HECs may be required to meet certain compliance standards even though their services do not fall into the same domain as their fiscal sponsor. Providing adequate time and resources to delineate the details of the relationship between the HEC and its fiscal sponsor is critical.

- *Legal liability analysis:* A thorough review of potential legal liabilities would be needed, with thought given to possible protections that would be required if the backbone organization were to be sued.

Recommendations

Provide recommendations for the development of future HECs. When detailing this section, consider what will make HECs successful in Connecticut. Avoid "no, because" and use instead "yes, if" – potential solutions on how to fix barriers are welcome.

Given our experience as a Reference Community and what we currently understand about the HEC model, we believe it is feasible for us to develop a Health Enhancement Community in the Greater Waterbury area. At the same time, there are many unknown factors, opportunities and potential barriers that would influence how a HEC would be implemented. Significant risks and considerations include:

- *Impact on segments of service delivery:* Different segments of the service delivery system will have high needs for information on the impact of a HEC on their operations and how they fit into the model.

- *Relationship to social determinants of health:* Sufficient consideration would need to be given to determining which social determinants of health could realistically be addressed which affect the conditions we are trying to prevent/improve, taking into account our current capacity and what is already being done in the community.

- *Technical assistance:* State technical financial assistance would be needed not only during the initial intensive planning phase, but through the signing of contracts to begin implementation. Such assistance would need to consider potential impediments such as current bidding laws and ordinances.

- *Local control:* Local control is a norm in Connecticut, and in our area. Ensuring that there is a balance between statewide requirements and local preferences (both between and within HECs) will be important.

<u>Other suggestions to make HECs successful in Connecticut</u>

- *Ties to capital improvements, built environment, and environmental justice:* An RFP to implement the HEC model should also support changes to physical environments that support better trauma-informed care (e.g., more private space). Consideration should also be given to issues of environmental justice that affect health, such as remediation for brownfields and contaminated sites, and making sure that school buildings do not worsen chronic conditions such as asthma.

- *Learning community:* A learning community should be established among HECs to exchange information about lessons learned and to ensure common definitions are being used across HECs.
- *Flexibility over time:* Flexibility should be incorporated into the RFP requirements for a HEC, with an opportunity to further define the model as collaboratives gain experience.
- *Marketing and branding:* Some higher-level branding of HECs should be done statewide, but not detailed messages – more along the lines of a "master brand" and "flavors" at the local level.

Appendix A – Memorandum of Agreement

Attach a copy of at least one executed Memorandum of Agreement between the Lead Applicant and Participant Organization(s), or between a Participant Organization(s) and another Participant Organization(s).

We have received executed MOUs from the following partners:

- Chesprocott Health District
- The Connecticut Community Foundation
- Greater Waterbury YMCA
- Staywell Health Center
- St. Mary's Hospital
- Waterbury Bridge to Success

We anticipate receiving executed MOUs from the following partners:

- City of Waterbury Health Department
- United Way of Greater Waterbury
- Waterbury Hospital *(may require further engagement)*

A copy of the MOU with the Connecticut Community Foundation follows.

HEC
Health Enhancement Community
A State of CT Office of Health Strategy Initiative

Memorandum of Understanding between:
Greater Waterbury Health Partnership/Health Enhancement Community
HEC Participant Organization

This Memorandum of Understanding (MOU) sets forth our understanding with respect to the proposed development of the Health Enhancement Community (HEC), an initiative led by Greater Waterbury Health Partnership (GWHP) and community based organizations.

We have come together in recognition that community health, non-profit and clinical resources could be streamlined to improve the health status of our community in two health priority areas: Healthy Weight and Child Well Being birth-age 8. We also assume that intentional interventions, a population focus, and decisions informed by data will result in long-term health improvement in the population served, enhanced access to programs and lower costs. To this end, we, as separate organizations, set out to establish this HEC to aid in the implementation of mid and up-stream health interventions that will improve the well being of residents today and tomorrow.

Vision/Goals:

As providers of health programs, health care, child care, vital social services, health advocacy and coordination of systems within this community, we come together with a common vision to create a Health Enhancement Community (HEC). The shared goals are based on the recognition that a collaborative planning and delivery model to serve residents with poorer health outcomes in the 2 priority areas will result in longer term improved health and well being and connection to vital social services and programming. The goal of the Waterbury HEC is to create and reinforce a more equitable health landscape that bridges the divides between race, ethnicity and incomes for people in Greater Waterbury.

Each party acknowledges a willingness and commitment to comply with all policies, procedures, protocols, or other effects of the items developed and consented to within this MOU.

The agreed upon name for this collaborative is the Greater Waterbury Health Partnership Health Enhancement Community. This name will be used by all partners in signage, letter head,

documentation, patient education materials, and any other materials that are co-created and used within the client population.

Our shared goals are to focus on (but not be limited to) the population in need of quality recreational or weight management programming, nutrition services, diabetes prevention programming, child well-being programs or child care programs in order to enhance quality, participation and access to needed services, decrease overall cost, and ultimately improve the overall health status of our community.

Organizational Structure and Oversight

- A HEC Participant Community Collaborative is established and will continue, with equal representation of each participant organization, to function as the collective body over the development and oversight of this new collaborative initiative. This HEC is built on the commitment and active participation of decision-makers from clinical and community organizations making contributions to the overall effort.

- The HEC will meet on a monthly basis during development and early implementation and thereafter conduct meetings at least quarterly. There will be officers of the HEC, as stated in the By-Laws.

- Additional groups and organizations can be admitted to the HEC collaborative with the acknowledged consent of all HEC Participant Organizations.

- While the HEC will allow the GWHP operational directors to have the freedom and ability to manage its day to day functions, the responsibility of the HEC collaborative will include:

    - Identifying the populations and areas/communities targeted
    - Ensuring the effective management of the target patient/client populations
    - Ensuring the seamless collaboration of clinical providers and community-based organizations within the new HEC
    - Determining gaps in the delivery system and collaborating on building new capacity
    - Facilitation and approval of financing strategies to maximize all available resources (federal, state, philanthropic, HCO contracts, etc.)
    - Identifying systems needs (e.g. IT, additional care management) and managing vendors, or consultants to ensure directed and coordinated efforts that function for the whole of the HEC Collaborative
    - Guiding GWHP staff to set and measure quality benchmarks that address both effective utilization of services, and ultimately, improved individual and community-wide health status

- Holding GWHP and HEC leadership to a continuous process of monitoring, evaluation and change to ensure ongoing effectiveness and cost efficiency.

- The HEC will be formed with representation from Saint Mary's Hospital, Staywell Health Center, Waterbury Hospital, Greater Waterbury YMCA, Waterbury Bridge to Success, Waterbury Department of Public Health and any other community organization admitted to the HEC Collaborative. The HEC reports to the GWHP Steering Committee on the implementation, operation, and evaluation of the HEC and any other matters as assigned by the Greater Waterbury Health Partnership Steering Committee. The HEC will meet monthly and/or at minimum, quarterly, at designated partner locations organized by GWHP staff.

- Data tracking mechanisms, meeting space, equipment and supplies related to running of the HEC will be provided by Greater Waterbury Health Partnership.

Funding sources, billing and reimbursement

- Nothing in this Memorandum will obligate any partner to transfer funds and individual billing between clinical programs or community-based organizations.

- A finance group may be created from HEC Participant Organization representation to discuss alternative payment and financial opportunities to support and sustain the HEC.

- Individual partner grant opportunities will be discussed with the other relevant partners, but individual grant money belongs to that of the individual partner.

- The Greater Waterbury Health Partnership will only hold grant funds that it has procured for the operation and management of the HEC and will disperse those funds to partners only when allowable through existing or future grant contracts with GWHP and funders.

- In the course of this HEC partnership, each organization may provide information that it wishes to remain confidential. Each organization pledges to treat any such information as confidential and not to disclose it nor to permit the disclosure of it to any third party.

- With respect to professional training needs and requirements, staffs at all levels may have training opportunities as funding allows for HEC work related requirements for each partnering organization.

- Each HEC partner agency staffs to appropriate levels and is responsible for their own employees related to partnership participation in HEC initiatives.

Statements of Autonomy and Partnership:

- While each HEC partner maintains their right to enter into arrangements with other providers, for the same or similar services, at the same time each partner also has a certain duty or loyalty to the partnership where transparency is a working principle.

- Each organization assures that boards and employees within their organizations and their constituents will be made aware of and understand the role of this collaborative.

- Neither partner is under the obligation to refer participants into partner programs related to HEC initiatives.

- Patients, residents and clients retain the freedom to attend programs and see whomever they choose.

- Each partner agrees to comply with all federal and state laws regarding HIPPA.

- No liability will arise or be assumed between partners as a result of this Memorandum of Understanding. However, both organizations will cooperate to allow the liability/indemnification issues of the other organizations to be addressed and resolved.

Greater Waterbury HEALTH PARTNERSHIP

HEC

This MOU is valid for one year from the last date of signature by any signatory to this MOU, or until it is superseded by subsequent agreement and/or extension of this MOU, whichever occurs first. This MOU will be reviewed annually. Proposals to make changes to the document are required to be made and reviewed 60 days prior to the annual review.

Signature: Althea M. Brooks Date: 8-24-2020

Name: Althea Marshall Brooks Title: Executive Director

On Behalf of: Waterbury Bridge to Success Community Partnership

Signature: [signature] Date: 9/8/2020

Name: Angie Mathis Title: Executive Director, GWHP

On Behalf of: GWHP

Greater Waterbury Health Partnership is supported by the following:

CHESPROCOTT HEALTH DISTRICT

Connecticut Community Foundation Timeless Impact

Trinity Health Of New England Saint Mary's Hospital

StayWell Health Center

United Way United Way of Greater Waterbury

Waterbury Hospital Waterbury HEALTH

Appendix B – HEC Partners

Meeting Summary
Greater Waterbury HEC Suburban Engagement Session
January 14, 2020

In attendance:

- Peter Adamo, CEO, Waterbury Hospital (Waterbury Health)
- Allison Blancato, Outreach Coordinator, St. Mary's Hospital
- Ellen Carter, Community Leadership Director, Connecticut Community Foundation
- Maura Esposito, Director of Health, Chesprocott Health District
- Dr. Alex Geerstma, Pediatrician, Waterbury, CT Chapter of American Academy of Pediatrics
- Kate Glendon, Public Health Specialist, Chesprocott Health District
- Jessica Jaramillo, Early Care and Education Coordinator, Bridge to Success
- Neal Lustig, Director of Health, Pomperaug Health District
- Joanne Nanavaty, Nurse Educator, Pomperaug Health District
- Jim O'Rourke, CEO, YMCA of Greater Waterbury
- JoAnn Reynolds-Balanda, VP of Community Impact, United Way of Greater Waterbury
- Sandy Russell, Community Resident, Prospect
- Jill Schoenfuss, Youth and Community Strategy Director, StayWell Health Center, Inc.
- Dawn Tendler, Pomperaug Community Resident
- Donald Thompson, President/CEO, StayWell Health Center, Inc.
- Cindy Vitone, Waterbury Health Department
- LoriBeth Williams, Rehabilitation Therapist, DSS and Waterbury resident

GWHP Staff: Angie Matthis, Executive Director; Caitlin Collins, Program Director
Consultant: Alison Johnson, Consultant to GWHP

Welcome and Overview

Angie Matthis welcomed everyone and reviewed the current status of the Health Enhancement Community (HEC) process in the greater Waterbury area. The HEC is a place-based initiative that will support long-term, collaborative, and cross-sector efforts that improve community health in defined geographies through broad, systemic change.

The HEC Initiative embeds health equity in its two priority aims:

- Improving child well-being in Connecticut pre-birth to age 8 years: assuring all children are in safe, stable, and nurturing environments
- Improving healthy weight and physical fitness for all Connecticut residents

The Greater Waterbury Health Partnership (GWHP) has been in Waterbury since 2013. GWHP facilities data collection and the Community Health Needs Assessment (CHNA) and formulates strategies to react to that data to address health concerns. GWHP also works collaboratively with community-based organizations and clinical providers. This is the second time that GWHP has been a part of the HEC process, which supports relationship building with community-based organizations.

Today's meeting brings together suburban and urban health districts to explore how we can rely on partnerships to accomplish joint health goals for our community.

What potential suburban partner organizations could we connect with related to HEC aims?

Participants were asked to think about their suburban/urban community, and to suggest organization/business names of potential partners that work within the HEC priority aims or would have an interest in a Health Enhancement Community Model.

Angie briefly reviewed a sample of the resulting list, which included senior centers, PTOs, health clubs, YMCAs, Boys & Girls Clubs, Police Activity League, school readiness, flu clinics, Boy & Girl Scouts, Parks & Recreation Departments, and nursery and elementary schools.

A four-page list of potential partners for the two priority aims of healthy weight for all, and child well-being is available upon request.

Partnership Questions Exercise

Given the list of partners that were identified, participants were invited to answer the following questions for their own communities:

- What value lies in formalized HEC partnerships with these newly identified resources/organizations?
- What gaps in services in your town or community do you have that could be supported by partnerships with other towns/districts/communities?
- How might you, your organization or neighbors personally benefit from partnerships operating in a reciprocal manner across town lines to bring expanded services around Healthy Weight and Child Well-Being?

A three-page list of answers given is available upon request.

Review of CHNA data around HEC priority aims

Angie Matthis reviewed a series of health indicators for the Greater Waterbury region (see the accompanying slides for details):

- Childhood and adult obesity in Waterbury, Greater Waterbury, and the state as a whole; people of color are disproportionally affected
- Diabetes
- Physical inactivity
- Children with asthma
- High school graduation rates
- Substantiated cases of child abuse and childhood deaths
- Key indicators of child well-being from the Kids Count Data book

Discussion points included:

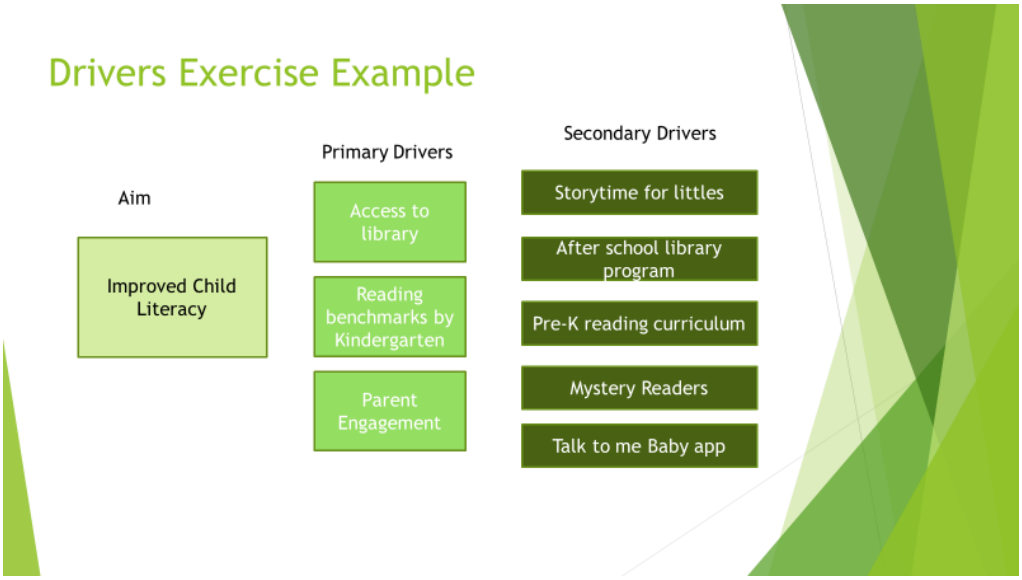
- The criteria used to determine obesity and child abuse cases.
- Historical effects of the highway bisecting the city leading to changes in conditions such as the disappearance of smaller food stores, which in turn helps lead to different health outcomes in different neighborhoods (Bunker Hill, Brooklyn, downtown) – smaller food stores went away; conditions changed
- How the "U" shape of one of the Waterbury census tracts influences data results, given that results are averaged across the entire tract
- Concerning the practice of primary care and pediatric medicine – it's traditionally a stronger process if you live in the same city or close to an academic center that is at the hub of that work, since you can stay closer and be updated with the latest information; years ago, there was a more integrated department of Pediatrics in Waterbury; we tried to do more with Yale and the CT Children's Medical Center, but it has fallen off for practical reasons
- There is a great deal of new relevant research on the development of children's eating patterns – how they evolve over time, how they are affected by commercialism and increasingly affecting onset of obesity; we did a recent study with the CT Community Foundation which shows that the onset of obesity has gotten younger & younger. It would be great to be able to share this information with surrounding communities.
- The CDC is reporting a leveling out of childhood obesity, but upon closer review, it's continuing to rise, especially in certain socioeconomic groups and populations such as Asian children. The implications are that more resources are required in certain areas.
- The Easy Breathing program which helped children with asthma reduce their ED visits was ended due to a lack of funding; if a program is solely grant funded, the program often lives only as long as grants are available.
- There is an alarming increase in adolescent suicide.
- Co-pays discourage the use of health services. For families who are on HUSKY (which has not copays), there is a leveling off of ED use.
- Looking at the rates of childhood deaths, it really matters where you live.

Identification of Primary and Secondary Drivers Exercise

Using a brainstorming exercise, participants were asked to identify drivers to help think through possible interventions to achieve the two HEC priority aims in our area, using the following parameters:

- Primary drivers are system components or factors that contribute directly to achieving the aim.
- Secondary drivers are actions, interventions, or lower-level components necessary to achieve the primary drivers.

As an illustration, Angie Matthis reviewed an example of primary and secondary drivers for improved child literacy:



A few sample healthy weight drivers were reviewed, including family income to afford good quality food, transportation, access to whole foods via giveaways, access to grocery stores, school lunch programs, recess and outdoor play.

One participant mentioned that a review of the literature found that both punitive and rewarding policy measures help reduce obesity; for example, a sugary beverage tax on the punitive side and subsidizing fresh fruit and vegetables on the rewarding side. Children are exposed to a great deal of marketing for sugary juices.

For child well-being, sample drivers included encouraging play time, parents that read, awareness of mental health resources for kids, postpartum depression support for mothers, ACES interventions, a longer gym time, school breakfast, community gardens, lead free homes.

A two-page list of answers given is available upon request.

What might a HEC look like for urban/suburban communities?

We are in the exploratory stage of thinking about partnerships between clinical providers and community organizations across the health districts.

As an example, Neal Lustig described a diabetes intervention program at the Pomperaug Health District that is helpful for understanding how a HEC might operate for urban and suburban communities. Over the last nine years, Pomperaug has been dedicated to expanding evidence-based intervention programs. The District applied for a grant with the Naugatuck Valley Health District for a diabetes self-management program (DSMP) under the State Innovation Model (SIM) in the Office of Health Strategy. The program started in March of 2018 and is being completed this month

Working out of the Chase Clinic, a community based organization, the two health districts and a provider, Prospect Waterbury Hospital, collaborated to deliver four DSMP sessions. The sessions run 2.5 hours a week for six weeks, using behavioral modification and goal setting and are run by non-medical Community Health Workers.

The two health departments enter data into a database in the cloud, tracking demographic data and pre and post Qualidigm educational test along with their HbA1c information. Waterbury Health Access assists with the social determinants of health. This is a challenging population to engage, so the program actively engages and trains residents to talk with patients. With the five people in each session, final results showed that people had reductions in HbA1c of between 4% and 27%, with an average of 11%. There was a clear correlation between the behavioral skills pre and post-test and participants HbA1c levels. We used incentives, including $50 gift cards and free books and CDs.

Peer-based, community-based education clearly works. There is a question for policy makers, which is how does this type of effort get paid for moving forward? This cost somewhere in the neighborhood of $2- $3K for this cohort, and was a grant funded program.

A suggestion was made that local corporations might be willing to fund initiatives that encourage people to eat in a healthier manner. For example, a local consulting firm offered funds to work with a nonprofit to address food deserts in Bridgeport, but the funds were not released as community engagement was needed before the program could be initiated. Perhaps focusing on smaller organizations (such as churches) whose membership is interested in increasing residents' overall well-being would be a way to successfully engage the community.

Next steps

Given this exploration of partner resources, what are next steps? Our goal is to inspire clinical providers to reinvest savings from their patients into the community local area; to facilitate that, our HEC hopes to be able to initiate payment reform or different types of payment models so that local providers are not always reliant on grants.

We received an extension of the HEC contract until June of 2020, and are in the process of negotiating that contract now. The shape of the work will change during this second phase as

we seek to formalize partnerships and identifications of interventions for our community, and there will be a final report to the state on our work. We will also be meeting with the Northwest Connecticut Community Foundation to explore the possibility of an expanded geographic scope under a HEC model.

The state is also in the process of looking at possibilities for funding such as the creation of a wellness trust and blending private foundation and public funding.

GWHP will continue to be the primary point of contact for the project. Alison Johnson will send follow up email with slides and notes from meeting for all attendees and those that could not attend.

Greater Waterbury HEALTH PARTNERSHIP

Dear Partner,

As we head into an uncertain Fall on many accounts, GWHP is completing work for the State of CT on the Health Enhancement Communities Phase II Planning. Like many of you, we have had to modify both our approach and our timeline due to Covid-19. I'm pleased to report that we are in the final step of closing out this phase of HEC for the State.

In this packet, you will find for your review and approval a summary of completed Phase II work. This work includes the following activities:

- Development and execution of a resident survey to collect information about current and potential health interventions related to Child Well-Being and Healthy Weight
- Development of proposed HEC structure/Governance By Laws
- Development of a HEC MOU to be executed by partners
- Creation of a system of metrics to be applied to HEC interventions
- A list of proposed HEC interventions informed by residents and partners
- A summary of future sustainability strategies

We know that these are challenging times for our partners, which is why we have chosen to complete these final steps of our work without a large discussion group meeting or Zoom session. We have opted to provide this review packet to allow you more flexibility to read and respond at a time convenient that is convenient or you.

Please review the summary of our work to date and if you are in agreement, please respond in the following manner:

1. ***Sign and return*** the Waterbury HEC Memorandum of Understanding (required by the State Office of Health Strategy) to: ccollins@staywellhealth.org
2. ***Provide feedback*** or recommendations on the list of proposed HEC Interventions by completing this brief Google Form: HEC Google Feedback Form
3. If you prefer not to provide feedback via Google Form, please email feedback to our consultant, Alison Johnson at : alison.johnson@snet.net

We kindly ask that all MOU's and feedback be returned to us by Monday, August 23, 2020 so that we can finalize our reports to the State of CT Office of Health Strategy on time. There will be more extensive information about sustainability of the HEC initiative in our final report, which will be sent to all HEC partner organizations in October.
Thank you for your support and participation in this important work.

In good health,

Angie Matthis, Executive Director, Greater Waterbury Health Partnership

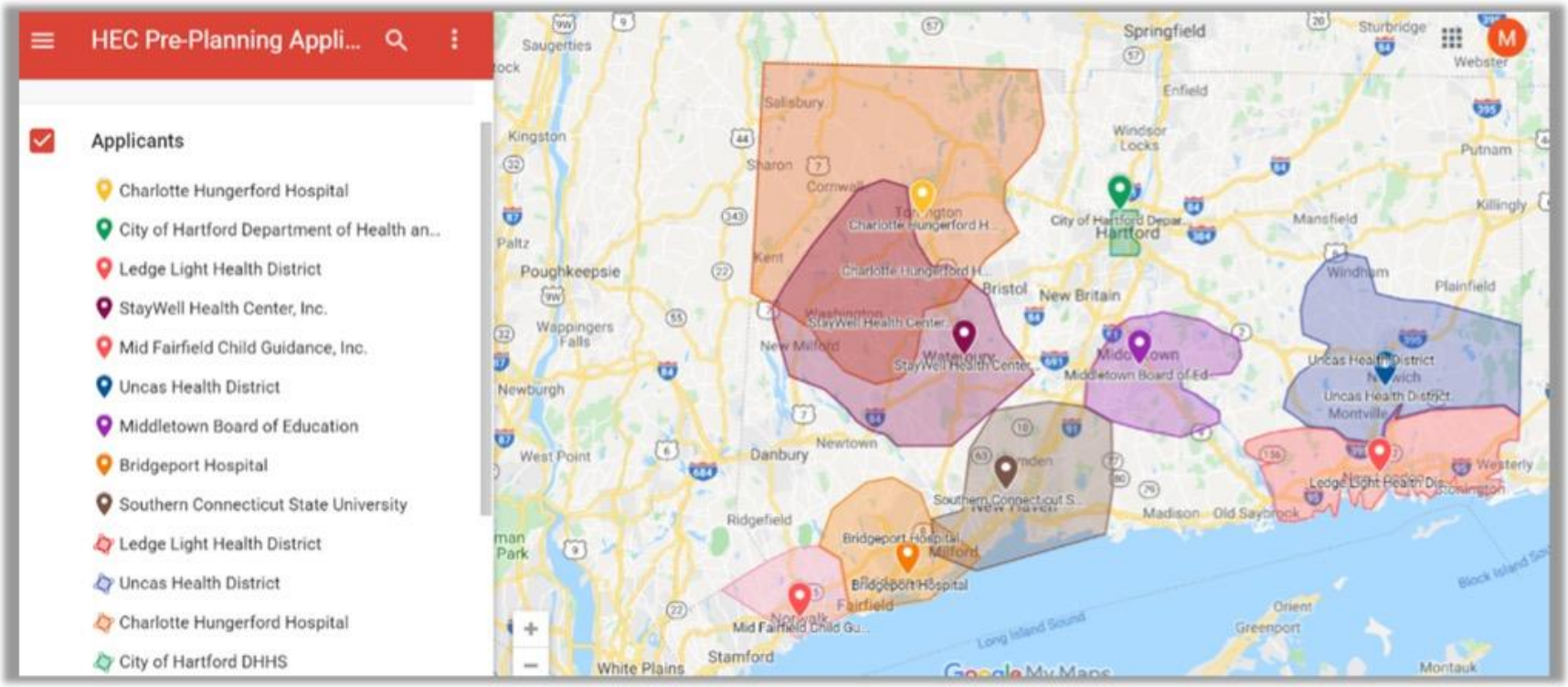
Appendix C – Preliminary or core set of interventions

Priority	Domain	Intervention	Provider or Possible Provider	Status	Program	System	Policy	Cultural	Metrics to be Deployed	Measure
Child Well Being	Care Coordination	Sparkler	BTS	New	x	x			Program Data	% of users with improved ASQ scores; use app
Child Well Being	Care Coordination	Mahmee	GWHP	New	x	x		x	Program Data/State of CT DPH	# of linkages made/patient satisfaction survey/% screened for PPD; digital platform
Child Well Being	Care Coordination	School Based Health Centers	Staywell Health Center	New	x	x		x	CT Dept of Education, Staywell data	% immunized, dental care, BMI within healthy range
Healthy Weight	Chronic Disease	Live Well Program Series	WCAAA, Hospital, Health Department	Current	x				Program data; BRFSS; CHIME	Rate of change in BMI by race
Healthy Weight	Chronic Disease	YMCA Diabetes Prevention Program	Greater Waterbury YMCA	Current	x	x			Program data; BRFSS, CHIME	% reduction BMI/rate of diabetes by zip
Child Well Being	Chronic Disease	Putting on Airs	Saint Mary's/GWHP	New	x	x	x		CHIME/State DPH	% reduction in ashtma-related ED visits
Child Well Being	Environment	Boost Schools	BTS	New	x	x			Program Data	% children completing program
Both	Environment	Parks improvement	City of Waterbury	New		x	x	x	DataHaven WellBeing	Walkability Index, Waterbury

Priority	Domain	Intervention	Provider or Possible Provider	Status	Program	System	Policy	Cultural	Metrics to be Deployed	Measure
Healthy Weight	Exercise	Ready, Set, Go	Greater Waterbury YMCA	Current	x				Program Data	% program completers, % reduction in BMI
Healthy Weight	Exercise	Yoga in our City	Waterbury DPH/Connecticare	Current	x				DataHaven CHNA	Self-reported improved health risk factors and well being index
Child Well Being	Exercise	School based Yoga	YMCA	New	x	x			State of CT Dept of Education	Rate of school suspensions
Healthy Weight	Food	Cooking Matters	Staywell Health Center	Current	x			x	Adult Obesity Prevalence	% reduction BMI and reduction of hypertension
Healthy Weight	Food	Food Corps	Waterbury Public Schools	Current	x	x	x		Waterbury DPH school nurses child obesity	Child Obesity Prevalence
Healthy Weight	Food	Brass City Harvest	Brass City Harvest	New	x	x			CDC	Obesity/Chronic Conditions by zip/ Limited Access to Healthy Foods/Food Deserts
Child Well Being	Food	School-Based Produce Stand Model	Brass City Harvest/Uconn	New	x	x	x		CDC	% residents with limited access to healthy foods

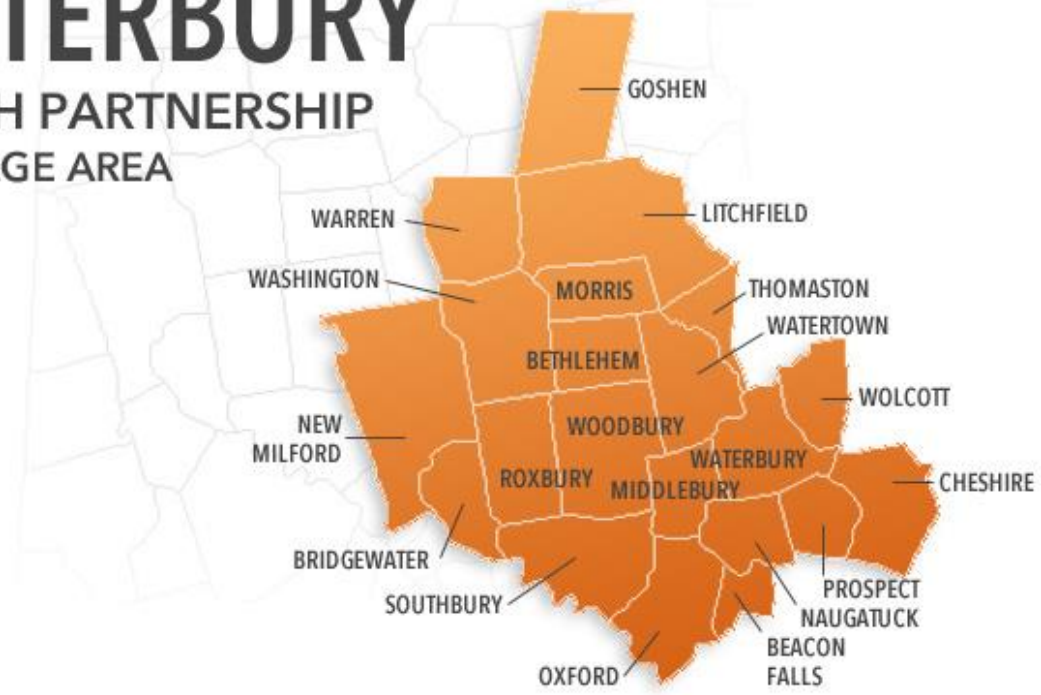
Appendix D – Geographic area and target population

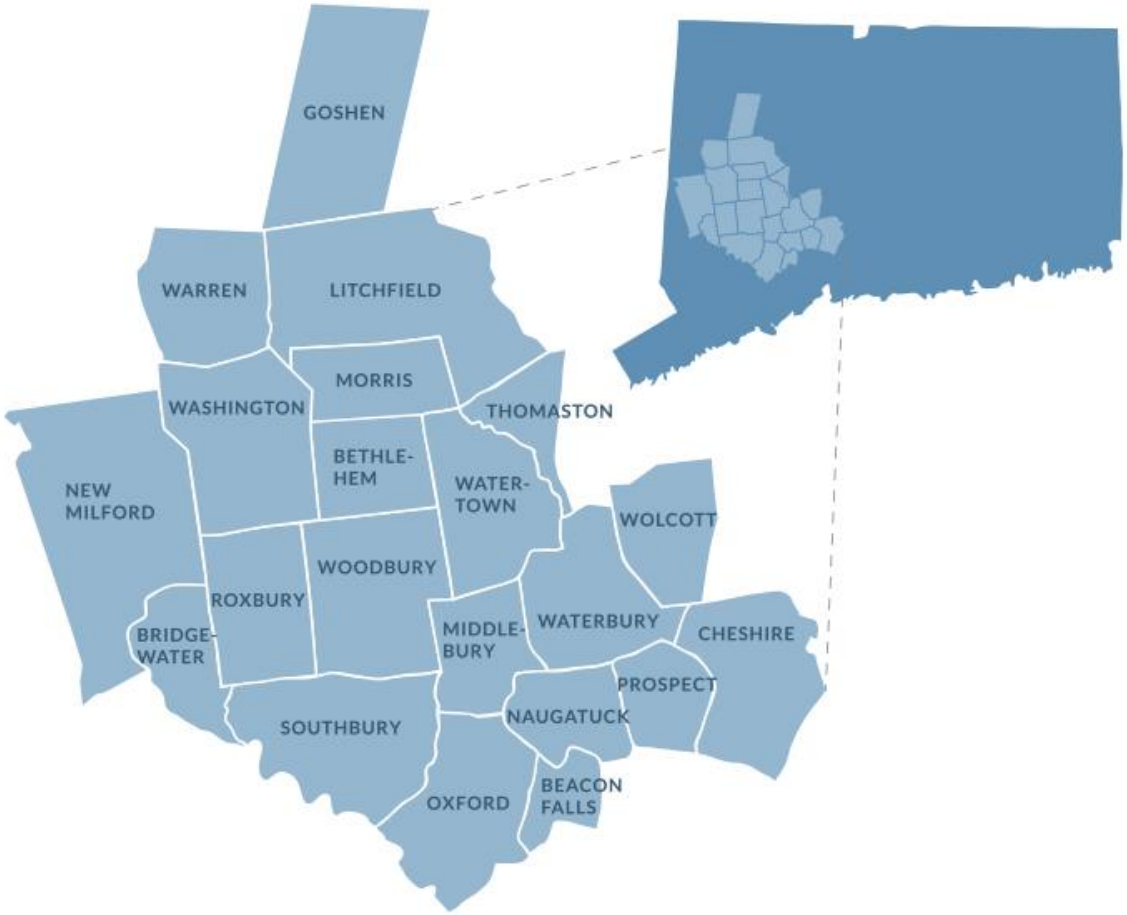
Our geographic discussion included review of six maps:



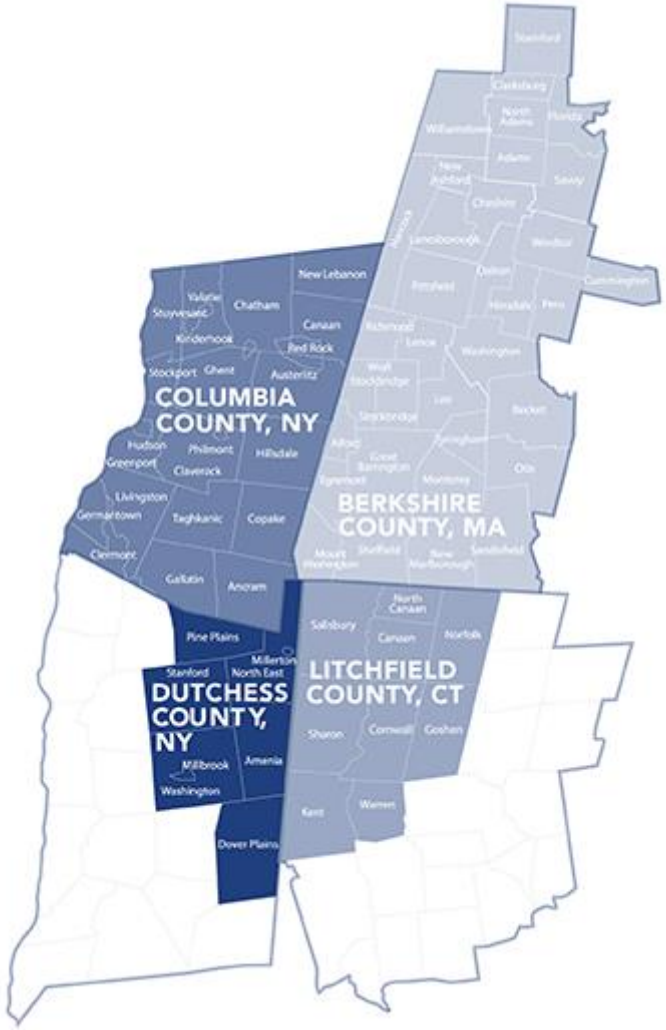
GREATER WATERBURY

HEALTH PARTNERSHIP COVERAGE AREA





Connecticut Community Foundation Service Area



Berkshire Taconic Service Area

Northwest Regional Map

State of Connecticut - Local Health Departments and Districts, June 2019

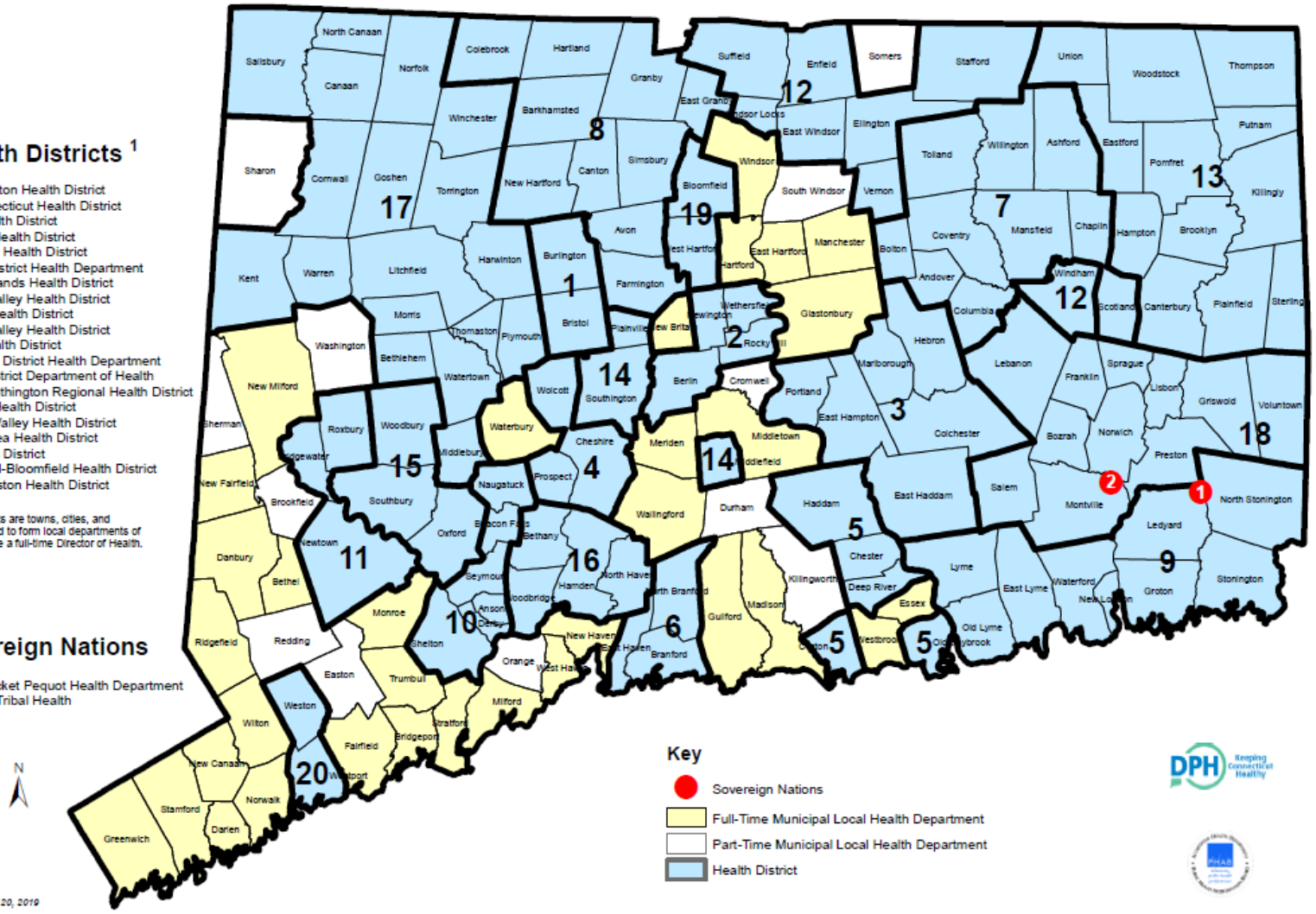
Health Districts [1]

1. Bristol-Burlington Health District
2. Central Connecticut Health District
3. Chatham Health District
4. Chesprocott Health District
5. CT River Area Health District
6. East Shore District Health Department
7. Eastern Highlands Health District
8. Farmington Valley Health District
9. Ledge Light Health District
10. Naugatuck Valley Health District
11. Newtown Health District
12. North Central District Health Department
13. Northeast District Department of Health
14. Plainville-Southington Regional Health District
15. Pomperaug Health District
16. Quinnipiack Valley Health District
17. Torrington Area Health District
18. Uncas Health District
19. West Hartford-Bloomfield Health District
20. Westport Weston Health District

[1] Health Districts are towns, cities, and boroughs united to form local departments of health and have a full-time Director of Health.

Sovereign Nations

1. Mashantucket Pequot Health Department
2. Mohegan Tribal Health



Appendix E – Governance structure, accountability mechanisms

Proposed Bylaws for the Greater Waterbury Health Enhancement Community

Article I- Name, Organization, Vision, Purpose and Core Values

Section 1 – Name

The name of the collaborative shall be **The Greater Waterbury Health Partnership (GWHP) Health Enhancement Community (HEC) Initiative.**

Section 2- Organization/Authorized/Composition

GWHP's HEC is a group of community members, clinical partners and organizations working together to develop, implement and track health interventions that improve outcomes related to Healthy Weight and Child Well Being in the Greater Waterbury community. The GWHP HEC is informed by resident feedback as a tool to guide decision making.

Section 3 - Vision

Through the power of collective impact, we envision a community where social, physical, and environmental infrastructure enables all residents to pursue and achieve optimal health status.

Section 4 - Purpose

The purpose of GWHP's HEC Collaborative Initiative is to support, promote, and coordinate a common agenda to ensure that all residents of Greater Waterbury have equal opportunity to pursue and achieve optimal health status through interventions that are constructed to be measurable, preventative, equitable, culturally competent and inclusive.

Section 5- Core Values

GWHP's HEC represents multiple sectors and is comprised of public, private and community stakeholders reflective of the diverse needs of the community. It strives to operate with transparency, collaboration, and in a manner which engages the community around health outcomes. It employs evidence-based strategies, shared measurement systems, and cooperative work to assist partners in pursuing mutually reinforcing activities.

Article II- Health Enhancement Community Initiative (HEC) Membership

Section 1 – Membership

The GWHP HEC shall have between 15 and 20 members referred to as "Participant Communities." As outlined in Article V, the Fiscal Agent and Backbone Organization, Staywell Health Center, shall have a membership role in the HEC at all times.

Section 2- GWHP Terms of Office

2.1 In order to ensure continuity of leadership, GWHP HEC Participant Community members shall generally serve for a term of three (3) years, beginning in January of their year of installation.

2.2 GWHP HEC Participant Community members may serve unlimited consecutive terms.

Section 3 – Responsibilities of GWHP HEC Participant Communities

- Adhere to the mission and purpose of the GWHP HEC
- Identify strategic opportunities and gaps and set priorities in accordance with community health data and monitor progress of HEC plan implementation
- Empower and serve on workgroups and subcommittees to implement the HEC plan
- Provide input on information presented to the HEC by the GWHP Executive Director, residents and Participant Communities
- Assist in the leveraging, securing, and monitoring of funding
- Track and report health outcomes to the community
- Inform others about the collaborative HEC; serve as an advocate for HEC priorities
- Attend meetings and special events; substitutes may attend meetings but will not have voting powers unless designated by proxy.
- Participate in an annual self-assessment of the HEC and collaborative functionality
- Provide input to evaluate
- Recruit and nominate new Participant Community members to ensure that the HEC broadly represents the Greater Waterbury community; help orient new members
- Follow the policies adopted by GWHP (such as Conflict of Interest, Confidentiality, and Communications).

Section 4 – Conduct of the GWHP HEC Participant Community Members

Expectations of the Participant Community members include, but are not limited to, the following:

- Prepare for and attend all quarterly GWHP HEC meetings
- Reside in Greater Waterbury (preferred); work in Greater Waterbury is acceptable in lieu of residency
- Actively participate in GWHP HEC, including giving information, perspectives, and guidance to the participant community collaborative in a respectful and thoughtful manner
- Serve as an ambassador and advocate for GWHP HEC in the community
- Serve as a HEC Participant Community member as a volunteer and without compensation
- Keep in mind the needs of GWHP HEC as a whole, while representing an individual constituency
- Identify existing or potential conflicts of interest relevant to GWHP HEC business and abstain from voting as appropriate

Section 5 – Meetings and Meeting notices

5.1 Regular Meetings - There shall be a minimum of four (4) regular meetings each calendar year at dates, times and places fixed by GWHP. Notice of regular meetings will be published by the tenth working day in January of each year. Regular meetings of the HEC may be held without further notice; however best efforts will be made to send electronic or written reminders of regular meetings a minimum of five (5) work days before the meeting.

5.2 Special Meetings - Special meetings of the HEC may be called by the Chair, or by 1/3 of the HEC Participant Community members. A special meeting must be preceded by at least two (2) days notice to each HEC Participant Community member of the date, time and place, but not the purposes, of the meeting.

5. 3 Executive sessions - Executive sessions may only be used to discuss personnel matters or issues which require full confidentiality. Votes cannot be taken during an Executive Session and the minutes will not detail what is discussed.

5.4 Meeting Guests - Guests are welcome at HEC meetings. After the end of the discussion of the relevant agenda item(s) that the guests came to discuss, the HEC may choose to go into Executive Session, and guests will be required to leave.

Section 8 – Quorum

The number of GWHP HEC Participant Community members may fluctuate over time. A quorum of the GWHP HEC must be present to conduct meetings and/or otherwise transact business of any kind. A quorum shall be equal to half plus one (1) of the number of seated members of the HEC Participant Community Members.

Section 9 - Annual Report

The GWHP HEC will report annually to the Greater Waterbury community on progress made to reach stated goals in the HEC plan, data collected on health interventions, and community well-being needs and priorities. Such report may be provided at an annual meeting or another meeting, the date, time and place of which shall be determined by the GWHP Executive Director. The GWHP Annual Report shall contain a section for HEC and will be publicly available on the GWHP website.

Section 10 - Voting

Votes of the GWHP HEC shall pass by simple majority of those present and voting, except where otherwise prescribed by these by-laws. At the option of the Chair, a conference call with two (2) business days' special notice may be conducted and vote(s) taken provided said members are given detailed information on the issue on which they are voting.

Section 11 - Vacancies
Vacancies on the GWHP HEC shall be filled by nomination from member agencies and a vote by the GWHP HEC Participant Community Members. Chair or Vice Chair vacancies will be filled by a HEC vote. Any individual that fills a vacancy on the HEC shall serve until the next annual election as an interim member.

Section I2 - Removal
A member of the GWHP HEC can or may be removed from the collaborative for missing three (3) consecutive or five (5) total absences at any point during the year. Notice will be provided to HEC member(s) that they are at risk of removal when they reach two (2) consecutive or four (4) total absences.

Article III- Officers

Section I - Chair
Any member of the GWHP HEC may nominate any member, or himself/herself to serve as Chair of the GWHP HEC. Nominations shall take place annually in January. The Chair of the GWHP HEC shall be elected by a majority of the GWHP HEC Participant Community membership. The term of office for Chair shall be two (2) years. The number of consecutive terms of office that a Chair may serve is two (2). Responsibilities of the Chair include:

- Ensure that the organization abides by its bylaws and established priorities
- In collaboration with backbone staff, establish agendas for all GWHP HEC business and annual meetings
- Preside or arrange for another officer to preside at each HEC business and annual meeting in the following order: Vice-Chair, other
- Support and work in partnership with backbone staff to make sure GWHP HEC resolutions are carried out
- Lead oversight of the HEC and evaluation of meeting goals
- Serve as ex-officio member of all committees
- Call special meetings as needed
- Appoint ad hoc committee Chairs
- Act as spokesperson for the HEC body and when doing so, clearly state that they are presenting the position agreed upon by the GWHP HEC vs. their personal or organizational position
- Assist backbone (GWHP) staff in identification, recruitment and orientation of new HEC members
- Maintain records of proceedings of the GWHP HEC collaboration.

Section 2 - Vice-Chair
Any member of the GWHP HEC may nominate any member, or himself/herself to serve as Vice-Chair of the GWHP HEC. Nominations shall take place annually in January. The Vice-Chair of the GWHP HEC shall be elected by a majority of the HEC Participant Community membership. The term of office for Vice-Chair shall be two (2) years. The number of consecutive terms of office that a Chair may serve is two (2). Responsibilities of the Vice-Chair include:

- Chair committee(s) on special subjects as designated by the HEC and Chair
- Attend all GWHP HEC business and annual meetings
- Be knowledgeable about the responsibilities of the Chair and be able to perform these duties in the Chair's absence, including presiding over meetings of the HEC
- Carry out special assignments as requested by the Chair

- Consider serving as Chair at annual nominations
- Assist in identification, recruitment and orientation of new HEC members

Article IV- Membership

Section 1 - Eligibility

Members are eligible to volunteer and/or be recruited on an ongoing basis. To ensure adequate community representation, members shall include, but are not limited to, members of the following sectors of the community: nonprofits, health insurance, public health, health care providers, faith-based organizations, philanthropy, government, education, business, civic and volunteer groups, and area residents and employees.

Section 2 – GWHP HEC Membership

2.1 HEC will have regular workgroups and ad hoc committees to carry out its work and involve members of multiple sectors. Members are encouraged to participate on workgroups and ad hoc committees. Regular workgroups may include the following priority areas:

- Healthy Weight
- Child Well-Being birth-8

Each regular workgroup will have at least four members. There is no maximum number of members who can participate. Workgroups will be formed based on data and have established goals that are reported up to the HEC for ongoing tracking and adjustment.

2.2 Responsibilities of Work Group members include:

- Support the GWHP HEC vision and purpose and provide expertise to further implementation of the plan
- Establish goals and objectives and related programming to implement HEC Intervention plan and priorities
- Select a Chair who represents the workgroup on the GWHP HEC Collaborative
- Meet on a regular calendar with meetings scheduled and agendas distributed in advance
- Identify common indicators and data to share across organizations to measure outcomes of actions
- Report to the GWHP HEC including common outcome indicators and data, as well as gaps, barriers and opportunities
- Inform others about the collaborative and serve as an advocate for HEC priorities
- Cultivate workgroup membership
- Consider serving as GWHP HEC Chair or Co-Chair in future years
- Attend annual, informational, educational or action meetings or events planned by the GWHP HEC

Section 3 - Ad Hoc Committees

The GWHP HEC may from time to time establish committees or task groups to conduct the business of the GWHP HEC. Committee members may include members of the GWHP HEC Participant Community, members of workgroups, or be recruited from the community at large. The GWHP HEC will charge each ad hoc committee with its duties. The GWHP HEC shall appoint ad hoc Committee Chairs if deemed necessary.

Article V- Fiscal Agent and Backbone Organization

Section 1 - Fiscal Agent

Staywell Health Care, Inc. shall serve as the fiduciary and backbone organization for the GWHP HEC collaboration. In that capacity, Staywell Health Care, Inc. shall provide the following functions:

- Provide financial management and accounting for GWHP's HEC-related activities, including grants management
- Assist in preparing the annual budget
- Report quarterly to the GWHP HEC concerning the status of the budget
- Provide GWHP HEC membership with a biannual report that details all funds received and expenditures made
- Have a seat on the GWHP HEC at all times
- Establish data management infrastructure and maintain GWHP HEC website access
- Supervise and review the job performance of the Executive Director and staff each year.
- The Fiscal Agent and Backbone organization may be changed by a unanimous vote of the GWHP Steering Committee. The Fiscal Agent and Backbone organization representative will recuse her/himself from this vote.

Article VI- Miscellaneous

Section 1 - Approval of By-Laws

The GWHP Steering Committee shall vote to adopt the By-Laws. The By-Laws shall be made available to the GWHP HEC membership and to the general public via the GWHP website, as requested.

Section 2 - Amendments to By-Laws

The GWHP HEC may amend these By-Laws, from time to time, with the approval of two-thirds (2/3) of the HEC Participant Community membership. The Steering Committee will review the By-Laws not less than every other year.

Section 3 - Nondiscrimination Policy

GWHP, HEC and all its projects and programs comprise a community of people with respect for diversity. GWHP emphasizes the dignity and equality common to all persons. GWHP does not discriminate against individuals on the basis of race, color, gender, gender expression, sexual orientation, religion, disability, age, veteran status, ancestry, or national or ethnic origin.

Section 4 - Grievance Procedures

GWHP and HEC provides a formal procedure for the resolution of complaints and concerns to ensure that problems are resolved in an equitable and respectful manner. GWHP will hear and resolve concerns about the collaborative from members of the community, Steering Committee members, workgroup members, staff, consultants, and volunteers of HEC. Some causes for concern might include inappropriate behaviors such as racial remarks, physical, sexual, or verbal abuse; harassment, or disrespectful behavior.

If it is appropriate, a person with a complaint or grievance about GWHP HEC should speak with the person(s) involved. When this method is not appropriate or does not resolve the conflict, the person with the complaint should bring it to either the Chair or the Executive Director, who will attempt to resolve the issues within 10 business days. The Chair or the Executive Director will explore the reason

for the complaint with the individual, discuss possible methods of resolution, and may also set a time at which to speak again with the person with the complaint.

Should the problem remain unresolved, the person making the complaint may bring it to the full HEC Participant Community Membership for review, discussion, and exploration of a resolution. After input from the HEC membership, the Chair will be charged with the final responsibility of resolving the issue, and will attempt to do so within ten business days.

Section 5 - Severability

If any section, clause, provision, or portion of these By-Laws area adjudged unconstitutional or invalid by a court of competent jurisdiction, the remainder of these By-Laws shall not be affected thereby.

Appendix F – Community/resident engagement strategy

Summary of Resident Survey

Greater Waterbury Area Health Enhancement Community

A survey was conducted in June to gather input from residents of the Great Waterbury area on health interventions that align with child well-being and healthy weight. Residents were asked to rate their awareness of existing programs, identify barriers to obtaining services, and make suggestions for new services in these areas.

Methodology: A 13 question survey instrument was developed by the HEC Leadership Team. The draft instrument was then reviewed by a HEC equity review committee and edits were made to the instrument. The survey was translated into Spanish and input on similar surveys was solicited from other HECs in the state.

Respondents were asked to provide their zip code, but no other identifying information unless they were interested in learning more about GWHP and the HEC process.

A link on Constant Contact and an invitation to fill out the survey in either English or Spanish was posted on the following social media outlets:

- Greater Waterbury YMCA Facebook page - 4,600 followers
- GWHP staff personal Facebook page - 400 connections
- Waterbury Observer Facebook page - 26,000 followers

The survey was also sent to:

- All 200 contacts in the GWHP mailing list
- The Connecticut Community Foundation
- Easter Seals
- Food Pantries
- The United Way of Greater Waterbury
- Waterbury Bridge to Success
- Wellmore

75 responses were received, including 3 in Spanish. Some responses were partial, as not all respondents answered every question.

RESULTS

- *Program awareness and usage*

  Residents were given brief descriptions of the following four programs and asked about their level of awareness and usage for each:

Priority	**Program**	**Program Awareness**	**Usage –** *for self and people they know*
Child well being	Family & Children's Aid	50%	8%
	TEAM, Inc.	33%	8%
Healthy weight	Brass City Harvest	81%	33%
	YMCA	84%	36%

- *Top barriers to program usage*

  Residents were asked to choose from a list of potential barriers which, if any, make it hard for them, their family, or people they know to use the programs.

Priority	**Barrier –** ***in order of most frequently cited***
Child well being	1. Transportation
	2. Cost
	3. Time of day program offered
	4. Child care /COVID-19 *(tied for 4th)*
	5. Language
Healthy weight	1. Cost
	2. Transportation
	3. Time of day program offered
	4. COVID-19
	5. Enough free time

Other concerns that were raised included mistrust due to staff not being able to relate to program participants (mentioned by two people), and being above the income bracket level served by still not being able to afford the program

Resources relied upon by residents

Residents were asked for a brief narrative description of where they look to for resources on their child's health and to support and maintain a healthy weight.

Most common responses for child health and well-being included:

- 211
- Child care provider
- Church
- Doctor/pediatrician/PCP
- Internet/Google/Web MD
- School
- Social media

Other resources cited include family, Waterbury Department of Public Health, Yale Hospital, and the YMCA.

The most common resources cited for maintaining a healthy weight included:

- 211
- Doctor/pediatrician/ PCP
- Fitness centers and sports a and recreation clubs, including YMCA
- Internet/Google/Web MD
- Mainstream media, including newspapers
- Schools and school nurse
- Social media

Other resources cited include books local parks, support groups, town recreation departments, Weight Watchers, and word of mouth.

- *Resident preferences and ideas for program design*

Residents were asked if they were able to create a program to help children stay healthy and help people maintain a healthy weight, what would they focus on? Where would the program be located, and how much would it cost? Common responses included:

- Accessible by bus, including downtown locations, the green; neighborhood locations
- Community gardens; increased access to farmer's markets; being able to pay with cards
- Focus on home environment

- Fun ways to exercise
- Family based education (topics include communication, emotional supports, nutrition)
- Income based or free cost
- Nutritional programs needed
- Outdoor physical activity, exercise
- Parks need attention – currently rundown; bike paths
- School based, healthy eating
- Yoga

Other responses included addressing chronic health issues, food vouchers for local grocery stores, helping children with speech impediments, immunizations, a medical home model, oral hygiene, using social media campaigns, and making sure that programs are advertised in Spanish.

- *Additional comments*

Residents were invited to share additional thoughts about improving child well-being and healthy weight for all. Sample responses included:

- Need to give a sense of safety to our different neighborhoods to allow children access to outside space and parks to play and enjoy nature. Additional non-competitive sports options for youth. Expand community garden programs for youth and families within our neighborhoods throughout the city. Healthy corner store initiative, complete street initiative and Completion of the Waterbury Greenway.

- In each neighborhood not just certain ones. We live in Bunker Hill and it would be nice for children/family programs to be hosted here not just at PALs/WOW/Fulton Park, etc.

- Schools should maintain healthy choices for lunch and snacks and implement nutrition and healthy living class.

- It is more important than ever to encourage all people to be active and not sedentary. I wish Waterbury had complete bike paths and greenway sections that went somewhere. Other towns have great recreation because of bike paths and rails to trails.

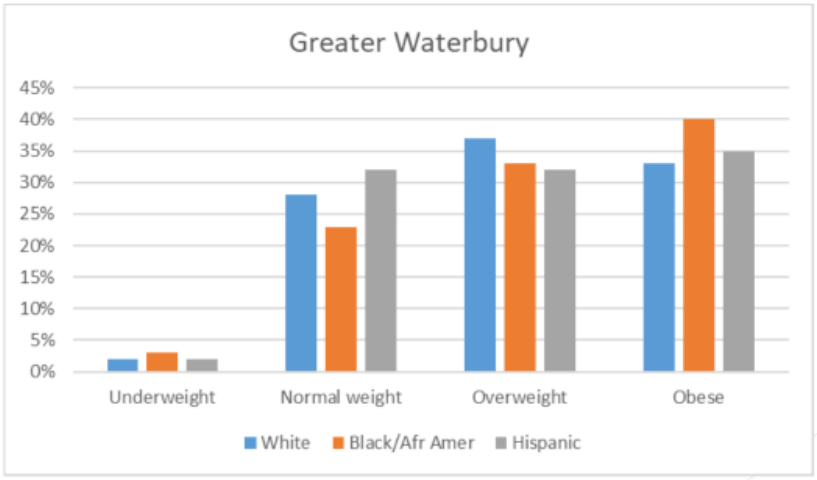
- *Becoming involved in the HEC process*

Eight residents expressed interest and provided their contact information to learn more about GWHP and the HEC process.

Appendix G – Data and measurement

Obesity disproportionately effects people of color

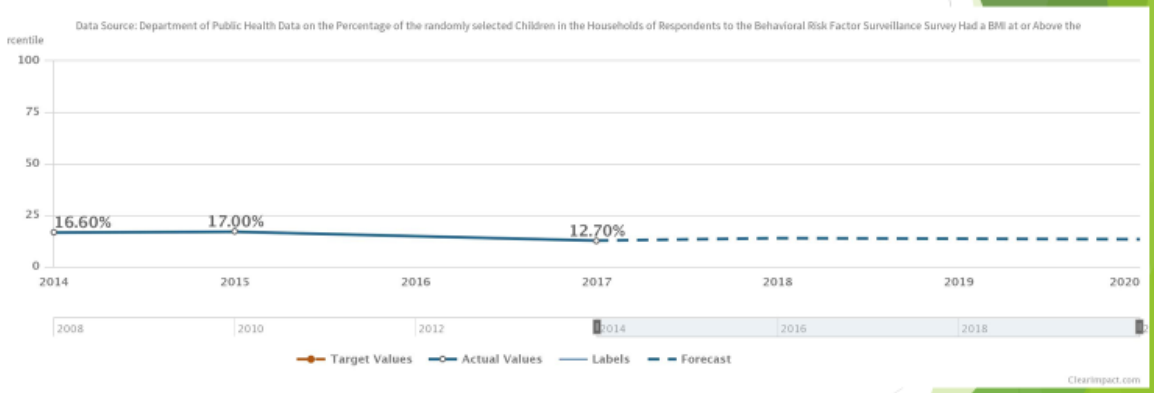
Source: 2019 DataHaven



Childhood Obesity

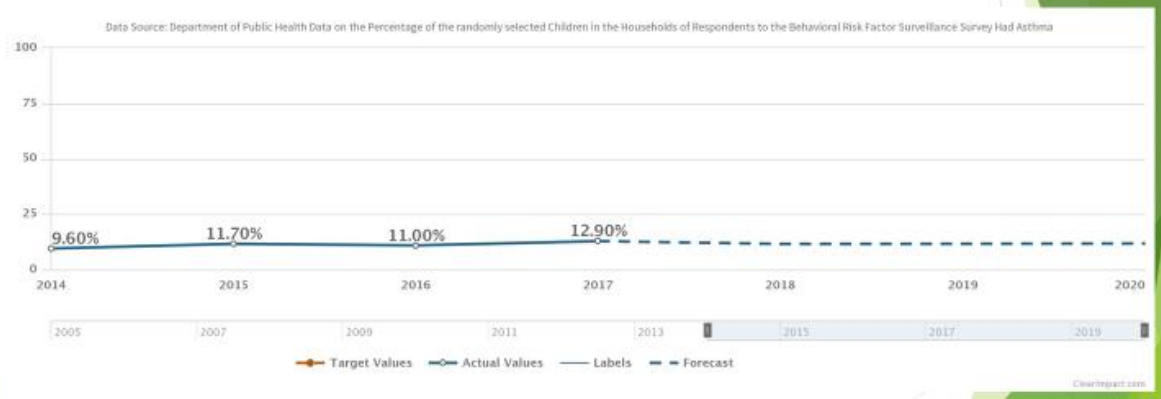
Children with BMI at or above 95th %

Source: State of CT DPH



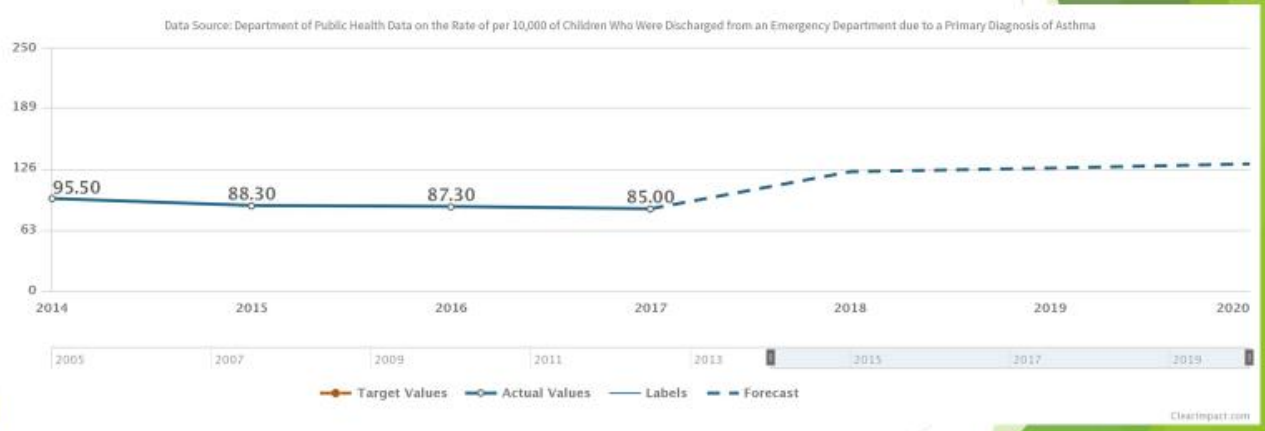
Children with Asthma

Source: State of CT DPH



Child Asthma ED Encounters

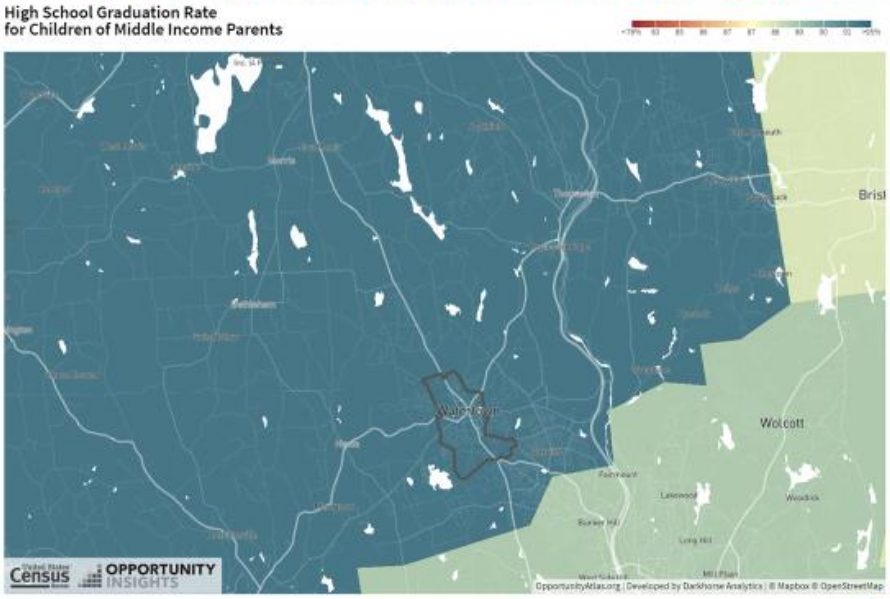
Source: State of CT DPH



Child Well-Being- HS Graduation Rate- 91%

Source: Opportunity Atlas

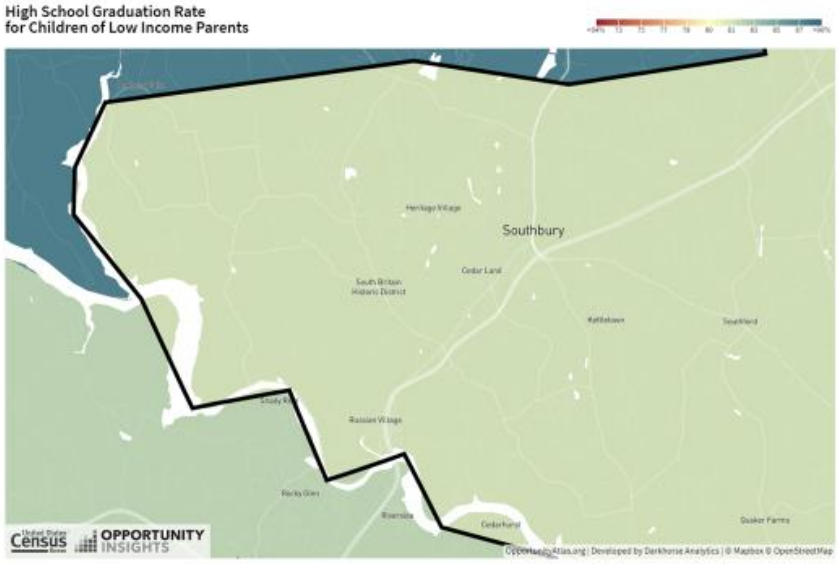
Middle Income Litchfield County-Woodbury, Watertown, Oakville, Thomaston, points north



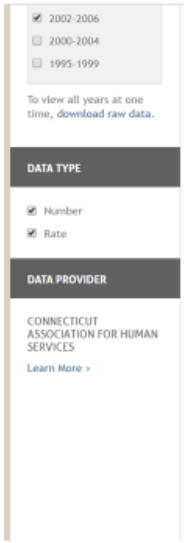
Child Well-Being- HS Graduation Rate- 82%

Source: Opportunity Atlas

Low Income/ New Haven County-Southbury, Waterbury, Wolcott, Cheshire

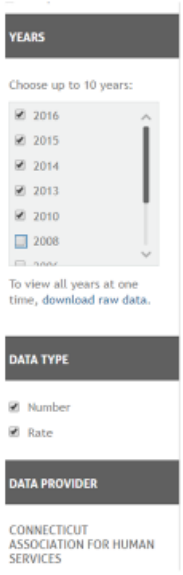


Child Deaths Ages 1-14
Source: Annie E. Casey Kids Count



Location	Data Type	2002 - 2006	2005 - 2009	2007 - 2011
Cheshire	Number	6	6	*
	Rate	21.6	21.3	a
Middlebury	Number	0	0	0
	Rate	0.0	0.0	0.0
Prospect	Number	*	*	*
	Rate	a	NA	a
Roxbury	Number	0	0	0
	Rate	0.0	0.0	0.0
Southbury	Number	*	*	*
	Rate	a	NA	a
Waterbury	Number	15	17	12
	Rate	13.2	35.8	25.3
Watertown	Number	*	*	*
	Rate	a	NA	a
Woodbury	Number	0	0	0
	Rate	0.0	0.0	0.0

Substantiated Cases of Child Abuse
Source: Annie E. Casey Kids Count



Location	Data Type	2010	2013	2014	2015	2016
Cheshire	Number	12	*	14	16	19
	Rate	1.6	a	2.3	2.6	3.1
Middlebury	Number	*	*	*	*	*
	Rate	a	a	a	a	a
Prospect	Number	11	*	*	*	*
	Rate	5.1	a	a	a	a
Southbury	Number	*	*	*	13	14
	Rate	a	a	a	3.0	3.3
Waterbury	Number	474	310	354	355	510
	Rate	16.2	10.6	12.6	12.6	18.1
Watertown	Number	38	16	23	15	16
	Rate	7.5	3.1	5.0	3.2	3.5

DATA PROVIDED BY
Connecticut Association for Human Services