

Meeting Report
October 8, 2008 ASTHO, NACCHO, NBCH
Community Health Partnerships: Learning from the Field

*Association of State and Territorial Health Officials (ASTHO)

**National Association of County and City Health Officials (NACCHO)

***National Business Coalition on Health (NBCH)

Executive Summary

The meeting was held as part of the National Business Coalition on Health/ Community Coalitions Health Institute (NBCH/CCH) work with the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) to promote collaboration and leadership from public health and business coalitions. The goal of Community Health Partnerships (CHP) is to strengthen existing, and catalyze new partnerships between NBCH member coalitions and state and local public health agencies for the purpose of advancing population health improvements at the community level.

The meeting objective was to learn from the field experience and both public health and business coalition perspectives about experiences in establishing and sustaining multi stakeholder community health partnerships with the common goal to improve population health with the goal to use this information to encourage other communities to develop community health partnerships and to help inform the national partners—ASTHO, NACCHO, and NBCH—about the potential roles and actions for each that will help to build and sustain community health partnership.

The energy, creativity, and mutual respect demonstrated by the field sites at this meeting supports the level of commitment for both more and continuation of community health partnerships with leadership from business coalitions and public health. Findings and observations from this input from the field include:

- High level of interest to both start and sustain partnerships between business coalitions and public health
- Observed value of these relationships from resources and expertise to ability to reach a broader population for common goals to improve health status
- Need for tools and information to support the development of new partnerships
- Importance of networking opportunities to learn from each other
- Number of ways in which these relationships evolve and the of stages of evolution
- Common barriers and ways to overcome these potential roadblocks
- Value of collaboration

- Issue of resources for partnerships—staff time, engagement with stakeholders, business case for employers, and funding support
- Potential actions for NBCH, ASTHO, and NACCHO to model community health partnerships at the national level and support members in development and sustaining local partnerships

Acknowledgements

NBCH/CCHI acknowledges the continued support provided through the Cooperative Agreement with Centers for Disease Control (CDC). Paul Jarris, MD, MBA, Executive Director of ASTHO and Patrick Libbey, Executive Director of NACCHO were actively engaged in development of the questions as well as ongoing insights and suggestions for the meeting. ASTHO generously provided the meeting space. Michelle Chuk, NACCHO, and Brittney Petersen, ASTHO, were most helping in meeting planning and in making certain their appropriate members were included in the meeting invitation.

All the participants are to be acknowledged for not only taking time to attend this meeting and to share their valuable insights and experience but also for their leadership and commitment to population health.

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Background

The meeting was held as part of the NBCH/CCHI work with ASTHO and NACCHO to promote collaboration and leadership from public health and business coalitions. NBCH/CCHI's Community Health Partnerships Project was inspired by Dr. Julie Gerberding, CDC Director, who has been encouraging public health departments to engage with other community stakeholders, particularly the business sector. The goal of Community Health Partnerships (CHP) is to strengthen existing, and catalyze new partnerships between NBCH member coalitions and state and local public health agencies for the purpose of advancing population health strategies at the community level. CHP is based on an underlying conviction that the

public health community and the business sector share a common interest in improving population health. For CDC and their core constituency (state and local public health agencies), improving population health represents their long-standing and stated mission. For employers, the connection is less obvious but includes the following business imperatives:

- Improving workforce — including family member and retiree -- health and productivity is a competitive asset;
- Reducing workforce illness relieves pressure on direct and indirect operating costs;
- Investing in the health of the community strengthens the current and future workforce pool that every employer must rely upon.

Seen from this perspective, the employer community, represented by NBCH member coalitions, and the public health community—members of ASTHO or NACCHO-- are natural partners with aligned interests. This focus on population health represents an important expansion for business from past and current work on health care improvement through value-based purchasing. Indeed, there is a growing trend in the thinking and actions of employers that investments in human capital -- maintaining a healthy workforce and preventing illness and disability -- must become a more central and unifying strategy.

The meeting was set up to bring together a cross section of the coalitions and their public health partners who are already engaged in some stage of community health partnership. NBCH, ASTHO, and NACCHO worked together in both the selection of the sites and the invitations to participants to help bring together this opportunity to learn from the field.

The meeting objectives were outlined to participants in preparation for the meeting as follows:

- To learn from the field experience and both public health and business coalition perspectives about experiences in establishing and sustaining multi stakeholder community health partnerships with the common goal to improve population health
- To develop from these field experiences information and actions to encourage other communities to develop community health partnerships
- To inform the national partners—ASTHO, NACCHO, and NBCH—about the potential roles and actions for each that will help to build and sustain community health partnership

Meeting Agenda and Format

The meeting agenda and format were set up to promote the interchange with all four site's participants as well as all three national organizations. Using a roundtable discussion approach, the meeting was in following major segments.

1. Overview and brief background perspective from each national organization leader—Paul Jarris for ASTHO, Patrick Libby for NACCHO, and Andy Webber for NBCH.
2. Overview from each field site led by the coalition director with additional comments and perceptions from public health participants:

- Bill Brunning, Mid-America Coalition on Health; Marti Macchi, Kansas Department of Health and Environment; Rex Archer, Health Department City of Kansas
- Cristie Travis, Memphis Business Group on Health; Yvonne Madlock, Memphis-Shelby County Health Department; Connie Binkowitz, Memphis-Shelby County Health Department; Susan Cooper, Commissioner, Tennessee Department of Health
- Laurel Pickering, New York Business Group on Health; Dorothy Rick, NYC Department of Health and Mental Hygiene; Sylvia Pirani, Director, Office of Public Health Practice, New York State Department of Health
- Barbara Wallace, Virginia Business Coalition on Health; Nancy Welch, Chesapeake Health Department; Laura Wimmer, Virginia Department of Health; Jeff Lake, Deputy Commissioner for Community Health Services, Virginia State Health Department

3. Facilitated Discussion

- Patrick Libby, NACCHO, Facilitator, for discussion about the value of the relationship and what has been gained from the relationship.
- Paul Jarris, ASTHO, Facilitator, for discussion to help identify common lessons learned, barriers, and suggestions for peers in developing or sustaining relationships.
- Andy Webber, NBCH, Facilitator, for discussion to focus on what is needed to strengthen and sustain these relationships.

4. Open Discussion to identify what ASTHO, NACCHO, and NBCH might do in the short and longer term to both expand the number of public health and business collaborations and to sustain current community health partnerships.

5. Wrap Up and Summary.

National Organization Partners Overview

The leaders of each of the three organizations—ASTHO, NACCHO, and NBCH—provided brief opening remarks to provide an overall depiction of the organization’s role and objectives in this collaboration and goals for the meeting.

National Business Coalition on Health (NBCH) and Community Coalitions Health Institute (CCHI)

Andy Webber provided background about NBCH and its sister organization CCHI focusing on the membership support role for its 60 members across the United States and the rich history of decades of business health coalition evolution. There is a business imperative for health and productivity with coalitions providing information at the employer level and interacting with the community by representing multiple employers. NBCH will be focusing on community impact by serving as a distribution network with its members, providing national outreach for members, and finding and disseminating best practices as well as modeling collaboration at the national

level with ASTHO, NACCHO, CDC and other organizations. Andy noted that Dr. Gerberding's leadership to change the momentum of discussion from *health care* to *health* meaning population health supports the need for the business community to work with public health. Andy coined the term "community health partners and partnerships" as the name for the NBCH/CCHI project and strongly supports the evolution of the coalition role. In the outreach to NBCH members, NBCH has found both great interest and great current examples of the four coalitions represented at the meeting. NBCH will use the learning from these field examples along with the NBCH member inventory to work with both members and ASTHO and NACCHO to further CHP.

Association of State and Territorial Health Officials (ASTHO)

Paul Jarris added his welcome to the meeting and provided background about ASTHO. ASTHO, established in 1942, has a long history starting after the Civil War and the cholera outbreaks of 1873. ASTHO members oversee agencies that provide a variety of services including but not limited to: management and distribution of vaccines, population-based primary care services around tobacco, injury prevention, obesity, diabetes, and substance abuse, and inspection, regulation, and licensing of food establishments, hospitals, laboratories, pools, and lead. Paul discussed the role of ASTHO along with other local, state, and federal public health organizations and stakeholders in addressing the health of the nation with the government roles strongly suggesting the need for the private sector as a critical partner. Paul advocated that we think: *how can we be better by working together?* And recommended that this meeting will help with this question.

National Association of County and City Health Officials (NACCHO)

Patrick Libby noted how most Americans—including business executives—do not understand or think about how public health impacts all Americans and has used the issue of clean water as one example. The general perception is that public health only deals with the indigent population and public or mass clinics. Most do not see the responsibility of public health for health and well being. Barriers for public health include the regulatory nature of many parts of the responsibilities, the perception of differing culture and values, and focusing on the differences rather than those areas of alignment. Patrick stated the collective obligation and shared responsibility public health has with the private sector for common alignment to "promote, protect, and prevent" while recognizing the motivations may differ. NACCHO members are local health departments—3000 city, county, multi-city, or tribal across the country. Size and organizational structure varies and NACCHO provides support to members with current activities concentrating on standardization, access to field tested tools and resources, and advocacy.

All three organizations have committed to working together to support their members in the development and sustainability of community health partnerships using the lessons learned from the field as a baseline to develop next steps and support tools and information.

Experience from the Field

Summaries of the collaborations from the business coalition perspective were prepared prior to the meeting and are also included in the NBCH/CCHI Membership Inventory Report on CHP.

The following summaries include the added insights from the public health officials. Each site participant was asked to respond to the following questions:

Who are you and who do you represent?

Why did you see this relationship as one in which you should invest time and resources?

How did the relationship develop?

What is the subject of the collaboration? (Participants were asked to describe this aspect briefly since the focus for the meeting was the relationship development.)

Kansas City

Bill Brunning, Mid-America Coalition on Health; Marti Macchi, Kansas Department of Health and Environment; and Rex Archer, Health Department City of Kansas represented the Kansas City area community health partnership. Rex and his predecessor have served on the Board of the Coalition and participated in the development of the strategic plan for the Coalition. Marti is on committees with coalition staff, members, and others and communicates daily with Coalition staff.

Bill has worked with his Board and members to understand the need to address health from total perspective of health and productivity plus community issues that directly relate to the cost such as the uninsured. This reinforces the necessity for collaboration with the model to address the costs and quality for all. Bill has also engaged with the Chamber of Commerce to have a broad representation from all business including smaller employers.

Mid-America has 14 ongoing projects with public health. The most current initiative on cardiovascular health began with an open discussion about common issues that built on prior successful collaborations. A major building block was the depression initiative that the Coalition led which began with help from public health in using the publicly available Behavioral Health Risk Factor Surveillance Survey tool used by CDC with employed populations for the baseline assessment data for project planning. One lesson learned was the value of working with public health epidemiologic support on the analysis of data and construction of evidence based programs.

One example of how the initiatives work and grow is the education and tools provided by the Coalition and public health to employers to address healthy food at the worksite—cafeterias, vending machines, CDC guide to healthy food at meetings, etc. This has led the employers to ask the city to mandate food labeling information for restaurants. Another example is when the Coalition brought the Leapfrog Group agenda to the community. While Leapfrog was not adopted, this did foster the beginning of public reporting by local hospitals. Yet another example is the pilot project of the Coalition for an electronic ID card for insurance that included Medicaid.

The Coalition, which includes all stakeholders in its initiatives, also piloted the CDC tool kit *Successful Business Strategies to Prevent Heart Disease and Stroke*. This allowed a field experience to inform improvements in the kit as well as recommendations on how public health

could adapt and use the kit with smaller employers. Additionally, the Coalition is now working to add a component to the kit about “Value Based Benefit Design” (VBBD). (VBBD provides health benefit design features including incentives to help produce the most effective health and economic impact.)

Investing time has been a significant factor in the success of the collaboration. This resource of time has been widely used to participate in meetings, educate employers about issues such as the fact that indigent care costs the entire community, engage with the Chamber of Commerce, and to support joint initiatives. Public health has integrated worksites into its programs whenever possible and has also invested time in learning the business language. All of this commitment of resources from both business and public health has led to a relationship founded on trust and successful results for both groups.

Business has contributed to public health in numerous ways including recent access to claims data from the coalition and helping to integrate public health into business organizations. One of the reasons cited for success is that public health has been a member of the coalition and also an active Board member. The Board participation also includes representation from Medicaid and a safety net hospital.

Over time the Coalition has been successful in getting more grant dollars from private and public sources in part due to the participation of public health. This helps with the issue of dues from members such as public health.

The Coalition has benefitted from the fact that Rex Archer had public health training in Michigan and worked for the private sector for a major automaker for several years. He came to the coalition understanding the business language. One area in which he provided help was in getting coalition members to understand there is no “health system” but an illness system in the United States. This was a major breakthrough to move the conversation to “health” from “healthcare”. Marti Macchi clearly brings energy, skills, and experience with an ability to work with all coalition stakeholders in the implementation of initiatives. Marti’s background in the private sector has added to her capacity to integrate the worksite into programs. The Coalition provides the “glue” to the private sector for collaboration on both prevention and chronic disease control. This collaboration affords the opportunity to approach system wide change with a macro marketing approach.

The Coalition has provided access to claims data for public health and is also supporting the development of creative approaches with the state as an employer. Membership dues are an issue for public health with coalition membership, especially in the current economic climate. The Coalition has been more successful over time in obtaining funding from grants so programs can be developed and not totally dependent upon membership dues for support.

Memphis

Cristie Travis, Memphis Business Group on Health; Yvonne Madlock, Memphis-Shelby County Health Department; Connie Binkowitz, Memphis-Shelby County Health Department; and Susan Cooper, Commissioner, Tennessee Department of Health, represented the Memphis area community health partnership. The Business Group is a separate entity with an employer only

structure through its Board and membership while providing leadership and support to the Healthy Memphis Common Table (HMCT), a broadly based multi-stakeholder group. There is also a regional health council sponsored by the public health officials in which MBGH participates. Some of the initiatives from the business coalition include:

- Sharing results of the common request for information, eValue8 (an endorsed tool available through NBCH), sponsored locally by MBGH with public health to be able to review collectively performance from all health plans
- Coordinating with public health on the application of value based benefit design principles, especially for diabetes and tobacco use cessation program using evidence based information
- Facilitating performance measurement and public reporting as a principle of value based purchasing and collaborating with public health and HMCT for a core measurement set
- Consumer engagement alignment with HMCT and public health for common messaging, coordination, and complimentary reinforcement in settings where people work, play, or worship

With increasing regional responsibility, the relationship with the Coalition—and HMCT—has created an opportunity to grow the public health constituency and to increase the understanding of what public health does and can do. The relationship is evolving over time with intersections at common points of interest. In the mid 1990s, a local Hepatitis A outbreak led public health to go to MBGH to help get information out to employers. The role of public health is seen as having the greatest affinity for the underserved and vulnerable populations. Trust and mutual respect have been established. A need is for the business case for population health and terms and language that is understandable to the various stakeholders. Opportunities have evolved with more understanding of each other. Based on a community assessment, the initial priorities were established for HMCT. This is now being advanced to work with neighborhoods that have identified an issue as well as ways to integrate with employers.

At the state level, government understands the value of public-private partnerships. This is exemplified by the support for common metrics, emergency preparedness discussions, and a strong health council that includes the CEO of a very large global business headquartered in Memphis. The “Get Fit Tennessee” program offers on line tools to aid business—especially smaller employers. The Coalition is a great liaison to the employer community and provides an entrée to employers. The investment in this relationship is now beginning to see evidence by the request for public health and business to be involved in appropriate initiatives and discussions with the view that the health of the community includes the economic engine that business provides.

New York City

Laurel Pickering, New York Business Group on Health; Dorothy Rick, NYC Department of Health and Mental Hygiene; and Sylvia Pirani, Director, Office of Public Health Practice at the New York State Department of Health represented the New York area community health partnership. One immediate fact that helped with the newly formed partnership in New York is

the fact that Laurel is very open to working with public health in part due to her experience in earning her Masters Degree in Public Health. NYBGH has regularly been asked to represent business in various planning and discussion including those related to specific conditions as well as Healthiest State initiatives.

The current relationship with NYBGH and the NYC public health department evolved through a common alliance with the National Association for Mental Illness (NAMI). NYBGH was working with NAMI to begin an initiative on depression—a project that developed as an outcome of findings from the employer use of the eValue8 tool to measure health plan performance. NAMI was aware of an initiative being planned by the public health department. NYBGH invited public health officials to their planning meeting with employers and determined that collaboration would benefit both organizations—as well as potentially advance improvements in population health. NYBGH would benefit from the common development communication materials and credibility the Department would add as well as by their participation on the NYBGH oversight committee. NYBGH was able to bring the health plans to the project. The public health initiative grew out of results of assessment data and support from the mayor for “Take Care New York” that highlights 10 areas for intervention with goals for improvement. Working with business expands the breadth of the initiative.

At the state level, with the complexities of 58 health departments, the challenge is how to engage business statewide since there is not a statewide business health coalition. The value of moving the focus on population health to other sectors is understood as a great potential benefit. The name for the NYC public health and NYBGH depression initiative—“One Voice”—received many positive comments during the meeting for how well this describes the collaboration. This initial initiative between public health and the Coalition in NYC shows the possibilities for additional group efforts. Getting through the organization maze is an important factor as well as clear takeaways for the members that are actionable. The universities and schools of public health can help with resources. NYBGH now has an intern from Columbia working in their offices.

Virginia

Barbara Wallace, Virginia Business Coalition on Health; Nancy Welch, Chesapeake Health Department; Laura Wimmer, Virginia Department of Health; and Jeff Lake, Deputy Commissioner for Community Health Services, Virginia State Health Department represented the Virginia community health partnership. VBCH has a long history of leadership in convening groups on health and medical issues as well as prevention and health promotion and is presently a sub grantee for a state level project. One area that makes the Virginia environment more complex is the complexity of the organizational structure under the Dillon rule with layered health districts due to the government structure of cities, towns and counties. The realities of the economic times are helping with the evolution of this relationship and implementation of jointly supported programs. Employers have been slow to take action. In the initiative in Virginia, public health has worked within the funded program parameters and extended the relationship to VBCH initially for information dissemination then to actual worksite group input that is being used to develop a replicable program and tools for all size employers. Language with business and misconceptions about public health were noted as part of the relationship building process.

The suggestion in this partnership was to think more in terms of a “merger” with a balance sheet for the stakeholders using the value definition for business. Another observation is that health can also be addressed by all size businesses in the “built” environment with an example of walking and walkways. Better data analysis including visual representation—by geographic area for example—and the realization that epidemiologic data is not the “business speak” were also mentioned. Virginia also has a Council on Virginia’s Future which is co chaired by government and business leaders. Public health and “health” need to be part of the fabric of this type of council. Commonalities were observed more than differences. On the education front, a suggestion was made that the MPH programs be retooled to include practice management with public health instructors. Part of the evolution of this relationship between the Coalition and public health began by two leaders coincidentally being neighbors who met through community related activities.

Discussion Summary

Both the facilitated and open discussion provided a rich and open response to the questions posed by each of the facilitators and a lively dialogue with all the participants. Highlights are noted below.

Value of Public Health Relationships with Business Coalitions

The value of the relationships between public health and business coalitions was noted in numerous ways with significant gains. These gains include shared resources, increased ability to scale change opportunities, networking, sustainability of projects and initiatives from gained knowledge and resources, added credibility, and good citizenship. The ways in which these relations have evolved is also varied as demonstrated by the participants with overlapping interests, grants and financial support, subcontracting or similar resource programming, self interest, “right thing to do”, mutual interdependency, synergy from public health, entrée point to employees, and increased viability with employees cited as reasons for the development of these relationships. Both public health and business expressed an understanding of the increased power, visibility, and credibility from speaking with “one voice” as well as the potential to maximize the points of common interest. Discussion evolved to the recognition for the need for public health to “take and get credit” perhaps thinking as a “merger” approach to intensify the program/connection and even co-brand. All partners need to share both successes and disappointments equally. Participants noted the need for all to show value collectively and individually to their constituencies.

The group noted the following as reasons to use time and resources to develop these relationships:

- Shared resources
- Scalable change
- Overlapping interests
- Motivators include: financial support, grants, “corporate good citizenship” or “right thing to do”, business case or concrete information
- Incremental, sustainable, replicable
- Networking

- Enhanced visibility of issue and message
- Expertise
- Added credibility and co-branding (with certain audiences)
- Improving employee health and health of community as a whole is good for business
- Grants and support and opportunity to generate other funding and resources
- Identification of overlapping goals (“finding the sweet spot”)
- Mutual interdependency and mutual failing if we are not working together effectively
- Basic synergy
- Opportunity for public health to send messages and disseminate information
- Mutual interdependencies
- Alignment and access to various audiences (“power of the voice”)
- Realization of the time individuals spend at workplaces
- Renewal of energies that may have leveled off over time—infusing new energy
- Access to and use of materials and information already available
- Realization that no one employer can have an impact on the health care delivery system without collaboration with others.

Lessons Learned

Following the discussion on the reasons for business and public health to come together, common lessons learned, including barriers and ways to overcome these obstacles, participants provided information from their experience including how they met by serving on committees or task forces together and that being together in these groups provided an opportunity to learn how to work together. Giving credit and acknowledging support and cobranding were all noted as important to the relationships. Lessons learned mentioned during this segment of the meeting:

- Building on working relationships from other venues allows participants to learn about each other and how to work together
- Recognition or “giving credit where credit is due” helps to solidify the relationship
- Co-branding, such as the example from NYC with “One Voice” is valuable or the “Common Table” from Memphis
- Learning from each other and being creative about a wide range of tools
- Overcome the expectation that either public health or business automatically has dollars to contribute
- Respect the resource commitments and restraints of partners
- Partner to get resources including potential joint grant monies
- Energy from groups can bring life into or revitalize projects
- Identify who to call to begin the connection and ways to set up meetings and make these links are critical areas where training and resource help may be useful including suggested questions and agenda that will help to discover overlapping interests, evidence based solutions to needs, data that helps to define common problems, etc.
- Significance of having public health as a member of the coalition and perhaps a board member or advisory to the board
- Necessity to take the conversation beyond “health coverage” and “health care system” issues to reach the *health* conversation

- Learning the language and terms of employers is important as part of the homework for public health officials as well as finding places where business can “fit” with current projects by broadening these initiatives with purchaser based leverage from employers
- Understanding that employer representation can be from human resources, employee benefits, medical department, or other functional area within a company
- Value of enhanced visibility, credibility, co-branding, and perspectives for an issue or message as well as resources
- Public health must work with business to engage people where they spend their time
- Equal partnership, shared credit, maximization of resources, access to additional resources (ex. Foundation or other grants)
- Need to put egos and other individual issues aside for the common goal(s)
- Civic good is a driver and a motivator
- Developing projects take seed grants and resources to develop relationships
- Illustrating an issue and how it directly impacts employers makes it easier to engage business
- “Merger” has a stronger feel than collaboration or partnership
- Being together at the same time provides an opportunity to identify potential collaboration
- Serving together on committees or being at meetings provides a chance to learn how to work with each other and to help identify connection points
- Co-branding is critical and is of great importance for public health as well as business
- Increased potential to get grants with collaboration (ex. Private foundations may have restrictions on funding public health and many government grants may be available only to public health)
- Understanding of “language” differences and what each party can realistically bring to an initiative (ex. Business does not have lots of resources)
- Need to reinforce the value of working together
- Access does not equal health
- Merit of bringing in the state or municipality as an employer with the health department and encouraging public health to model value based purchasing principles

Discussion included probing participants on “how to” start the relationship. Suggestions included setting up an initial discussion with the lead from local public health (or business coalition) to learn about their organization and agenda. This discussion will help to lead to the identification of overlapping interests or needs. Public health has evidence based solutions to business and employer needs as well as data. The conversation identified that a common interest is population health—employees and community wide. The business case for community wide needs to be defined. Another issue is the fact that “access to health insurance (or coverage)” does NOT assure health. In creating the dialogue, participants recommended that public health learn the language of business. Public health officials represent the health of the entire community—not just those served in the medical model or underserved.

Strengthening and Sustaining Collaboration Relationships

The needs to start, strengthen and sustain the collaborative efforts of public health with business coalition's discussion identified a number of areas for information and process needs. These include:

- Necessity of just sitting down and strategically planning the reason to work together along with the possible ways of participating with one another through boards and committees, membership for public health with the coalition perhaps with service on the coalition board with or without voting privileges
- Need for quantifiable return on investment and good case studies
- Sharing knowledge especially public health's insights and evidence based solutions perhaps as a tool kit for coalitions to use with their employers
- Identification of evidence, with examples, of how an employer can reduce their overall spending on employees based on wellness and prevention programs
- Evidence and reasons for business engagement in broader public health activities
- Clarity for the roles and reasons for engagement by each stakeholder along with examples that also incorporate the impact of public policy (ex. Tobacco free cities or food labeling requirements for restaurants) as well as worker productivity
- Recognition of the evolutionary process to develop understanding, trust, and shared vision
- Develop good case studies about how public health and business have worked together
- Formalizing the relationship as a critical element for sustainability
- Joint fundraising
- Conduct a strategic planning session to identify "low hanging fruit" and longer term opportunities
- Develop and use tool kits from community experiences or subjects to learn from others
- Create a state level leadership council with all stakeholders and try to raise funds from external sources to support the council and its activities
- Convince the state as an employer to engage with the business coalition
- Reexamine potential expansion of participants and use of eValue8 data
- Make the business case to the coalition Board of Directors about statement of benefits of engaging with public health and population health
- Understand the continuum of health and the connection between public/community/health and employee health
- Joint strategic planning

Additional debate on the business case for employers identified the need to look at both health and productivity aspects with examples –and data—from cost differences with communities that have better health status than others. Another issue is the potential for short term business focus versus longer term that reinforces the need to define interim goals and measures. Participants pointed out the complexity of engaging employers when most coalition members are from Human Resource organizations within their company and getting to the "c suite" is necessary for real sustained commitment. This conversation further reinforced the need to determine what roles each stakeholder—especially employers and public health—can take on at the various stages of progression of a Community Health Partnership. Defining a continuum and evolution

with a flexible approach to participation and a multi faceted approach to actions was concluded to be a way to look at developing tools and information that would be helpful.

Suggestions for NBCH, ASTHO, and NACCHO

- Guidelines for coalitions on how to get involved and why
- Business case and case studies
- Help bring Alliance for the Healthiest Nation to the local level—customized community messages, collect and disseminate local best practices, and help make connections
- Consider a focus point such as children born in 2000 will be first generation impacted by current actions and goals
- Emphasize inclusiveness of the Alliance for the Healthiest Nation—a role and action for everyone
- Support a link from the Alliance to community based web sites
- Provide information on how U.S. ranks internationally in terms of health status and how this translates to business competitiveness
- Look internally at your own organization and then mobilize communities (ex. Healthy foods policy, tobacco free sites, etc.)
- Recognize that difference size employers behave differently and provide tools and information that is relevant to the audience
- Include as many voices or perspectives as possible
- Incorporate membership from local and state government—recognize where decisions are made
- Provide evidence about how community efforts make a difference including the role of policy
- Develop descriptions or examples of the different roles that public health and business (and other stakeholders) might have at various stages
- Build a set of tools and information that can be used at all stages of the evolution of community health partnerships

Alliance for the Healthiest Nation and Community Health Partnerships

The three initial members are the Association of State and Territorial Health Officials (ASTHO), the Centers for Disease Control and Prevention (CDC), and the National Association of County and City Health Officials (NACCHO). The Alliance is actively engaging partners from a variety of fields—public health, medicine, third party payers, business, purchasers, policy, government, and academia—with the following vision:

An integrated national system where the participants value health and work together to achieve optimal health for all. A comprehensive system that priorities prevention, and protects people and communities from emerging threats.

The three specific routes to making the U.S. the healthiest nation, using a grass roots approach – complementary with the “tops down” efforts already underway-- are to:

- Change the debate from a focus on “healthcare” with its discussions of access and cost to a more proactive, prevention focused national discussion on “health”

- Change how we define a successful system...from measuring disease and “unhealthiness” to tracking measures of health
- Engage the users of the system where they live, work, shop and play, providing specific actions that they can take immediately to create the healthiest home, healthiest community, etc.

The Alliance addresses the total impact of health, not just the 97% of the dollars that are spent on health care, by considering the social determinants of health and health equity and the health of employees is a critical asset to business. The discussion at the meeting centered on where there are points of intersection for alignment with the Alliance for the Healthiest Nation. Ideas discussed:

- Customization of the Alliance for the Healthiest Nation to local community
- Integration with healthiest state or city
- Ability co-brand with the Alliance
- Benchmarks and goals for the Alliance
- Illustrations for actions that would be useful for the Alliance for the Healthiest Nation
- Connection of the Alliance to employers

Discussion concluded that the Alliance for the Healthiest Nation would benefit from the parallel effort of environmental sustainability and needs to move from an intellectual conversation to one where mobilization and action are demonstrated.

Next Steps for NBCH, ASTHO, and NACCHO

NBCH, ASTHO, and NACCHO are taking this input from the field developed through this meeting along with findings from their own memberships—NBCH member inventory for example—to determine a relevant set of next actions. Based upon initial discussion by the three organizations, the following activities are expected over the next 12 to 18 months. ASTHO, NBCH, and NACCHO are committed to work together to help develop and sustain Community Health Partnerships by modeling effective communication and collaboration at the national level.

Following are the major areas for next collaborative activities for the three national organizations:

1. Encouraging and supporting the growth and continuation of Community Health Partnerships by the following:
 - Development of a set of materials to include recommendations and support information for the continuum of stages of community health partnership focusing initially on assistance for early stage needs

- Support the development of new relationships by helping to identify potential partners from current information such as the NBCH member inventory and encourage the growth and expansion of existing relationships
 - Conducting a meeting in November 2009 to bring partnerships together for joint education and training with the opportunity for networking and to introduce the seed grant program
2. Developing a framework for the business case for community health partnerships with alignment with existing initiatives such as the Alliance for Healthiest Nation and the National Quality Forum
 3. Planning and developing a “seed grant” program to support Community Health Partnerships
 - Development of the criteria, selection process, evaluation, oversight, and administrative processes
 - Fundraising to support program
 - Communications for the program for fundraising support and resource development, proposal application information, and ongoing program activities
 4. Continuing to align with Alliance for the Healthiest Nation

Appendix

Mid-America Coalition on Health Care—Working with Public Health

Summary

The Mid-America Coalition on Health Care (MACHC) has a long relationship with public health, as participants, advisers, and as MACHC members. The Director of the Kansas Health Policy Authority, the Health Director for Kansas City, MO (and former president of NACCHO), and the CEO of the region's safety net hospital have positions on the Board of Directors. Public health concepts and resources underlie virtually all MACHC projects.

About Mid-America Coalition on Health Care

The Mid-America Coalition on Health Care is a 30 year non-profit collaboration of employers and all components of the bi-state Kansas City region's health care delivery system. It has 60 members, representing over 500,000 lives. The MACHC's mission is to improve the health of employees and their families, promote employee and community wellness and illness prevention, develop strategies and initiatives for containing business health care costs, and generate and communicate health care information to the community. The MACHC accomplishes its mission through the collaboration of major employers and *all* healthcare delivery stakeholders (physicians and medical societies, health plans, hospitals, public health, academic institutions, labor, bi-state governmental units, and pharmaceutical companies).

Mid-America Coalition on Health Care and Public Health

The MACHC has a strong history of partnering with local, state, and national public health organizations. This mutually beneficial relationship is built on the recognition that both partners have overlapping interests in improving population and community health, especially in worksite settings.

In 1998, the MACHC partnered with the Kansas Department of Health & Environment to assess the health risks of a representative sample of 45,000 employees and dependents in eight member companies. The Behavioral Risk Factor Surveillance Survey tool was administered, and the aggregate results were analyzed by Mercer, Inc against the goals of *Healthy People 2010*. This survey has led employers to participate in a series of different initiatives over the past decade.

Community Initiative on Depression (CID)

In 2000, the Coalition partnered with the American Psychiatric Association on the Community Initiative on Depression, focused on the human and financial costs of depression – both one of the most prevalent and most undiagnosed diseases in the workplace. The CID followed a public health model, working with worksites, clinicians, researchers and the larger community. It engaged 15 employers collaboratively with health plans, clinicians, universities, local health departments, local and national mental health associations, community organizations, the media, national academic researchers, various components of local, county, regional, state and national governments, and pharmaceutical companies.

Although this project concluded in 2005, many efforts continue: A representative of the MACHC co-chairs the APA's Workplace Mental Health Advisory Board and sits on AHRQ's depression-

focused Technical Expert Group in the Evidence-Based Practice Centers. The CID has been cited by a wide range of organizations (including the Institute of Medicine, SAMHSA, and the Robert Wood Johnson) as a leading community approach to depression.

Community Initiative on Cardiovascular Health and Disease (CICV)

The second project based on the 1998 BRFSS survey was the Community Initiative on Cardiovascular Health and Disease (CICV), started in 2005 in conjunction with the departments of health of Kansas and Missouri and the Centers for Disease Control and Prevention. Fourteen employers (over 120,000 lives in the Kansas City area) collaborated with providers and public health partners to address ways to reduce CV risk factors across worksite, clinical and community settings. The four-year initiative focuses on hypertension and hyperlipidemia (the CDC's two priorities), as well as smoking, obesity, nutrition, and physical inactivity,

Grounded in the CDC's *Heart-Healthy/Stroke-Free Worksite Toolkit*, baseline surveys were taken to assess corporate leadership support, employee attitudes and risk factor knowledge, health plan benefit design, and environmental support for reducing CV risk factors. Key intervention areas include leadership support, environmental improvement, clinical risk rating reduction, benefit design, and data integration. Employer progress from baseline is being reviewed using the comprehensive data sets developed in the MACHC's new Value Based Benefits project (below). For clinical settings, a Web-based Toolkit was developed to educate/activate the healthcare community to address gaps in coordination of care for patients with Acute Coronary Syndrome. In the community sector, a HeartSafe Communities model is being piloted with the Kansas Department of Health and Environment in a large and a small community to increase CPR/AED education and AED placement, and to develop policies to reduce delays in seeking treatment.

The CICV has been designated the CDC's national pilot for its *Heart-Healthy/Stroke-Free Worksites Toolkit* and is cited as its "best practice" project. Through the CICV, the MACHC is represented on a wide variety of State panels including the Kansas Governor's Council on Fitness, the Missouri Council on Activity and Nutrition, and the Missouri and Kansas Heart Disease and Stroke Prevention Advisory Boards.

Value Based Benefits / KC²

The employer data shortcomings uncovered in the CICV have spurred a parallel track focused on Value Based Benefits, growing to 17 employers (over 462,000 lives). The MACHC's public health partners are participating as both employers and as health experts. They believe the project tools and learnings could be adapted by State health agencies to deliver health and wellness programming to small and mid-sized companies in communities without an employer-driven coalition. KC² is the national VBB pilot for the National Business Coalition on Health.

Additional Public-Private Partnership Activities

In addition to these projects the MACHC has conducted two projects focused on the medically indigent and uninsured (through the Robert Wood Johnson Foundation and the Mid-America Regional Council) and one on hospital quality reporting (cited by CMS as its "poster child for quality matters.")

More details about these projects, and other work of the Coalition, are at www.machc.org.

Lessons Learned and Observations

The Mid America Coalition on Health Care has established an excellent relationship with public health and has benefited from its tools and expertise. The MACHC recognizes and incorporates the strength of public health partners in such areas as community planning, health promotion and education, evidence-based best practices, evaluation, and replication of successful initiatives. Lessons learned and observations for this exceptional example of collaboration by a coalition with public health include the following.

- Use of established tools—e.g., BRFSS (Behavior Risk Factor Surveillance Survey) and *Business Strategies to Prevent Heart Disease and Stroke Toolkit* (www.cdc.gov/DHPSP/library/toolkit/)—developed by public health expedites the assessment and intervention planning processes.
- Public health has access to population and community health data valuable to employers in planning and measuring interventions. Their epidemiologists can be a vital resource.
- Tools and information from public health support the “sell to business” that the MACHC develops to help with employer education, and they support initiatives focusing on the hidden costs of health (e.g. the medically indigent) that business pays for indirectly.
- Mutually beneficial relationships can best be built over a long term series of demonstrated successful relationships, each building on trust and respect and the alignment of common agendas.
- Broad project approaches focus on worksite, community, and health providers. This builds on public health and “health policy” concepts to frame the project in business-related terms and actions.
- State and local public health and the CDC can provide resources, tools, subject matter experts, and funding for projects.
- Coalitions can provide public health with insights into worksite health issues from the perspective of employers and access to laboratories for health improvement initiatives.
- Planning should include detailed work plans, interim and longer term goals and measures, ongoing progress reporting to stakeholders, and defining stages for the evolution of projects.
- Engagement of both parties “demystifies” public health for employers and adds a public health construct to each project and dialogue.
- Public health partners have multiple resources for incorporating evidence-based best practices into coalition projects, many of which are no or low cost .
- Successful coalition projects can be replicated by savvy and “entrepreneurial” public health representatives in small and mid-sized communities which do not have coalitions or sophisticated employers focused on improving employee health status.
- Coalitions provide leadership to expand the dialogue on such important community issues as emergency preparedness to include the business sector

Memphis Business Group on Health 2008 – Working with Public Health

Summary

Memphis-based employers decided to work together to achieve cost containment, monitor quality and influence the development of a competitive health care market in

Memphis by establishing the Memphis Business Group on Health in 1985. The mission of the Memphis Business Group on Health is to facilitate the purchase of efficient and effective health care services for the Memphis community. MBGH participated in other community based initiatives that helped lead to the development of the Healthy Memphis Common Table. MBGH has now moved its major project support for health improvement to the Healthy Memphis Common Table. MBGH determined that the most effective way to address health and health care improvements is through collective action with other stakeholders. MBGH continues to provide a forum for the business sector while also working with community stakeholders.

About Memphis Business Group on Health

In 1985 seven Memphis-based employers decided to work together to achieve cost containment, monitor quality and influence the development of a competitive health care market in Memphis. To accomplish this, they formed the Memphis Business Group on Health (MBGH), a 501c (3) not for profit organization. Today, MBGH has 37 members and affiliates that employ approximately 50,000 in the greater Memphis area. The mission of the Memphis Business Group on Health is to facilitate the purchase of efficient and effective health care services for the Memphis community. In order to accomplish this mission, MBGH members believe that:

- employers should be active in the development of the health care delivery system;
- providers should be held accountable for the quality, satisfaction and cost of services they deliver;
- accountability is reliant upon the collection, reporting and use of appropriate information; and
- Employers should use such information to select high performing providers.

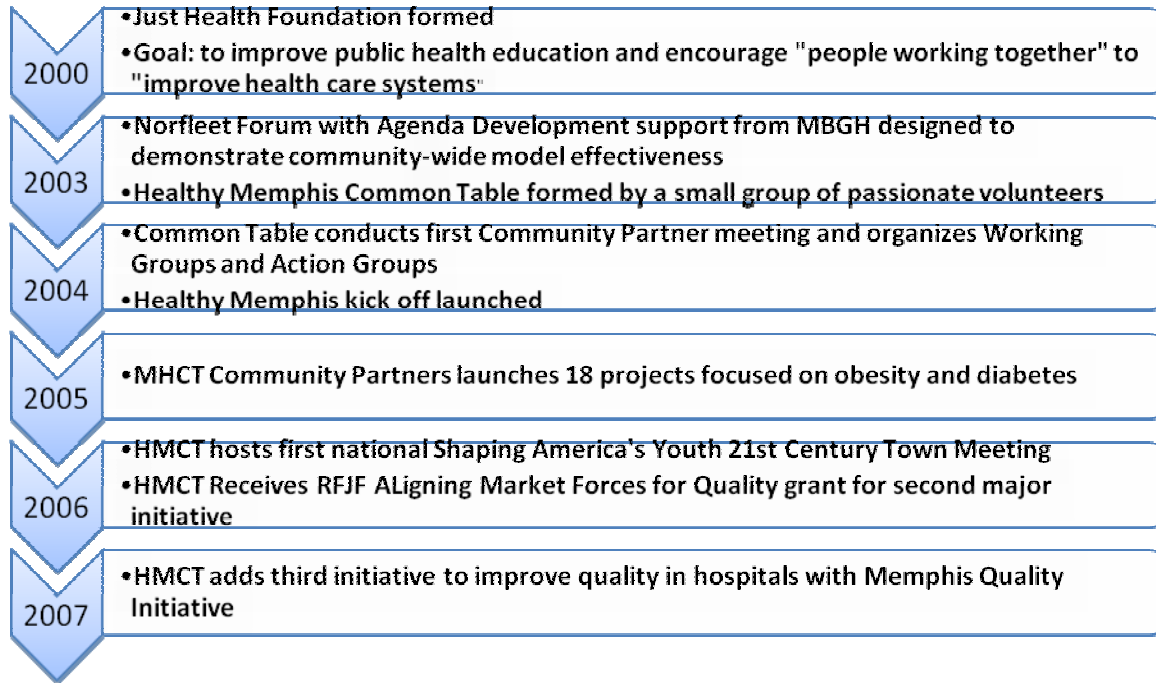
MBGH supports value based purchasing for its members with information, competitive choices, and utilization management, and provides staff support for worksite wellness for employee health. The history of involvement in community initiatives is based upon the coalition's principle that employers *should be active in the development of the health care delivery system.*

Memphis Business Group on Health and Public Health

MBGH has had public sector employers as members for years including City of Germantown and City of Memphis and has been actively engaged in the community. This history of active engagement in the community has included the consistent message for the need to organize around projects with common approaches to specific measurable goals and objectives for evidence based activities that can be evaluated and results shared throughout the community. This coupled with the recognition that business needs to be directly engaged in health care quality improvement for the

community, MBGH participated in other community based initiatives that helped lead to the development of the Healthy Memphis Common Table.

The following chart summarizes the development of Healthy Memphis Common Table. Memphis Business Coalition on Health was engaged in every step.



MBGH has moved its major project support for health improvement to the Healthy Memphis Common Table. MBGH determined that the most effective way to address health and health care improvements is through collective action with other stakeholders. This has allowed MBGH to benefit from broader engagement and to in turn bring expertise and the employer purchaser perspective to the joint efforts which has helped with funding from private foundation grants. In 2007, NBCH was able to support the MBGH by providing meta leadership training for the MHCT leadership group.

The four initiatives of the MHCT that involve MBGH and public health are:

- Reversing the increase in obesity and diabetes by 2008 (the original mission when MHCT was established) involving all levels of input and action with all stakeholders
- Engaging consumers, providers, and payers to improve quality through public reporting of performance on key measures of outpatient quality of care in a project that is part of the RWJF Aligning Forces initiatives
- Hospital quality improvement collaboration under the Memphis Quality Initiative
- Chartered Value Exchange development beginning with identification of needs and involvement of stakeholders in this information collaboration

Lessons Learned and Observations

These extraordinary collaborative efforts with leadership from the Memphis Business Group on Health have shown the following:

- Necessity for longer term commitment by business leaders to deal with reality of the time and effort involved in developing the relationships that allow these stakeholders to work together effectively
- Identifying and understanding the value of community wide projects as compared to those that could be done by the business sector coalition only
- Need for examples and information for business to understand and support this long term commitment to community including how this benefits the business sector
- Call for creative approaches to engage all community stakeholders and ways to involve stakeholders at multiple levels including the development of trust
- Fact that these initiatives are sustainable with commitment and resources aligned around a common agenda
- Complexity of measures to show community wide improvement and direct attribution of project efforts to those improvements with need to look at a variety of measurement approaches such as self report surveys as well as clinical measures
- Amount of effort to maintain the group and the six working groups, many actions teams, and projects
- Importance for alignment around common goals with recognition that various stakeholders also need their own group for networking, education, and input into the agenda

New York Business Group on Health – Working with Public Health

Summary

The New York Business Group on Health has a long history of education and collaboration including a major initiative with the Mayor's Office in the development and ongoing management and administration of health insurance products for small business. The most recent NYBGH collaboration with the public sector is with the New York City Department of Health and Mental Hygiene to promote screening for depression by primary care practitioners. The Collaboration additionally includes the City, NY County Medical Society, NAMI-NYC, and all health plans in the area. The goal of the project is to increase the number of persons appropriately diagnosed and treated for depression.

About New York Business Group on Health

Founded in 1982, the New York Business Group on Health (NYBGH) is a not-for-profit coalition of 150 businesses and is the only organization in the New York Metropolitan area exclusively devoted to employer health benefit issues. NYBGH functions as the forum for businesses to explore contemporary healthcare issues and find practical

resolutions. Members include employers and health-related organizations. The mission of NYBGH is to provide leadership and knowledge to employers to promote a value-based, market-driven healthcare system.

NYBGH addresses health issues through initiatives in quality, cost, access, education, and collaboration with the goal for cost effective quality healthcare in the tri state area. NYBGH on worked with the public sector through the NYC Mayor's office on the development of a set of health insurance options for small businesses in NYC as one major effort of joint collaboration.

New York Business Group on Health and Public Health

NYBGH has been a leading coalition in the use of eValue8 with its members. eValue8 is an evidence-based request for information tool to assess and manage the quality of health care vendors. The eValue8 tool uses a standard annual request for information survey to gather hundreds of benchmarks in critical areas such as adoption of health information technology, member and provider communications, disease management, program administration, provider performance, patient safety, pharmacy management, behavioral health and financial stability. The results from eValue8 showed a very low rate of identification of depression in the working population of its members compared to the overall work age population data. The analysis of claims data reported by individual NYBGH members – combining employer claims data for health, mental health, prescriptions, and lost work time related claims – showed a high rate of prescribing for selective serotonin reuptake inhibitors (SSRIs), class of [antidepressants](#), as well as a high loss of productivity associated with mental health. The combination of this low rate of identification and diagnosis plus the high costs associated with mental health led to the creation of a NYBGH task force on Mental Health. NYBGH task forces are working groups of members who plan programs and activities for the entire membership.

The NYBGH Mental Health Task Force was formed as a response to the increasing awareness of the impact of mental health issues on employees' health and productivity. An initial focus of the Task Force is depression based on information gained through [eValue8](#) and other sources that indicates that many people with depression are not being identified and are not getting appropriate treatment. The group's work in depression is focused on:

- Increasing awareness
- Decreasing stigma
- Promoting screening with consumers and physicians
- Advocating for appropriate referral and treatment
- Providing employers with information and resources to address the issue at the worksite

The NYC Department of Health and Hygiene had a campaign called “Take Care New York”. “Take Care New York” is a comprehensive health policy that sets an agenda of ten (10) key areas for intervention. It recommends coordinated action on evidence based interventions by health care providers, city agencies, businesses, public/private partnerships, and individuals. The initiative included information about depression with encouragement for consumers with the question *have you asked your doctor for a simple test for depression?* The NYC Department effort included a public health campaign with the encouragement for patients to ask their physicians who in turn promoted the need for a common screening test to be used by physicians as part of their practice.

With the two complimentary projects, NYBGH invited public health members to their Task Force meeting. The discussion at that meeting with both groups led to a joint collaboration to focus on increasing screening for depression in primary care. NYBGH was able to get all the area health plans to participate. The current project is the “One Voice” initiative in which all the New York Metro health plans have agreed to collaborate on sending a single, common message to physicians promoting depression screening with the PHQ-9. This initiative is working in conjunction with the New York City Department of Health and Mental Hygiene’s Depression Initiative.

The next step is to address the need to align reimbursement to promote this screening and treatment improvement. The City will also working with medical clinics that provide significant care to the Medicaid population.

The NYBGH Executive Director, Laurel Pickering, is also a member of the NYC Department of Health and Mental Hygiene Advisory Council that advises the Commissioner of the Department.

Lessons Learned and Observations

- Lessons learned and observations from the coalition perspective include:
- Both employers and public health have common areas of interest
- Using common tools and measures – such as the same screening tool – across all stakeholders is an important factor in addressing the solution
- Employers can benefit from the common messaging and broad reach of public health communication campaigns
- Employers add to total health measurement (direct and indirect costs of both health care and productivity) to the public health perspective
- Coalitions can build on existing relationships (such as with the health plans) and past experience with other initiatives
- Value of public health engagement needs to be demonstrated to the employers
- Public health can benefit from the purchaser perspective and measurement approaches
- Coalitions and public health need to have effective ways to identify common areas of interest.

Virginia Business Coalition on Health Working with Public Health

Summary

Virginia Business Coalition on Health (VBCH) has worked with community health initiatives involving the public health sector with a broad range of initiatives and with other stakeholders engaged in the programs. VBCH collaboration has included activities from dissemination of public health information to the business community, to running a program that provides training for professionals in prevention and early intervention of children's health, to being a partner through a sub grant with the Department of Health on a project focusing on the prevention of stroke and cardiovascular disease, and serving for two terms on a State Planning Grant (SPG) commission for "Covering the Working Uninsured". This work and leadership by VBCH support its mission to represent the business sector in solutions to improve health care access and quality and reduce cost.

About Virginia Business Coalition on Health

The Virginia Business Coalition on Health (VBCH) is a non-profit, founded in 1983 under the name of the Hampton Roads Health Coalition. Since 2006 it has since expanded Virginia-wide and has a membership of more than 70 purchasers - small, medium and large alike, in both the private and public sectors of communities throughout Virginia - representing more than 200,000 employees and their dependents. VBCH, a mixed-model coalition, is represented by at least 70% the 'employer' community, and with no more than 30% representing the provider community of hospitals, health plans, benefits professionals and the pharmaceutical industry ...believing that all parties working together provides the best solutions in health care quality and cost.

The Virginia Business Coalition is committed to improving the quality of health care. VBCH is a Virginia Roll-out Leader for The [Leapfrog Group](#) which publicly reports hospital quality and patient safety data, since 2003. VBCH also collects and compares data on nine health plans in Virginia through the [eValue8 RFI Tool](#) since 2006. Just recently, VBCH engaged two of its member businesses, City of Chesapeake Public Schools and Chesapeake Regional Medical Center in the implementation of Health Map RX, a diabetes care management program, for its' employees. VBCH engages in community quality improvement, [education](#) and communication, and [workplace wellness](#) and health promotion.

VBCH, through membership with the Stanford Heart Network at Stanford University, provides **HeartBiz** a cardiovascular risk identification, risk reduction and lifestyle intervention and modification program. Tools include a Cardiovascular Risk Assessment (CRA) for a heart attack or stroke in the next 5 to 10 years along with "personalized" tips and education for improving health with the ability to track risk reduction over time. In the VBCH pilot CVD study, member employer City of Virginia Beach City Public Schools and the consolidated City of Virginia Beach with their combined 16,000 employees participated in a primary prevention 3-month longitudinal study using the **HeartBiz** risk assessment tool, face-to-face clinical sessions and a nurse case-management model. Participants had to have two or more risk factors of the six CVD risk factors—smoking, high cholesterol, high blood pressure/stress, physical inactivity, overweight/obesity, and diabetes. Virginia Health Quality Center provided data analysis for the

project which demonstrated the potential-- based upon the three month trial—to significantly impact the health and quality of life if offered to all employees. More at www.myvbch.org

Virginia Business Coalition on Health and Public Health

The Coalition is involved through its public service project (Square One Children's Health and School Readiness) to provide training for professionals in prevention and early intervention and children's health. This initiative started 10 years ago with support from local and federal agencies as a regional collaborative. It is thriving today with support from local municipalities, community foundations and higher education.

These efforts plus the HeartBiz project have helped pave the way for a sub grant for VBCH with the Virginia Department of Health. The Department has a 5 year cooperative agreement for chronic disease management with the CDC. VBCH works with the Program Manager for Cardiovascular and Stroke Prevention, VDH Division of Chronic Disease Prevention and Control, and is a member of the Virginia Healthy Pathways Coalition established by the Virginia Department of Health. The Healthy Pathways Coalition is initially focusing on Prevention of CVD, assuring alignment with the Centers for Disease Control and Prevention's (CDC) Heart Disease and Stroke Prevention Program Priorities. VBCH is a strong partner representing the business sector. VBCH's CEO represents the National Business Coalition on Health and Virginia Business Coalition on Health on the National Diabetes Education Program (NDEP) Business Health Work Group which promotes diabetes information and education for all sectors via a website sponsored by NIH and CDC.

Lessons Learned and Observations

The following are lessons learned and observations from the expanding relationship between VBCH and public health.

- Relationship building takes time to build trust and to establish an understanding of what each party can bring to the relationship
- Staff changes impact the relationship as new stakeholders—from either business or public health—need to learn about the other
- Engagement in planning benefits the relationship by increasing the understanding of what the initiative means in terms of implementation tasks and developing roles and responsibilities appropriate for the stakeholders
- Public health funding helps to support the resources needed by the coalition for the initiative(s)
- Public health brings clinical expertise and information to the initiative that can be used to benefit both the coalition and the community
- Prevalence data provided by the Health Department can help business to tailor projects. This data is generally set up by health district so requires some manipulation to correspond to cities and counties.

- Complexities of government structure must be addressed for successful community partnerships. Virginia is one of 8 states that actively operates under the Dillon Rule * which adds another challenge to the collaborative efforts among large metropolitan regions. Under this rule, cities are not part of counties but stand alone and cities, along with some counties, have charters that set out their specific governmental powers.

Meeting Attendee List

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