HMA

HEALTH MANAGEMENT ASSOCIATES
HMA COMMUNITY STRATEGIES

HEALTHY NEIGHBORHOODS FINAL REPORT

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Prepared for Delaware Health Care Commission

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Introduction

In February of 2015, Delaware received a four-year State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI), a component of which was the Healthy Neighborhoods initiative. The intent of the Healthy Neighborhoods model was to create a clear, streamlined process for accountability of federal dollars and sustainability beyond SIM funding. On January 31, 2019, the State reached the end of award year four of funding from CMMI.

Over the past four years, the Heathy Neighborhoods Initiative has generated significant stakeholder engagement, with three active Local Councils each with associated neighborhood Task Forces representing a diverse cross-section of community stakeholders in Delaware. In December of 2017, Health Management Associates (HMA) created a disbursement model that allowed Local Councils to begin to draw down funds from the CMMI SIM grant monies in support of local, community-driven initiatives designed to address one or more of four established priority areas: Behavioral Health, Healthy Lifestyles, Chronic Disease Prevention and Management, and Maternal and Child Health. Through Healthy Neighborhoods, eight initiatives were funded, seven of which related to behavioral health and one related to promoting healthy lifestyles/reducing chronic diseases.

In this final report, we will juxtapose the original model with the evolution of the implementation of Healthy Neighborhoods, reporting on both the successes as well as the challenges during the SIM grant period as it relates specifically to Healthy Neighborhoods. Overall, the implementation of Healthy Neighborhoods provides significant lessons learned for the State of Delaware as it moves into the implementation of Healthy Communities Delaware. HMA has developed this report with the intention of comprehensively documenting Healthy Neighborhoods efforts in order to provide information and guidance to Healthy Communities Delaware stakeholders as the State continues to move forward towards its goal of improving the health and wellbeing of its residents.

Healthy Neighborhoods Structure

As introduced above, the Delaware Health Care Commission (HCC) was awarded a four-year SIM grant in 2015. The purpose of the State's SIM efforts was to improve health care for Delawareans as well as promote the sustainability of the health care system. Healthy Neighborhoods was one component under the State's multi-pronged SIM initiative, which also included a focus on the integration of behavioral health and primary care, payment reform, workforce development, and the development of a population scorecard with cross-payer population health measures. Healthy Neighborhoods was specifically designed to allow community-based collectives to develop and implement innovative approaches to promoting population health across the following four priority issues:

1. Healthy Lifestyles
2. Maternal and Child Health
3. Mental Health and Addiction (Behavioral Health)
4. Chronic Disease Prevention and Management

In November of 2017, HCC selected HMA to support Delaware's final year of Healthy Neighborhoods efforts, with a direct focus on engaging community stakeholders to develop initiatives focused on the

priority areas in their communities and distributing the SIM mini-grant funds so that the initiatives could be implemented. In response to this charge, HMA developed a Healthy Neighborhoods model that was grounded in the foundational work of the Delaware Center for Health Innovation (DCHI) and a variety of other key stakeholders from across the State. HMA's Healthy Neighborhoods model was launched via a statewide webinar[1] in December of 2017.

The Healthy Neighborhoods model uses the Collective Impact Model as a framework to ground its work in the community. The Collective Impact Model is an innovative and structured approach to making collaboration work across diverse, cross sector entities to address complex community issues, while also achieving significant and lasting social change utilizing the five key elements outlined in the figure below:
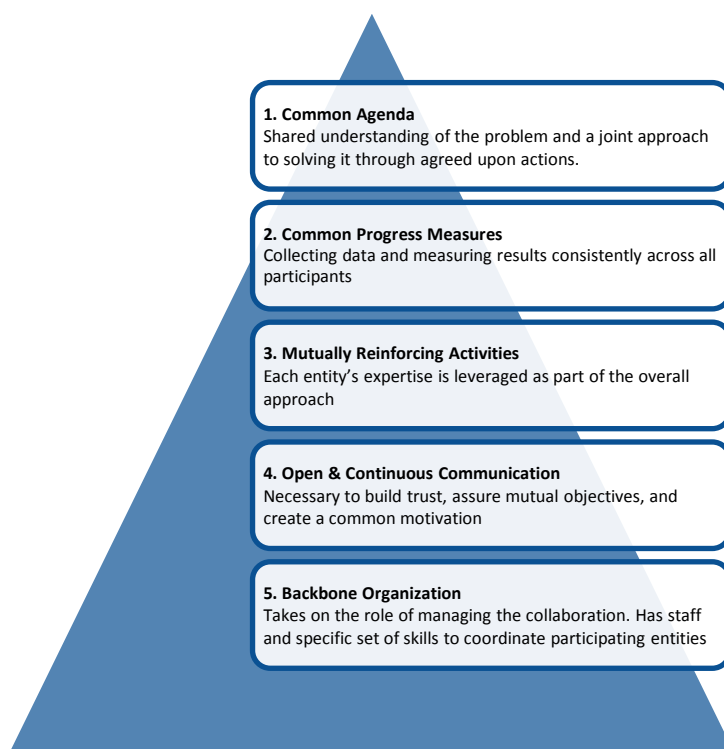

1. Common Agenda
Shared understanding of the problem and a joint approach to solving it through agreed upon actions.

2. Common Progress Measures
Collecting data and measuring results consistently across all participants

3. Mutually Reinforcing Activities
Each entity's expertise is leveraged as part of the overall approach

4. Open & Continuous Communication
Necessary to build trust, assure mutual objectives, and create a common motivation

5. Backbone Organization
Takes on the role of managing the collaboration. Has staff and specific set of skills to coordinate participating entities

Figure 1: Five Key Elements for Collective Impact initiatives. _Source_: Based on Collaboration for Impact. The Collective Impact Framework. https://www.collaborationforimpact.com/collective-impact/

To support the implementation of the model, HMA built upon the previously established community-based infrastructure in 1) Wilmington/Claymont, 2) Dover/Smyrna, and 3) Sussex County. Each Healthy Neighborhoods locale had an existing Local Council comprised of a diverse group of community providers and stakeholders, as well as Neighborhood Task Forces charged with developing initiatives aimed towards impacting at least one of four Healthy Neighborhood priority areas. The roles of these collectives are each described in more detail below. In Sussex County specifically, the Sussex County

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[1] https://dhss.delaware.gov/dhss/dhcc/files/healthyneighborhood2.pdf

Health Coalition leveraged its existing infrastructure, consisting of their Board and several health/community-focused Committees, to engage in Healthy Neighborhoods work.

In addition to the Local Councils and Task Forces, select representatives from each of the Healthy Neighborhoods entities served on a Statewide Consortium comprised of statewide leaders, health systems representatives, funders, and community advocates. As described in more detail below, the Statewide Consortium operated as the sounding board to support implementation readiness of the proposed initiatives across all locales, focused on shared learning, sustainability, and policy as it relates to the health of Delawareans.
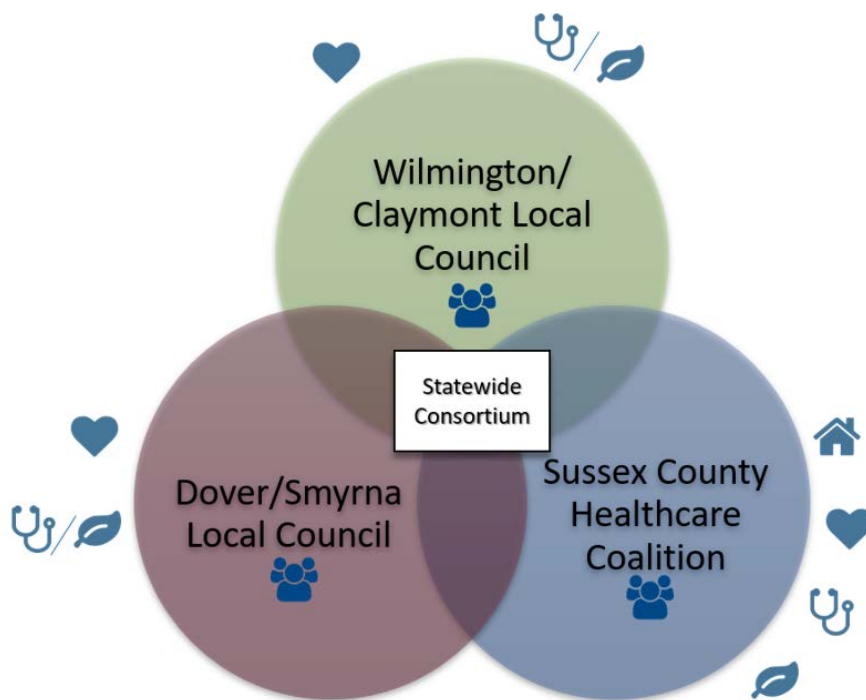

Figure 2: Selected Healthy Neighborhoods Local Councils and their respective Neighborhood Task Forces.

Symbol	Representation
👥	Healthy Neighborhoods Stakeholders
❤	Behavioral Health
🩺	Chronic Disease Management and Prevention
🍃	Healthy Lifestyles
🏠	Maternal and Child Health

Table 1: Legend for Figure 2. The symbols for each Neighborhood Task Force and description.

Roles, Representation, and Participation

Local Councils

As introduced above, each of the three targeted Healthy Neighborhoods locales (Wilmington/Claymont, Dover/Smyrna, and Sussex County) was led by a Local Council (with the Sussex County Health Coalition leading the work in Sussex County based on their longtime existing infrastructure). As part of the Healthy Neighborhoods model, each Local Council was composed of:

- at least one representative from each Task Force,
- local leaders with expertise in the four priority areas,
- cross-sector entities and organizations to ensure representation of all critical entities,
- delivery system entities,
- community based organizations (CBOs),
- community advocates, and
- community stakeholders.

While each Local Council was made up of diverse stakeholders from the local target communities, due to a number of factors (including the time constraints for getting money out to the community during the SIM time period), the Local Councils in Wilmington/Claymont and Dover/Smyrna ultimately consisted of stakeholders who were able and willing to come to the table. In Sussex County, the Sussex County Health Coalition was able to leverage its extensive history and community-based structure to continue to engage diverse stakeholders in this work. Although all counties' Local Councils did include representation from each of the groups listed above, during focus groups held at the end of the grant funded period (described in more detail below), stakeholders in all counties reported that there were indeed key stakeholders missing from each table simply because there was not ample time and/or resources to support their active engagement within the SIM grant timeframe.

At the outset of their collaboration, each Local Council developed a set of By-Laws that described their collective focus and role within the Healthy Neighborhoods process. As part of Healthy Neighborhoods, each Local Council served in the "Board of Directors" role for their respective Healthy Neighborhood locale. In this role, the Local Council retained responsibility for supporting its Neighborhood Task Forces, including approving Task Force requests for Healthy Neighborhoods funding for their proposed community-based initiatives.

The Local Councils in Dover/Smyrna and Wilmington/Claymont were each led by two Co-Chairs, who, with support from HMA as the Backbone Organization, maintained the following responsibilities:

- Developing meeting agendas with support of backbone organization and other Local Council members, presiding over all meetings of the Local Council and obtaining approval of the meeting minutes at meetings;
- Managing the business of the Local Council, including calling for a vote to approve a proposed Task Force Initiative for funding;
- Providing advice and guidance to all other officers and Task Force Chairs so that their duties are properly performed;
- Working in cooperation with applicable stakeholders including HCC, HMA, the Healthy Neighborhoods Task Forces, and the Statewide Healthy Neighborhoods Committee and Consortium;
- Reporting to the Local Council on all matters that may affect this collective entity;
- Coordinating communication between the Local Council and the community; and

- Participating on the Healthy Neighborhoods Consortium and reporting back to the Local Council on relevant information and issues.

In order to support a Collective Impact approach that values the contributions of all participants, the Local Councils each established a model for shared decision making, which was captured in their By-Laws. For example, the Dover/Smyrna Local Council utilized an adaptation of the Consensus Model of Decision Making,[2] a creative method for reaching agreement within diverse groups that encourages comprehensive solutions that all members can support. Through this adapted model, if consensus on a decision could not be reached through group discussion of identified issues, the Dover/Smyrna Local Council engaged in a vote during which a three fourths majority opinion results in a decision, as further outlined in the following call out box and figure.

Description of the Modified Consensus Model of Decision Making

After the culmination of the initial "test for consensus" (during which each individual expressed their agreement or veto/block of the proposal), the facilitator of the Local Council meeting actively asked attendees who voted to "block" the initiative to state their concerns to the group in order to ensure that everyone's concerns/reason for dissent are stated. After the concerns were outlined, the meeting participants discussed the stated concerns as a collective, after which the facilitator once again tested for consensus. If consensus could not be reached during the second test for consensus, the facilitator called for a vote on the issue at hand. During the vote, if a three-fourths majority of participants voted "yes" that the initiative should be approved, the initiative was officially "passed" by the Local Council.

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[2] https://www.consensusdecisionmaking.org/#TheBasics

Consensus Decision Making Process
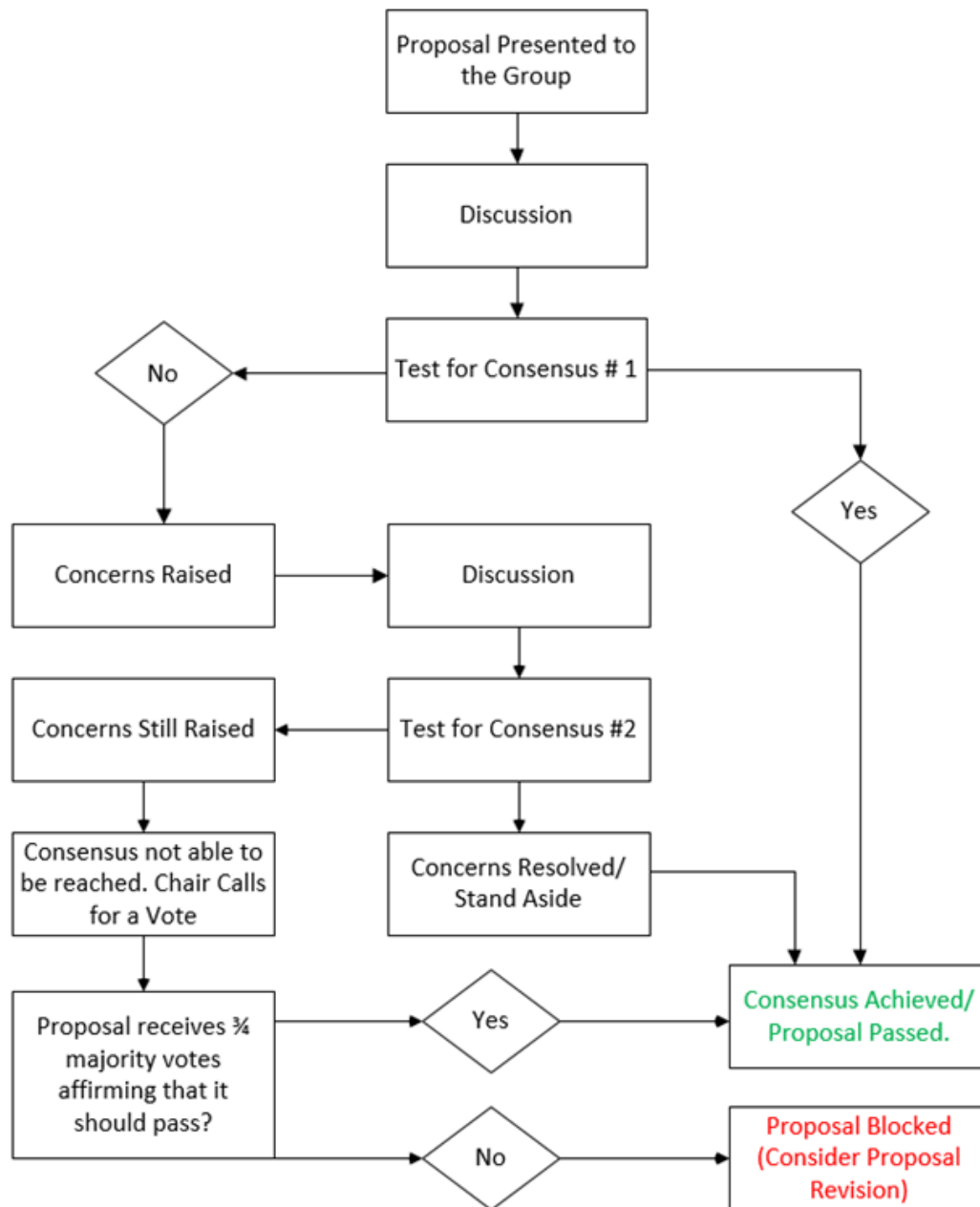
Figure 3: Modified Consensus Decision Making Process

This process for Consensus Decision Making was used by the Dover/Smyrna Local Council to approve initiatives developed by its Neighborhood Task Forces that were deemed "ready" to move on to request funding from CMMI.

Neighborhood Task Forces

Once established, each Local Council was asked to designate Neighborhood Task Forces to focus on one or more of the SIM priority areas based on their local community needs and capacity. Once developed,

Neighborhood Task Forces were meant to include a diverse range of motivated community stakeholders and leaders that could collaborate to impact outcomes across the priority area of focus.

In practice, the Sussex County Health Coalition was able to leverage its existing Committee infrastructure to focus on the identified priority areas. The Dover/Smyrna and Wilmington/Claymont Local Councils each decided to establish two Task Forces to support its initiative development, one focused on Healthy Lifestyles and Chronic Diseases and the other focused on Behavioral Health.
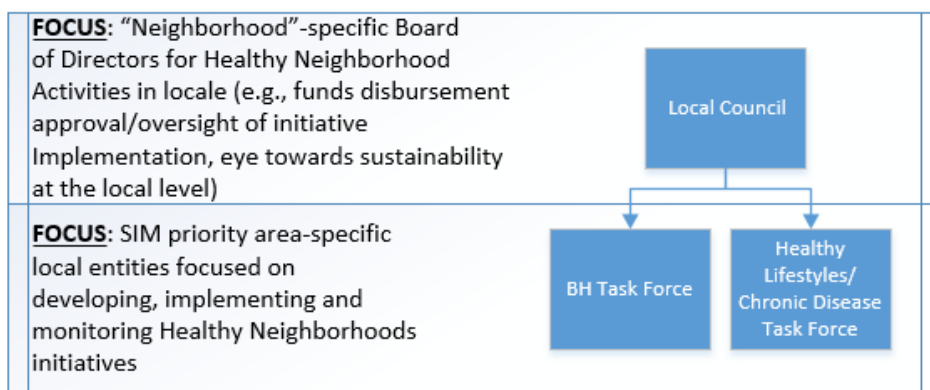

FOCUS: "Neighborhood"-specific Board of Directors for Healthy Neighborhood Activities in locale (e.g., funds disbursement approval/oversight of initiative Implementation, eye towards sustainability at the local level)

FOCUS: SIM priority area-specific local entities focused on developing, implementing and monitoring Healthy Neighborhoods initiatives

Local Council

BH Task Force

Healthy Lifestyles/ Chronic Disease Task Force

Figure 4: **Example of Established Healthy Neighborhoods Infrastructure**

Participation on each Task Force was open to all Healthy Neighborhoods stakeholders, as well as others who resided in, worked in, and/or served the target communities and supported the specific priority/ies on which each Task Force was focused. Specifically, each Task Force was responsible for engaging in the following activities as part of Healthy Neighborhoods:

- Creating and proposing data driven, evidence-based initiatives;
- Requesting funds from Statewide Fiscal Agent once the Local Council has approved request; and
- Supporting quality improvement efforts related to initiatives based on data.

In practice, due to timeline considerations related to proposing and funding the priority-specific initiatives, the vast majority of the Task Force's efforts were focused on the first two activities, with the organizations implementing local initiatives (referred to as "implementation partners") primarily responsible for collecting output/outcome data related to their initiative's implementation and utilizing that data for quality improvement efforts. In addition, similar to the challenges experienced by the Local Councils, the Task Forces mostly consisted of stakeholders who were able and willing to come to the table, as there was not sufficient time to put towards directed outreach and engagement of diverse community stakeholders.

Finally, each Task Force also selected a Chair and Co-Chair who also held a seat on the Local Council and reported to the Local Council on the Task Force's work at each Local Council meeting.

Statewide Consortium

In addition to the Local Councils and Tasks Forces within each Healthy Neighborhood, HMA created a single Statewide Consortium comprised of Local Council Co-chairs, statewide leaders, and advocacy

organizations from communities. The local Fiscal Agent, once selected, was also supposed to serve on the Consortium, but, as further described below, this role was not filled due to grant constraints. As part of the three-step funds distribution process (described in more detail below), the Statewide Consortium acted as a Sounding Board for Local Councils.

At the outset of their collaboration, the Consortium developed a Charter that described how the Consortium was going to advise and support the Local Councils and Task Forces, using the following five pillars as a cornerstone:

1. **Shared Learning**: Sharing best practices across Delaware;
2. **Policy**: Supporting and advising policy change to sustain initiatives and create a healthier Delaware;
3. **Sustainabilit**y: Developing a method for sustainability of the Healthy Neighborhoods efforts, such as establishing Health Promotion Trust and being established as part of the delivery system;
4. **Data**: Identifying and analyzing user-friendly community-level data; and
5. **Sounding Board**: Advising Neighborhood Task Forces on proposed initiatives as part of 3-step process of disbursements.

Once established, the Statewide Consortium met on a monthly basis to review initiatives that had been deemed ready at least one week before the established meeting date. Prior to each meeting, the Consortium members received copies of the Readiness Assessment documents for the relevant initiatives for their review, and during the meeting they heard a presentation from the implementation partner(s) and other stakeholders (where relevant) about the initiative. Following the presentation (and in writing, prior to the meeting), the Consortium members were asked to share their feedback and guidance for the implementation partners to support their ability to enhance the proposal. The Consortium had no approval or oversight role related to the initiative's implementation; rather, their feedback was meant to support the implementation partners to enhance the proposal through strategic recommendations, such as additional partners and stakeholders that they could engage, other areas of the state where similar work was occurring from which lessons learned could be drawn, and alternative resources/funding streams they should consider as they move forward. Consortium meetings were held in person, with an option for virtual participation to accommodate attendance of all members from across the entire state.

HMA Backbone Agency Support

From the outset of its contract, HMA staffed a team of consultants to support the Healthy Neighborhoods initiative. Liddy Garcia-Bunuel served as the overall Project Manager to ensure deliverables were met and provide the overall vision and strategy for the initiative. Sarina Coates-Golden provided coordination and logistical support across the Healthy Neighborhoods efforts. Laquisha Grant, Kristan McIntosh, Joshua Cole, and later, Maddy Shea, served as the points of contact and the providers of administrative support and technical assistance for the Local Councils and associated Neighborhood Task Forces. These four staff members were assigned to a Local Council (and its associated Task Forces) on a geographic basis, with Laquisha Grant serving as the Wilmington/Claymont

point of contact, Kristan McIntosh serving as the Dover/Smyrna point of contact, and Joshua Cole and (subsequently) Maddy Shea serving as the points of contact for the Sussex County Health Coalition. Jeremy Martinez provided subject matter expertise on obtaining and updating community-level data and measuring outcomes. And finally, Lori Weiselberg supported the identification of sustainability options for Healthy Neighborhoods following the conclusion of the SIM grant. HMA's Healthy Neighborhoods team also worked closely with the HMA team that oversaw the Behavioral Health Integration work under the SIM grant to support coordination and alignment, including participating in regular cross-team conference calls and stakeholder meetings as relevant.

Technical Assistance & Support for Local Councils and Task Forces

HMA provided support to the Local Councils and Neighborhood Task Forces across five stages of technical assistance, which were specifically designed to support each Healthy Neighborhood locale to develop a collective infrastructure and support community-driven initiatives that could be funded as part of the CMMI SIM project. As illustrated below, HMA's five stages of technical assistance included recruitment and re-engagement, clarification of roles and responsibilities, identification of initiatives, readiness support, and funding request and implementation.

Figure 5: **HMA's Technical Assistance Framework**

As mentioned above, HMA placed a significant amount of effort into supporting stages 3 through 5, as the SIM funding had to be disbursed and used for implementation prior to January 31, 2019 (approximately a year from the release of HMA's Healthy Neighborhoods model). In addition, HMA's predecessor in this work, DCHI, had spent significant time and effort recruiting and engaging individuals to join these collectives, as well as starting to establish roles and responsibilities of the groups, so HMA was able to build on this work to move the implementation efforts forward.

Based on that reality, a key role for HMA was to ensure initiatives proposed by the Neighborhood Task Forces were aligned with the CMMI priority areas (and restrictions) and ready for implementation. HMA staff mentioned above provided one-on-one technical assistance to the Neighborhood Task Forces to ensure the proposed Healthy Neighborhoods initiatives were each data-driven, evidence-based, supported by the community, and reinforced by an associated logic model developed during the process to ensure measurable outcomes. This Technical Assistance was supported by the Readiness Assessment process, described in more detail below.

Initially, as part of this support, HMA proposed to provide a one-day work session in the early months of 2018, in which the Neighborhood Task Forces could move their initiative towards readiness by obtaining and reviewing community-level data, researching evidence-based strategies, creating logic models, and ensuring collaboration with other initiatives. HMA envisioned having representatives from each Task Force/Local Council attend this work session at the same time to ensure collaboration across the state. Unfortunately, due to differences in regional "readiness" related to initiative development, as well as the rapid timeline for developing initiatives and getting funding disbursed for implementation, this statewide work session was not able to be implemented. However, it could be a best practice to consider as part of Healthy Communities Delaware's implementation, as there was a significant amount of stakeholder interest in this type of work session.

Implementation Partner Oversight
Another critical component of HMA's Backbone Agency role was to provide oversight for the implementation partners who were selected to implement Healthy Neighborhoods initiatives. This oversight included requiring them to document their outputs and outcomes of their initiatives via an interim and final report, as well as holding monthly conference calls with them to discuss project implementation and troubleshoot any identified issues. In addition, members of HMA's team also conducted one site visit with each implementation partner, during which we were able to speak about implementation successes and challenges in more detail, see the site at which the program was operating (in most cases), and dive deeper into the sustainability of the initiative following the culmination of Healthy Neighborhoods funding.

Fiscal Agent Responsibilities
Related to disbursement of the SIM mini-grant funds to the selected implementation partners, HMA's initial model proposed to identify one or more organizational entities to serve as a locally-based Statewide Fiscal Agent in partnership with HCC, with HMA serving as the interim Fiscal Agent until a local Fiscal Agent was selected. Unfortunately, due to federal grant regulations (e.g., what entities could serve as a sub-grantee under SIM) and time constraints for funds distribution, a local Fiscal Agent was not able to be selected as part of the SIM grant's implementation. Based on this, HMA retained responsibilities for the Fiscal Agent role through the end of Healthy Neighborhoods.

As the Fiscal Agent, HMA was responsible and accountable for managing disbursements to community-based implementation partners to fund their initiatives. In this role, HMA sought to establish clear guidelines and deadlines with transparent processes, including establishing a Memorandum of Understanding (MOU) with each implementation partner once the initiatives' Disbursement Request

was approved by CMMI. As the Fiscal Agent, HMA worked to ensure that the SIM funds were all used in accordance with Federal statutes, regulations, and the terms and conditions of the grant, as documented within the MOU and maintained through the oversight activities, listed above.

Although a local Fiscal Agent was not able to be identified during Healthy Neighborhoods/SIM implementation, as part of the sustainability efforts under Healthy Communities Delaware, as described in more detail below, a local Fiscal Agent, the Delaware Community Foundation, has been selected.

Other Support Related to Data and Social Network Analysis
In collaboration with the Division of Public Health (DPH) and Delaware Community Foundation, HMA sought to provide some support for the Neighborhood Task Forces to define problems and propose solutions, including holding one jointly presented webinar for Healthy Neighborhoods stakeholders on this topic. Further, as part of its technical assistance, HMA also provided support to the Task Forces related to the creation of logic models for the proposed initiatives that helped to inform what data the implementation partner could collect (using the S.M.A.R.T. model[3]); how to monitor the initiatives with an eye towards improving strategies and implementation; and what objectives, outcomes, and impacts would be achieved through the established initiative.

In addition, HMA conducted a Social Network Analysis at the beginning of 2018. This Social Network Analysis built upon the Healthy Neighborhoods work implemented to date and sought to map the many existing connections and partnerships across the State. A Social Network Analysis is a tool to visualize and summarize the structure of the overall network across systems, as well as the location of individuals within the network and the strength of their connectivity. To construct and visualize the social network, HMA gathered network data via electronic surveys dispersed in two rounds of data collection. The survey posed questions to each organization about peer institutions within their community. The first round targeted all stakeholders and contacts identified by DCHI. Building upon those pre-existing contacts, the second round solicited input from the newly identified stakeholders.

Once gathered, HMA used the survey results to analyze existing networks and to identify and recruit additional organizations to Healthy Neighborhoods wherever possible. Given the rapid timeline of implementation, we recognize that outreach and engagement of stakeholders identified through the Social Network Analysis could have been more robust with additional time, but we believe that the Social Network Analysis itself provides valuable insight into additional stakeholders who could be engaged to participate in Healthy Communities Delaware moving forward.

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[3] Specific, Measurable, Attainable, Realistic, Timebound

Figure 6: Sample Finding from Social Network Analysis: Organizations with Influence and With Whom Respondents Would Like to Partner

Delaware Health Care Commission

As the direct CMMI SIM grantee, the Delaware Health Care Commission (HCC) retained full decision-making authority for the Healthy Neighborhoods efforts. HMA, as a sub-recipient of HCC, provided implementation support, engaging HCC in all key decision points as the work progressed. Coordination between HCC and HMA was supported by HMA's SIM Project Management team, who conducted regular meetings and conference calls with HCC to support the implementation success of Delaware's SIM projects.

Healthy Neighborhoods Processes for Funds Distribution

Now that all the stakeholders and their roles have been clearly described, what follows is a description of the processes utilized as part of the Healthy Neighborhoods model to ensure rapid funds distribution to the implementation partners.

In order to develop the Healthy Neighborhoods model, HMA worked to build off the foundation established by its predecessor in this work, DCHI, wherever possible, with a focus on distributing funding to the communities as quickly as possible so that they could implement their selected initiatives. At the outset of its contract with HCC, HMA's Healthy Neighborhoods team conducted an array of listening sessions with key community stakeholders, including those who had been involved in Healthy Neighborhoods at that point and others who were focused on work related to population health improvement. These listening sessions allowed HMA's team to gain invaluable perspective about the work that had been done to date, including what was working and what could be improved, as well as obtain feedback on the proposed model in order to refine it into the model that was implemented during the final year of the SIM grant, further described below.

Equitable Resource Allocation

As referenced above, a core component of Healthy Neighborhoods was the availability of mini-grant funds to support community-development initiatives related to the four SIM priority areas. Therefore, at the outset of its work, HMA developed a process for equitable resource allocation of the available funds across the three counties to ensure equitable access to the mini-grant funds for each of the Local Councils. HMA's approach to equitable resource allocation was premised on the Punjab Equitable Resource allocation model[4] supported by UNICEF and used in the Punjab province of Pakistan to promote equity in access and use of services. The intention of this model was to distribute funds based on both the population size, as well as the health and social needs of each locale. Prior to its roll out, HMA tailored the model to suit the resource considerations of Healthy Neighborhoods.

In order to align the model with Healthy Neighborhoods, HMA first selected a combination of needs index attributes from the model, as well as proxy indicators for the four priority areas of Healthy Neighborhoods. HMA then used each attribute's Needs Index Allocation to assign weights to each attribute, which was used to determine the amount of funds allocated to each locale (inclusive of the Local Council and associated Neighborhood Task Forces) to fund their proposed initiatives. The selected attributes and their weights are outlined in the table below.

Table A: Resource Allocation

Needs Index Attributes	Indicator	Source	Needs Index Allocation
Equitable Resource Allocation Model			**60%**
Population	Number of persons	Census Population Estimates	20%
Length of Life	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	National Center for Health Statistics - Mortality files	20%
Quality of Life	Percentage of adults reporting fair or poor health (age-adjusted)	Behavioral Risk Factor Surveillance System	20%
Priority Areas			**40%**
Chronic Disease Prevention and Management [Proxy Indicator: Diabetes Monitoring]	Percentage of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	Dartmouth Atlas of Health Care	10%
Maternal and Child Health [Proxy Indicator: Teen Births]	Teen birth rate per 1,000 female population, ages 15-19	National Center for Health Statistics - Natality files	10%
Addiction and Substance Abuse [Proxy Indicator: Drug Overdose Deaths]	Drug Overdose Mortality Rate	CDC WONDER mortality data	10%

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[4] https://www.unicef.org/health/files/Punjab_Model_FINAL.pdf

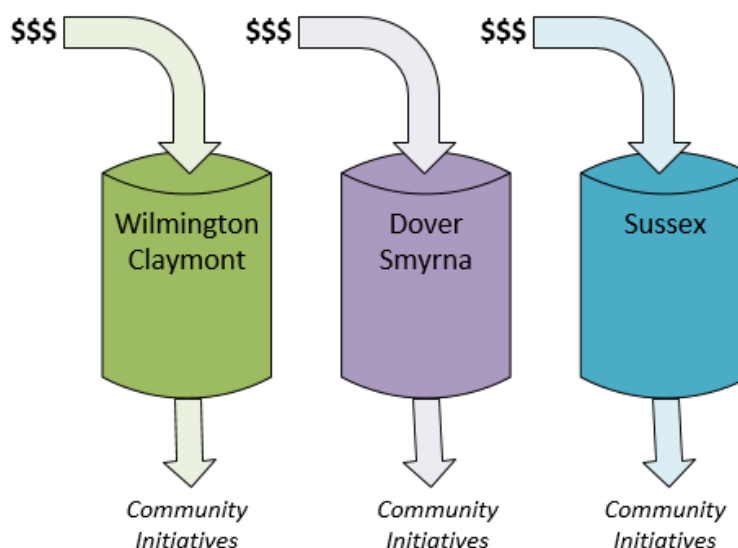| Healthy Lifestyles [Proxy Indicator: Smoking	Percentage of adults who are current smokers	Behavioral Risk Factor Surveillance System	10%

Figure 7: Illustration of Funds Flow to Three Healthy Neighborhoods Locales to Community Initiatives

Based on this model, including the selected attributes and weights of each attribute, 36% of the available Healthy Neighborhoods mini-grant funding was allocated to the Wilmington/Claymont Local Council, with 32% apiece allocated to the Dover/Smyrna and Sussex County Local Councils.

Three-Step Process for Disbursement

Once the available mini-grant funds were equitably allocated across the three Healthy Neighborhoods locales, HMA created a systematic process for Funds Disbursement. In an effort to ensure accountability for all funds distributed, while also ensuring that the mini-grant funds are quickly disseminated to the local communities across Delaware, HMA sought to create a standardized, three-step process for funds disbursement.

As illustrated in the graphic below, the process included: 1) completing a standardized Readiness Assessment by the Neighborhood Task Forces, 2) presenting and receiving feedback from the Statewide Consortium on the initiative, and 3) getting approval to request the funds from the Local Councils. Once approved by the Local Council, a Disbursement Request was submitted to CMMI for their approval to un-restrict the mini-grant monies. Once the CMMI un-restriction was provided, HMA as the Statewide Fiscal Agent distributed money directly to the lead agency implementing the approved Healthy Neighborhoods initiative.

Figure 8: **Three-Step Process for Healthy Neighborhoods Mini-Grant Disbursement**

The specific steps in the Healthy Neighborhoods funds disbursement process are described in more detail below.

Readiness Assessment

As described above, each Healthy Neighborhood Task Force was focused on one or more of the SIM priority areas within their county of focus. Collectively, the Task Forces each worked together to develop initiatives designed to positively impact outcomes related to their priority area of focus, as well as an implementation partner(s) who could implement the proposed initiative. Once the initiative and associated implementation partner was identified, the first step in obtaining funds was to complete the Healthy Neighborhoods Readiness Assessment. The Readiness Assessment was a tool, developed by HMA, that was designed to assess readiness for implementation of the initiative across several standardized measures, including ensuring that:

1. the initiative was informed by community need;
2. the initiative received input and buy-in from diverse stakeholders;
3. the initiative was accompanied by a Logic Model with anticipated outputs and outcomes;
4. the initiative was evidence based/evidence informed; and
5. the initiative was accompanied by a logical budget for implementation, justifying the requested funds.

These components were identified based on similar work that HMA has done nationally to ensure accountability of the initiative to both funder and community priorities. As a collective, Task Forces were asked to work with their identified implementation partner(s) to complete the Readiness Assessment, a process that was supported by the HMA point of contact working with each locale. A copy of the Readiness Assessment tool used for Healthy Neighborhoods is included in Appendix 3.

Once the Neighborhood Task Force completed the Readiness Assessment, an HMA consultant who had not previously worked on the Tool's development reviewed the completed Assessment Tool and provided the plan with a score based on their responses. Based on the aggregate score across each section, the Plan was deemed to be one of the following:

- "Not Ready," meaning the Task Force still had work to do to move towards funding readiness, which would be supported by HMA and the Local Council;
- "Almost Ready," meaning the Task Force was missing a few key pieces of pre-initiative work (e.g., a Logic Model), but HMA could support them to develop these components so that they could move towards becoming ready; or
- "Ready," meaning that the Task Force had all of the pieces in place for funding readiness and was able to proceed to the next step of the process.

Critically, when a Task Force's completed Readiness Assessment was determined to be "Not Ready" or "Almost Ready," this was not the end of the process for that initiative. In those cases, the HMA point of contact was able to work with the Task Force and Local Council to provide additional technical assistance and support to ensure that the initiative could move forward to "Ready" as quickly as possible.

Of note, although HMA strove to develop a funds disbursement process that was as non-burdensome as possible for the community groups who were participating, the Readiness Assessment was a point in the process that was deemed to be challenging for the Neighborhood Task Forces in some cases. However, many stakeholders expressed that this point in the process was valuable as well, given the fact that it gave the Neighborhood Task Forces an established structure that was aligned with funder priorities and best practices within which they could develop initiatives. Given this, Healthy Communities Delaware presents an opportunity to reduce the burden on community groups proposing initiatives, while still retaining lessons learned from the Healthy Neighborhoods Readiness Assessment.

Statewide Consortium Sounding Board

As introduced above, the Healthy Neighborhoods Statewide Consortium was established to serve as a Sounding Board for each Neighborhood Task Force. Modeled off Delaware's Blueprint Community initiative, the Sounding Board (Consortium) convened on a monthly basis during the final year of the SIM grant funded period to review and provide feedback on the "Ready" Readiness Assessments from the Task Forces. In this Sounding Board role, the Statewide Consortium members listened to representatives from each Task Force and the selected implementation partner as they presented their initiative and its components and provided feedback on the proposed initiative based on their knowledge and expertise. For example, a member of the Consortium who is also a Co-Chair of another Local Council might provide information about a best practice that they identified as part of their research that could be implemented within the project, while another Consortium member might contribute to the proposed outcome measures based on their knowledge of existing available community health indicators and other data.

The purpose of the Consortium as a Sounding Board was not to approve the Task Force's initiative, but rather it was designed to support and enhance the proposed initiative, leveraging the selected Consortium member's diverse statewide knowledge and expertise. Meetings were held in-person, with a virtual option to accommodate attendance from across the state. Once the Sounding Board provided input on the Task Force's initiative, the Task Forces incorporated the suggestions into its plan as relevant.

For more information about the individuals who participated in the Sounding Board Consortium process, see the list of Consortium members in Appendix 2.

Request for Funding from Local Councils

Following their presentation to the Consortium and the incorporation of their feedback into the plan as relevant, each Task Force then presented the planned initiative to the Local Council for a vote for approval to seek Healthy Neighborhoods funding. As referenced above, each Local Council established voting procedures for this process within their By-Laws. Once the Local Council voted to approve the Task Force's initiative, the HMA point of contact for the locale supported the Task Force to complete the Disbursement Form (with information about the initiative pulled directly from the approved Readiness Assessment). The Disbursement Form was then signed by the two Local Council Co-Chairs and submitted for CMMI's review in partnership with HCC.

Once approved by CMMI, funds were disbursed directly to the implementation partner by HMA in its Fiscal Agent role. For each approved initiative, HMA also executed a MOU with the implementation partner that detailed scope of work, budget, and reporting requirements.

Figure 9: **Visual of Funds Disbursement Process Directly to Implementation Partners**

Overall, the process for funds disbursement was effective, but it took longer than expected to reach actual funds disbursement to the initiative partners. Because the Consortium only met one time each month, Neighborhood Task Forces were required to plan the completion of the Readiness Assessments around these scheduled monthly meetings and the associated Local Councils were required to meet just after the Consortium meeting to approve the initiatives in a timely manner. This often challenged the local stakeholders to amend their regularly scheduled meetings to accommodate the Statewide Consortium or risk delaying the approval process for their initiative until the following month. This established schedule was deemed necessary given the wide array of stakeholders participating in the

Consortium (for whom it was helpful to have a set schedule), but it also did result in delays for some locales who had to wait until the next month to move their initiatives forward to approval.
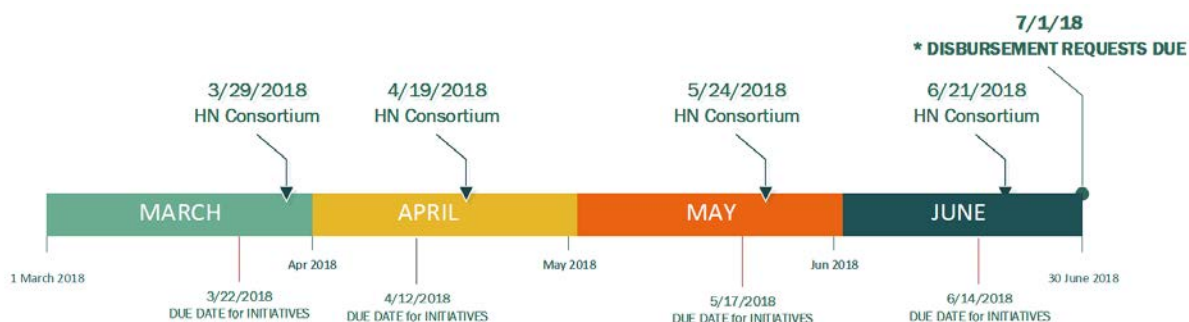
Figure 10: Healthy Neighborhoods Consortium Timeline

The process of working with HCC to obtain CMMI approval to un-restrict the mini-grant funds (step 5 in the below visual) was also a component of the process that took longer than expected for some of the proposed initiatives. To help to streamline this approval process, HMA and HCC worked with CMMI to establish an approved Disbursement Request Form that contained all the CMMI-required information in an easily digestible format. In addition, HMA and HCC established a process for regular check ins with the CMMI reviewers, and in some cases, held conference calls with CMMI and the implementation partners to support the early identification and resolution of any issues that could have delayed approval on their end.
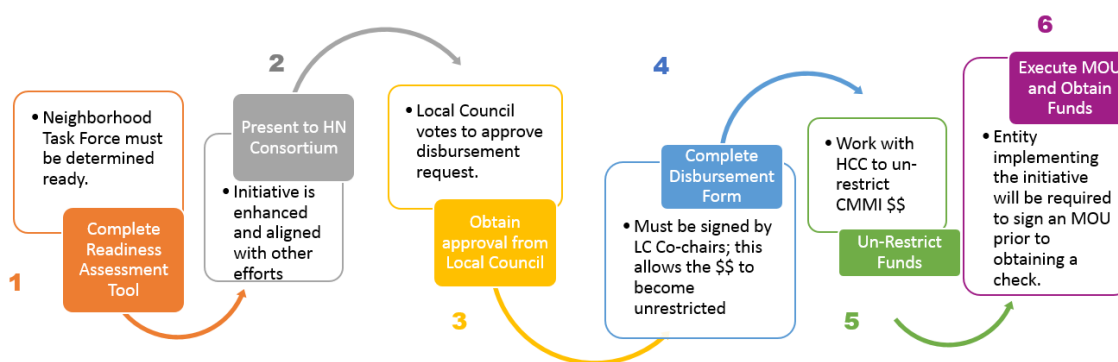
Figure 11: Complete Process for Funds Disbursement

As the State moves forward with Healthy Communities Delaware, there is clearly a lot to learn from the establishment and implementation of the Healthy Neighborhoods funds disbursement process, including both strengths of the model (e.g., the structured statewide approach), as well as opportunities for additional flexibility outside of the CMMI SIM restrictions and reduced burden for community stakeholders.

Initiative Implementation

Overall, the three Healthy Neighborhoods Local Councils and their associated Task Forces were able to utilize the established process to submit Disbursement Requests for ten community-driven initiatives, eight of which were approved by CMMI for un-restriction, resulting in a total of $516,259 flowing into the communities. Seven of the approved initiatives related to behavioral health, and one related to healthy lifestyles/chronic diseases. The two initiatives that were not approved were proposed Open Streets initiatives in Claymont and Smyrna, respectively, but based on strong community interest in this model and the success of this initiative in Dover as part of Healthy Neighborhoods, these implementation partners (and the Task Force stakeholders who put forward the proposals) continue to work to identify alternative funding opportunities to support these events moving into 2019.

To ensure accountability to the funder and community, each entity implementing an approved Healthy Neighborhoods Initiative was required to complete both an interim and final report. The reports included, to the best of the implementation partner's ability give the short timeframe for implementation, short-term and intermediate-term outcomes based on their established logic model, a summary of their implementation progress relative to an established work plan, and a financial report related to their expenditures to date. HMA, as the Statewide Fiscal Agent, monitored and supervised this work through the oversight activities outlined above.

Descriptions of all eight of the funded initiatives implemented as part of Healthy Neighborhoods are included below.

Dover/Smyrna Local Council & Task Forces

Dover Open Streets

Budget: $77,898
Implementation Partner: National Council on Agricultural Life & Labor Research Fund (NCALL)
Website: http://www.ncall.org/ and
https://www.facebook.com/OPENSTREETSDOVER/
Contact name: Chanda Jackson
Email address: cjackson@ncall.org
Funded: 7/10/2018

NCALL was selected to implement six Open Streets events from April through November of 2018. Open Streets are evidence-based programs that temporarily open streets to people by closing them to cars. By doing this, the streets become places where people of all ages, abilities, and backgrounds can come out and improve their health, promoting the use of public streets for recreation and active living (e.g., biking, walking). In addition, along the Open Streets route, there are established activity hubs, designed to engage participants in healthy activities (e.g., yoga, Zumba, cardio drumming, and education about healthy lifestyle activities like good nutrition and accessing community services and supports). In 2018, NCALL implemented these Open Streets events in partnership with a wide range of health care focused organizational partners, including Bayhealth (who provided health-related information and education),

the National Guard (who provided a pull up bar and punching bag), Capital School District (who supported healthy nutrition options for participants), Food Bank (who provided smoothies and other healthy food demonstrations), and Departments within University of Delaware (who supported the evaluation). As part of implementation, NCALL worked to align this Open Streets initiative with its current Restoring Central Dover initiative and partners, and they are committed to continuing to implement Open Streets in some capacity moving beyond the SIM grant in order to continue to positively impact the "culture of health" for Dover residents. Outcomes of the initiative's implementation included:

- Each of the Open Streets events that were implemented in 2018 attracted up to 600 participants to come to downtown Dover and participate in fitness-related activities. Each Open Streets event included between 9-12 physical activity Hubs in which community members could engage, as well as different themes and activities. This variety not only helped to reach the target population, but also supported Dover residents to get active in a way that was engaging and fun
- As an in-kind contribution to the Open Streets events, NCALL and its partners provided healthy meal options, including turkey hot dogs, chicken sausages, and spinach sausages to support a focus on nutrition in combination with active living. They also established a "mock grocery store" to help people engage in making healthy food choices.
- One of the benefits of the Open Streets events held this year, as reported by NCALL, is the "enhanced level of collaboration and awareness surrounding health" among diverse community stakeholders working in Dover. Partner entities supporting the event included a diverse cross section of health-related entities, including Bayhealth, Westside Family Healthcare, Delaware Food Bank, Capital School District's food truck, and Brandywine Counseling's COPE (Community Outreach and Prevention Education) van
- NCALL partnered with the University of Delaware to evaluate the impact of the events, and the evaluation included a participant survey. Results demonstrated that the vast majority of respondents:
  - o Strongly liked the Open Streets event and planned to attend another
  - o Learned of new places to be active because of attending the Open Streets event
  - o Intended to be active in the next 7-days following the event, and the majority of these respondents said that intention was because they attended the Open Streets event
- Walking was the most common activity at each event with respondents reporting a mean of 30 minutes of walking per event.
- During the last Open Streets event, held November 29th, NCALL provided educational information about physical activities that participants can engage in outside of these events, including information about activities in the community's local parks and other recreational facilities (e.g., a Dover-based walking group that meets before and after work, a local church that offers free yoga classes).
- Community members who attended the last event reported that they very much look forward to the Open Streets events in 2019 as a way for them to be physically active.

Homeless Engagement Initiative

Budget: $52,195

Implementation Partner: Dover Interfaith Mission for Housing (DIMH)

Website: https://www.facebook.com/www.doverinterfaithmission.org/

Contact name: Jeanine Kleimo

Email address: jkleimo@verizon.net

Funded: 7/9/2018

DOVER INTERFAITH MISSION FOR HOUSING INC

DIMH is a nonprofit organization founded in 2008 that consists of a collective of local faith communities concerned with the needs of homeless individuals in the Greater Dover area. DIMH was selected to implement an initiative that uses a Community Health Worker (CHW) and safe, accessible storage (via lockers, donated to this pilot in kind) to engage homeless individuals in care. In "exchange" for the use of a locker, the CHW used an adapted version of Screening-Brief Intervention-and Referral to Treatment (SBIRT) in order to screen each individual with whom s/he meets for a myriad of health and behavioral health (BH) needs, as well as those related to social determinants of health, provide education and information about identified needs and community resources to address those needs, and (based on the result of the screening) make referrals to appropriate services and supports in the community. In addition to this work, during the Healthy Neighborhoods implementation timeframe, DIMH's CHW expanded her role to include providing the "Living Well" curriculum of care to DIMH clients struggling with their health. Living Well is an evidence-based intervention designed to improve the ability of individuals living with mental health conditions to self-manage their co-occurring medical illnesses. Outcomes of the initiative's implementation included:

- Since the initiative's funding, DIMH had been able to connect over 100 homeless individuals with resources addressing social determinants of health. Over 150 homeless individuals were screened for Medicaid eligibility and connected to an enrollment broker based on their eligibility.
- DIMH's Healthy Neighborhoods staff facilitated monthly self-management courses related to diabetes and other chronic diseases, pain, and cancer thriving and surviving. In collaboration with DIMH, Bayhealth Medical Center provided health screenings, blood pressure and blood glucose checks, medication management and health assessments, as well as a respiratory therapist who provided DIMH's clients with additional support.
- As a result of the initiative, homeless individuals served by DIMH reported fewer barriers in accessing community services and supports. Many reported following through on the CHW's referrals to treatment and community services, as well as being satisfied with the referral(s) based on their identified needs. Moreover, homeless individuals served by the initiative reported an increased sense of hope for the future.

Community Health Worker for Domestic Violence Initiative
>Budget: $43,655
>Implementation Partner: People's Place
>Website: www.peoplesplace2.com/
>Contact name: John Baker
>Email address: jbaker@peoplesplace2.com
>Funded: 8/31/2018

Through this initiative, People's Place hired a full time domestic violence (DV) Community Health Worker (CHW) and part time High Risk Advocate, who maintained a joint focus on delivering direct services and supports to individuals, including helping them navigate the services system and connect with community resources that meet their needs, as well as building the system's capacity to meet the needs of individuals who have experienced DV within the Kent County service system. The CHW's capacity building assistance included activities like engaging and educating community providers who interact with individuals who have experienced DV, including those that are addressing these individuals' needs related to experiences of violence, mental health, SUD, housing, etc. For many victims of domestic violence, the first source of help is often not law enforcement or the DV Hotline, but rather their primary care provider. As part of this initiative, the CHW engaged and supported these local providers in their role as "first responders" to this vulnerable population, providing local providers with the tools and education to identify family violence/DV and appropriately respond with a linkage to safety resources and supports, including connecting the individual to the People's Place CHW and/or High-Risk Advocate for support navigating what are often complex, co-occurring needs. Outcomes of the initiative's implementation included:

- This initiative created a unique opportunity in Dover to identify victims and survivors earlier than was previously possible, connecting each individual identified to physical and behavioral health services, as well as safety supports, in order to improve their health and safety outcomes.
- People's Place's Healthy Neighborhoods CHW supported training and education for, as well as the establishment of referral relationships with a number of community providers, including OB/GYNs, school Wellness Centers, and primary care providers.
- Since the initiative's funding, People's Place received 51 referrals of individuals and families experiencing DV. In response, the CHW and High-Risk Advocate, hired through the mini-grant funds, successfully referred 35 individuals to community providers, and supported 6 individuals to file for protective services.
- Individuals and families served by People's Place have reported increased access to services and supports designed to meet both individual and whole-family needs, as well as an improved sense of safety and wellbeing.

Kent County Police Connections Alliance

    Budget: $46,279

    Implementation Partner: Connections

    Website: http://www.connectionscsp.org/

    Contact name: Cheryl Heiks

    Email address: cheiks@connectionscsp.org

    Funded: 8/31/2018

The Kent County Police Connections Alliance (PCA) initiative was designed to bring together a group of stakeholders who interact with individuals experiencing substance use disorders (SUD) and/or co-occurring disorders (COD), including hospital emergency room personnel, municipalities, state and local police forces, community and faith-based organizations, and paramedics. When anyone within this network identified an individual living with SUD and/or COD, including those who have experienced an overdose, they were trained to connect to Connections' PCA team, which included a Clinician and a Peer Specialist. Once connected, the PCA team members focused on warmly engaging the individual living with SUD to access an appropriate array of SUD treatment and support programs. In addition, entities within the network were trained to engage not only the individual living with SUD, but also his or her family members who could benefit from treatment and support to address the trauma of having a family member living with SUD. As part of this initiative, the Clinician and Peer Specialist worked throughout the Kent County community, partnering with law enforcement and local hospital systems to improve their response to individuals experiencing behavioral health issues and their families. Outcomes of the initiative's implementation included:

- The PCA team successfully partnered with the Smyrna Police Department to assign a Connections Clinician to engage in "ride alongs" with on duty police officers to engage individuals experiencing a behavioral health crisis in assessments, diverting them to treatment and support services where appropriate. Connections also established a relationship with BayHealth, through which the Connections Peer Advocate is co-located at the BayHealth emergency room (ER) to connect individuals with SUD who show up in the ER to care

- Based on this good work in Kent County, other law enforcement agencies have expressed interest in developing a similar partnership with Connections. Currently, Connections is in discussions with Sussex law enforcement agencies to site a Clinician with one of those agencies as an expansion of this program. Other agencies have expressed interest in incorporating the Angel Program and are partnering with Connections to increase access to treatment in this way.

- Because the Clinician who was hired for this position had deep roots in the Delaware behavioral health treatment and crisis response system, individuals served by this initiative were given access to a comprehensive array of community-based treatment and support resources at the time of engagement with police. Even in situations where arrest was the only option, police became familiar with the available treatment options and are now knowledgeable of and comfortable with the process for accessing them.

- The initiative successfully diverted individuals from not only emergency room treatment, but to other more cost-effective treatment settings. Individuals identified during a crisis were engaged

in intensive outpatient treatment, medication assisted treatment (MAT), and medication management services. PCA successfully diverted some individuals, where possible, from arrest, connecting them to available resources as an alternative.

Wilmington/Claymont Local Council & Task Forces

Community Health Worker for Domestic Violence Initiative

Budget: $63,193
Implementation Partner: Delaware Coalition Against Domestic Violence
Website: https://dcadv.org/
Contact name: Sue Ryan
Email address: sryan@dcadv.org
Funded: 8/31/2018

DCADV's Domestic Violence (DV)-Community Health Worker Collaborative Project was designed to integrate DV services with health care services. Through this initiative, DCADV collaborated with Westside Family Healthcare and Christiana Care to provide training on trauma-informed methods to screen for domestic violence and safety protocols. Three trained and experienced DV-Community Health Workers (CHWs), staffed by Child Inc., did everything in the traditional CHW scope of work, while also addressing the safety and supportive needs of DV victims and survivors. Upon receiving a referral from DCADV's primary care provider partners, a DV-CHW engaged the individual and addressed her safety through a trauma-informed risk assessment, while also providing brief counseling and case management to help the victim and her children create a long-term Safety Plan. Overall, DCADV provided project management support for the initiative, including evaluation, policy coordination, and training. DCADV also worked to collaborate with Westside Family Healthcare to enhance their ability to screen for and respond to patients experiencing DV and to create responsive connections with the DV-CHW. DCADV further advocated for system-wide policies to institutionalize and sustain the practice of DV specialized CHWs, including partnering with People's Place (project described above) as part of these efforts. Outcomes of the initiative's implementation included:

- Staff and project partners of this initiative were all engaged to provide services and supports to individuals experiencing DV in Wilmington/Claymont communities. As part of these efforts, they worked hard to walk the line between connection to health/behavioral health resources and ensuring safety related to the DV situation
- The DV-CHWs and Program Manager all completed Christiana Care's 5-day CHW training, as well as training on topics that include LGBTQ-related issues, DV 101, trauma informed care, local legal resources, and DV and Health with a specific focus on confidentiality. The CHWs have also engaged in training on DV and parenting, as well as safety planning, and mental health 101 (in partnership with another Healthy Neighborhoods grantee, MHA).
- Through this initiative, DCADV engaged in a comprehensive review of existing legislation relevant to the project in order to identify possible allies within the General Assembly. In addition, DCADV is now an active member of the newly revitalized Delaware Domestic Violence Coordinating Council Medical Committee.

- As introduced above, DCADV is working closely with People's Place to coordinate their related Healthy Neighborhoods initiatives. A core goal of this collaboration is to establish a service delivery model to support individuals and families impacted by DV through collaborations between primary care and social services providers that can be replicated statewide.

Peer Recovery Specialists

Budget: $95,040
Implementation Partner: Mental Health Association (MHA)
Website: http://mhainde.org/wp/
Contact name: Emily Coggin-Vera
Email address: ecoggin@mhainde.org
Funded: 8/31/2018

In Delaware today, peer specialists work across the BH system, in the state psychiatric hospital, community mental health agencies, group homes, recovery centers, the mental health court, supportive housing, and most state contracted mental health services. The importance of peer support was recognized when these services became Medicaid reimbursable in Delaware in 2015. However, as of April 2016, only 29 individuals in Delaware had been certified as Peer Specialists. After a survey of the community, MHA identified that a major barrier to become a certified Peer Specialist was getting the required 1,000 hours of peer experience needed for certification. Based on these findings, MHA sought to reduce this barrier through this Healthy Neighborhoods initiative, as part of which MHA supported peers to be placed in mental health clinics within Wilmington/Claymont so that they could receive their supervised peer support work hours, including payment for their time working at the site. Each site at which a Peer Specialist was placed was responsible for staffing a Supervisor to provide day-to-day supervision for the peers. In addition, MHA had on staff a Peer Placement Coordinator, who conducted weekly supervisory group sessions with the Peer Specialists, as well as provided one-on-one support to Peer Supervisors across the network. Each Peer Specialist was also assigned a mentor at MHA that was already working as a certified Peer Specialist. Outcomes of the initiative's implementation included:

- In collaboration with the host agencies, MHA was able to interview and place 8 Peer Specialists throughout the Wilmington/Claymont region, providing group supervision on a routine basis. The eight Peer Specialists were placed at the following host agencies: Brandywine Counseling (2 peers), Gaudenzia Fresh Start (2 peers), AIDS Delaware, Claymont Community Center, MHA, and Hope Street Delaware, and seven of them achieved their supervised hours as a result of the Healthy Neighborhoods initiative. Five of these interns have already retained full time employment as Certified Peer Specialists.
- Each Peer Specialist placed at a site had their own caseloads and worked under supervision to connect clients to practical resources like food banks, clothing, paying for power, as well as transportation to and from appointments. Given their lived experience, Peer Specialists were able to connect with individuals who had gone through similar difficulties, supporting them to be successful in achieving and maintaining recovery related to their behavioral health needs.

- In total, the Peer Specialists supported 1,154 unique individuals across all of the program sites, including recording 1,998 instances of assisting consumers with identification of their strengths and goals and 1,555 instances of helping consumers self-advocate.
- Near the end of the grant-funded period, MHA reconvened the Peer Specialists to present their experiences. The following are direct quotes from those who served as Peer Specialists as part of Healthy Neighborhoods:
  - "The confidence I have gained through this placement has had a very positive impact on me. I am now a case manager for BCCS." – Peer who was homeless when they began their supervised hours
  - "The placement taught me a lot about being accountable. I was leaning about myself as I was helping others. It helped me in my professional life and my personal life." – Peer who drew from their experience of losing two children, supporting clients through a holiday grief support group at their host agency.

Sussex County Health Coalition

Botvin Lifeskills Training

Budget: $52,932
Implementation Partner: Sussex County
Healthcare Coalition
Website:
https://www.healthysussex.org/
Contact name: Lisa Coldiron
Email address: lcoldiron@pmgconsulting.net
Approved: 9/20/2018

The Botvin LifeSkills Training and Prevention program, a supplement to the Sussex County Health Coalition's larger Botvin-focused initiative, was designed to educate and empower high school youth living in the Sussex County communities hardest hit by the addiction epidemic in Delaware. Through the initiative, the Sussex County Health Coalition implemented an evidence based, substance use prevention intervention within Sussex County middle schools and the Western Sussex Boys and Girls Club. Middle school youth in Sussex County, who are at great risk of engaging in substance use/abuse as they age, participated in the Botvin LifeSkills Training program in order to: (1) build awareness of the scope of prescription drug abuse in Sussex County and the harms that opiates and other prescription drugs are creating for the community at large; and (2) build skills to resist drug use and learn pro-social and personal management skills in order to support their ability to avoid substance abuse in the future. As part of this initiative, the Botvin LifeSkills course was facilitated by trained High School Peer Ambassadors and supported by the initiative staff, including the Botvin Coordinator and 4-H Peer Ambassador, during the implementation timeframe. Outcomes of the initiative's implementation included:

- Sussex County Health Coalition successfully trained 11 Seaford High School youth in Botvin LifeSkills so that they could become Peer Ambassadors to support 200 middle school youth across Sussex County

- As part of this initiative, the Sussex County Health Coalition leveraged the work of their School Based Mental Health Service Program, as well as other work that they are doing in collaboration with Sussex County schools to support this Botvin LifeSkills initiative. For example, the high school Botvin ambassadors supported an upcoming family support event at the middle school to further spread their message.

School-Based Mental Health Services

Budget: $85,057
Implementation Partner: Sussex County
Healthcare Coalition
Website:
https://www.healthysussex.org/
Contact name: Lisa Coldiron
Email address: lcoldiron@pmgconsulting.net
Approved: 9/20/2018

The Sussex County School Based Mental Health Collaborative, supported in part through Healthy Neighborhoods, is taking place in four of the highest risk school districts in Sussex County including the Seaford, Woodbridge, Cape Henlopen, and Indian River School Districts. Overall, these four school districts collectively support 22,082 students, one in five of whom (approximately 4,417 individuals) will experience a severe mental disorder in their lives based on statistics. When left untreated, this high prevalence of mental health conditions can result in maladaptive outcomes, including school dropout, premature death, homelessness, incarceration, unemployment, and high rates of hospitalizations, all of which culminate in increased cost to the health care system and the state, and poor health of Sussex communities. Specifically, the initiative was designed to educate 250 school personnel in the four-targeted high need school districts to screen youth for behavioral health risk using the Care-2 Assessment and RISK (Risk Identification Suicide Kit) Assessment. Once youth are identified as being "high risk" or needing support related to behavioral health, school staff worked to engage them in a "brief intervention" (e.g., providing the youth and their families with information related to available resources and the importance of accessing community support, engaging them in the preventive activities, described in more detail below) and referred them to an appropriate behavioral health provider or community based organization. These screenings, brief interventions, and referrals to treatment were supported by the initiative's hired Mental Health Consultant and Collaborative Contractual Coordinator, who was tasked with providing both group-based and one-on-one support to school personnel to help them develop their capacity to connect youth in need to appropriate community care. Outcomes of the initiative's implementation included:

- The Sussex County Health Coalition partnered with University of Delaware staff to provide Trauma Informed Care training to Cape Henlopen school district staff. The collaboration introduced the RISK assessment, used to evaluate students who present with risk factors for suicide, that has since been adopted.
- With the support of the initiative, Cape Henlopen's Mental Health Committee staff implemented a fully electronic system to manage and track the mental health referrals that are received, including demographic data.

- Bolstered by SIM dollars, the Sussex County Health Coalition was able to expand existing prevention work and trained the students and staff of 16 schools in the "Yellow Ribbon" suicide prevention program, reaching nearly 11,000 students.

Stakeholder Input

As part of the close out of Healthy Neighborhoods and the transition to Healthy Communities Delaware, the Healthy Communities Delaware development team hosted three two-hour focus groups, one in each county, with Healthy Neighborhoods stakeholders from across the state. The objective of each of the meetings was to identify and capture best practices from the CMMI SIM Grant Healthy Neighborhoods work, as well as to learn enhanced engagement strategies for future efforts under the Healthy Communities Delaware model.

The meetings were structured engage participants to "look back" and "look forward" across five core themes of Healthy Neighborhoods implementation and Healthy Communities Delaware planning, including:

1. Communications/community input
2. Authentic community engagement
3. Convening/technical assistance/backbone role
4. Proposals that impact population/community health
5. Top community health priorities

Each focus group had between 7 and 14 participants, most of whom participated in person (with one group, Dover/Smyrna, opting to allow for virtual participation by phone for those who could not be there in person). The focus groups were each held on the following dates:

- November 29, 2018: Sussex County Health Coalition
- November 30, 2018: Dover/Smyrna Local Council
- December 14, 2018: Wilmington/Claymont Local Council

The following table summarizes key focus group findings related to lessons learned by each topic.

Communications/Community Input	
In general, there was both positive feedback and opportunities for improvement expressed by focus group participants related to the communication about Healthy Neighborhoods.	
Looking Back	- Participants appreciated the combination of meetings, phone calls, and email communication about the work being undertaken in their specific locales. - Many folks expressed the challenge that the transition from DCHI to HMA posed as part of their work, resulting in reduced engagement (in some cases), inconsistent messaging, and shortened timeframes for project planning/implementation. - A broad range of stakeholders indicated that they found value in meeting as a collective, saying that the Healthy Neighborhoods forum allowed for

	opportunities for communication among diverse stakeholders that was positive.
Looking Forward	• A number of participants said that the communication with the community, including community members and smaller nonprofits, is a key area for improvement moving forward. • Several participants stated that in order to engage community members and stakeholder from across the state, we must be prepared to meet stakeholders where they are, selecting times and locations that are comfortable for these stakeholders (e.g., churches, community centers, and locations that are in all regions of the State). • Some individuals indicated the difficulty for some community organizations and community members to engage in an initiative with such a comprehensive view of health, citing a lack of understanding of the intent/activities because it is so broadly focused and a difficulty in determining where their organization fits within the structure/what their role could be.
Authentic Community Engagement	
Overall, stakeholders in all three counties indicated that there were some key organizations and stakeholders missing from the Healthy Neighborhoods table. Many participants believed that Healthy Communities Delaware is a new opportunity to engage some of these stakeholders in this work to improve the community's health.	
Looking Back	• Many stakeholders agreed that Healthy Neighborhoods was not entirely effective in engaging community members themselves in the work, due in part to the rapid timeline necessary for getting the SIM mini-grant funds out the door. As one participant noted, "We would have done it differently with additional time." • A number of participants acknowledged that although everyone has good intentions (e.g., to improve community health), there remains siloes and often times competition for limited resources among some community groups working in the same locales.
Looking Forward	• Participants stated that robust communication is necessary to reduce the identified siloes/sense of competition among community groups. As one participant stated, "We can do more together than any of us can do alone." • Participants emphasized the need to ensure statewide representation within the Healthy Communities Delaware model overall, including hosting meetings in rotating locations and at times that are accessible to all, as well as ensuring that the Leadership Council includes equitable representation from Sussex County based organizations.
Convening, Technical Assistance, and Backbone Role	
In all three of the focus groups, the backbone agency role was expressed as critical to continuing the work initiated by Healthy Neighborhoods, though this type of support looks a bit different in each of the locales (depending on the existing infrastructure they have in place).	
Looking Back	Across all counties, the backbone role has a number of components that participants thought were helpful, including: • Technical Support to attain funding, including support filling out grant applications

	• Leadership support, including convening, meeting minutes follow ups, etc. • Data Analysis to document community needs, specifically noting that a backbone organization could support communities to interpret the data (rather than simply mine the data) and use it to inform community initiatives • Evaluation to capture Return on Investment of funded initiatives • Capacity Building Assistance for participating organizations (e.g., helping entities build concrete skill sets related to grant writing, building connections to funders, etc.)

Looking Forward	• All focus group attendees agreed that if the Local Council structure is going to continue, backbone and technical support is necessary under Healthy Communities Delaware.
	• When asked whether participants thought that the Local Council infrastructure should continue, the participants had differing responses.
	   o In **Wilmington/Claymont**, participants expressed that they only wanted to meet if there was a purpose to their meeting. Under Healthy Neighborhoods, the Wilmington/Claymont Local Council's expressed purpose was to approve Healthy Neighborhoods applications. Without this purpose under Healthy Communities Delaware, the group is not sure if there is a need for them to continue to meet moving forward.
	   o In **Dover/Smyrna**, participants unanimously felt as though they would benefit from continuing to convene as a group of stakeholders. Several expressed that this type of group helped to minimize competition by ensuring transparency, communication, and collaboration, and another participant reported that the Healthy Neighborhoods table was the first opportunity for many of the involved stakeholders to connect with each other around the work that they do every day.
	   o In **Sussex County**, participants expressed resounding support for the Sussex County Health Coalition's Committee structure, which provides the "functional framework" to have discussions with diverse stakeholders about these complex community issues. Participants reported that partnerships are formed at the table, and that the Committees' discussions truly do translate into real action on behalf of the community.

**Proposals that Impact Population/Community Health** *Overall, participants expressed excitement for the projects that were launched as part of Healthy Neighborhoods and felt that they were aligned with the community health priorities in their community, while also recognizing a number of limitations based on the nature of the federal grant (e.g., CMMI requirements/priorities, rapid timeline for distributing funds). Many participants also noted opportunities to expand on what has been done as part of Healthy Communities Delaware (e.g., involving housing and community development sectors, aligning funding streams to result in larger impact).*
Looking Back	• Many participants expressed significant limitations in their ability to propose initiatives under the Healthy Neighborhoods process due to CMMI requirements and priorities, including certain initiative ideas and "big visions" that were ultimately not able to be funded by Healthy Neighborhoods.

Looking Forward	• A number of participants expressed enthusiasm for the opportunity presented by Healthy Communities Delaware to align both programmatic and systems investments around a particular community need in order to result in greater impact for the community.
	• Several participants stated the importance of ensuring that the Healthy Communities Delaware proposal process is transparent and clear, and Many participants emphasized the importance of ensuring that there are cross-agency collaborations within project proposals (especially since the proposals will not flow through the Local Council structure as part of Healthy Communities Delaware).
	• Several folks stated that although Policy, Systems, and Environment (PSE) proposals are desirable as part of Healthy Communities Delaware, we should be careful not to lose the possibility of a small, pilot project receiving funding (as innovative pilot projects that are effective can turn into systems projects).
	• There were a number of suggestions provided related to how proposals should be submitted as part of Healthy Communities Delaware, including a combination of both verbal and written pitches.

Top Community Health Priorities

In addition to the focus group discussion, the Healthy Communities Delaware development team provided a worksheet for attendees at the meeting to allow them to rank specific sectors they felt were priorities in their county. Attendees ranked the community priorities that they felt were the most critical in their communities to address on a scale of 1 to 4.

- Through this process, number of priorities were identified as being important, including:
  - Behavioral Health
  - Housing
  - Transportation
  - Social Factors
  - Education
  - Employment
  - Food/Nutrition
  - Safety
- Overall, participants indicated that many of these identified needs are inter-related with one another, with many of them rising to the top as being critical to address in their communities. As part of the focus group discussions, several attendees indicated an interest in a more in-depth community planning process that uses data to prioritize these issues related to health in their communities.

Sustainability

Sustaining the Healthy Neighborhoods efforts has been at the core of the SIM Grant and the Healthy Neighborhoods Initiative. This section includes strategies that were initially proposed, as well as the existing Healthy Communities Delaware model, a result of 18 months of working with state leadership.

Original Sustainability Strategies

HMA supported the development and consideration of a number of sustainability strategies, as delineated below.

A **Prevention and Wellness Trust Fund** is designed to support health-promotion and disease-prevention activities at the community level and sustain support for community-based programming. It is a model that can be used to shift spending from "sick care" to activities that help maintain or improve health. There are many ways to fund a Trust which may include contributions from health insurers and hospitals, as well as foundations, philanthropy, retail fees and other funding sources. A Trust was considered as an option for Delaware to support sustainable funding for Healthy Neighborhoods activities, given its success in other locales. For example, in 2012, the Massachusetts legislature created a first-in-the-nation Prevention and Wellness Trust Fund (PWTF) which was funded by a one-time assessment on the state's largest health insurers and hospitals. The Trust was designed to operate for four years and distribute funds through competitive grants to local partnerships for interventions aimed at achieving measurable improvements in preventable health conditions, healthy behaviors, and health disparities.

Another model to secure funding for prevention and wellness that was considered is the **social impact bond** (SIB). SIBs provide a new way to pay for social programs and have the potential to save money and improve accountability. Like "pay-for-success" projects, SIBs are an innovative financing mechanism aimed at helping state and local governments fund social programs through a combination of government initiation, private investment, and non-profit implementation.

For government to attract a private investor and for the SIB agreement to be successful, proposed programs must demonstrate effectiveness in addressing targeted social problems. Investors need to know how much these programs will cost, and the programs need to show cost savings in a reasonable time frame.

SIBs work by allowing private entities to provide capital up front that government can repay at a later date. SIBs are a contract between a private entity and the public sector. The private party commits to pay for a program that leads to improved social results and public-sector savings. The private investors are then repaid when objectives are achieved. Financial guarantees to the investors can be arranged by

involving another entity, like a private foundation, in case the program does not produce the desired results. The diagram (right)[5] depicts the entities involved and their respective roles.

Social Impact Bonds: How they Work + Who is at the Table

In addition, a number of complementary programs related to Healthy Neighborhoods were analyzed. First, the **PROMISE program** (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) offers a variety of home and community-based services geared toward those with behavioral health needs and functional limitations. The PROMISE program was designed to improve health outcomes and reduce duplicative clinical care through improved coordination, ultimately reducing costs of long-term care. The services PROMISE provides includes, but is not limited to, independent and other activities of daily living, financial coaching and employment support, nursing and respite care, psychosocial rehabilitation and non-medical transportation.

Second, **Blueprint Communities** is a program resulting from the partnership between the University of Delaware Center for Community Research and Service (CCRS) and FHLBank Pittsburgh. The Blueprint Communities initiative was implemented to revitalize communities and neighborhoods in need through leadership training, capacity and relationship building, and comprehensive regional planning. The initiative also encourages public and private funders to invest in target communities. The teams formed around each Blueprint Community receives leadership training technical assistance in creating and implementing revitalization plans.

Third, the **Robert Wood Johnson Foundation (RWJF) Culture of Health** Prize celebrates communities that prioritize health through their demonstrated partnerships and commitments to promote healthy living for all. A Culture of Health recognizes that health and well-being can be greatly affected by the social, economic and physical characteristics of where folks live, learn, work, and play; the safety of our surroundings; and the relationships we have in our families and communities. The Prize helps realize the vision of local leaders for more healthy communities.

Finally, in 2018, the Delaware Division of Public Health completed a **health assessment and accompanying improvement plan** (CHA/CHIP). As HMA made progress through the Healthy

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[5] http://www.ncsl.org/research/labor-and-employment/social-impact-bonds.aspx

Neighborhoods model, the team worked to ensure continuous alignment between the priority areas of the Healthy Neighborhoods work and those outlined in the State Health Improvement Plan.

The **Community Health Needs Assessment Committee** is divided into CHNA North and CHNA South subcommittees to cover the state of Delaware. These committees build off local hospital and other association community health needs assessments data collection for the entire state. The HMA team sought to collaborate with the North and South subcommittees to created targeted, data-supported, and evidence-based initiatives in each Healthy Neighborhoods.

Evolution of the Sustainability Plan: Healthy Communities Delaware

Ultimately, HMA's focus on sustainability included the development of strategies and the identification of possible partners that were invested and capable of sustaining place-based population health initiatives. We met with previous subcommittee members of the DCHI Healthy Neighborhoods Committee focused on sustainability. Quickly we identified a few natural leaders whose work aligns with sustaining the SIM funded Healthy Neighborhoods and are from anchor institutions. Dr. Karyl Rattay, Director of the Department of Health and Human Services Division of Public Health, and Steve Peuquet, the former Director of University of Delaware's Center for Community Research and Service, were identified and engaged to serve as co-ambassadors for the development of the sustainability plan.

Rapidly, Drs. Rattay and Peuquet created a development team of individuals to help them develop and flush out a model (see Appendix 4) that includes a leadership council, a community investment council and a backbone organization. With a subcontract in place between HMA and the University of Delaware, resources were put in place to ensure each component was successfully launched. The Healthy Community Delaware model, was launched on January 14, 2019 with Secretary Walker, Senator Coons and Governor Carney all as active presenters and participants, demonstrating significant state buy-in.

Leadership Council

The leadership council (LC) is the "think tank" of the model. It consists of approximately 35 members, with a 7-person executive committee. The LC members represent a cross-sector of entities including: Federally Qualified Health Centers, hospitals, banks, local elected officials, housing alliance, Managed Care Organizations, United Way, philanthropists, Hispanic Commission, DCHI, state planning, community action agencies, community development entities, foundations, faith-based leaders, universities and technical colleges. Strong efforts have been made to attract very knowledgeable people across the public, private and nonprofit sectors, across disciplines and issues areas, and across different geographical areas of the state. The primary responsibilities of the council are to:

- Pursue ideas and actions that are evidence-based using a collective impact approach to improve community health;
- Discuss, decide and prioritize major short-term, mid-term and long-term goals of the Healthy Community Delaware (HCD) that are based on reliable data; and
- Provide ideas and feedback on the composition and implementation of different investment portfolios for different low-wealth communities across the state.

The LC had its inaugural meeting in November 2018 and plans to meet every other month moving forward. The two ambassadors for the model. Drs. Rattay and Peuquet, will co-chair the meetings.

Community Investment Council

The community investment council (CIC), which officially launched in January 2019, will attract investors willing to provide financial and/or in-kind resources. Some contributions will be pooled to support the overall functioning of the system, but most will be allocated by individual investors for the implementation of impactful community projects and programs. Investors may include state government, county and municipal government, hospital systems, universities, major foundations, United Way, major banks, community development financial institutions (CDFIs), corporations and others.

Currently, all geographic areas already have a portfolio in play, whether acknowledged or not. However, most are very ad hoc, oftentimes with mis-aligned and/or ill-defined goals. HCD seeks to establish blended investment portfolios for investors. HCD will bring capacity to the table in helping communities explicitly define and implement investment portfolios that can improve community health. Once established and funded, HCD will need to measure the impact of these community investment portfolios and fine-tune them over time.

HCD will be focused on addressing improvement in vital conditions within neighborhoods, such as education, jobs, wages, employment, stable housing, safe neighborhoods and homes, and healthy food. These investments are longer term and seek to address upstream root causes of illness. The investment portfolio will also address more of the acute, short-term needs of communities, but by investing upstream over time, we believe we will have fewer acute needs over time.

Backbone Organization

The backbone organization is the administrative entity that manages the day-to-day operations of HCD. Responsibilities of the backbone organization will include:

- Support the functioning of the Leadership Council and Community Investment Council;
- Provide technical assistance and training to local community-based groups;
- Gather and analyze primary and secondary data to identify needs and formulate investment portfolios; and
- Measure the individual and collective impact of program and projects (portfolios).

The backbone organization will not be one entity but three in an established partnership between Delaware Department of Health and Social Services, University of Delaware, and the Delaware Community Foundation.

Post SIM grant funding, the HCD development team has requested $500,000 of tobacco settlement funds to provide initial support for the backbone organization. If awarded, these funds will be available starting in July of 2019.

Bi-Directional Community Input

An important part of the HCD model is obtaining regular input from the community to minimize a top down approach. We believe communities need to be engaged given that they are uniquely positioned to understand what is needed in their neighborhoods and can bring great insight to the process of building healthier more resilient communities. It will be the role and responsibility of the backbone organization to regularly communicate with and obtain input from the community.

For more information about Healthy Communities Delaware and to stay connected, visit: https://sites.udel.edu/cas-hcd/about/

Example of How This Could Work

Below is an example of how the Healthy Communities Delaware model might work in practice.

To begin, the LC reviews data and determines statewide priorities. The backbone organization communicates priorities to a variety of local stakeholders, including local councils, consortiums and other entities. Local community-based organizations, with or without the help of a local council, brainstorm about how their entity can address the established priority, and they write an abstract about their concept.

Once submitted, the LC reviews the abstracts, looking for alignment between entities, and short-term, mid-term and long-term funding opportunities to ensure both urgent needs and vital conditions are addressed. Once the LC reviews the submitted abstracts, they prioritize entities whose initiatives can be aligned. These entities are asked a few additional questions and possibly, to tweak their initiative to ensure alignment. They then present in front of the LC. The LC listens and supports the creation of collaborative relationships between entities. The entities that have capacity and are proposing the best initiatives will be asked to write a full proposal.

Proposals are reviewed by LC. The backbone organization then creates blended portfolios based on proposals and presents them to the CIC. CIC members may decide to pool their resources or decide to fund different initiatives that are best aligned with what they want to fund.

The backbone organization obtain commitments from funders and notifies communities entities who are part of the funding package that they have been awarded dollars to implement proposed initiative. The backbone organization will work with community entities to ensure that they are able to evaluate impact, and periodically report to the investors who funded initiative on progress related to established outputs and outcomes.

Conclusion

The Healthy Neighborhoods model, which is now being transformed into Healthy Communities Delaware, was launched successfully under the CMMI's SIM grant. Healthy Neighborhoods implementation offered the opportunity for targeted investments in initiatives that local communities thought to be critical for their neighborhoods. Even though the time to develop, fund, and implement the selected initiatives was short, the selected implementation partners were all successful in

implementing their selected initiatives and have a plan to sustain their efforts (at least in part) following the conclusion of the SIM funding. Most importantly, through Healthy Communities Delaware, state leaders have identified other funding mechanisms to continue to support local initiatives that improve population health in a targeted, strategic way.

Overall, Healthy Neighborhoods achieved a number of noteworthy accomplishments, all of which would not have been possible without significant effort and energy by all of the participating local stakeholders. A selection of these accomplishments includes:

- Established infrastructure to support diverse collectives of stakeholders, including health, behavioral health, and social services providers, community-based organizations, community advocates, and other stakeholders with expertise in the SIM priority areas;
- Supported the development of valuable partnerships and relationships among diverse community organizations, both within and outside of the identified community initiatives;
- Strengthened communication across the State about ongoing initiatives through Statewide Consortium and Local Council collectives;
- Funded eight community driven, local initiatives, designed to improve population health within selected locales; and
- Supported the creation of a sustainability model that can support local initiatives developed to improve community health and wellbeing moving forward

Although, as outlined in this report, challenges were identified during Healthy Neighborhoods implementation—including those related to vendor transition, short timeframes for initiative development and implementation, limited resources and time for activities like stakeholder engagement, and restrictive requirements—local stakeholders have an opportunity to learn from these identified issues moving into Healthy Communities Delaware, supporting the creation of a sustainable infrastructure that is supportive of community-driven initiatives focused on collectively improving population health. What is evident from Healthy Neighborhoods is the commitment, expertise, and passion Delawareans bring to this work, which, if aligned, will ultimately result in improved health outcomes and reduced health disparities across the State.

Appendix 1: Glossary of Commonly Used Terms

Below is a summary of common terms, phrases, and abbreviations that appear frequently in the report.

Abbreviation (Optional)	Term or Phrase	Description
CBO	Community-Based Organization	A public or private nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community for improved equity.
CIC	Community Investment Council	A body of local and regional organizations positioned to invest in Delaware communities to improve health outcomes
CMMI	Centers for Medicare and Medicaid Innovation	An organization of the United States government under the Centers for Medicare and Medicaid Services. Owner of the SIM grant.
DCHI	Delaware Center for Health Innovation	A non-profit organization dedicated to the implementation of Delaware's State Healthcare Innovation Plan. It was established in early 2014 to work with the Health Care Commission and the Delaware Health Information Network (DHIN) to guide the State Innovation Models effort and track its progress.
HCC	Delaware Health Care Commission	A policy-setting body created by the General Assembly to conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs. Client of HMA.
HMA	Health Management Associates	An independent national research and consulting firm in the healthcare industry specializing in publicly funded health care and underserved populations. State contractor, fiscal agent and back bone organization for award year 4 of the SIM grant.
MOU	Memorandum of Understanding	A legally binding document. Used between HMA and the Implementation Partners.
SIM	State Innovation Model Initiative	A partnership with states to advance multi-payer health care payment and delivery system reform models. Each state-led model aims to achieve better quality of care, lower costs, and improved health for the population of the participating states or territory.

Appendix 2: Statewide Consortium Membership

Healthy Neighborhoods Statewide Consortium
As of April 18, 2018

Participants

Sarah Lynn Bercaw, Dover/Smyrna Local Council Co-Chair

Valerie Cannon, Delaware Department of Health and Social Services, Division of Social Services

Cassandra Codes-Johnson, Delaware Department of Health and Social Services, Division of Public Health

Lisa Coldiron, Sussex County Health Coalition

Gina Crist, Wilmington/ Claymont, University of Delaware Extension (RWJF Culture of Health)

Rysheema Dixon, Wilmington/Claymont Local Council Co-Chair

Cheryl Doucette, Sussex County Health Coalition

David Edgell, Dover/Smyrna Local Council Co-Chair

Keanna Faison, Delaware Health Care Commission

Troy Hazzard, Sussex County Community Representative

Roger Hesketh, University of Delaware's Center for Community Research and Education (Blueprint Communities)

Tyrone Jones, United Way of Delaware (Promise Communities)

Charles Madden, Wilmington/ Claymont Local Council Community Representative

Tanner Polce, Delaware Office of the Lieutenant Governor

Ava Stallings-Hardy, Dover/Smyrna Local Council Community Representative

Gwen Angalet, Healthy Neighborhoods Committee

Staff

Liddy Garcia-Bunuel, Health Management Associates

Sarina Coates, Health Management Associates

Appendix 3: Readiness Assessment Tool

Neighborhood task forces are required to complete this tool to ensure readiness of their initiative for receipt of funding and implementation. If determined "not ready" or "almost ready," HMA will provide technical assistance (TA) and support to ensure the initiative has been designed based on need, evidence, with ample community buy-in and a plan for data collection through which the initiative will measure and demonstrate outcomes based on a logic model.

Instructions

Your specific point of contract (POC) will help neighborhood task forces complete the below questions and attach all necessary documentation. Remember there are no right or wrong answers; rather, your responses will determine your level of readiness and areas of necessary TA. Once complete, please submit to the local point of contact for your Local Council:

- Wilmington & Claymont: Laquisha Grant; lgrant@healthmanagement.com
- Dover & Smyrna: Kristan McIntosh; kmcintosh@healthmanagement.com
- Sussex: Joshua Cole; jcole@healthmanagement.com

HMA will score the responses and make the determination if an initiative is ready for funding. If the initiative is determined to not be ready, the designated point of contact will provide necessary technical assistance. SIM funding must be distributed and spent by end of January 2019, thus it is critical initiatives spend the time to become ready to ensure funding is drawn down and spent.

Community Need (20%)
1. What is the community need(s) you plan to address through this initiative and how did you identify this need(s)?
2. What data sources did you use?
3. What did the data suggest?
4. Was the data broken down by state, county or zip code?

Evidence-Based Research (20%)
1. Describe the initiative that you are proposing to implement to address the identified need.
2. How did you select the initiative? Did you explore evidence-based or evidence-informed models* during the initiative development process? Please list the models you considered that informed this initiative, as well as the associated outcome data for each.
3. How will these models be adapted to meet the needs of your target population/community?

This can include nationally recognized evidence-based practices or policies, as well as initiatives/programs currently being implemented within/outside of Delaware that have demonstrated effectiveness in addressing a similar community need.

Community Buy-In (20%)
1. Describe the community support/buy-in that you have obtained for this initiative. How did you obtain this community buy in? In particular:

     a. Name community members who represent the target population <u>AND</u> helped inform the initiative.

     b. Name community organizations that serve the target population <u>AND</u> helped inform the initiative.

     c. Name potential stakeholders you've engaged that may be able to help you fund/sustain the initiative beyond the grant period.

2. Do you have any plans for gaining additional community buy-in at this time (e.g., a community forum, etc.)?

3. Are there any community groups/entities with whom you were not able to connect? Describe these individuals/entities and the efforts you undertook to connect with them, as applicable.

Budget (20%)

1. Attach your proposed budget using template for this initiative, including line items for all activities, as well as the individual/entity who will implement the activities.

2. How did you develop the budget? Which entities were involved in its development?

3. How did you decide which organization(s) is best to implement the initiative? Were there others who were considered?

4. How are you aligning with and leveraging other related initiatives and/or resources? Is there in-kind support included as part of your proposed initiative?

5. How will this effort be sustained past funding?

Outcomes (20%)

1. What outcomes are you expecting? By when?

2. Do you have a logic model, that defines short-term, intermediate and long-term outcomes? If yes, attach this to this application.

3. What data will you use to track and measure outcomes? Where will this data be stored?

4. Who is responsible for tracking and measuring outcomes? What does the reporting structure look like (e.g., entity implementing initiative reports to [who?] on a [frequency] basis through [processes]/shared database/etc.)?

5. Who will complete the interim and final reports that will be sent to the Fiscal Agent and Local Council?

Appendix 4: Healthy Communities Delaware Model Visual

HEALTHY COMMUNITIES DELAWARE (HCD)

HCD INFRASTRUCTURE

Direct contracting with community implementation partner

COMMUNITY INVESTMENT COUNCIL (CIC)

Core Functions of CIC:
- Participants individually review and consider funding all or part of worthwhile projects/programs that enhance community health
- Participants contribute limited funds to a pool for the operation of the BBO

LEADERSHIP COUNCIL

Core Functions of Leadership Council:
- Governs the overall operation of the HCD initiative with significant stakeholder involvement at all levels
- identifies critical conditions and priority health needs statewide
- Identifies and advocates for statewide policies that advance population health
- Encourages alignment of local health-related initiatives and statewide priorities
- Encourages alignment between health and community development investments and the creation of a balanced investment portfolio
- Convenes periodic symposia at the county and statewide levels

Backbone Organization (BBO)

Core Functions of BBO:
- Provides overall management and logistical support for CIC and the overall Healthy Communities Delaware initiative
- Provides and/or facilitate the provision of training/technical assistance/coaching services in support of local planning efforts
- Monitors the implementation of projects/programs, and evaluate their impacts

BBO contracts with community implementation partner

Community Input

Proposed Projects

Investor Priorities

Individual Stakeholder

Community Based Organization

Task Force/ Partnership

COMMUNITY LEVEL PLANNING AND PROJECT/PROGRAM IMPLEMENTATION

Model supports existing and new, emerging task forces and/or partnerships.

Local stakeholders are encouraged to form alliances and partnerships and work collaboratively to plan and carry out activities that improve community health.